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Attitudes towards patients infected with HIV

'PREJUDICE (noun) — a judgement or opinion formed beforehand or without due examination'. When confronted with patients with human immunodeficiency virus (HIV) infection general practitioners are forced to recognize their own prejudices. There can be few doctors who have retained a neutral attitude towards infected members of high risk groups. Disquieting feelings of remorse for infected haemophiliacs and their families and of vindictiveness towards drug abusers or promiscuous homosexuals are probably the initial reactions of many doctors.

Few general practitioners can have received training in the management of HIV infection. It is also probably true that more is still taught about haemophilia than about drug abuse or homosexual behaviour. While the correct care of haemophiliacs is important, HIV infection is predominantly a disorder linked with the much larger groups of drug abusers and promiscuous homosexuals, and medical practitioners need to be well informed about the behaviour of members of these groups in order to care for them properly.

These two risk groups have not enjoyed much sympathy or support from the general public prior to the HIV epidemic and the disproportionate number of cases of HIV infection among them has exacerbated this. Labels such as 'the gay plague' are difficult to remove, and it seems likely that the present campaign in the UK to highlight the dangers of sharing needles will intensify antagonism towards drug abusers.

In the USA blacks make up 12% of the population but account for 24% of cases of acquired immune deficiency syndrome (AIDS). In addition, half of the women with AIDS are black, as are two out of three children infected with HIV. The temptation to condemn the infected individual and, implicitly, their membership of a particular group is proving irresistible to some outspoken public figures on both sides of the Atlantic. Doctors must resist such temptations. Appending a tacit 'innocent' or 'guilty' to a diagnosis will only serve to hinder the care of patients. For the foreseeable future the majority of HIV seropositive children in this country will be born to mothers infected as a result of injecting drugs. Should care be given to the 'innocent' child but denied to the 'guilty' mother?

It may be helpful to consider the disorder from the standpoint of someone who is infected with HIV. The distinctions that are made between the various stages of the infection may be helpful in deciding a patient's treatment and coming to a prognosis but to the infected individual such distinctions may be artificial. In the light of present knowledge all those who have become infected will remain infected. Every day brings them face to face with publicity about preventing AIDS, for example 'Don't die of ignorance', serving as a constant reminder of what lies ahead.

The threat to health care workers from patients infected with HIV has been shown to be extremely small,[1] but this has not abolished the fear of such transmission and it would be unrealistic to expect a rapid resolution of this anxiety. It will be instructive to observe the change in attitudes towards HIV infected patients among carers and the general public as AIDS is no longer seen as a disease of special groups in society but as a disease which can affect everyone. In fact, the evolving pattern of the epidemic may result in other risks. A rising incidence of pulmonary tuberculosis has been observed in immunodeficient patients[2] and the spread of this disease among high

risk groups and their medical and nursing attendants must be carefully monitored.

Another major influence on the attitude towards infected patients is the cost of their care. Enormous sums of money have already been spent caring for patients with AIDS and even conservative projections of future costs quickly assume astronomical proportions.[3,4] This money may be seen to be lost from other areas of patient care. How many hip replacements or renal transplants will not take place because AIDS patients are receiving zidovudine? Prescribing plastic syringes for diabetics may only have become possible because of the outcry following the free distribution of needles and syringes to injecting drug abusers but a similar extension to other areas of expenditure seems unlikely. Some tough decisions lie ahead for doctors when deciding priorities. In reaching these decisions they must take care to avoid unfair discrimination. 'Discriminate (transitive verb) — to treat differently because of prejudice'.

R.T.A. SCOTT
General Practitioner, Alexandria, Dumbartonshire

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Medical manpower planning: factors influencing workload in general practice

GENERAL practice is constantly changing and the effect of present trends is to increase the workload of the general practitioner. These trends, which are discussed below, must be taken into consideration when planning medical manpower.

The majority of patients with chronic disease are now cared for in general practice; for example only about 10% of patients with epilepsy are followed up by hospital outpatient departments.[1,2] For patients with chronic disease there are times when care in hospital is essential, and this has led to shared care programmes being set up. These involve cooperation between general practitioners and primary care nursing colleagues, liaison nurses and consultant physicians. The workload involved in this liaison is considerable and is increasing.[3,4] Many practitioners are setting up disease registers, and organized call and recall systems for patients with chronic diseases. This not only increases administrative time and costs, but also the number of consultations with each patient. The use of computers can reduce administrative work and make it more efficient, but new services require additional resources. Some of the increased work involved in caring efficiently for the chronically ill could be carried out by practice nurses and nurse practitioners and there is evidence that they wish to take on such tasks.[5] However, the extent to which these team members can take on this work will depend on the degree to which general practitioners are permitted to delegate and on the acceptability to patients of this change.

As large mental hospitals close, patients with chronic mental illness and mental handicap are moved into the community and become the responsibility of general practitioners. Their care requires a high degree of skill, and also the ability to organize and coordinate community resources. Such work is time consuming, and does not receive serious attention in the debate about the community care of the mentally handicapped.

There is no evidence that the rationing of health care and costs in the National Health Service by waiting lists will be abolished in the near future. Patients who are waiting for appointments in specialties such as neurology and ophthalmology or for operations are often anxious and sometimes in pain. They are therefore likely to consult their general practitioner and increase his workload. Attempts to shorten waiting lists by the increased use of day surgery and the early discharge of patients postoperatively results in general practitioners providing care previously provided by the hospital. This policy increases both the range and quantity of work undertaken by the primary health care team.

More general practitioners are now screening their patients for hypertension, diabetes, high alcohol intake and hyperlipidaemia and this trend is strongly encouraged by the government. It has been found that preventive care is more common in training practices and practices which have low lists where there is better than average medical manpower.[6]

The rapid increase in the number of cases of the acquired immune deficiency syndrome will dramatically increase the number of people in the community who need long term and sometimes frequent care. General practitioners will be expected to play a major role in providing care at all stages of the illness.

More women are now being trained as doctors — in 1984 46% of medical students were women.[7] The majority of women doctors get married and have children, resulting in absence from work, disruption of their career and a need to combine work with domestic commitments on a long term basis. As the proportion of women general practitioners increases, the implications for medical manpower planning must be considered.

One in 10 general practitioners is a trainer and the trainer's contract requires two sessions to be put aside for teaching and supervising the vocational trainee. Many practices also teach medical students, and the trend is for medical students to spend more time in general practice. The General Medical Council recommends that hospital doctors should spend some of their time in training in general practice.[8] Thus, the amount of time that general practitioners spend in teaching is likely to rise.

Many doctors value the time they spend working as school, occupation or prison medical officers and many also serve on professional committees. Although it would seem likely that this work would erode the amount of time the doctor has available for patients, it has been found that doctors who work for more than three hours outside the practice also spend more time in contact with patients in the practice.[9]

Doctors who spend longer with each patient might be expected to see fewer patients in each consultation session and this might reduce the total number of patients that they could care for. A survey comparing the care of patients allocated at random to surgeries booked at 5.0, 7.5 and 10.0 minute intervals by analysing tape recordings of the consultations[10] found that in surgeries booked at 10 minute intervals the doctor identified more problems, carried out more preventive procedures, and spent more time listening to patients and explaining their