away from the meeting with the two words 'discrimination' and 'education' foremost in my mind. I believe these terms are also relevant to doctors and health care workers.

In his paper 'Present and future prospects', Dr W. Harris of St Mary's Hospital gave an outline of current treatment, which is having a considerable impact on the course of the disease, though serious side effects are common. The cost of care in established cases is becoming astronomical as frequent blood transfusions are often required as a result of the treatment. The rate of spread of the disease in the homosexual population in this country is now slowing, but it is estimated that there will be an increased spread from intravenous drug users. Many countries are unwilling to reveal the incidence of the illness for fear of discouraging tourism.

Dr T. Carter of the Health and Safety Executive reminded us that at most times in our history there has been a serious infection in our midst such as tuberculosis or leprosy, and that human immunodeficiency virus (HIV) infection is less infectious than hepatitis B. Only eight cases of sero-conversion have been reported so far among health care workers worldwide. He discussed prevention of infection at work — not only for health workers, but for groups such as teachers, the police and first aiders.

The last speaker was Norman Willis, General Secretary of the TUC who believes the TUC can play a part in limiting the spread of the disease. He referred to discrimination at work and to the social implications of the disease. Screening employees, or potential employees, is divisive, impractical and is of no value. When people are discriminated against because of HIV infection they rarely resort to an industrial tribunal because of fear of publicity. People with AIDS must be educated and protected and should be treated in the same way as any other patient.

The discussion that followed was varied, but I suspected that even this interested group of people understood little about the disease. There was only one request for compulsory testing for HIV — from a prison officer — and he was not applauded.

The topics for the workshops in the afternoon related to procedures in the workplace, discrimination at work and in the wider community, care and counselling for AIDS patients, and the legal implications for trade unionists. Although each group had a separate subject, each came back to discrimination — at work, in housing, in insurance, even in treatment by doctors.

There is a need for education of the whole community, including health and social service workers, about the disease and how it is spread and this must lead to a change in attitudes. General practitioners have a valuable role to play in educating the community and trade unions too must play an active part.

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Sir,

Further to the editorial 'AIDS, HIV and general practice' (July *Journal*, p.289), we would like to draw attention to the creation of two posts for primary care doctors in London. Funded by the charity Help the Hospices the two appointments are based at the two major centres for the care of patients with AIDS in London, St Stephen's Hospital, Chelsea and St Mary's Hospital, Paddington.

The overall aim of each post is to train general practitioners in aspects of AIDS and HIV infection before developing links between the hospital and the community. These links will involve individual patient management and will try to improve communication about and understanding of AIDS from a community perspective.

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The case for smaller lists

Sir,

In his editorial (November *Journal*, p.481) Dr Roland argues that a doctor with a large list size providing five minute consultations fulfils many of the criteria often used to assess his quality of service but then appears to condone the view that there is no defence for maintaining such a large list.

This is yet another illustration of the dilemmas facing general practitioners, politicians and health planners when deciding what service is required, at what cost, and by whose quality assessment. To state that patients rightly have increasing expectations is to further compound the problem. The doctor can be expected to proffer advice and treatment with explanation and consideration, but not to absorb and resolve the effects of society's and an individual's actions.

The general practitioner is now being asked to widen his terms of contract to areas in which he has neither specialist skills nor resources. The solution is not to reduce his list size, increase his numbers, provide additional resources or pay him more. It is for everyone to have realistic expectations and no one to believe they have a predetermined right to anything — an educational and preventive lesson which doctors, patients and society will find difficult to learn.

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Sir,

I must take issue with the editorial by Martin Roland (November *Journal*, p.481) The case for further reduction in general practice list size is indeed answerable.

It should be perfectly possible for a general practitioner with a list size of 2500 to practise day-to-day care and also extend his or her services into prevention. One thing is necessary for this — organization.

With the present regulations, a good practice nurse, with the aid of questionnaires and simple procedures like measurement of blood pressure, urine testing and blood lipid estimation, should be able to carry out a large slice of preventive care, with referral to the general practitioner if necessary when problems arise. The nurse, of course, can be employed with 70% reimbursement. Also, with the health visitor attached to the practice and the help of the midwife, both geriatric and paediatric surveillance can be accomplished with all the team working together.

After all, we do not expect the pilot to land his plane and, at the same time, organize care and facilities for the passengers. If we do not use the facilities available to us, then be it on our own heads. Present list sizes can be coped with well, given thought.

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