variation alone, subjects selected because they represent an extreme value in a distribution can be expected to have less extreme values on subsequent measurements. That this phenomenon applies to cholesterol was clearly shown in the multiple risk factor intervention trial[1] where there was a significant drop in cholesterol in study subjects between the first and second screening stages, before any intervention took place.

We are concerned that uncontrolled studies of this nature are being widely published, creating the impression that general practitioners are achieving more in the field of prevention than may be the case. We have learned to observe patients with high blood pressure for a period of time before intervening; should we not be doing the same with cholesterol measurements?

The high proportion (13%) of subjects with a cholesterol level greater than 7.8 mM in Dr Jacobs' study raises an interesting problem. The recent policy statement of the European Atherosclerosis Society[2] recommends that referral to a lipid clinic or specialist physician should be considered at this level. We doubt that specialist medical or lipid clinics in the UK could cope with this tremendous increase in workload and it is therefore essential that these patients are properly observed and managed in general practice.

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Inappropriate use of casualty departments

Sir,

Dr Elizabeth Horder's letter (August *Journal*, p.372) is useful because it pulls together a number of questions about the use of hospital facilities. But the questions themselves may be inappropriate. We must remember that the National Health Service is a demand-led service for patients; it is only a convention of the medical profession that hospital care is secondary.

Dr Horder does not state the overall level of attendances in the casualty department surveyed. Cardiff has had one of the busiest casualty departments in the UK for many years. A numerical survey of attenders made some years ago, in response to a similar complaint, showed that the high level of attenders actually represented one patient per consulting session per general practitioner in the district. While the department was inundated with patients, each general practitioner in the city was unaware of seeing only 19 patients per surgery session instead of the expected 20.

If casualty departments are overloaded in the eyes of their staff and management, it is not because the local general practitioners are work-shy, but because the departments provide a focus of assembly. A better relationship between casualty staff and surrounding practices can be developed if both sides take the trouble to talk to each other. In Cardiff the initiative came from general practice. Stop recriminating and start talking; and keep on talking — every six months.

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Sir,

Elizabeth Horder raises the old question of the inappropriate use of casualty departments. Our group practice was disturbed to find that in a six-month period in 1986[1] one in 25 new consultations took place in the local casualty department rather than in our surgeries. The self-referral rate was 92% (similar to other studies) and on analysis more than 50% of cases could or should have been dealt with in our surgeries. This would have increased each partner's workload by less than two patients each per week.

Many patients attend a casualty department simply because they feel it is more appropriate. Surprise at the size of the numbers highlights general practitioners' ignorance of the extent to which patients receive help from other sources. Dr Horder implies that if general practitioners provided more detailed advice about what they can deal with, if patients could contact a doctor they know with one telephone call, and if general practitioners were more willing to do the work, casualty departments everywhere would be less pressurized. Our practice provides a detailed practice booklet, does not use deputies and has demonstrated that the increase in workload would not be great. We guarantee patients an appointment the same day if they want one and the wait is usually much shorter than in the local casualty department. The patient travels a shorter distance to be seen by a more experienced doctor at the surgery. Yet all this does not help persuade patients to contact us and not go to a casualty department.

Myers[2] showed that patients' perceptions of the general practitioner's ability play an important part in their decision where to attend. Davies[3] demonstrated that more than half of the patients attending a casualty department who were questioned went there because they thought their problem was unsuitable for their general practitioner, or did not want to bother him. Fisher[4] found that 68% of attenders thought their doctor would have sent them to the casualty department anyway, 52% thought they would need an X-ray and only 10% thought their general practitioner would stitch wounds, a finding confirmed by Cartwright[5] and Morgan.[6]

Ignorance, not only of the services offered by some general practitioners but of their availability, can also be demonstrated. Holohan[7] found that 52% of patients asked did not know the practice emergency arrangements and Davies[3] demonstrated that a high proportion attended casualty departments for speed or convenience. Morgan[6] found the main reason was availability of hospital care (32%), with appropriateness (17%) and accessibility (13%) also being important factors. Fisher[4] showed that only 4% of patients preferred hospital doctors. Studies in Sheffield[4] and Newcastle[6] demonstrated that having no general practitioner was a problem in less than 2% of cases, although this may be more of a problem in London,[8] as confirmed by Horder who found that 14% of the attenders were not registered with a doctor.

Patients underestimate the willingness of their doctors to stitch cuts and strap sprains, and exaggerate the likelihood of referral, according to Holohan[7] and Peppiatt.[9] The latter showed that, for all complaints except fractures, head injuries with loss of consciousness and overdoses, 81% of general practitioners felt the patients should contact them.

I suggest this problem has no solution and no matter what action is taken, general practice will always take place in accident and emergency departments. Why then do we try to artificially divide this work and run two separate organizations for emergencies? Why not have one efficient system with general

practitioners based in casualty departments?[10]

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AIDS in Africa

Sir,

The otherwise excellent discussion paper on human immunodeficiency virus (HIV) infection and the acquired immune deficiency syndrome (AIDS) in general practice (May *Journal,* p.219) unfortunately accepts that those who have visited Africa, south of the Sahara since 1977 are a high risk group. The Chief Medical Officer, Sir Donald Acheson, has referred to these people as a high risk group as has the Blood Transfusion Service (leaflet NBTS 1181). However, the Northern Region Blood Transfusion Service has admitted that this is an error and the matter has been raised with the Department of Health (Institute of Child Health, personal communication).

Many of the studies purporting to show a high incidence of HIV antibodies in Africa are now discredited, in particular the evidence that antibodies existed i Zaire as far back as 1977.[1] This was based on testing of frozen stored plasma, which can produce false positives and, as the identity of the donor was not known, other diseases which can give false positive results could not be excluded, for example *Plasmodium falciparum* malaria.

There is good evidence that AIDS, as a clinical syndrome, only appeared in Africa after it appeared in the USA.[2]

More relevant to British general practice is the fact that between 1983 and 1987 only three cases of AIDS originating in Africa were reported in greater London, less than 2% of the total.[3] Prior to that time it may be that over-diagnosis occurred owing to lack of specific antibody tests, since many tropical diseases mimic the disease clinically. Of even greater relevance is that the only risk factor for a number of patients with AIDS in the UK has been sexual contact with someone from the USA.

Zimbabwe (which has testing facilities, and samples can be sent away from rural areas) had reported 57 cases to the World Health Organization by July 1987 and Tanzania 1130, but the USA had reported 37 019 cases (WHO epidemiological record no. 27, p.202). One in six babies born in New York is reported to be HIV positive and half a million people are estimated to carry HIV antibodies in New York alone.

I believe advice to screen those who have had contact with sub-Saharan Africa is misplaced, rather we should be advising people who travel to the USA of their likely risk.

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General practice and the European Community

Sir,

I read with interest Professor Horder's leader (August *Journal,* p.341) on vocational training in the European Community. However, the article implies that Denmark has taken the lead in setting training standards for general practitioners because of the lengthening of its training. The idea of a qualitative enhancement of vocational training owing to longer training (especially if based on a preponderance of hospital modules) needs to be justified by evidence. I know of none, although I stand to be corrected.

If, as Professor Horder states, we are running the risk of becoming fossilized in our training standards it might partly be due to our inability to relate to other European medical systems and learn from both their mistakes and their considerable achievements in the field of primary health care.

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Sir,

Professor Horder (August *Journal,* p.341) comments on the serious medical unemployment in Italy, France and West Germany. This may have unforeseen consequences when governments comply with the Single European Act and remove barriers to the free movement of people and services. Will unemployed doctors gain priority over non-European-Community nationals in filling unfashionable junior jobs in the National Health Service? Will public health service jobs have to he advertised outside national boundaries? Will the Commission of the European Community force changes in the organization of the NHS to allow doctors to establish a general practice wherever they wish, with open access to non-private patients[1] and consequent radical alteration in the role of family practitioner committees? Should this happen, medical incomes would be reduced by competition. Increased consultation rates, over-prescribing and too many visits may result.

Previously recognized language difficulties may pose a problem requiring an amendment to the Single European Act to safeguard patients in the clinical setting. A European version of the Professional and Linguistic Assessment Board (PLAB) language tests is not possible because the General Medical Council is prevented by the European Community from testing either the professional competence or linguistic skills of European Community nationals.[2]

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