to which the district general hospital model has never been subjected. The Green Paper[1] stated its support for general practitioner hospitals if they can be shown to be cost-effective; this has to be a research priority, alongside clarification of their potential clinical role and a willingness on the part of planners to follow through the consequences of such research.

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The specialist contribution to the care of the terminally ill patient: support or substitution?

THE provision of terminal care in the community today is one of the most difficult subjects to discuss. It may be worthwhile to look at the origins of the hospice movement and the reasons for the foundation of the various cancer help organizations. His Royal Highness, the Prince of Wales, has described Dame Cicely Saunders as the 'Mother Superior of the hospice movement' and undoubtedly she was a pioneer who has done a great deal to promote good terminal care. She herself said that the hospice movement was developed to look after both people dying from cancer and the smaller group of patients suffering from advanced multiple sclerosis. However, the picture is now very different. Many hospices have as their main aim the care of people 'until the time is right for them to come to the hospice' and have created home care services linked to the hospice. A multi-million pound movement has grown from a foundation concerned with the pain control of patients dying from cancer.

The Registrar General's figures indicate that on average a general practitioner is involved with the death at home from malignancy of fewer than two patients a year with another four of his patients dying from cancer in hospital. Even if all of the general practitioner's patients dying of cancer did so at home this would still make up a very small part of his work.

Home care services have been established on the assumption that most patients would prefer to die at home and the only reason they do not do so is that there is not enough help available. Now that these services exist they should be used as a resource in the community. However, some thought needs to be given to their activities in order to maximize the advantages and minimize the disadvantages.

Any seriously ill patient who wishes to remain at home has both emotional and physical needs. In the National Health Service, the general practitioner is well-established as the choreographer of patient care. This role is crucial when considering the home care of the terminally ill. The first decision that must be made is whether the patient can stay at home. Is there enough physical professional support to back up the emotional support that the home environment is said to provide? The general practitioner's knowledge of local services is invaluable in making that decision. He will know the range of nursing, social and voluntary services available in the area.

In many parts of the country the general practitioner now has access to a community terminal care team. Like any other resource, these home care services need to be evaluated. Unfortunately, services for the terminally ill have mushroomed in a disorganized fashion based on demand and not on need. Teams range from home care services of long-established hospices providing 24-hour, seven-days-a-week multiprofessional cover to isolated nurses acting in an 'advisory capacity' with no back-up resources.

Audrey Ward, in the report for the Nuffield Foundation,[1] looked at the effect of home care services on home deaths as a percentage of total deaths three years before and three years after a home care service was established. No dramatic impact from the intervention of a specialist team was observed.

It is important that the home care teams be given clear objectives so that they can be readily assessed. It is also important that the members of the teams are part of the caring network and liaise effectively with their primary and secondary health care colleagues. Every patient who is dying and wishes to do so at home needs a medical assessment, a nursing assessment and a social work assessment. Thus it could be said that comprehensive care can only be provided if all three modalities are available 24 hours a day.

There is a danger that this concept of terminal care implies that such care can only be provided by an experienced specialist

team. Such a conclusion would progressively undermine the skills of other primary and secondary health care colleagues in this area of work. There is also a danger that the label 'terminal care' implies that the treatment has changed in some way, that the drugs are used differently and 'more time is needed', that 'counselling is needed' and that all these tasks can only be done by 'caring' and special people. The care of many terminally ill patients does present a challenge, necessitating a good knowledge of the action of drugs and a clear idea of which profession can offer the best help. But this is by no means true for all patients. We work in a unit which has a referral rate of some 600 patients and families a year and such experience enables us to understand the more difficult problems and recognize the rare syndromes associated with terminal malignancy. Indeed, one of the main medical objectives is to make sure that the presumed diagnosis is correct.

We suggest that there is a need for regional units, as in many other specialties of medicine, which the general practitioner can use as he feels fit. Domiciliary visits can be made by team members with the general practitioner to provide help and support and not necessarily with the aim of taking over the care of the patient. Only in this way will the lessons learned by a specialist team who see many such patients a year be transferred to the general practitioner who only sees a very small number. It is never necessary for the team to take over the care of a patient unless that is what the patient and his practitioner wants. It is time that it became recognized that the majority of terminally-ill patients are well-treated, few are mishandled and only a few cause problems. Perhaps we should remind ourselves that it is better to help a colleague with a difficult case than to tell him he is wrong and that he should make way for the expert.

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Pharmacists and primary care

TRADITIONALLY, the local chemist was a respected figure who was consulted about many minor ailments. The advent of free medical care for all in 1946 eroded the consultative role of the pharmacist and the reduction in the need for medicines to be compounded by pharmacists simultaneously lessened the emphasis on practical pharmaceutics. Since then, medicines have become more effective, more complex and, potentially, more dangerous and pharmacists now have a greater role in double-checking the doctor's prescription and in instructing the patient about his therapy.

A degree in pharmacy has been a mandatory requirement for entry to the profession since 1970 and indicates a level of scientific training in the use of medicines that is superior to that of medical graduates. The potential of pharmacists as a health service resource is much underestimated by the medical profession.

General practitioners should be aware of the recommendations of the Committee of Inquiry into Pharmacy appointed by the Nuffield Foundation.[1] Their report makes far-reaching suggestions for increasing the contribution of pharmacists to health care, both in hospital and in the community. The recommendations which are of direct relevance to general practice are concerned with the active involvement of community pharmacists in the clinical care of patients, both independently and in conjunction with general practitioners.

The independent role envisaged for community pharmacists is a professionalization of their traditional role of giving advice. It is suggested that the existing system of remuneration be changed to resolve the potential conflict between the pharmacist's commercial need to sell medicines and his professional role in advising and guiding the patient without necessarily recommending a medicine. Pharmacists who contract to provide advisory services (free at the point of use under the National Health Service) would be required to have adequate facilities for confidential consultation. In the long term, undergraduate and postgraduate education of pharmacists would be adjusted to provide for a greater clinical input (including behavioural sciences).

Although general practitioners may view these proposals with concern, their effect is likely to increase the appropriateness of patients' requests for consultations with their general practitioner while formalizing and improving an advisory service which already exists. Issues of status and inter-professional rivalry must not be allowed to obscure the benefits to patients that would result from more efficient deployment of the expertise of pharmacists in certain aspects of patient care. Pharmacists are aware that their comments on prescriptions are sometimes resented by the doctor and regarded as implied criticism or meddling. Increased collaboration would reduce these misperceptions.

The computerization of prescribing at all levels (pharmacy, general practice and health authority) has created unprecedented opportunities for collaboration in patient care and in operational research. We will fail our patients if these opportunities are not grasped. The Nuffield report deserves the fullest possible support from general practitioners.

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