- 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