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# AIDS, HIV and general practice

THE Communicable Diseases Surveillance Unit has reported 45 new cases of the acquired immune deficiency syndrome (AIDS) in the United Kingdom during May 1987, making the cumulative total of cases 791 with 444 deaths. Although the rise in the number of cases of AIDS has been rapid, the absolute number is still small and the uneven distribution of infection with human immunodeficiency virus (HIV) makes it extremely unlikely that general practitioners working outside the main urban areas will have seen a patient with AIDS.

This lack of experience in dealing with these patients makes general practitioners vulnerable, both individually and collectively, to criticism of their diagnostic skills in relation to AIDS. This is illustrated by the recent case of Dr Jack Norell and his trainee, Dr R.T. Dattani, who have challenged a medical services committee judgement that they failed to diagnose AIDS in one of Dr Norell's patients. The case is a curious one on several counts, not least because the committee appeared to take the unusual step of ruling on a matter of clinical judgement. The point of raising this case is that, despite the rarity of the syndrome, general practitioners are expected to be skilled in diagnosing AIDS. Set against this expectation is the unhappy fact that general practitioners and others involved in primary health care are not seen to be a major resource in the fight against AIDS, as witnessed by the lack of involvement of general practitioners in recent national symposia on HIV and AIDS and by the very brief consideration given to the potential contribution of general practitioners in the House of Commons Social Services Committee report *Problems associated with AIDS.* Indeed, the Committee gives a rather negative picture of general practice by repeating the report of a general practitioner refusing to enter the room of a person who had died of AIDS to certify death. It is to be hoped that no further incidents will tarnish the reputation of general practice as accessible and available to all types of patients.

The continuing rise in the number of AIDS patients will resolve any uncertainties about the important role of general practitioners in caring for these patients. At the end of April, 5924 people were reported to be HIV seropositive but the DHSS estimated that the true total might be thirty or forty thousand. It is generally considered that 15–20% of people who are seropositive develop AIDS after three years. Thus by 1990, approximately 8000 people will have AIDS in the UK. Further increases after 1990 appear to be inevitable but the rate of increase depends on at least two uncertain factors: first, the infectivity of the virus in the heterosexual population, and second, the effect that mass education will have on present patterns of sexual behaviour. Even taking the most optimistic view about the future numbers of AIDS patients, most general practitioners will be directly involved in the care of these patients within three years.

Expertise in the investigation and care of AIDS patients is at present concentrated in a few specialist medical units. These units fulfil a crucial function and will continue to do so but, as the number of patients increases, primary health care teams and general practitioners in particular will need to develop the skills to enable them to contribute to the care of these patients. The demands placed on the specialist units are high; in addition to providing care for the seriously ill, they are also centres for clinical research. Perhaps their most important role in the future, however, will be an educational one. Each region and district will need to draw on the knowledge of the specialist units to create educational programmes and strategies so that general practitioners will have accurate and up-to-date information about the clinical features of the syndromes caused by HIV and will understand and will be able to apply the important principles of management in the care of patients with AIDS. General practitioners will also need information and advice to help them in their important role as health educators in the local community and to fulfil their responsibilities towards the staff they work with and employ.

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We should not ignore the major part which primary care is currently playing in prevention and health education. All general practitioners are already involved in advising patients who are or consider themselves to be at risk of HIV infection. In its evidence to the Social Services Committee, the College pointed out the crucial role of general practitioners in preventing the spread of this epidemic. Education of the public and of health professionals is the only defence we have against HIV infection. Mass education campaigns will need to be complemented by personal advice. Only general practice can provide this personal service to the whole population.

If educational programmes for general practitioners are to be effective, there needs to be close cooperation between health authorities and the regional committees responsible for postgraduate medical education. Voluntary organizations such as the Terence Higgins Trust have taken the lead in providing practical help, counselling and support for people at all stages of the infection and general practice needs to establish links with these organizations so that we can use their experience to ensure the best possible support for infected patients.

Support will also be needed for general practitioners and others in the primary care team. It is likely that the uneven geographical distribution of AIDS cases will continue and a heavy burden will be placed on teams working in areas of multiple deprivation, who are already under strain through lack of resources coupled with high demand.

The challenge posed by AIDS is immense. General practice plays a central role in the health care system of this country and general practitioners need help in preparing to meet this challenge. The College has set up a working party to identify and report on the needs of general practitioners in caring for patients with AIDS. The editor of the *Journal,* Dr Graham Buckley, has accepted an invitation to be the convenor of the working party and members of the College are invited to write to him at the *Journal* office to give their views on the role of general practitioners in caring for those with, or at risk from, HIV infection and AIDS and to outline their own educational requirements.

# To burn out or to rust out in general practice

NOW that a generous but mandatory retirement age may be introduced fewer general practitioners will 'rust out' in the job. However rust out may be less of a problem than 'burn out'. Burn out in the caring professions is defined as the 'loss of concern for the people for whom one is working in response to job related stress'[1] or as a 'psychological withdrawal from work in response to excessive stress and dissatisfaction'.[2]

Three stages of burn out have been described.[1] The first is an imbalance between the demands of work and personal resources, which results in hurried meals, longer working hours, spending little time with the family, frequent lingering colds and sleep problems. The sensible response at this stage of job stress is for the professional to take stock, seek advice and reorganize his or her life and practice.

The second stage involves a short-term response to stress with angry outbursts, irritability, feeling tired all the time and anxiety about physical health. The informed response to this stage of stress is to get away from it all by going on a course, a short holiday or letting someone else take the strain for a while.

A few progress to the third stage of 'terminal' burn out which creeps up insidiously: the sufferer cannot re-establish the balance between demands and personal resources. The burnt out professional treats individuals in a mechanical way, goes by the book, is late for appointments, refers to patients in a derogatory manner and uses superficial, stereotyped authoritarian methods of communication. This stage has many of the characteristics of 'bad' doctors, and is seen too in social workers, nurses and clergy.

All caring professions are particularly prone to burn out and the Americans have taken to studying it with enthusiastic openness. American doctors have not been quite as reticent as British doctors about having their profession studied.[3] British general practitioners have faced job stress from the point of view of their wives[4] and its effect on families,[5] but as yet there is only scant recognition of the effect of stress on working style.[6]

New doctors are high achievers used to academic success. Those who enter general practice find the emphasis is on dealing with people rather than diseases. For some, this is a professional *volte-face.* They encounter the human dramas and dilemmas of patients and may find apparently few of the emotionally neutral intellectual challenges of diagnosis for which they were trained.

Nowadays vocational training creates expectations of certain standards in general practitioners. The practice that the new principal joins may deviate considerably from the standards set by vocational training. The new general practitioner may try to accomplish too much too soon, alienate his colleagues and find his plans blocked. This is a classic scenario for burn out, which thrives on frustration. Too often new principals are unprepared for this form of frustration; indeed they may not realize that their own appointment was a major step forward for the practice and that the practice now needs time to adjust. One study has revealed that 36% of new principals were having such serious problems with their senior partners that they were thinking of leaving.[7] The study also found that some of the new principals were fearful of mentioning change to their senior partners and many were unaware how to effect change anyway. This study illustrates the factors without and within the individual which predispose to frustration and lead to job stress.

Patients of course contribute to job stress. Doctors look after many distressed people for whom medicine can do little. Patients who are unable to marshall the motivation to extract themselves from undesirable situations may be the very stuff of general practice to some doctors but deeply frustrating to others.

Caring professionals learn to ration their compassion in order to be effective.[8] Some doctors may need to be advised to become emotionally a little detached for their own sake. It is a useful tactic for each individual to reflect on how he or she copes with stress. As general practitioners become more organized and efficient their daily lives may be packed with more and more internal deadlines which leave little time for reflection and breaks. Many doctors' work spills over into their half-days and holidays, which may be fine for them but bad for their families.

What is the difference between burn out and workaholism, touchiness or depression? Workaholics enjoy their work, using it to avoid deep or intimate contact with other people and they maintain tight control over their lives. Some doctors are of course constitutionally touchy while others become touchy in response to stress. It is the chronic nature of burn out, however, that distinguishes it from transient touchiness. There is undoubtedly overlap between burn out and depression, both of which need professional help.[8] It is here that a helping hand may be had from the new National Counselling and Welfare Service for Sick Doctors.

Partnerships are now the norm in British general practice yet many doctors work more in confederation than in true partnership. Partners may not meet as a group for mutual support, problem solving or policy making. The daily deadlines may isolate each partner and the confederation rolls on from its own momentum. The conventional wisdom about a successful practice was that the partners must never socialize outside work and that they must keep their spouses out of practice affairs. This distrust may be a legacy of the past which we need to dispose of. All the evidence is that general practice is becoming more complex and we can hardly afford to spurn each others support inside or outside work.

One particular problem is that burnt out doctors often have nowhere to go because mid-career shift is not common in medicine. General practitioners reach their financial high point early, around