

felt that visualization of the tympanic membrane was important for diagnosing otitis externa.

This survey demonstrates that although there is widespread knowledge that aural toilet, antibiotics and steroid ear drops are appropriate treatment for otitis externa, there are a number of general practitioners who appear to have difficulty in making this diagnosis. The pattern of our clinic referrals leads us to believe that this is because aural toilet is not being performed by general practitioners and thus the diagnosis cannot be made. Is this because the facilities in general practice are inadequate or should ear, nose and throat departments be doing more to teach the technique of aural toilet? Is it a suitable procedure for general practice?

In addition, eight respondents would treat patients with otitis externa with antibiotics alone. Antibiotics and steroid ear drops are appropriate treatment for both otitis externa and chronic otitis media.¹ We would suggest that if the diagnosis is in doubt a short course of ear drops should be prescribed to accompany the antibiotics; this has few, if any, risks and much potential gain.

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Reference

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Trainees' knowledge of AIDS and HIV

Sir,

I read with interest, and concern, about general practitioner trainees' lack of knowledge about the acquired immune deficiency syndrome (AIDS) and the human immunodeficiency virus (HIV) (*October Journal*, p.401). I agree that there should be improved teaching about HIV infection for trainees: they should be aware of the problem, not only for their patients but also for their self-protection.

The problem of managing needlestick injuries in general practice is discussed in a letter from Lockie and colleagues in the same issue (*October Journal*, p.431). The suggestions in this letter are a succinct summary of the recommendations in the official guidelines.^{1,2} I would add that the general practitioner could also contact the local National Health Service occupational health department, as NHS occupa-

tional physicians are involved with needlestick injuries and occupationally acquired HIV infection. They should be able to give the best current advice, or know the 'local expert'. There has been a suggestion that zidovudine should be given within an hour of exposure to HIV infected blood as prophylaxis,³ but there has been debate about this approach.^{4,5}

There is likely to be a local or regional policy agreed between NHS occupational physicians, virologists and consultants in communicable diseases: it would be advisable for the general practitioner managing the needlestick injuries to be aware of this policy.

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Vocational training

Sir,

The paper by Dr Styles on the training experience of doctors certificated for general practice in 1985-90 (*December Journal*, p.488), raises doubts about the relevance of vocational training. At a time when the thrust of government policy is to care for mentally ill patients and elderly patients with long term illnesses at home rather than in hospital, it is surprising that less than half of trained doctors submitted any post-registration experience in care of the elderly or in psychiatry in 1990 (41.7% and 40.7% respectively). It is not clear whether in the general practice trainee year any remedial tuition is provided to cover these deficiencies.

We should not perhaps be surprised, therefore, that the government found it necessary to impose a new contract on general practitioners in which elements of care of the elderly are spelt out.¹ Social services departments rely on general practitioners to assess the social, physical and mental well being of patients.² However, there may be doubt whether many recently trained general practitioners can fulfil that function efficiently. It appears that much vocational training may not be relevant to

the needs of growing sections of the population.

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Confiding relationships in elderly people

Sir,

We were interested to read Dr Walsh's letter (*February Journal*, p.80), but feel that he has missed the point of our paper (*November Journal*, p.459). General practitioners assessing the whole population of elderly people need to know if lack of confiding relationships is a strong predisposing factor for depression, as it appears to be in younger people. Our study, carried out by two nurses and one trained lay interviewer, replicates the screening approach that some primary care teams are now applying to the assessment of elderly people. The questions asked were not as comprehensive as those that might be asked in full psychiatric or psychotherapeutic assessment, but that is the nature of screening. The questions on depression were derived from the comprehensive assessment and referral evaluation (CARE) interview schedule, which has been well validated against diagnoses made by experienced psychiatrists,¹ and probably represents a more thorough assessment than most general practitioners achieve in routine history taking.

Screening and casework should not be confused. Our study did not imply that lack of confiding relationships should not be enquired about during individual consultations, nor that it was not implicated in the causation of depression in some cases. Our results suggest, however, that enquiring about confiding relationships does not merit inclusion as a routine question when screening elderly people. The value of psychotherapeutic approaches in some older people with psychological problems is well documented² but we should avoid generalizing from this experience to whole populations.

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