LETTERS

Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing.* Failure to comply with this may lead to delay in publication.

Audit of prescribing habits in a sheltered housing development

Sir,

It has been shown that the elderly need supervision while receiving long term medication.[1] Of those aged over 65 years 92% take some form of medication[2] and more than half of them take it inaccurately.[3]

I have carried out an audit of drug taking habits in the elderly in a sheltered housing development with the additional aim of practising tertiary prevention, since it has already been shown that reliance on self-referral by this group is unsatisfactory.[4]

In total, 30 persons were visited in 24 flats. The age range was 62–93 years with a mean age of 76 years. Each person completed a questionnaire in my presence and permitted a search of their medicine cupboards. Details of all prescribed, old and new, and 'over the counter' drugs were noted. To improve compliance a card with instructions on how to take long term prescribed drugs was left with the patient.[5]

On average there were nine different drugs in each flat and seven per person. Only two people were taking no prescribed drugs while 16 had no over the counter preparations. The smallest number of drugs found in any flat was three, the largest 26 while the mode was five. Over the counter drugs made up 24% of all drugs found (Table 1) and previous studies have shown that these drugs have a negative effect on compliance.[6] None of the patients had told their general practitioner that they were taking over the counter preparations.

An attempt was made to simplify the drug regimens of these patients since multiplicity and frequency of drug taking has shown a negative effect on compliance.[7] Any old and unnecessary drugs were removed from the flats; these made up 18% of all drugs found (Table 1). Following the audit eight people had the number of prescribed drugs they were taking reduced while four had the number increased, although none of these were then taking more than three drugs daily.

Table 1. Drugs found in the audit.

Drug types	Prescribed	Over the counter	Old[a]
Gastrointestinal	13	17	13
Cardiovascular	46	1	4
Respiratory	15	7	4
Central nervous system	18	2	3
Infection	4	0	3
Endocrine	3	0	0
Blood/nutrition	2	7	0
Musculoskeletal	17	13	5
Eye	0	1	4
Ear, nose and throat	0	0	0
Skin	3	3	3
Total	121	51	39

[a]Old drugs are those originally prescribed by the general practitioner but no longer intended to be used.

The survey showed that it may be helpful for a member of the primary health care team to collect old drugs on routine visits. Forty per cent of the patients in this survey had their prescriptions altered thus reiterating the need for adequate supervision of drug taking in an elderly community.

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Homeless families

Sir,

I would like to point out some of the strategies employed by South Manchester health authority in response to the increase in homelessness. Since 1980 the number of homeless families has risen from less than 100 to over 600 across the city. Initially, most of the families were located in south Manchester and most of the single homeless in central and north Manchester, and a specialist health visitor was allocated to homeless families in south Manchester. There were a large number of children and a clinical medical officer was allocated to spend one half day visiting the hostels used, to ensure that immunization and developmental follow ups were completed. The hostels were also visited by local general practitioners.

In the years since, the staffing allocation has been increased and later this year will consist of three full-time and one part-time health visitor, a visiting family planning nurse and four senior clinical medical officer/clinical medical officer sessions serviced by part-time clerical help. For several years all the agencies involved, including health, social services, housing and education departments, women's aid and Shelter, have met regularly to formulate ways of providing adequate provision for these families. One result of these meetings has been a great improvement in the standards of accommodation offered and its provision across

larger areas. Concentration of families on one site causes many of the problems which beset families in temporary accommodation, such as gaining access to general practitioners and schooling. There are now only occasional problems with gaining general practitioner cover.

Many of the aims of the agencies involved, such as the development of self-contained temporary accommodation and one health visitor per 50 families, have been achieved. Needless to say the ultimate aim is to see the provision of sufficient housing to eliminate the problem altogether.

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General practitioners: prevention of HIV disease/ AIDS

Sir,

Discussion has taken place in this *Journal* regarding primary care provision for patients with human immunodeficiency virus (HIV) infection and the acquired immune deficiency syndrome (AIDS). Many practices will now have both patients who are infected and patients who are ill. Clearly demands made on general practitioners will progressively increase and it is therefore timely that the reactions and attitudes within primary care have been documented in the *British Medical Journal* of 20 February.

In 1981 this department sought advice from the Joint Committee on Postgraduate Training for General Practice in developing educational objectives in the area of AIDS/HIV infection for future general practitioners undergoing full time senior house officer appointments within genitourinary medicine. At that time the RCGP acknowledged the opportunities for prevention that such experience might afford to the future general practitioner.

We have now updated the educational content of our post and our objectives with regard to HIV disease are summarized below.

A. Epidemiology

1. Knowledge and awareness of the problem both nationally and locally.
2. Ability to use both national and international data and knowledge to contribute locally towards the prevention of HIV disease, making use of the 'lag period' before increased spread of infection from intensely affected areas (like London) occurs.
3. Understanding of the value of epidemiological data assimilated by the local specialist unit relating to extension of the HIV epidemic. Ability to utilize such data to plan and modify primary care services.

B. Aspects of health education

4. Competence in providing a multidirectional health education approach to HIV disease based on a comprehensive understanding of modes of virus transmission; with adaptation for individual practice populations.
5. Confidence and competence in promoting safe sexual practices in combination with encouragement to risk groups to re-evaluate their approach to personal relationships.
6. Ability to participate in meetings and talks organized with public groups to promote knowledge and preventive aspects of HIV disease.

C. Aspects of counselling

7. Confidence in guiding and supporting individual patients requesting the HIV antibody test.
8. Competence in counselling patients and their partners worried about HIV disease.
9. Competence in counselling patients and their partners known to be infected with HIV.

D. Clinical caring in HIV disease

10. Experience in all aspects of clinical, psychological and social management of individuals who are HIV antibody positive. Understanding and experience of those aspects of terminal care which pose particular difficulties in relation to HIV disease.
11. Ability to provide support and to make available services for the partners and relatives of antibody positive individuals.
12. Familiarization with the in-ward management of patients with AIDS or HIV disease. Experience of the 'hands-on' approach to caring.

E. General practice preparation and organization

13. Confidence (based on experience) to guide and support all members of a primary health care team in adjusting to the increasing demands for their skills as the HIV epidemic progresses.
14. Understanding of fears, anxieties and stresses experienced by health care professionals (and their families) working with patients suffering from HIV disease. (Ability to provide internal support within the practice team.)
15. Ability to promote and maintain the highest levels of confidentiality within the primary health care team as the foundation for successful general practice care for HIV disease.

It is our belief that as the HIV problem expands and as a greater understanding with regard to heterosexual transmission is achieved, there may be potential for greater training of future general practitioners within genitourinary medicine, possibly as an elective option. In addition to HIV prevention, there exists a clearly demonstrated potential to prevent tubal occlusive infertility,[1] and to move from the prevention of cervical cancer to the prevention of cervical pre-cancer.[2]

Milne and Keen[3] emphasize the preventive potential available to general practitioners who see two-thirds of the population each year. Closer collaboration and increased understanding between primary care and genitourinary medicine may enhance this potential. In addition, attention may be afforded to the 'absent' one-third where risk factors are identifed.

We would welcome any comment, or addition to our objectives from your correspondents.

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AIDS and general practice

Sir,

I welcome the College working party report on the acquired immune deficiency syndrome (AIDS) (May *Journal,* p.219) as it highlights many broad issues. However, I would like to focus on some specific problems relating to long term care, and make some suggestions as to how these may be overcome.

District policies. The size of the problem and the resources available to deal with it will vary between districts. There is, therefore, an urgent need to develop district policies which clarify important issues, such as:

- roles and responsibilities of different professionals in hospital, general practice and the community;