Human immunodeficiency virus infection and the acquired immune deficiency syndrome in general practice

WORKING PARTY OF THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

Introduction

THE acquired immune deficiency syndrome (AIDS) was first described clinically in California and New York in 1981 in homosexual men and intravenous drug misusers.[1] The recognition of the seriousness of the problem for the whole population was delayed by the initial restriction of the human immunodeficiency virus (HIV) to these two groups of people and the slow progression from infection to the appearance of the clinical disease. The lack of a cure or vaccine for the disease means that the only weapon for combating the epidemic is prevention of spread of the virus.

Size of the problem

By the end of March 1988, 782 people in the United Kingdom were known to have died from AIDS; 8443 people were reported to be infected with HIV[2] but the DHSS has estimated that the true total might be 30 000 to 40 000. Following a conference of experts on 23 March 1987, the Secretary of State for Social Services estimated that approximately 4000 people will have died from AIDS by the end of 1989.

Beyond 1989 predictions about the number of cases of AIDS and HIV infection are difficult to make because they will depend on at least two uncertain variables. The first is the extent to which education of the general public will influence sexual behaviour. Evidence from San Francisco suggests that homosexuals in that city have changed their sexual behaviour as a result of educational programmes[3] but this change occurred only after the population had developed a high prevalence of the virus. The second major uncertainty is that the infectivity of the virus in the heterosexual population is not known. If changes in patterns of sexual behaviour do not occur and if there is rapid dissemination of the virus in the heterosexual population, then the present figure of approximately 40 000 infected people in the United Kingdom could rise to 3.2 million infected in February 1992. It is estimated that half a million people in New York are already infected.[4]

Role of general practitioners

Of the 30 000 to 40 000 people which conservative estimates suggest are already infected, many are likely to develop AIDS, 20 to 30% of them within three years.[5] AIDS will then no longer be confined to a few geographical areas and by 1992 many general practitioners will not only be dealing with patients who suspect that they are infected with the virus but also helping to care for patients with clinical AIDS. Professor Adler[6] points out that patients with AIDS spend most of their time out of hospital and that the first acute infection in the disease may be the only time when hospital admission is required. As the number of cases rises, subsequent acute infections and terminal care for AIDS patients will be managed in the community, with general practitioners and district nurses playing a major part. Primary health care teams have little time to prepare themselves for these clinical responsibilities.

On the 13 May 1987 the Social Services Committee of the House of Commons reported on *Problems associated with AIDS*.[7] The Committee also recognized that most people with AIDS in the United Kingdom spend over 80% of their time between diagnosis of the disease and death living in the community and that community care is not only cheaper but also desirable in its own right. Many of the comments made to the Select Committee concerning general practitioners were negative about their present contribution to the care of AIDS patients. General practitioners were portrayed as ignorant about AIDS and even, in some cases, unwilling to provide care to AIDS patients.

Letters to the Working Party from Members of the College have emphasized that general practitioners are keen to demonstrate that they are both willing and competent to care for AIDS patients. Members point out that through their access to the whole population, general practitioners will have an important practical role to play in the prevention of HIV infection. This point was also made in the College's evidence to the Select Committee.

Provision of care for AIDS patients

Marked geographical differences in the prevalence of HIV infection and the type of people infected are a feature of the epidemic in the UK at present.[8] The largest group of HIV positives are homosexuals in the Thames regions and the second largest group is in Scotland, where the majority are intravenous drug users.[8] These two groups differ in their use of medical services, and, together with differences in the organization of medical services, there are consequently differences in the way in which care is being provided for infected patients in the two localities.[9] In the London regions liaison between primary and secondary care is difficult and specialists in genitourinary medicine have taken the lead in providing the necessary medical care.[6] Many patients have not wished their general practitioners to be informed of their infection and care has been based on hospital clinics. In contrast in Edinburgh, medical care is shared between general practitioners and the consultants in a number of different specialties, including infectious diseases, paediatrics, obstetrics as well as genitourinary medicine. In Edinburgh, general practitioners have taken a lead in the diagnosis of HIV infection and in research.[10,11] The sharing of information between medical colleagues has not been found to be such a major problem as in London. From this early experience, it is already clear that a uniform system of care for HIV infected patients will not be implemented throughout the country. Local factors will be crucial in determining the pattern of care which is provided and it is vital that good liaison and communication between the different providers of care is fostered in each district.

This paper was presented for discussion at the March 1988 Council meeting. The working party would welcome comments on the paper from members of College. Members of working party: Dr E.G. Buckley (Chairman), Dr A.G. Donald, Professor V.W.M. Drury, Professor D.J. Pereira Gray, Dr P. Hill, Dr D. Murfin, Dr J.R. Robertson.

There is a danger that community care for AIDS patients will be developed without incorporating general practitioners into the network of services. The Select Committee[7] envisaged that the model of community care which emerges for AIDS patients will also be applicable to other patient groups. If general practice is to continue to play a central role in community care, there is an urgent need to convince both government and patients of the important contribution which general practitioners can make to the care of AIDS sufferers.

This report seeks to identify the tasks and challenges facing general practitioners in helping to prevent the spread of the virus in the United Kingdom and in caring for infected people. The report concludes by making recommendations for initiatives by the College.

Ethical considerations

The initial restriction of infection to homosexual men and intravenous drug users has influenced the way in which AIDS sufferers are perceived by the general public. They are stigmatized and blamed for their illness and it is understandable that infected people are reluctant to disclose the nature of their illness. There are some signs that attitudes are beginning to change[12] as it becomes more widely appreciated that a large proportion of the population are at risk of infection through heterosexual transmission of the virus.

Although HIV may be a new virus, the social and ethical problems which it poses are not new. Before the discovery of antibiotics, tuberculosis and syphilis were chronic incurable illnesses and patients were in danger of being stigmatized if the nature of their illness became generally known. Doctors and patients are having to re-learn old lessons concerning professional and personal responsibilities. This section of the report looks at the ethical issues associated with HIV infection, because practical strategies of care and decisions in the management of individual patients need to be based on principles which are supported by the medical profession and society in general.

General principles

The ethical foundations of medical practice have recently been considered by Thompson.[13] These are relatively easy to state in general terms: beneficence — a doctor tries to help rather than harm the patient; respect for person — a doctor recognizes the right of patients to make their own decisions; justice — a doctor recognizes that he or she also has a duty to society and not just to an individual patient. Ethical dilemmas occur when these aspirations are in conflict with each other. The Pond report[14] on the teaching of medical ethics emphasizes the importance of analysing clinical problems to make the ethical dilemmas explicit and clear. General solutions cannot be provided and decisions will depend on the judgement of the people concerned, and will be taken in the light of prevailing social and legal views. Present judgements concerning the confidentiality of medical information and the necessity for informed consent before carrying out tests for HIV infection may change if the epidemic continues unabated.

Confidentiality

Two examples are considered here which present similar problems of confidentiality but where general practitioners may respond differently: (1) A boy with haemophilia is found to be HIV positive when he visits the general practitioner. Should his school be informed of this fact? (2) A young woman is found to be HIV positive when she attends a genitourinary clinic. She feels well and does not wish her general practitioner to be informed. How should the specialist in genitourinary medicine respond to this request?

Whereas most general practitioners would wish to be informed about the HIV status of their patients, many would be hesitant about giving the same information to a school. Generalizations are not helpful and before responding to the questions posed above, it is necessary to have much more information about the particular circumstances of the two cases and the context in which they occur. It is also necessary to clarify the ethical issues involved.

Ethical judgements on AIDS should be based on the available evidence. Thus, we know that the risk of transmission of HIV through normal social contact is remote; in the absence of other high-risk behaviour infections have not occurred in households of patients with AIDS.[15] Infections have been shown to occur through needlestick injuries and through blood spillage in individuals with skin lesions.[15] In addition to these general facts we need to assess our knowledge of the individuals concerned. For example, in case 1, does the boy understand that he may infect other children if he bleeds from a laceration? In case 2 is the general practitioner's receptionist a friend of the patient?

The dilemmas posed by such cases concern all aspects of the ethical basis of our dealings with patients. Is disclosure in the best interest of the patient? Is the patient able to make a mature decision about disclosure? Is maintenance of confidentiality in the best interest of others? The ethical issues can be resolved by discussing with patients the implications of disclosure or of withholding information and by helping them to take action which minimizes the risk they pose to others. Nevertheless occasions will arise in general practice when the doctor will feel obliged to break the usual confidentiality of medical information because others are being placed at risk of harm. People who are aware that they are HIV positive and who do not inform their sexual partners of this fact are legally accountable if that partner becomes infected.[7] Professor Ian Kennedy in his evidence to the House of Commons Select Committee[7] argued that a doctor would be contributing to a felony if a sexual partner of a patient could have been protected from infection by being given information by the doctor. The content of a consultation is not privileged in a legal sense and medical records must be produced if a doctor is ordered to do so by a court of law. On the other hand, doctors can be legally liable in the civil courts for breaches of confidentiality which lead to financial loss by a patient. General practitioners are also liable for any breaches in confidentiality by their employees. The precise legal boundaries concerning confidentiality with respect to HIV infection and AIDS have yet to be tested in court.

General practitioners are naturally most concerned about other doctors withholding information about the HIV status of their patients. This occurs most commonly when HIV infection is diagnosed in a genitourinary clinic. Patients may have deliberately avoided consulting their own general practitioner because the anonymity of a clinic is attractive to those who recognize that they are at high risk of infection. Even if a test proves to be negative and even though clinics have established systems of pre- and post-test counselling, opportunities for continuing health education for the patient are possibly lost if the general practitioner is not informed.

If the test carried out in the genitourinary clinic proves to be positive, then withholding this information from the general practitioner effectively excludes him or her from contributing to the future care of the patient. The organization of the health service in the UK is based on general practice as one of the main providers of primary care. It is unrealistic for hospital based services to be able to provide comprehensive care for HIV positive patients in the community, even with the present relatively small

numbers of identified cases. The high mobility of young adults who are the group most affected at present make it difficult for hospital out-reach teams to provide care in any meaningful way. In addition, sudden illness and less acute health problems which the patient may not recognize as being related to HIV may be presented to general practitioners, who are likely to respond inappropriately if kept in ignorance about the patient's HIV infection. Specialists should therefore seek permission from the patient to inform the general practitioner. Personal communication by telephone may be a useful first step in ensuring that information is kept confidential. This method has the advantage of allowing discussion on the immediate management plans.

It has been suggested that many people fear that knowledge of their being tested for HIV will not be kept confidential if general practitioners are informed.[7] There is an urgent need for the public to be reassured about the importance which general practitioners place on confidentiality. Public discussion and debate on this issue should therefore be encouraged.

An issue which is related to confidentiality and to informed consent concerns eligibility for life insurance policies. At present general practitioners receive requests for information from insurance companies not only about the patient's HIV status but also whether the patient has ever been tested for HIV and whether the doctor considers the patient to be in a high risk group for HIV infection. The system of providing insurance companies with information from a patient's medical record is well established and is helpful to the companies in forming a judgement about the life expectancy of the patient and deciding the terms on which a policy can be offered. There are doubts as to whether this system continues to be in the best interest of patients. Most people do not know in detail the content of their own medical records. The consent given to the general practitioner which allows the release of detailed information from the medical records cannot be a fully informed one and the quasi-judicial use of medical records has been criticized in the past.[16] In addition, patients who realize the potential future use to which their medical records can be put may avoid consulting their general practitioner. It is of great concern that outside commercial considerations may be distorting the way in which patients receive care. There is a need for further discussions and debate about this problem within general practice and with patient's organizations and the insurance industry.

Informed consent

Apart from patient's consent to provide insurance companies with information, as discussed above, there are two major aspects to informed consent relevant to HIV infection. The first issue is relatively straightforward and concerns the testing of people who are apparently well. Legal and ethical considerations agree in requiring informed consent by individuals before testing for HIV antibodies can take place. Because of the urgent need to improve our knowledge of the prevalence of the infection in the community, the case for anonymous testing without informed consent was put forward to the House of Commons Select Committee but was rejected on pragmatic as well as legal grounds.[7] Testing without consent is an infringement of an individual's right to privacy and bodies such as the UK Central Council for Nursing, Midwifery and Health Visiting and the British Medical Association have provided clear guidelines to their members advising them not to be involved in such activity.[17,18]

There are occasions when a general practitioner may advise a person who is well that he or she should be tested. For example, a woman who is known to be at high risk of infection and who has become pregnant should be informed of the possible risk of the fetus becoming infected and the possible adverse effects of the pregnancy on the speed of onset of AIDS. This information may persuade the woman to be tested and to seek a termination of the pregnancy. If the test is not carried out or is negative, her antenatal and perinatal care should proceed as if she is infected. Detailed recommendations about the appropriate care during pregnancy and delivery are contained in a report for the Royal College of Obstetricians and Gynaecologists.[19]

The second aspect of informed consent relevant to HIV infection is much more difficult and concerns the investigation of unwell people who consult the doctor. Those who advocate not telling patients that a test for HIV is included in a range of investigations do so on the basis that the patient gives implied consent to the doctor to look for all possible causes for their ill health and that explicit consent to each investigation would raise unnecessary anxieties. This view which is based on the ethical foundation of beneficence — the doctor is expected to help the patient, in this case by finding the cause of an illness — is in conflict with the ethical concept of respect of person. This concept challenges the view that doctors always know what is in the best interest of patients and may go even further in encouraging patients to take more responsibility for their own health. There is no simple resolution to this dilemma but there has been a general shift in society and in medicine towards valuing patient autonomy even at the risk of engendering additional anxiety for the patient.

Practice organization

Responsibilities

Although the problems posed by the HIV epidemic are not new, the consequences of failures in administrative and clinical activities are so serious that it is essential for general practitioners to examine their practice organization and where necessary improve on existing procedures. In addition to their own clinical role, doctors have responsibilities as employers to see that their staff are adequately informed and trained to deal with patients with AIDS. Other members of the primary care team need to be involved in the creation and implementation of clear policies in caring for patients and in protecting staff from infection.

Communication

General practitioners need to take care about the way in which a patient's HIV status is recorded in the manual and computer records and in communications about patients. Other members of the primary care team who have access to the records need to be identified and involved in discussions about confidentiality.

In communications outside the practice, links with other people and other organizations who are involved in the care of AIDS patients should be established before actual cases are being dealt with. This will enable all concerned to appreciate the contribution that each service can provide and will avoid problems which might otherwise arise owing to misperception of the roles of the different agencies. Establishing contact with these outside bodies at an early stage will help in creating the trust necessary to achieve a good working relationship.

Practical procedures

It is likely that few people who are HIV positive know of this and members of the practice team who carry out clinical procedures such as venepuncture and pelvic examination should be aware of the risks involved and take sensible precautions routinely and not only when dealing with known cases.

General practitioners should produce guidelines on safety and hygiene for those handling possible infected material and performing procedures and provide for safe disposal of clinical

waste.[20] Such procedures need not be elaborate; for example the wearing of disposable gloves and use of household bleach.

Conversely, staff such as receptionists may be reassured about the lack of risk involved in speaking to and touching people who are HIV positive.

Education

Practices should take steps to educate both the staff and patients about AIDS. All members of staff including the doctors themselves should keep up to date with developments in the treatment and care of AIDS patients. Posters, leaflets, local meetings and consultations can all be used to educate the practice population about the risks of HIV infection.

Counselling

Counselling of patients with regard to HIV infection is needed in different ways at different times. Young people who are at high risk of becoming infected because of their sexual behaviour or misuse of drugs require counselling to help them avoid infection. Other people require counselling to help them cope with the psychological distress which accompanies the fear of infection or when a test is confirmed as positive. Attention has been focussed mainly on the immediate pre- and post-test period when counselling is emotionally highly charged. Special AIDS counsellors have been appointed and this may imply that the existing clinical staff do not have the time or expertise to provide counselling themselves. Undoubtedly counsellors who have special training and expertise in dealing with AIDS sufferers have much to contribute but it would be a pity if counselling were to be seen as an activity which is separate from normal interactions between doctors and patients. A major component of the work of the AIDS counsellors should be the support and education of clinical staff so that the doctors and nurses who are dealing directly with patients can become more skilful in this part of their clinical work. A specialist counsellor cannot always be available to patients at the moments when counselling is most appropriate.

Counselling is more than information giving. It involves an attempt to understand the way in which patients perceive the problems they face. It also involves assisting patients to cope with the emotional aspects of their problems and to help them reach their own decisions in solving these problems. Stated in these terms counselling can be seen as no different from the way in which many general practitioners perceive their own work. Because of the continuity of care which they can provide, general practitioners have a unique contribution to make in counselling. As with other serious chronic health problems, such as cancer and diabetes, there will be times when referral to specialists will be necessary for help with physical and psychological problems.

Because counselling is an integral part of the care provided by general practitioners, the important elements of counselling which should be included at different stages of HIV infection need to be considered alongside doctors' other clinical responsibilities.

Clinical responsibilities of general practitioners

Health education

In the introduction to this report, it was pointed out that prevention of infection is the only defence we have against the HIV epidemic. The important role which general practitioners have to play in prevention in general has been recognized in the Government's white paper.[21] General practitioners have access to the whole population and a high proportion of patients consult each year. The HIV epidemic presents a clear challenge to general practice to demonstrate that preventive care can become a reality.

The Government has already funded mass advertising campaigns designed to inform the general public about the risks of infection. General practitioners, however, can provide health education about AIDS which is tailored to the needs of an individual and there is a need for suitable material in the form of leaflets and posters to be available to doctors. With health visitors and other members of the health care team, general practitioners can also reach groups of patients as well as individuals.

The unworried well

It is difficult to identify people in a practice population who are at high risk of infection. Without making specific enquiries it is unlikely that general practitioners will be aware of which of their male patients are active homosexuals or even which are intravenous drug misusers. They may know if their patients have visited Africa, south of the Sahara since 1977, but are unlikely to know if such patients had sexual intercourse with men or women living there. Although up to now these have been the high risk groups in the population, in order to help prevent further spread of the virus, general practitioners need to discuss the dangers of infection with all patients who are likely to have new sexual partners of either sex. Consultations by young adults who seek advice about contraception provide a useful opportunity to ascertain the patient's knowledge about the risks of infection and, if appropriate, give information about sensible precautions for avoiding infection, thus reinforcing and filling any gaps in the Government's education campaign on AIDS. General practitioners should be able to give clear guidance to their patients about which sexual practices carry a low risk of transmission of infection.

At present it is unusual for men to consult general practitioners for advice about contraception. If general practitioners were able to prescribe free condoms, this might encourage a group of people who are potentially at high risk of acquiring and spreading the virus to come and see doctors.

The worried well

There are two groups of people who consult general practitioners because of anxiety about the possibility of HIV infection. The first group are those who because of their sexual behaviour or misuse of drugs really are at risk of infection and the management of this group will be considered later.

The other group of people worried about HIV infection are those who are at no risk or minimal risk of infection but are unduly anxious. In many cases this reflects a lack of knowledge about the mode of transmission of HIV and the general practitioner needs only to provide information and reassurance. In a few cases people may be preoccupied by the idea of infection; individuals with this type of problem present in different ways.[22] Physical complaints may be presented as evidence of infection despite reassurance that the person's sexual history precludes the risk of infection. Guilt about previous sexual activity may be a feature. If reassurance and negative HIV tests are not effective in ridding patients of their fears they may need to be referred for psychological or psychiatric help.[22]

Pre-test management

Many general practitioners are already being consulted by patients requesting tests for 'AIDS'. Before carrying out a test for HIV antibodies it is important that the patient understands the nature of the test and the consequences of carrying it out. If the patient is requesting the test because he is taking part in un-

safe sexual practices or because of drug misuse involving the sharing of needles, the general practitioner needs to impress on the patient the importance of changing this behaviour irrespective of the result of the test. Once people understand that the test does not diagnose AIDS but is an indication of exposure to HIV and that the test can require up to three months from contact before it becomes positive,[23] they may reconsider having the test.

Being identified as seropositive or even having had the test may make the person ineligible for life insurance and consequently for some mortgages. Appreciation of this fact may also persuade some patients not to have the test.

In spite of these considerations many patients will wish to be tested in the hope that the result will be negative and so reassure them about their future health prospects. However, a second test after three months may be necessary to rule out infection.[23]

Post-test management

The general practitioner must give the results of HIV testing to the individual concerned in person, not only if the test is positive but also when it is negative so that areas covered in pretest counselling can be explored further and arrangements made for follow-up.

Informing people that they have antibodies against HIV can be compared with telling people that they have cancer but there are differences. First, there is no possibility of revealing the result of the HIV test in a gradual manner. Secondly, in addition to the concern patients will experience about their future health and life expectancy, they will also fear the stigma and social consequences of infection.

Immediate post-test counselling requires time in the consultation. As in other life crises individual reactions vary widely from denial to emotional outpourings. Patients will tend to assume the bleakest prognosis and general practitioners should emphasize the distinction between being HIV positive and developing AIDS. The general practitioner should discuss the practical steps which the patient can take to maintain good health.

Miller[22] has described the needs of patients in the early days after being informed of a positive test result. He emphasizes the importance of providing a 'life line' for patients. This may be the home telephone number of the doctor and/or the voluntary agencies (such as the Terence Higgins Helpline number). It is also important that patients should not be alone at this time and arrangements should be made to see the patient again in the next few days, preferably with their partner or a member of their immediate family. Reinforcement of positive advice and frank discussion about the uncertainties in prognosis will be necessary. At this point it is also necessary to discuss the changes patients may need to make in their sexual behaviour and personal hygiene so that sexual partners and other family or household members are not put at risk of infection.

General practitioners may wish at this stage to enlist the help of others in the care of the patient. In so doing the issue of condientiality should be raised with patients and this is an opportunity to help them decide whom they wish to inform of the test result and how they will do it.

The general practitioner should expect patients to experience psychological problems as they adjust to the knowledge of the test result. Anxiety and depression are likely to be the main features and may occur after the patient has apparently come to terms with the diagnosis. It is important for general practitioners to see their patients who are HIV positive on a regular basis in order to be able to detect the early signs of psychological distress, provide emotional support, encourage a healthier lifestyle and monitor physical well-being.

Tests which detect HIV antigen and measure the integrity of the immune system are becoming widely available and general practitioners will need to discuss with local specialists and the local laboratory service the precise way in which an HIV positive person should be monitored. Early indications suggest that treatment with anti-viral drugs may be effective in delaying the development of AIDS[24] and therefore it is important for early signs of breakdown in the immune system to be detected.

The immediate post-test management of an HIV positive patient is only the first step in what should be regarded as a continuing commitment by the general practitioner. As the major resource for long-term care for patients in the community it is important that general practitioners are involved as soon as possible in the care of HIV positive patients.

Early symptoms of HIV infection

Adler and Mindel have described the clinical features of early HIV infection and AIDS.[5,25] Acute infection with HIV is usually asymptomatic and it is therefore often difficult to determine the duration of infection at the time of diagnosis. This makes it difficult to establish the prognosis for progression to AIDS both for individuals and for populations. Some people have a glandular fever type illness at the time of infection and neurological disorders at this time have also been described. As the prevalence of HIV infection increases, general practitioners should include this condition in the differential diagnosis of glandular fever like illnesses. At present this diagnosis need only be seriously pursued if a patient is in a high risk group and general practitioners should therefore take a sexual and drug history if faced with this clinical condition.

Symptoms of chronic infection

Patients may present to a doctor at a late stage in their illness and general practitioners need to be aware of the clinical features of chronic HIV infection and AIDS. Persistent generalized lymphadenopathy, weight loss, fever and diarrhoea are the features of chronic HIV infection. There are many other causes of persistent generalized lymphadenopathy other than HIV infection, for example glandular fever or toxoplasmosis and the way in which this clinical finding is investigated will depend on the history. The constitutional symptoms of diarrhoea, weight loss and fever may run a fluctuating course in chronic HIV infection. In the absence of lymphadenopathy, diagnosis will be difficult unless it is clear from the history that the patient is in a high risk group.

Persistent generalized lymphadenopathy and constitutional symptoms are poor prognostic signs and indicate the need for specialist advice regarding treatment. Nevertheless both persistent generalized lymphadenopathy and the constitutional symptoms can resolve spontaneously. AIDS related complex — a term used to describe a combination of persistent generalized lymphadenopathy and constitutional symptoms together with abnormal laboratory tests — is not particularly valuable now that the laboratory indices of immunological competence are more precise.

The acquired immune deficiency syndrome

By the time the patient develops opportunistic infections such as *Pneumocystis carinii* or a tumour such as kaposi's sarcoma, the diagnosis of HIV infection is likely to have already been made. Once the diagnosis of AIDS has been made the prognosis is still not hopeless and Adler[6] has shown that his patients continue to spend most of their time in the community with only short spells of hospital care. As the number of cases increases, general practitioners will have an increasingly important role to

play in the care of AIDS patients in the community. Good communication between the different agencies providing care is of crucial importance at this stage of the illness. Antiviral treatment is improving the prognosis in AIDS and the early aggressive treatment of opportunistic infections is required.

Terminal care

In areas of existing high prevalence of AIDS, such as central London, hospitals and hospices will soon not be able to cope in providing places for the terminal care of AIDS patients.[6] Voluntary organizations are attempting to provide more hospices and general practitioners may be able to contribute to the care of patients in these settings. However, the major role of general practitioners in the terminal care of AIDS patients will be for patients who wish to die in their own homes. General practitioners will need to acquire skills in controlling patient's symptoms and in supporting the family and other informal carers.

Educational needs of general practitioners

Because AIDS has only appeared in the UK in recent years, few general practitioners have received any formal education about it and even fewer have experience of diagnosing and treating patients with the disease. There is therefore an urgent need for programmes of postgraduate education about AIDS and HIV infection. This problem is compounded by the fact that public awareness about AIDS means that new information about the epidemic is often provided direct to the general public and, as the point of first contact with the public, general practitioners need to be able to explain and place this information in context. General practitioners therefore need ready access to information as well as regular updates about new knowledge.

Knowledge about AIDS is the first educational need which must be met but is only the starting point for developing the clinical skills to diagnose AIDS and care for those with the disease and for learning how to counsel patients who are found to be HIV seropositive and those who request an HIV antibody test.

Present state of postgraduate medical education about AIDS

In July 1987, the working party contacted all the regional advisers in general practice in the United Kingdom to ascertain what educational activities were being organized concerning HIV and AIDS. The prompt response from the advisers is a measure of the importance which they are giving to this problem. All reported that symposia and other postgraduate meetings had been organized for general practitioners and some advisers had collaborated with specialists in providing educational material in innovative ways such as audio-conferences and the production of videos. However, several advisers commented that their regions did not yet have a comprehensive strategy for ensuring that all general practitioners were fully informed about the epidemic.

The Working Party also contacted faculty secretaries to enquire about educational activities in their faculty. Some faculties have identified individuals who will seek to establish strategies of continuing education for members and will coordinate local initiatives. As with the regional advisers, it emerged that there is a lack of a general framework for identifying and meeting the educational needs of general practitioners in caring for AIDS patients.

Distance learning

It is difficult to ensure that all general practitioners will attend postgraduate courses on HIV and AIDS and even more difficult to ensure that they will learn from such experiences. Distance learning combined with assessment of knowledge is a feasible and well established method of continuing medical education. The College through the CLIPP programme has demonstrated that it is possible to reach thousands of general practitioners with educational material in a way which allows participants to assess their own knowledge of a subject. We should continue to develop distance learning material on HIV and AIDS which can be sent to general practitioners on a regular basis. The educational material should aim to increase the knowledge of general practitioners about the disease and should also challenge the recipients to examine how they will respond to the clinical problems associated with HIV infection.

Small group learning

The development of small group learning has been a feature of continuing education in general practice over the past 10 years and is now well established as an effective means of learning new skills and also influencing clinical behaviour and attitudes. However, in the past, small group meetings have been a minority interest involving only enthusiasts. To prepare for the clinical epidemic of AIDS, participation in such meetings should form a normal part of continuing education for general practitioners so that the complex clinical and ethical issues involved in the care of HIV positive and AIDS patients can be examined and sensible strategies agreed.

Recommendations

A major new health problem such as AIDS not only requires specific medical action, it also challenges the utility of existing institutions and traditions in medicine and society at large. We as general practitioners must demonstrate that we can maintain the health of the population and care for the sick. We cannot assume that patients and other doctors will turn to us for help simply because we are there. So far general practitioners have been largely excluded from the public debate about the epidemic. There is an urgent need to emphasize the contribution which general practitioners can make in the prevention of HIV infection and the care of AIDS patients. This is matched by the need to ensure that general practitioners are competent to play an important part in the management of this disease.

Policy

At the September meeting of Council 1987, the College affirmed that 'general practitioners must be willing to treat and advise patients who are HIV positive and/or suffering from AIDS. These patients should have access to and be provided with all the care and support which general practice can provide. General practitioners should be taking a lead in demonstrating that infected patients pose no threat to others in normal social, domestic, or work activities.' The College should highlight the major contribution which general practitioners can and will make in the prevention of HIV infection and the care of AIDS patients by organizing a national conference on AIDS, HIV infection and general practice, which could be used as an opportunity for the College to reach a mass audience as well as providing a forum for the detailed discussion of practical clinical problems.

The College should also establish links with other national organizations involved in the care of AIDS patients, such as the Faculty of Community Medicine, so that sensible guidelines can be agreed concerning the care of AIDS patients which will prevent unnecessary fragmentation and duplication of services. It is equally important for good relationships to be built up between the College and voluntary organizations who are active

in this field. These organizations may need to be convinced of the willingness of general practitioners to become involved in the care of AIDS patients. Contact with other organizations needs to be established at every level: nationally through the College Council and its officers, regionally through the College faculties and at a practice level by individual College members.

Education

Centrally, the College should be able to provide members with up-to-date information about AIDS and HIV infection. Existing services can respond to specific requests for information and the *Journal* will continue to publish original papers and updates about the epidemic.

As part of the CLIPP programme, a distance learning booklet has already been produced. There is a need for the College to continue to support this programme of distance learning so that further material about HIV and AIDS can be sent to all general practitioners.

The faculties of the College should plan a strategy of postgraduate education about AIDS which is appropriate for each locality. This is likely to involve further development of existing small group meetings. An important task for faculties is to monitor and evaluate the education programmes which are taking place in their own region.

Research

The College is already supporting individual research work about AIDS via its research fellowships but should become more directly involved in research about this epidemic. There is much which is still unknown about the natural history of the disease and the way it affects different groups and individuals. The present methods of detecting and reporting HIV positive patients give only a poor indication of the extent of the epidemic and general practitioners are well situated to produce data which could give a more accurate estimate of the number of people who are infected and the number of people who are at risk of infection. Research is also needed into the most effective ways of helping high risk individuals to avoid becoming infected and into the ways in which AIDS sufferers can best be cared for in the community. The College should consider mounting studies in these areas.

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