system and the patients are sure of getting a nurse whom they know, and this is of enormous importance in the lessening of anxiety to relatives. This surety of always being able to talk to someone you know gives confidence to the family, and this confidence prevents abuse of the system. We had expected that perhaps people would ring up unnecessarily in the night but it has not proved so. Our staff comprised two full-time State-registered nurses, now expanded to three, and one part-time nursing auxiliary. In addition a part-time social worker, occupational therapist, and physiotherapist have always been available for help and advice, together with the Hospice medical staff, who can be consulted at any time.

Liaison Service

The value of this liaison service between the Hospice and the community can be gauged, firstly, by the welcome and relief expressed by patients and their families; they frequently say, "I feel so much safer now, I feel I am not alone now." Secondly, through the use of the clinic made by district nurses, who appreciate having someone to talk things over with. Thirdly, by the increasing number of general practitioners referring patients directly to the outpatient clinic because, they say, "You have so much more experience in these matters." This is not that they abandon their interest in the patient by any means but they have recognized that we have something to offer in teamwork with them, and perhaps I might say for emphasis that I worked with about 600 general practitioners. Fourthly, by the number of hospital medical social workers who ask for domiciliary support for a patient who wants or has to be discharged from an acute ward until he requires terminal care.

The most important factors contributing to the success of this hospital-based domiciliary service are the continuity of care and the good communication existing between the treating hospital, the general practitioner, and the Hospice—together with adequate assistance and support in the home. Without this the whole thing falls. Now continuity of care involves the supervision of the patient by someone familiar with the treatment and the drugs used in the control of his symptoms. How often does one hear the fear expressed by a patient that the new doctor may not know what pills the patient has been on, or that he cannot take such and such a drug?

The custom of bringing patients back to the treating hospital for follow-up appointments when no further active treatment is considered is well meant but misplaced. A dying patient finds such visits exhausting; he does not always see the same doctor and continuity of care becomes progressively less. And I think if we are honest we will say that we see this very frequently. The reason for the follow-up appointment is so that the patient should not feel abandoned. But if a consultant can refer his patients to a unit such as ours, there is no sense of abandonment, only one of progression from one caring unit to another, and because the patient lives in our locality his general practitioner will be known to us personally and our communication with him will be direct and specific. But communication with the general practitioner is not always very easy particularly after hours (that is, after 7 pm and at weekends) and in this I speak with sad experience. Again the night-call system used by many London practices whereby a mobile doctor can be directed through a central bureau to an emergency is the bare fulfilment of an obligation, not I submit good medical care. The patient and his family feel abandoned by the doctor whom they know.

Night nurses are in short supply and although most areas have some form of night nursing service frequently this offers no more than a late night visit for injections and "tucking down." The Marie Curie Memorial Foundation gives grants to local authorities to be used at their discretion for the employment of night nurses for patients suffering from cancer. This system operates well in some areas, but less than well in others. Nursing aids urgently needed for the dying are not always as readily available as they should be. Domestic help is woefully

inadequate, particularly for lack of funds but also for lack of people. The burden of the care of a dying patient at home is heavy, especially for the elderly—who do not easily accept a stranger into the home.

The financial problems in nursing a dying patient at home are considerable. Invalid diet means higher food bills. There are numerous chemist's items, increased heating costs, and loss of wages, either those of the patient, or of the relative who has to give up work to nurse him. Supplementary Benefits, National Society for Cancer Relief grants, rent rebates, Income Tax relief, and the Attendance Allowance need either a declaration of resources—which many people are unwilling to give—or the fulfilment of certain strict requirements. Methods of applying for such aid are often so complicated and cumbersome that the relative feels unable to cope.

Re-housing or minor structural repairs may make all the difference to a patient being able to stay at home, and die at home if he so wishes. But the machinery for obtaining these is geared to the healthy with time to spare. The deliberations of the various committees involved can be so protracted as to be useless or too late for the dying.

Better liaison between hospital and community is very much part of our present thinking. The experiment in which I have participated during these past three years has shown how close this liaison can be, how greatly the patient benefits from such a liaison—and what satisfaction it can bring to all who participate.

St. Christopher's Hospice, London S.E.26

MRS. B. J. McNULTY, S.R.N., Sister in Charge, Outpatient Clinic and Home Care Programme

Local Government Services

W. MITCHELL

It is better to die living than to live dying. Thus the needs of the dying are very much those of the living, and every resource should be made available to all who want to die in their own homes. Idealistic I may be, but we must strive towards it; otherwise apathy will allow a less ideal situation to prevail.

Although I do not live directly in the area of which St. Christopher's is the centre, I am in the area that their arms stretch out to. So I am very well pleased that if ever I am in the position of needing help I know where to go. There are centres where such excellent care is not given. There is, for example, much criticism of domiciliary care, understandable because from area to area it varies tremendously. The National Council for the Single Woman and her Dependent did a survey some time ago which showed up just these variations. I thought originally, when I sat down to write this, that in 1974 when the reorganization of the health services takes place these problems will be cured. Unfortunately a lot of dying people are going to need the support of the domiciliary team before that date, and proposals must be made for a reliable service after that date.

Domiciliary Team

I see the organizational domiciliary team as Cogwheel Care of the Dying. Various disciplines participate. There must be a drive wheel to set the train of cogs in motion. The cogs as I see them are initially the hospital, nursing, and medical social work team—they know the present and future needs of the patient. The local health authorities have the facilities to provide for certain of the needs. The G.P. provides medical care and support for the family and the social workers and the voluntary services play a

very valuable supporting part. The drive cog, however, must be somebody who can be easily contacted by the hospital, told of the patients discharged, and can visit the home and assess the problems and the needs of the patient and family without intrusion. A member of the caring team who has the necessary experience could well be the health visitor. In many areas she performs this task already for geriatric patients, and to extend it to the care of the dying seems logical.

For a domiciliary team to work effectively and efficiently they must be told in advance about the patient's need. A 'phone call from the ward sister, the general practitioner, or health visitor can start the drive wheel. Having assessed the needs by contact with the patient, the hospital, and the G.P.—by visiting the patient's home and by talking to the relatives—one is made aware of what is needed. Arrangements can be made for what is necessary from the local health authority—such things as day and night nursing services; perhaps help with cancer patients from the Marie Curie Foundation; a sitting service; a laundry service; Meals on Wheels—provided by the local health authority or the voluntary services; bathing services and disposable dressing service; loan of special beds or physical aids. From the social service department arrangements can be made for home helps and the valuable social workers' supportive help; any adaptation to the home that is necessary can be made before the patient's discharge.

Many of you may well be thinking that half these services are either non-existent or scanty in your area, and this is why I stress the importance of the 1974 reorganization. Area health authorities must be told that they are expected to provide a certain laid-down minimum for the care of the dying, and for the incapacitated. Incidentally, I find it very difficult to differentiate between the dying and the incapacitated. At what point do you die? If we do not think of the pre-terminal and the terminal phases together people are likely to fall through the net, and it is perhaps in the pre-terminal phase that they need the help so desperately—even more perhaps than in the terminal. The local authority should be told that their social services directorates must provide a certain laid-down minimum of services required by the area health authority. This is so essential now that home helps have been taken out of the health field.

It is somewhat sad that some of the services so essential to the needs of the dying have to compete with roads and libraries for finance from the rates. Having been the chairman of a health committee, I have had the experience of having to argue for what I considered were essential services against the cases put by my fellow chairman for perhaps libraries, or roads, or whatever it was. I found I never knew the strength of the cases they were putting up.

National Standard of Service

There must be a national standard of service. It must not be so patchy that if you live, for example, in one London borough you can get all the services I have mentioned, but if you live around the corner or across the road in another borough you can get hardly any of them. If the supportive services are available, the family will feel better able to cope with a dying relative at home and be more prepared to do so.

The voluntary services have a much greater part to play in care of the dying than perhaps many professionals think. All these organizations tend to work in isolation and with little communication with each other in some areas. Because of this and for the good of the community which they so ably serve, there is a need somewhere to tie the strings of communication. At the moment voluntary services are brought into the picture of the care of the dying or the incapacitated by their own bush telegraph—the G.P., the health visitor, the district nurse, or—as I have been told—even the milkman. Some hospitals now have voluntary service organizers, but I should far prefer to call that person a co-ordinator. The voluntary services co-ordinator has an invaluable part to play, and I hope that in 1974 she or he

will be acting as co-ordinator of the voluntary services that care for the dying in the community as well. It should be made obligatory on an area health authority to employ such a co-ordinator.

If the voluntary services co-ordinator knows the capabilities of the people involved, she or he can assure them that they will be usefully employed. There are many people in the community who have special qualities. Although they do not want to join any of the organizations such as I have mentioned, they would willingly apply to the voluntary services co-ordinator. It may be only calling in to see a dying patient once a week, perhaps giving encouragement in a particular interest or hobby that that patient has. The volunteers have got time: time to listen, time to sit with the knowledge that what they are doing is worthwhile. Sometimes in a less practical sense they have more to give the dying patient than perhaps the professional with many others to care for.

London Borough of Greenwich

MRS. W. MITCHELL, S.R.N., S.C.M., Former Chairman of Health Committee, Member of Central Health Services Council

Four Recurring Themes

K. R. O. PORTER

Four points have recurred throughout the whole course of today's discussion; let me identify them for you. The first is a new attitude. As a doctor, one is, I think, frequently thrown back on one's training as a medical student. And the way one was taught—certainly, in my day—there was no room for terminal care. It was the attitude of: "I am sorry, there is nothing more that I can do for you." It is of course true that we have got to try and cure as frequently as we can, but I think there are three aspects to medical care: to cure, sometimes; to alleviate, often; to support, always. If we can get that over to the people who are working with us in the care of terminal illness and to those under our care, then I believe something will be achieved.

One approach is the personal approach to care in hospitals—the setting aside of special beds and the establishment of special units for terminal care, and this is my second point—where people should die. I personally favour the wish of probably the bulk of people to die at home, among those whom they love, in familiar surroundings. But some will inevitably die in hospital, some will die in private nursing homes. I am a great believer in the pattern of a special unit where the real problems of the care of the dying can be handled. There may be centres of excellence, such as Cicely Saunders has described at St. Christopher's, but what we really need is to develop more small specialized units where the very tiny proportion of people who require special facilities can be cared for. Let us take, for example, the South-east, where my own regional board is. We have already started along this road: assuming we know for a fact that in the South-east we have 9,300 deaths a year from malignancy—that of course does not cover everything—and assuming that half of these cases will die at home under relatively tranquil well-supported circumstances, probably about 10% of those will require the care of special units. In our area for the population we have, for the number of deaths we have, something around 80 beds will be required. Clearly we have got to make sure that these units are not too big. We have got to make sure that the units are close to the patient's own homes, so that frequent visiting is possible and the beds can be used intermittently by patients who may be admitted and then returned back home again—perhaps several times. In national terms, somewhere around 12 beds per half-million population would be a good start towards meeting the need. These units cannot be built