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.

Patients' knowledge and attitudes to HIV and AIDS

Sir,

A study was undertaken in a 11 400 patient practice in Solihull to assess patients' knowledge of the routes of transmission of the human immunodeficiency virus (HIV), their attitudes to their own risks and their attitudes to their general practitioner should he or she become infected. Of 104 questionnaires distributed to patients as they attended for routine appointments and to collect prescriptions 103 were returned. The average age of respondents was 28 years (range 15–75 years); 66% were female and 34% male.

Blood transfusion and sexual intercourse were identified as routes of transmission by 83% and 99% of patients respectively. However, 14% regarded blood donation and 11% kissing as 'at risk' activities.

Eighty eight per cent of people felt that they did not run any risk of catching the acquired immune deficiency syndrome (AIDS) and had therefore not made any change in their behaviour (included in this group were six patients attending antenatal clinics). The majority (78%) reported that if they did feel at risk then they would consult their general practitioner first rather than a sexually transmitted disease clinic (6%) or telephone helpline (7%). The practice nurse was identified by only 3% of patients as the first provider of information.

When asked if they felt that their general practitioner should be tested as his/her work involved daily contact with patients who may be HIV positive, 76% felt that he/she should and 55% felt that patients should have the right to know the result. If they knew their general practitioner was HIV positive or had AIDS then 35% of patients would change doctors and only 43% would allow him/her to routinely examine them. Fewer would allow such a general practitioner to examine their child (34%) or spouse (34%).

The survey highlights several points. First, health education about the methods of catching AIDS is still needed and people need reassurance on the safety of blood donation. Secondly, if general practitioners are to be the first contact for advice then they will need to be up to date and have good counselling skills. Finally, if patients are going to remove themselves from a general practitioner's list on finding that he or she is HIV positive then the doctor and the practice are going to suffer financially as well as having to cope with a public illness. The press is interested in doctors and their illnesses and breaches of confidentiality have occurred in the past. Health care professionals should be assured that if they seek advice or counselling on HIV then the service is completely confidential, otherwise they will not come forward and learn how to make their medical practice safer.

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General practice house officers

Sir,

I am the only house officer in the country who is working in general pratice. In 1985 a scheme in which general practice was included as part of a pre-registration rotation post was described.[1] A further three years on, no other such schemes exist. I am now the fifteenth house officer in this scheme, evidence that the experiment has matured into an accepted post at St Mary's Hospital at least.

The difference in attitudes of doctors in the community and in the hospital service is now a cliche. However, general practitioners know the pressures of hospital life, having spent the majority of their training in a hospital. Most hospital doctors have spent only a few weeks as students in the community and yet will be accepting and discharging patients from and to a network of medical care about which they have received only minimal education. The general practice house officer scheme offers the chance for a few doctors to broaden their experience to include general practice at pre-registration level.

The general practice house officer sees a wide variety of clinical presentations. In addition to the experience of general medicine and general surgery gained as a house officer in hospital, he gains experience in virtually all the other hospital specialties. The nature of general practice means that he is often the 'first on the scene' and thus has the opportunity to investigate, evaluate and treat patients on the basis of his own clinical findings.

For the house officer who intends to have a hospital career, the insight gained into general practice is considerable. He visits the patients in their homes and interacts with their families. He works alongside the district nurses, health visitors, physiotherapists, social workers and the many other groups that are necessary for the effective care of patients in the community.

Further, such a post need not be just for those doctors who intend to remain in hospitals. The committed general practitioner could also benefit. Attitudes and approaches differ, even between practices, and to see another practice in operation in addition to the training practice may enable better transfer of ideas and a more progressive attitude.

In addition, the practice forges another link with the hospital. The house officers bring with them the ideas, current practices and research interests of the consultants and registrars under whom they have served, thus providing a regular flow of information. The partners have the satisfaction of seeing the house officers progress as they come to terms with their new environment and responsibilities. Additionally, the house officer can help to some extent with the workload of the surgery.

Perhaps most important are the benefits for health care as a consequence of a broader and hopefully better education for doctors. The understanding of the community and problems that occur within it being necessary for the solving

of conflicts that occur between the community and the hospital.

As with any new scheme or idea, problems are encountered. Assessment of patients by doctors of house officer grade, prescribing by pre-registration doctors and lack of continuity of care for patients are the three problems most often mentioned by those introduced to the idea for the first time. In practice, these and other problems are largely surmountable by the availability of the partners, the house officers' appreciation of their increased responsibility and regular discussion between the partners and house officers.

Those people who have heard about the scheme vary, from those who feel all doctors should rotate to a post in the community to those who feel that any time spent out of a hospital during the pre-registration year is completely unacceptable. At present, my own view lies somewhere in the middle. I do not believe that all house officers would want to spend time in general practice and not all general practices would want house officers. Even if it were possible, such schemes should not be compulsory as their success depends largely on the enthusiasm of the house officers and general practitioners involved. However, there are real benefits for the individual house officers, for the practices and for health care in general. Where the enthusiasm exists the scheme can and does work. The impetus for the establishment of such schemes is likely to have to come from general practitioners themselves.

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Knowledge of health issues among Asian and white schoolchildren in Glasgow

Sir,

Asians (people originating from the Indian subcontinent) in the UK have been shown to have different morbidity and mortality rates to whites.[1-4] However, comparatively little has been written on health and related issues concerning Asian teenagers.

In 1986 I undertook a self-completion questionnaire survey of 385 13- to 16-year-old schoolchildren at three Glasgow schools to study a number of health and social issues. These included questions about their general practitioner; their own health; and knowledge about two health campaigns in Glasgow — 'Glasgow 2000' and 'Good hearted Glasgow'. In the sample there were 191 Asian and 194 white schoolchildren, matched by age and sex.

The response rate among Asians was 182 out of 191 (95.3%) and among whites 180 out of 194 (92.8%). The overall response rate was 362 out of 385 (94.0%). The responses were consistent with a preliminary interview study and the administration of questionnaires to schoolchildren in school is a reliable and valid method of data collection.

The response to questions on health and health services are shown in Table 1. Asian schoolchildren were significantly more likely to know their general practitioner and recall his or her name than their white peers were. One explanation is that Asian children are used as interpreters by parents and other relatives in consultations with general practitioners. Certainly the need for professional health interpreters in Glasgow has been documented (Gardee MR, Greater Glasgow Health Board internal communication, November 1986).

Table 1. Percentage responses to questions on health and related issues.

	Asians ($n = 182$)	White ($n = 180$)
1. Know own GP	*91.1*	*77.5****
2. Consulted GP in past 2 weeks	*17.3*	*17.9*
3. Take regular medication	*17.1*	*13.0*
4. Have anxieties about health	*21.4*	*18.1*
5. Know about 'Good hearted Glasgow'	*4.4*	*5.1*
6. Know about 'Glasgow 2000'	*16.1*	*25.3**
7. Regard NHS as something to be proud of:		
Yes	*53.9*	*40.4**
No	*15.0*	*21.9**
Don't know	*31.1*	*37.6**

n = total number of respondents. *** $P<0.001$; * $P<0.05$; Asians versus whites.

Over one in six schoolchildren in both groups had consulted their general practitioner in the two weeks prior to the survey and similar proportions were anxious about their health including worries about weight, height and death. One in six Asians and one in eight whites took prescribed or non-prescribed medications regularly — mostly vitamin pills.

Relatively small numbers of children knew about 'Good hearted Glasgow' because the study was undertaken shortly after its launch in May 1986. Significantly fewer Asian than white children knew of 'Glasgow 2000' but both proportions were relatively low for a community based smoking prevention campaign then in its third year.

More Asian schoolchildren thought that the NHS was something to be proud of than their white peers did. This may be due to an awareness of the benefits of a state health service fostered by their parents who would be aware of the shortcomings of medical care on the Indian subcontinent.

The information from the survey indicates that race and ethnicity of children should be taken into consideration when providing primary health care and health education.

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3. Coronary Prevention Group. *Coronary heart disease and Asians in Britain.* London: Coronary Prevention Group, 1986.
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Continuing medical education

Sir,

The 1989 spring conference of the Royal College of General Practitioners is to have continuing medical education as its theme. Continuing education is part of a learning experience involving keeping up-to-date with appropriate knowledge and skills and fostering the right attitudes. The focus at present is practice based learning for the entire team and bringing about behavioural change. Drury[1] has remarked on the higher uptake of distance learning, audit within practices and small group activity while Ridsdale[2] rightly points out that the work of a general practitioner may make continuing learning difficult.

The appointment of course organizers with special responsibility for continuing medical education will facilitate the educational needs of general practitioners particularly those who are isolated. It is encouraging to see the creation of fellowships by the MSD Foundation to develop initiatives, innovative workshops, courses and research in continuing education.

Savile[3] has commented that accountability in medical education provides an opportunity for general practitioners to show they can manage their own continuing medical education effectively. The