practitioners based in casualty departments?[10]

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References

1. Hobday PJ. Patients attending casualty from one group practice. *Practitioner* 1988; **232:** 552-555.
2. Myers P. Management of minor medical problems and trauma: general practice or hospital? *J R Soc Med* 1982; **75:** 879-883.
3. Davies T. Accident department or general practice? *Br Med J* 1986; **292:** 241-243.
4. Fisher J. Self-referral to an accident and emergency department. *Nursing Times* 1981; 29 Jan: 196-201.
5. Cartwright A, Anderson R. *Patients and their doctors 1977. Occasional paper 8.* London: Royal College of General Practitioners, 1979.
6. Morgan W, Walker JH, Holohan AM, *et al.* Casualty attenders: a socio-medical study of patients attending accident and emergency departments in the Newcastle-upon-Tyne area. *Hospital and Health Services Review* 1974; June: 189-194.
7. Holohan AM, Newell DJ, Walker JH. Practitioners, patients and the accident department. *Hospital and Health Services Review* 1985; March: 80-83.
8. Davion AG, Hildrey ACG, Floyer MA. Use and misuse of an accident and emergency department in the east end of London. *J R Soc Med* 1983; **76:** 37-40.
9. Peppiatt R. Patient's use of general practitioners or accident and emergency departments. *Practitioner* 1980; **224:** 11-14.
10. Hobday PJ. Night workload in one health district. *Br Med J* 1984: **289:** 663-664.

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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References

1. Wendler M, Schneider J, Gras B, *et al.* Seroepidemiology of human immunodeficiency virus in Africa. *Br Med J* 1986; **293:** 782-785.
2. Bayley AC. Aggressive Kaposi's sarcoma in Zambia, 1983. *Lancet* 1984; **1:** 1318-1320.
3. Chirimuuta R, Chirimuuta R. *Aids, Africa and racism.* Bretby, Derbyshire: Chirimuuta, 1987.

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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References

1. Tormey WP, Chambers JPM. Europe's doctors after 1992. *Lancet* 1988; **1:** 1339-1340.
2. Kessel N. Testing overseas doctors. *Br Med J* 1988; **297:** 558.