The enjoyment experienced by both parties in this study may have reflected the intentional informality and the exclusion of any suggestion of critical review which is inherent in peer review. One unexpected benefit from the success of these visits has been a greater sense of cohesion between geographically widely separated members of the vocational training scheme.

Inter-practice visiting is unusual but this study has shown that such visits can be enjoyable and educationally useful to the established principal without being burdensome to the practice visited. Inter-practice visiting on an occasional basis should receive formal encouragement, perhaps even funding, since it could prove a useful stimulus to improving our practices.

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Care in the community: charity or right?

Sir,

At our November faculty meeting on 'Carers' a number of important issues were raised which have not attracted much professional or public attention.

We began with a very interesting talk from Dr Dee Jones, St Davids Hospital, Cardiff, who reported on some of the work she had done on carers in the community. She highlighted the very heavy burden borne by female relatives of dependent persons. Her results showed that while resources for community care were generally being allocated according to need, they fell far short of what was necessary. Five per cent of this support was provided from voluntary groups and agencies.

We then had a speaker from a charitable organization which provides paid home-helps, on a flexible basis, to those in need. This organization was run by a local management committee of concerned citizens. Its establishment was aided by the West Glamorgan community services council. It is funded by central government via the Welsh Office, joint financing from the local authority and health authority and by private commercial concerns such as Sainsburys and Marks and Spencers. This charitable organization has one full-time coordinator and she is responsible for the administration of the service. The home-helps are part time and are paid at normal home-help rates. However, their hours are restricted so that they will not get above the threshold to pay national insurance or income tax; they do not have the option to increase their hours above this limit. This was necessary in order to keep the costs of the scheme down.

While this charitable organization is motivated by the very best of intentions, we must question this general approach to providing support for carers in the community. The organization is trying to provide a service which our social service departments should be providing. Time and time again, however, we are told by social services that they do not have the money and resources to expand their activities. But the money is there. The problem is that it is being diverted to various charitable and voluntary agencies active in these areas. The government is therefore making a clear political choice as to how state support to carers in the community is distributed. They are cutting back on democratically accountable public services and are handing the task over to the voluntary/charitable sector. No doubt this will be presented as 'the acceptable face of privatization' stepping in where the statutory services have failed.

The present Prime Minister is on record as favouring the restoration of 'Victorian values'. Is this to be another, albeit subtle, way of doing it? Are we to see a future where more and more caring services are to be provided based on this model where local worthy people, motivated by Victorian senses of public duty, establish charitable organizations to cater for 'the needy poor' of their local parishes? Their efforts will be pump-primed by central government but will in time be expected to generate their own financial support from 'socially concerned' private enterprise, jumble sales, flag days and who knows what else.

It may seem ungrateful and hard-hearted to be so critical of the well meaning efforts of the voluntary sector but we must not retreat from the present position that adequate support for carers in the community is a social right. And if it is a social right then it must be provided for and administered by democratically accountable public bodies and not left to the chance of charitable provision. Charitable and voluntary effort will always have a role in complementing the statutory services but they must not be allowed to supplant them. Such an approach failed in Victorian times and is bound to fail again.

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Visiting the elderly

Sir,

Two years ago we set up a voluntary scheme from within our practice population to visit the elderly who are either infirm or relatively housebound. The visitors also act as a liaison between the medical services and our patients. As the scheme has grown we have looked for other practices who might be doing the same thing. We would very much like to hear from them if they would be interested in meeting to discuss the issues and to compare results.

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Generic inhalers

Sir,

I have recently finished my vocational training and become a principal in general practice. I have always been a great enthusiast of generic prescribing but several of my patients have complained that their generically prescribed drugs are not as good as the original brand named products. In most cases I have been able to reassure them by an explanation about generic prescribing.

However, in the case of aerosol inhalations the quality of the delivery mechanism is just as important as the actual content of the aerosol cannister. Several asthmatics have complained that salbutamol inhalers are not of as high a quality and do not deliver the same effect as the original brand product. Recently one of my patients had an inhaler which lasted only four days and delivered 40 doses at most.

I have taken this up with the pharmacist and will contact the manufacturer but I would be interested to know if other practitioners are finding similar problems with generic inhalation medicines.

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AIDS, HIV and general practice

Sir,

I recently represented the College at a seminar on the acquired immune deficiency syndrome (AIDS) which was organized by the TUC for their members. I came

away from the meeting with the two words 'discrimination' and 'education' foremost in my mind. I believe these terms are also relevant to doctors and health care workers.

In his paper 'Present and future prospects', Dr W. Harris of St Mary's Hospital gave an outline of current treatment, which is having a considerable impact on the course of the disease, though serious side effects are common. The cost of care in established cases is becoming astronomical as frequent blood transfusions are often required as a result of the treatment. The rate of spread of the disease in the homosexual population in this country is now slowing, but it is estimated that there will be an increased spread from intravenous drug users. Many countries are unwilling to reveal the incidence of the illness for fear of discouraging tourism.

Dr T. Carter of the Health and Safety Executive reminded us that at most times in our history there has been a serious infection in our midst such as tuberculosis or leprosy, and that human immunodeficiency virus (HIV) infection is less infectious than hepatitis B. Only eight cases of sero-conversion have been reported so far among health care workers worldwide. He discussed prevention of infection at work — not only for health workers, but for groups such as teachers, the police and first aiders.

The last speaker was Norman Willis, General Secretary of the TUC who believes the TUC can play a part in limiting the spread of the disease. He referred to discrimination at work and to the social implications of the disease. Screening employees, or potential employees, is divisive, impractical and is of no value. When people are discriminated against because of HIV infection they rarely resort to an industrial tribunal because of fear of publicity. People with AIDS must be educated and protected and should be treated in the same way as any other patient.

The discussion that followed was varied, but I suspected that even this interested group of people understood little about the disease. There was only one request for compulsory testing for HIV — from a prison officer — and he was not applauded.

The topics for the workshops in the afternoon related to procedures in the workplace, discrimination at work and in the wider community, care and counselling for AIDS patients, and the legal implications for trade unionists. Although each group had a separate subject, each came back to discrimination — at work, in housing, in insurance, even in treatment by doctors.

There is a need for education of the whole community, including health and social service workers, about the disease and how it is spread and this must lead to a change in attitudes. General practitioners have a valuable role to play in educating the community and trade unions too must play an active part.

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Sir,

Further to the editorial 'AIDS, HIV and general practice' (July *Journal*, p.289), we would like to draw attention to the creation of two posts for primary care doctors in London. Funded by the charity Help the Hospices the two appointments are based at the two major centres for the care of patients with AIDS in London, St Stephen's Hospital, Chelsea and St Mary's Hospital, Paddington.

The overall aim of each post is to train general practitioners in aspects of AIDS and HIV infection before developing links between the hospital and the community. These links will involve individual patient management and will try to improve communication about and understanding of AIDS from a community perspective.

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The case for smaller lists

Sir,

In his editorial (November *Journal*, p.481) Dr Roland argues that a doctor with a large list size providing five minute consultations fulfils many of the criteria often used to assess his quality of service but then appears to condone the view that there is no defence for maintaining such a large list.

This is yet another illustration of the dilemmas facing general practitioners, politicians and health planners when deciding what service is required, at what cost, and by whose quality assessment. To state that patients rightly have increasing expectations is to further compound the problem. The doctor can be expected to proffer advice and treatment with explanation and consideration, but not to absorb and resolve the effects of society's and an individual's actions.

The general practitioner is now being asked to widen his terms of contract to areas in which he has neither specialist skills nor resources. The solution is not to reduce his list size, increase his numbers, provide additional resources or pay him more. It is for everyone to have realistic expectations and no one to believe they have a predetermined right to anything — an educational and preventive lesson which doctors, patients and society will find difficult to learn.

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Sir,

I must take issue with the editorial by Martin Roland (November *Journal*, p.481) The case for further reduction in general practice list size is indeed answerable.

It should be perfectly possible for a general practitioner with a list size of 2500 to practise day-to-day care and also extend his or her services into prevention. One thing is necessary for this — organization.

With the present regulations, a good practice nurse, with the aid of questionnaires and simple procedures like measurement of blood pressure, urine testing and blood lipid estimation, should be able to carry out a large slice of preventive care, with referral to the general practitioner if necessary when problems arise. The nurse, of course, can be employed with 70% reimbursement. Also, with the health visitor attached to the practice and the help of the midwife, both geriatric and paediatric surveillance can be accomplished with all the team working together.

After all, we do not expect the pilot to land his plane and, at the same time, organize care and facilities for the passengers. If we do not use the facilities available to us, then be it on our own heads. Present list sizes can be coped with well, given thought.

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