

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).¹⁻³ 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.⁴ 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%.⁴

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.⁵ 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.⁶

It has been shown that 1 x 10⁻⁷ ml of plasma infected with hepatitis virus will transmit the disease.⁵ 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.⁷ 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 Peterson¹ 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 Cooper² 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