LETTERS

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AIDS — is general practice meeting the challenge?

Sir,

The acquired immune deficiency syndrome (AIDS) epidemic poses a major threat to public health in the UK.[1] It is therefore important to ask whether general practitioners have the knowledge, skills and motivation necessary to fulfil their responsibilities as health educators and providers of health care.[2-4]

A postal questionnaire survey of general practitioners' knowledge, attitudes and response to AIDS was carried out among the principals of a south west London family practitioner committee. A total of 318 doctors were approached in May and June 1987 and of these 165 (52%) returned completed questionnaires; 102 agreed to a telephone interview and were contacted. There were no significant differences between interviewees, other respondents, and all the general practitioners approached in terms of the doctors' personal or practice characteristics.

Of the 165 doctors returning questionnaires 46 (28%) had patients with AIDS and 82 (50%) had patients infected with human immunodeficiency virus (HIV). The majority of doctors (94%) knew that the AIDS test measured antibodies against HIV, but only 60% were aware that a raised antibody titre meant a person's body fluids were infectious. Most (94%) understood that HIV was not spread among the non-sexual household contacts of AIDS patients, and 88% were aware that accepted procedures for avoiding HIV infection in medical workers were the same as those for avoiding hepatitis B. However, only 60% knew HIV was easily inactivated by simple disinfectants and only 62% knew HIV was less infectious than hepatitis B.

Nearly 60% of doctors did not feel competent to provide AIDS counselling and advice, the reasons given being insufficient knowledge about AIDS (40%) and uncertainty about appropriate counselling skills (40%). Nonetheless 60% of doctors made a point of offering advice on AIDS to homosexual patients and intravenous drug abusers; and 50% said they counselled promiscuous heterosexuals and the sexual partners of high risk patients.

There had been little discussion of AIDS with members of the primary care team other than the practice nurse — 63% of doctors had given advice to practice nurses, 44% to receptionists, 27% to district nurses, 23% to health visitors, and 7% to midwives.

A high proportion of doctors had made changes to their practice procedures as a result of AIDS. In all, 76% had changed their methods of venepuncture, 70% their procedure for minor operations, 39% their method of sterilization and 17% their system of record keeping. There was no consistency in the systems of working adopted. The changes made to venepuncture in high risk patients included referring patients to hospital (10 doctors), switching task from nurse to doctor (12) and wearing additional protective clothing, principally gloves (32). The changes made to sterilization (of scissors) included switching to a disposable product (five doctors), using disinfectants (five) and purchasing an autoclave (five) or steam sterilizer (two).

Of the 82 doctors interviewed, 43% said the AIDS epidemic had heightened their awareness of the need to elicit patients' sexual histories: however only 28% said they did so routinely. Few doctors (6%) were reluctant to accept homosexuals onto their lists, but 58% were reluctant to accept intravenous drug abusers.

The findings suggest that many general practitioners in this area of London are knowledgeable, skilled and committed to dealing with AIDS. However, attention must be given urgently to the need for technical direction on venepuncture and sterilization, the need for support in developing counselling skills and improving knowledge and the need to incorporate teaching on AIDS into the vocational training of new general practitioners.

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How easily can practices be contacted during normal working hours?

Sir,

The Patients' Liaison Group of the College has from its inception been interested in various aspects of the availability of primary care to patients.[1] One area of concern is the amount of information available to patients about the extent to which they can contact their doctor's practices during the normal working day.

The Acheson Committee reported[2] a wide variation in the arrangements for patients contacting practices during normal working hours and we wondered whether improvements had been made in the past few years which would make contact easier. We were interested in the provision of receptionist services, including services for making appointments, dealing with queries, repeat prescriptions and so on, during the normal working day. As the available literature was not very helpful we sent a questionnaire to all family practitioner committees asking for general statistical information about reception arrangements in the practices for which they were responsible.

Two-thirds of the family practitioner committees replied to our questionnaire but less than one in six were able to provide information about daytime reception cover. Of these only half reported that

reception services were available in most practices in their area during the whole working day. Fewer than half the committees responding answered the question about the extent of employment of ancillary staff by practices and only a tiny proportion of these said that practices took up their full allocation; the vast majority of practices took up between one and one and a half whole-time equivalents and the balance less than one. Nearly one-third of committees thought the information we were seeking should be available and that they would like to have it.

This survey revealed a lack of general information and considerable variations between practices, confirming Patients' Liaison Group members' local knowledge of practices with no reception staff situated in the same neighbourhood as those with full-time services.

This small survey has raised several questions about what patients might reasonably expect. Should information about reception times be available in the same way as surgery consulting hours? What is the present situation and are changes taking place? We would welcome the views of general practitioners, family practitioner committees and patients.

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Home births

Sir,

The First International Conference on Home Births, held at the Wembley Conference Centre on 24/25 October 1987, brought together representatives of over 20 countries, and today's most famous campaigners for natural childbirth and informed choice, including Michel Odent, Wendy Savage, Luke Zander, Sheila Kitzinger, Beverley Beech and Janet Balaskas.

The dramatic decline in home births is due to the alleged risks but even today 10 to 12% of women in Britain would choose a home birth if given the option. None of the statistics in Rona Campbell's recent publication, *The place to be born,* support the claim that hospital births are safer than home births and the figures suggest that for some women the iatrogenic risk associated with delivery in an institution may be greater than any possible benefit.

Melody Weig, an independent midwife, told the conference how she had treated five cases of retained placenta with less blood loss than cases dealt with in hospital where the sister insisted on waiting for a doctor. She then described a case of prolapsed cord where she had to keep her hand on the presenting part throughout the 50 mile journey to the hospital while the mother stayed in the 'knee-chest' position. On arrival at the forewarned hospital, Caesarean section delivered a healthy baby. The crucial factors in safety would seem to be the competence and autonomy of birth attendants.

Many women have difficulty relaxing in an unfamiliar, clinical room and studies with animals have shown that a change in environment during labour can dramatically increase the incidence of stillbirths. During labour, many women doubt their ability to cope with the labour and to give birth. Reassurance, encouragement and care by someone they know and trust are surely preferable to hazardous technology such as epidurals and forceps.

John Davis, Professor of Paediatrics at Cambridge, felt that babies should be given the best chance to grow into well-balanced citizens, unharmed directly or indirectly by their birth. A small proportion of babies struggle when anaesthetized for surgery and investigation revealed that these babies had required resuscitation at birth and obviously 'remembered' the experience. There is strong evidence that babies react sensitively to their mothers, and thus maternal depression (emotional or drug-induced) may be of lasting significance. Michel Odent has found that some babies born at home have a static weight for two or three days then start to gain weight; the initial loss observed in hospital may well be a sign of emotional or physical stress.

Patients need general practitioners' support, not only for home births but also for more humane and physiological obstetric care. Unless doctors listen and respond to the desires of the consumer, the relationships between doctor and patient, and the profession and society, are likely to become adversarial. Consumer groups and the facts are creating an opportunity for general practitioners to improve their patients' experiences in childbirth. As one speaker reported, some general practitioners attend their first ever home birth as a principal; it is never too late to start.

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Advantages of a fellowship

Sir,

I finished vocational training in the UK in 1979. Since 1982 I have been working in a primary care clinic in Israel and recently it became clear to me that there would be advantages in spending a couple of years in academic medicine, critically examining research and teaching techniques.

It appeared that only in the USA do the financial resources exist to fund any numbers of 'fellowships'. The *Fellowship directory* published by the Society of Teachers of Family Medicine in Kansas City lists over 40 programmes for fellowships in family medicine and at first the range of places and structures was confusing. The content of the programme, the location and the level of remuneration were the factors influencing my choice of scheme.

After visiting several centres I applied and was accepted to a two-year fellowship programme at St Margaret Memorial Hospital in Pittsburgh. One fellowship is available each year. The programme is based at a modern, well equipped, community hospital which has two family health centres where the 30 residents of its family practice residency programme see their 'practice' patients and are taught family practice. The programme includes training in teaching, actual teaching, clinical work, training in research as well as a research project and a master of public health degree course at the University of Pittsburgh.

Working as a fellow one is not overwhelmed by patient load while trying to learn and a suitably designed fellowship programme will provide all the necessary training and courses.

The Residency in Family Practice at St Margaret Memorial Hospital is, in British terms, a vocational training scheme for general practice that lasts three years and starts immediately after medical school, qualifying the trainees to take the examination of the American Board of Family Practice.

The hospital is a private, non-profit making, community based hospital where local doctors, generalists as well as specialists, admit their patients who need inpatient care, investigations or pro-