

## References

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## AIDS — preventing a pandemic

Sir,  
Acquired immune deficiency syndrome (AIDS) is a disease complex caused by a recently discovered pathogen, human T-cell lymphotropic virus type III (HTLV III).<sup>1-3</sup> It is believed that this virus has been transmitted to humans from a primate reservoir and is spreading with no natural defences to combat it.<sup>4</sup> HTLV III is closely related to a group of retroviruses that cause fatal illnesses in sheep, horses and goats; the plasma and blood of affected animals remain infective for life and mortality rates reach 100%.<sup>4</sup>

The first cases of AIDS were reported in sexually-active male homosexuals in New York and this has led to it being branded by the popular press as the 'gay plague' and labelled by professionals and lay public alike as a sexually transmitted disease confined to the deviant sectors of society. This misconception is both naive and dangerous — AIDS is a blood-borne disease similar to hepatitis B in its epidemiology and mode of transmission and is confined at present almost exclusively to male homosexuals, intravenous drug users and people who came into medical contact with contaminated blood and blood products. Homosexuals are particularly at risk owing to the trauma caused by anal intercourse, giving an increased risk of blood inoculation — 50% of male homosexuals acquire antibodies to hepatitis B within two years of becoming sexually active.<sup>5</sup> In the UK screening for HTLV III positive serology has revealed a prevalence of 17% in male homosexuals at risk and of 1.5% in intravenous drug addicts.<sup>6</sup>

It has been shown that 1 x 10<sup>-7</sup> ml of plasma infected with hepatitis virus will transmit the disease.<sup>5</sup> If hepatitis B is a true model for the transmission properties of the AIDS virus, AIDS would appear to be readily transmissible on multi-use non-sterile medical needles and similar instruments (for example, acupuncture needles, tattooists needles), by electrolysis in beauty salons, ear piercing and by non-sexual contact between cuts, sores and

abrasions of carriers and healthy people. In 1967 Ringertz and Zetterberg reported an increased risk of transmission of hepatitis B in cross country runners — events were conducted through forests where runners sustained minor cuts and abrasions to their exposed arms and legs.<sup>7</sup> The authors concluded that hepatitis B was being transmitted by direct contact from one wound to another, either by multiple wounds caused by a single twig or by communal bathing in stagnant pools.

At present it is fashionable for men to wear ear-rings, the practice of tattooing is common and the lower socioeconomic classes and intravenous drug abusers often live in crowded unhygienic environments. These are the circumstances that favour the transmission of blood-borne diseases to the general population. Once established these diseases can spread rapidly unless preventive measures are taken. Government policy must therefore call for a ban on multi-use electrolysis, acupuncture and tattooing needles and tighter controls on the practice of ear piercing before it is too late.

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## Quality in general practice

Sir,  
As doctors, much of our time is spent in simplifying matters which seem complicated, and throwing light where they are obscure. *Policy statement 2. Quality in general practice* fails to do this at several points.

*Quality assessment.* This term is now

associated with attempts to measure outcome — what in other fields of work would be called quality control — and has alienated some doctors within the College as well as many more outside. To these doctors, measuring the unmeasurable seems like arrogance or idiocy. More than 30 years ago Peterson<sup>1</sup> concluded that the variables defied measurement and that improvement is more likely to accrue from consideration of the nature of the future doctor. The College has acknowledged this in the *What sort of doctor?* report but the statement does not make this difference clear. A change of jargon to, say, 'performance improvement' might at least have helped.

*Professional development.* If a doctor has been licensed and vocationally trained, he should be fit to practise. If he is not, either the undergraduate training or the vocational training is at fault and needs revision. The universities are responsible for the former, and the JCPTGP for the latter.

It is an impertinence, and is seen as such, for the College to assume a responsibility for which it has no statutory authority. And its judgement in claiming such responsibility is doubted by doctors who know the unmeasurable outcome of their efforts to be more important than their ability to pass examinations, however intelligently planned.

The College's responsibility is to help the doctor (as by the *What sort of doctor?* friendly peer review) whose training has been deficient. At least, having originated the idea, it has the authority for that.

*Practice teamwork and management.* Shared ideas and experience in this area have been on offer for a long time now. They should not be imposed, at least until the desirable differences between practices have been explored. Practices serve both communities and individuals, and in neither are any two alike. We have paid scant heed since Lees and Cooper<sup>2</sup> drew this to our attention more than 20 years ago.

*Accountability, incentives and resources.* Paragraph 53 on data and technology (from the previous section) should be linked to paragraph 58 in this section. Systematic operational data at all levels should be gathered, in the view of most doctors, 'to say what resources are needed to run family practitioner services'. If these resources are supplied in terms of time and tools, encouragement through *What sort of doctor?* patterns may make good the defective training.

There is much commonsense in the policy statement, but most of it has been seen as such already. One wonders, therefore, if more time for reflection would have been valuable and perhaps resulted in a more mature philosophy. The flavour of the statement is of frustration

and slightly confused assertion, a mistrustful desire to centralize authority. It is disappointing and it will not do.

Perhaps the 60-odd doctors whose names appear on page ii as being collectively responsible for the statement do not agree with these views, or perhaps they erred by consulting the membership with undue haste in the height of the holiday period. I had thought of sending photostats of this to each of them to enquire, but will settle for this form of protest. After all, we cannot take it back now. It is only open to us to be more careful in the future.

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## Professional confidentiality: the patients' view

Sir,

The concept of professional confidentiality is of primary importance in the doctor-patient relationship, endorsed from the time of our admission to the profession by the Hippocratic oath. The concept of confidentiality has changed since the introduction of medical records. The recording of patients' personal information may result in their reluctance to impart clinically important yet delicate details.<sup>1</sup> Some practitioners, however, may be obsessively preoccupied with the

confidentiality of the current consultation. Yet, is this what the patient always expects?

In a prospective series of 1000 consultations the attitudes of patients to the confidentiality of a consultation were assessed by examining their behaviour in opting for an open or confidential consultation. The patients were called from the waiting room by the practitioner, and led down a corridor to the consulting room. On entering the room the practitioner immediately sat at his desk and observed the patient's spontaneous behaviour with regard to closure of the consulting room door. On passing down the corridor, the patient had passed people waiting outside the practice 'treatment' room, and was thus aware of the possibility of being overheard during the consultation. Indeed, in some consulting rooms it was possible for the patient to see others waiting outside the open door during the consultation.

Of the 1000 consultations a total of 678 (67.8%) were carried out in an open room — 197 male patients (52.9%) and 481 female patients (76.5%) chose a consultation of this type. The results obtained with respect to diagnostic category are shown in Table 1. For urogenital and gastrointestinal conditions male patients were unanimous in their choice of consultations in a closed room; these conditions may conform to the male concept of socially undesirable illnesses. For female patients confidentiality assumed less importance for these conditions, especially for those under 50 years of age. For psychiatric conditions both male and female patients chose consultations in a closed room with the exception of six women who were diagnosed as suffering from endogenous depression — a condition which was not noted to occur in the group of males studied. A seasonal varia-

tion was noted which may perhaps be temperature related — closed consultations varied between 19% in the summer and 40% in the winter.

While it should be recognized that many variables are involved in the decision by patients to leave the consulting room door open, this study suggests that patients do not always seek confidentiality in a consultation. Some patients may consider that being observed in consultation with their doctor endorses their 'sick role'.<sup>2</sup> Also, it should be remembered that some patients have already related their problems to others while in the waiting room.

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## Patient satisfaction

Sir,

During the period of the College's quality initiative we would like to draw attention to another side of the quality initiative — that of patient satisfaction. We believe that it is axiomatic that a satisfied patient is one whose expectations have been either met or addressed.

In industry, there is a marketing technique where all parties in a transaction are asked their expectations, and what they believe the other parties' expectations are. By analysing the results any mismatch between what is supplied and what people want can be determined.

It has long been reported by many authors,<sup>1,2</sup> that a high percentage of patients are satisfied with their general practitioner. However, it was our experience, listening to people talk in check-out queues and in other public places, that there was a great deal more dissatisfaction than appeared in print. We sought to discover if principals in general practice and their staff knew or had thought about their own and their patients' expectations; we also asked the doctors' patients what were their expectations of the medical encounter.

To overcome methodological difficulties, we approached practices at random (80% refused), selected four group practices and approached a few of their patients selected at random and interviewed them in their homes (90% of those located agreed to be interviewed). We thought it important to talk to patients in their homes as it is believed that patients are reticent about criticizing their own doctor, but not doctors in general.

The questions asked of doctors, receptionists and patients were:

Table 1. Patients' choice of a closed or open consultation room by diagnostic category.

	Total number of patients	Number of patients by diagnostic category						
		RT	UG	GI	MS	Derm	Psych	Misc
<i>Male patients</i>								
Open consultation	197	127	0	0	14	23	0	33
Closed consultation	175	53	27	46	13	10	13	13
Total	372	180	27	46	27	33	13	46
<i>Female patients</i>								
Open consultation	481	250	47	43	57	22	6	56
Closed consultation	147	44	13	24	10	5	27	24
Total	628	294	60	67	67	27	33	80

RT = respiratory tract including ear, nose and throat. UG = urogenital including anti- and post-natal, gynaecological and contraceptive consultations. GI = gastrointestinal. MS = musculoskeletal. Derm = dermatological. Psych = psychiatric. Misc = miscellaneous including cardiovascular, ophthalmological and other conditions not included above.