We should not ignore the major part which primary care is currently playing in prevention and health education. All general practitioners are already involved in advising patients who are or consider themselves to be at risk of HIV infection. In its evidence to the Social Services Committee, the College pointed out the crucial role of general practitioners in preventing the spread of this epidemic. Education of the public and of health professionals is the only defence we have against HIV infection. Mass education campaigns will need to be complemented by personal advice. Only general practice can provide this personal service to the whole population.

If educational programmes for general practitioners are to be effective, there needs to be close cooperation between health authorities and the regional committees responsible for postgraduate medical education. Voluntary organizations such as the Terence Higgins Trust have taken the lead in providing practical help, counselling and support for people at all stages of the infection and general practice needs to establish links with these organizations so that we can use their experience to ensure the best possible support for infected patients.

Support will also be needed for general practitioners and others in the primary care team. It is likely that the uneven geographical distribution of AIDS cases will continue and a heavy burden will be placed on teams working in areas of multiple deprivation, who are already under strain through lack of resources coupled with high demand.

The challenge posed by AIDS is immense. General practice plays a central role in the health care system of this country and general practitioners need help in preparing to meet this challenge. The College has set up a working party to identify and report on the needs of general practitioners in caring for patients with AIDS. The editor of the *Journal,* Dr Graham Buckley, has accepted an invitation to be the convenor of the working party and members of the College are invited to write to him at the *Journal* office to give their views on the role of general practitioners in caring for those with, or at risk from, HIV infection and AIDS and to outline their own educational requirements.

To burn out or to rust out in general practice

NOW that a generous but mandatory retirement age may be introduced fewer general practitioners will 'rust out' in the job. However rust out may be less of a problem than 'burn out'. Burn out in the caring professions is defined as the 'loss of concern for the people for whom one is working in response to job related stress'[1] or as a 'psychological withdrawal from work in response to excessive stress and dissatisfaction'.[2]

Three stages of burn out have been described.[1] The first is an imbalance between the demands of work and personal resources, which results in hurried meals, longer working hours, spending little time with the family, frequent lingering colds and sleep problems. The sensible response at this stage of job stress is for the professional to take stock, seek advice and reorganize his or her life and practice.

The second stage involves a short-term response to stress with angry outbursts, irritability, feeling tired all the time and anxiety about physical health. The informed response to this stage of stress is to get away from it all by going on a course, a short holiday or letting someone else take the strain for a while.

A few progress to the third stage of 'terminal' burn out which creeps up insidiously: the sufferer cannot re-establish the balance between demands and personal resources. The burnt out professional treats individuals in a mechanical way, goes by the book, is late for appointments, refers to patients in a derogatory manner and uses superficial, stereotyped authoritarian methods of communication. This stage has many of the characteristics of 'bad' doctors, and is seen too in social workers, nurses and clergy.

All caring professions are particularly prone to burn out and the Americans have taken to studying it with enthusiastic openness. American doctors have not been quite as reticent as British doctors about having their profession studied.[3] British general practitioners have faced job stress from the point of view of their wives[4] and its effect on families,[5] but as yet there is only scant recognition of the effect of stress on working style.[6]

New doctors are high achievers used to academic success. Those who enter general practice find the emphasis is on dealing with people rather than diseases. For some, this is a professional *volte-face.* They encounter the human dramas and dilemmas of patients and may find apparently few of the emotionally neutral intellectual challenges of diagnosis for which they were trained.

Nowadays vocational training creates expectations of certain standards in general practitioners. The practice that the new principal joins may deviate considerably from the standards set by vocational training. The new general practitioner may try to accomplish too much too soon, alienate his colleagues and find his plans blocked. This is a classic scenario for burn out, which thrives on frustration. Too often new principals are unprepared for this form of frustration; indeed they may not realize that their own appointment was a major step forward for the practice and that the practice now needs time to adjust. One study has revealed that 36% of new principals were having such serious problems with their senior partners that they were thinking of leaving.[7] The study also found that some of the new principals were fearful of mentioning change to their senior partners and many were unaware how to effect change anyway. This study illustrates the factors without and within the individual which predispose to frustration and lead to job stress.

Patients of course contribute to job stress. Doctors look after many distressed people for whom medicine can do little. Patients who are unable to marshall the motivation to extract themselves from undesirable situations may be the very stuff of general practice to some doctors but deeply frustrating to others.

Caring professionals learn to ration their compassion in order to be effective.[8] Some doctors may need to be advised to become emotionally a little detached for their own sake. It is a useful tactic for each individual to reflect on how he or she copes with stress. As general practitioners become more organized and efficient their daily lives may be packed with more and more internal deadlines which leave little time for reflection and breaks. Many doctors' work spills over into their half-days and holidays, which may be fine for them but bad for their families.

What is the difference between burn out and workaholism, touchiness or depression? Workaholics enjoy their work, using it to avoid deep or intimate contact with other people and they maintain tight control over their lives. Some doctors are of course constitutionally touchy while others become touchy in response to stress. It is the chronic nature of burn out, however, that distinguishes it from transient touchiness. There is undoubtedly overlap between burn out and depression, both of which need professional help.[8] It is here that a helping hand may be had from the new National Counselling and Welfare Service for Sick Doctors.

Partnerships are now the norm in British general practice yet many doctors work more in confederation than in true partnership. Partners may not meet as a group for mutual support, problem solving or policy making. The daily deadlines may isolate each partner and the confederation rolls on from its own momentum. The conventional wisdom about a successful practice was that the partners must never socialize outside work and that they must keep their spouses out of practice affairs. This distrust may be a legacy of the past which we need to dispose of. All the evidence is that general practice is becoming more complex and we can hardly afford to spurn each others support inside or outside work.

One particular problem is that burnt out doctors often have nowhere to go because mid-career shift is not common in medicine. General practitioners reach their financial high point early, around

30 years of age; in a non-hierarchical structure general practitioners have few career goals to strive for. Partnerships, like all groups, may have a natural lifespan. Practice vacancies should not be the preserve of the newly qualified vocational trainee nor should the experienced general practitioner applying for a practice vacancy be viewed with suspicion as such an exchange may invigorate the doctor and the old and new partnership.

It has to be admitted that we do not know the extent of the problem of burn out: it may be just American hype. Still there are many similarities between the burnt out and the bad doctor and the figures for alcohol problems in general practitioners are not receding. It would be sad if we ignored burn out; it is an aspect of bad doctoring that can be prevented or arrested in its earlier stages and understood in its later stages.

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Useful address: National Counselling and Welfare Service for Sick Doctors, 3rd Floor, 7 Marylebone Road, London NW1 5HH. Telephone 01-580-3160.

The dying child at home

IN recent years there has been increasing interest in the care of the incurably ill and dying child. A children's hospice, Helen House, has operated in Oxford for four years[1] and another near Leeds, to be known as Martin House, will open during 1987. Recently national meetings to discuss the provision of terminal care for children have been sponsored by the King's Fund Centre[2] and by Help the Hospices. Children's hospices have also been discussed in the correspondence columns of *The Times.*[3] As might be expected there is complete agreement that whenever possible the dying child should be cared for in his own home. When this is not possible the child could be cared for in the paediatric ward of his local district general hospital. Children's hospices can help to meet the extreme needs of a few families but in the UK no more than two or three such establishments can be justified.

Much of the work on home care of dying children has been carried out in the USA[4,5] but there have also been contributions from the UK.[6] General practice has played little or no part in the current debate on children's hospices or in contributing to the published work. Perhaps this is not surprising as few general practitioners have responsibility for more than one or two terminally ill children in their entire careers. On the other hand all family doctors spend a large part of their time dealing with children and some time dealing with the terminal care of adults at home. In all practices children die every year from accidents and in the perinatal period. These areas of work provide experience which family doctors should draw on when required to assist families caring for their dying child at home.

Adequate nursing support and a concerned and committed doctor are invaluable to a family managing the illness of their child at home. Indeed, in the absence of one of these factors it is unlikely that they will be able to cope at home whatever other resources are available to them. Although many general practitioners are willing to provide this support, our experience at Helen House suggests that others are either unable or unwilling to help in this way. Some families have lost trust in their doctor and feel unable to approach him, while others have been denied help.

Martinson and Enos[7] have identified six conditions which must be met before successful terminal care at home is possible:

- Cure-oriented treatment has been discontinued and the emphasis is on care and adding quality to life.
- The child wants to be at home.
- The parents desire to have the child at home.
- The parents, other children in the family, and/or significant others recognize their own ability to care for the ill child.
- A nurse is available and willing to be on call 24 hours a day for professional consultation and support.
- The physician agrees with the plan and is willing to be on call as a consultant to the nurse and to the family.

The general practitioner may be involved in deciding if terminal care at home is possible. His contribution will be especially important if he has remained involved with the child's care from the time of diagnosis. A child's attendance at a regional or national centre for specialized treatment does not reduce the importance of the family doctor and should not be used as an excuse for lack of involvement. In all cases the provision of nursing and medical cover in the home will depend greatly on the attitude of the doctor and the primary health care team. This care demands a commitment which cannot be limited by rotas but equally must be shared so that no single person — parent, nurse or doctor — feels isolated.[8] The control of pain and other symptoms in the dying child is less well documented than for adults but practical advice is available.[8-10]

In some health districts nursing cover can present problems. In the best circumstances a community nurse with paediatric training will work closely with the general practitioner and the health visitor. Macmillan nurses trained in the terminal care of adults can often make a valuable contribution. In less fortunate health districts community nurses with paediatric training may not be available. This is a disadvantage but is not insuperable as what is required is basic nursing care and love.

Much of the interest in quality assurance in general practice has concentrated on the provision of the major services which form the backbone of general practice. If we are to give due weight to quality then this word must also be applied to infrequent episodes such as terminal care in childhood. The families of dying children do not ask for specialist expertise but for help with the control of symptoms and the mobilization of community services. Above all they ask to be listened to and acknowledged as the experts in the care of their own child. This is work which primary care teams could be undertaking more often than seems to be the case at present.

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