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 multi-directional 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;

- shared care policies;
- criteria for admission, outpatient referral, urgent assessment, use of specific community resources, cash limited allowances, antiviral therapy and psychological or psychiatric referral;
- rationing devices for use of scarce community resources;
- what is thought ethically correct to tell ambulance staff about transportation of an AIDS patient;
- which general practitioners are not prepared to take on AIDS patients;
- how best to obtain records from a previous general practitioner;
- how to transfer records to a new general practitioner when an AIDS patient moves out of the area.

There needs to be a multidisciplinary group responsible for developing and reviewing district policies on these and many other AIDS-related issues.

*Protocols.* As a general practitioner I need to know how to identify problems related to the disease, its treatment, or to psychological, occupational, social or financial sequelae. I also need some guidance on which problems to handle myself, and when and to whom, referrals should be made. Protocols need to be district and practice specific. They provide a way to reduce uncertainty and ensure high standards with available resources.

*Shared care records.* Hospital communication in relation to AIDS patients is poor. Many people are involved and drug regimens are complicated and frequently changed. In addition, patients move around, and records can take months to catch up with them. Many of these problems could be overcome by the use of a shared care record as for diabetes. In our district we are evaluating the use of a shared care record kept by patients with schizophrenia. Where long term care is provided by many different people, a shared care record held by the patient can:

- improve communication;
- reduce need for correspondence;
- make the patient the source of up-to-date information;
- increase patient autonomy;
- provide information if notes are mislaid;
- identify key workers and carers, current medication, community resources used and management and progress;
- provide information for patients on how to identify problems and what action to take;
- provide information for a new general practitioner when a patient moves.

It is now time to develop and undertake pilot studies to evaluate the use of a shared care record for AIDS patients.

*Information transfer.* A current problem in general practice is how to transfer information about one patient, to the notes of others in his family. This has implications for informed consent and confidentiality which need to be clarified before information can be transferred. It is also important to identify the quickest and safest way to transfer the records of a patient with AIDS to a new general practitioner when the patient moves.

*Ethical dilemmas.* The working party have highlighted several ethical dilemmas but we need a way of identifying a wide range of ethical dilemmas faced by general practitioners, hospital staff, other health professionals, patients and carers. When this has been done, we can start to develop effective ways of teaching medical students and trainees how to deal most effectively with these problems. I have designed and used a game called Medilemma to overcome the difficulties which face trainers and course organizers in teaching about ethical dilemmas in general practice. Its success has convinced me of the value of games as educational tools.

*Disease and recall registers.* The effective long term management of chronic diseases such as diabetes and schizophrenia necessitates practice disease and recall registers. If we are to provide effective shared care for AIDS patients such registers are essential.

*District specific information.* There is also a need for a district specific information system which is regularly updated and circulated to all relevant high risk groups and health professionals. It should include data on consultants, clinics and counsellors; policies and local support groups; voluntary agencies and community resources; and general practitioners prepared to provide special services. This should be jointly developed by representatives of all interested groups. The present lack of such information must lead to inappropriate use of available resources, as well as failure to identify gaps in the services.

*Where do we go from here?* There is an urgent need to develop and evaluate the areas described here. Small pilot studies should be mounted and would be relatively cheap to undertake. The College is ideally placed to provide expertise and support for these small scale research projects which would have far reaching implications for training and provision of high quality care.

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## Effusion following otitis media

Sir,
The study by Wilmot and Cable (April *Journal* p.149) yields useful epidemiological information about the relationship between acute ear infections and chronic middle ear effusions. It raises the interesting question of whether general practitioners should re-examine children after an episode of acute otitis media in order to detect persistent middle ear effusion.

The authors report that examination after 10–14 days is 75% accurate in predicting an effusion at three months; we would question the practical usefulness of this information. The importance of follow up is to detect hearing problems rather than the presence of an effusion. No reference is made to the fact that children with unilateral effusions rarely have hearing problems bad enough to impair language development.

We believe otoscopy and impedance testing should take second place to a history of hearing problems or language delay. Properly conducted hearing tests provide the correct basis on which action may be taken.

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## Survey of patients' satisfaction with access to general practitioners

Sir,
Dr Allen and colleagues (April *Journal,* p.163) claim their survey shows patient dissatisfaction with, among other things, out-of-hours calls, and suggest this may well reflect 'respondents' higher aspirations compared with earlier studies.[1,2] Many would agree that what was originally established as an emergency only service is gradually changing into an extension of daily consulting, especially among the young, and Dr Allen's study supports that view. It would appear that patients are dissatisfied if they cannot telephone their doctor directly at any time. If this trend continues, general practitioners' out-of-hours work will be much greater by the time the under 40 year olds are over 60 years olds. The General Medical Services Committee must bear this in mind when the out-of-hours contract is renegotiated.

Over half of the patients thought their length of wait for a doctor long or very