however, that the evidence supports routine amniotomy or the early use of oxytocin.

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Care of dying patients in hospital

Palliative care teams have helped

EDITOR,—It is disappointing that Mina Mills and colleagues make no comment in their paper on the care of dying patients in hospital about changes that may have led to improvements in the past decade.¹ Their study showed a lack of nursing care for dying patients, but whether this poor standard of care was applied to all patients admitted to hospitals in the study is not clear. For example, what was the standard of care for patients with stroke or other chronic disability? A similar study performed 10 years after the original would have been useful in showing any improvements or otherwise in practice. Nursing care may still be a problem, but perhaps this reflects general attitudes and staffing levels rather than a specific failure to address the needs of dying patients.

Several reasons exist for assuming that change may have occurred since 1983. In 1987 the Department of Health issued a circular directing district health authorities to examine their provision of services for dying patients.² It was in this year too that palliative medicine became a recognised medical specialty. A substantial increase in Macmillan nurses has occurred, from 260 in 1984 to 1200 in 1994 (personal communication, Cancer Relief Macmillan Fund). Parallel to these changes has been an increase in hospital palliative care or support teams, from 13 in 1983 to 216 in 1993.³

To conclude that "we need to identify and implement practical steps to facilitate high quality care of the dying" without a brief discussion of the role of hospital palliative care teams shows an ignorance of current practice. As well as organising education for nursing and medical colleagues these palliative care teams try to help patients identify symptoms that distress them and work with the patients and staff to resolve these whenever possible. A recent paper showed the effectiveness of hospital teams in establishing early contact with dying patients and linking them with palliative care resources in the community.⁴

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Things have improved

EDITOR,—Mina Mills and colleagues paint a grim picture of the quality of care of dying patients in Scottish teaching hospitals in 1983.¹ They

conclude by exhorting the medical profession to "implement practical steps to facilitate high quality care of the dying" and to transmit the knowledge and skills of the hospice movement into all settings. While we agree that these findings are still relevant to current clinical practice, we believe that the situation has improved in the 10 years since the study was conducted.

The engine for change within hospitals has been the spread of the hospital support team. The first hospital support team was started at St Thomas's Hospital in 1978.² The *Directory of Hospice and Palliative Care Services* for this year reports that nearly 240 hospitals have support teams or support nurses.³ The purpose of the support team is to provide the skill learnt from the hospice movement in general hospitals. Support teams work. Hockley *et al* reported how the provision of a hospital support team at St Bartholomew's Hospital produced a considerable reduction in the number of complaints received concerning care of dying patients.⁴

We work in a Macmillan support team in a London teaching hospital. When the team started in 1987 we saw 342 patients a year. In 1993 the team saw 442 new referrals. By working alongside the other consultants in the hospital we provide informal education for staff and disseminate the skills of palliative medicine beyond the confines of hospices. The support team also provides a more formal educational role: all medical students, nursing students, and house officers are given instruction in the care of dying patients. Only by education and example can the horror stories reported by Mills and colleagues be avoided. We believe that the growth of the hospital support team has gone a long way to achieving these objectives.

More work needs to be done, and there is no cause for triumphalism. Many hospitals still do not have support teams. The need for skill in palliative care is not restricted to oncology patients but extends to all patients experiencing distress in their terminal illness. The standard of medical and nursing care provided to dying patients in hospital certainly needs to be improved, but hospital support teams are an important way of achieving this.

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Guidelines may have improved care

EDITOR,—Mina Mills and colleagues' report on the care of dying patients in hospital fails to mention changes that have taken place in Scotland in the 11 years since their study, particularly in relation to patients dying of cancer. Guidelines on palliative care for patients with cancer have recently been published jointly by the Scottish Partnership Agency for Palliative and Cancer Care and the Clinical Resource and Audit Group of the Scottish Office Home and Health Department.² They emphasise the importance of several factors that were clearly missing in the four hospitals surveyed by Mills and colleagues—namely, an approach that focuses on the patient, good communication, and teamwork. The guidelines have been commended to health boards and NHS trusts by Scotland's chief medical officer, and a recent programme of one day conferences organised by the Scottish Partnership Agency presented the guidelines to purchasers, providers, and practitioners and

initiated discussion about implementation at local level, including the development of local protocols. The Scottish Partnership Agency is committed to continuing to work for the implementation of the guidelines across the country.

The Scottish Partnership Agency was set up in 1991 to bring together statutory and voluntary bodies involved in palliative care for patients with cancer in Scotland. Since then the importance of providing palliative care, not just at the terminal stage of illness but alongside care at an early stage, has been increasingly recognised. Scotland's hospices and specialist palliative care units are in the forefront of providing education and training so that their experience of caring for terminally ill patients can benefit people who do not need their specialist skills but nevertheless have the right to a far higher standard of care than was found by Mills and colleagues.

Many health care professionals are now keen to provide the holistic care that the authors found to be missing, and this represents a vital shift in attitude since the study was conducted. These professionals need to be provided with the opportunities for training, the support, and the environment in our general hospitals to enable dying patients and their families to receive the highest possible quality of care.

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Care may not be recorded in the notes

EDITOR,—One of the most striking findings in Mina Mills and colleagues' study of the care of dying patients in hospital was the discrepancy between the nursing care given to the patients and the care recorded in the nursing notes.¹ This discrepancy seems to be an everyday occurrence a decade after the study was carried out. The present working practices of nurses, especially those more academically qualified, promote paperwork at the expense of patients' care. My nursing colleagues have pointed out how frequently an inverse relation exists between the quality of the documentation and the quality of the nursing care received by patients. It is to be hoped that clinic audit will address this issue more widely.

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Carers need support

EDITOR,—Mina Mills strikingly illustrates the isolation of patients dying in hospital, particularly their minimal contact with both medical and nursing staff as death approaches; this contact was so short that on occasion it could be measured in seconds.¹

Greater thought needs to be given to what keeps caring professionals away. In my experience as an observer on a palliative care unit, helplessness in the face of death provokes such anxiety that professional carers develop defences against it.² Resorting to technology and disease "labelling," busyness, performing routine procedures such as taking pulse and blood pressure may all be seen as defences that are attempts to distance professionals from recognising their own horror at death's