Note to authors of letters: Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use *double spacing* and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk; please include your postal address). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.

General practitioner teaching in the community

Sir,

Gray and Fine's study (October *Journal*)[1] is encouraging in revealing a high level of interest among GPs in teaching, but it is difficult to interpret as responders were not given any detail about what the undergraduate teaching task might involve. Without such information, responses to questions about time, money, and other resources that would be needed to deliver general practice-based teaching are purely speculative.

The general practice component of the Leicester course concentrates on clinical skills development and has always been demanding of GP teachers. In a recent survey of ecperienced teachers,[2] published after Gray and Fine's survey was submitted, we reported strong support for the educational objectives of the course but concern about the feasability of delivery, particularly the requirement to reduce consulting rates during a teaching session. When asked to compare their situation with 1990, 47% said they were now less able to deliver quality teaching compared with 17% who reported that their ability had increased.

Since our survey, progress has been made in linking the payment for teaching directly to the reduction in delivery of patient care incurred. We would therefore strongly support the authors' conclusion that issues of time, reward, and staff development need to be addressed, but would emphasize that this needs to be in the light of clear educational objectives and the consequent anticipated teaching tasks.

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Bereavement care

Sir,

I was pleased to read the interesting review papers by Woof and Carter[1] in the July and August issues of the *BJGP*. The review emphasizes the importance of general practice and primary care teams in supporting the bereaved. The majority of GPs see bereavement care as a natural extension of palliative and terminal care.

A study by a department of psychiatry[2] in 1995 found that, of the 68 GPs who responded, 70% wished to provide bereavement support for bereaved realtives, but only 10 GPs said they had received any formal training in bereavement support skills.

It has been reported that the bereaved do value the support of their GP. If GPs are to feel able to provide such support, the provision of education on normal and abnormal grieving processes, and how to support specific bereavements (e.g. the loss of a child or the loss of a young parent) is necessary in both vocational training and continuing medical education.

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Genital warts and cervical screening

Sir,

Woodman *et al*'s claim that a history of genital warts should not influence clinical management in relation to cervial screening[1] illustrates the danger of using population statistics alone to determine the management of individual cases, and exposes the fallacy of equating absence of (conclusive) evidence with evidence of absence (of association). Policies thus constructed are unlikey to carry much weight in medico-legal circles.

Human papilloma virus, the aetiological agent in genital warts, has fulfilled most (though not all) of the Bradford Hill criteria for causation[2] in relation to carcinoma of the cervix. The presence of HPV16 DNA in cervical specimens is associated with an 8.7-fold (95% CI = 5.1-15.0) increased risk of high-grade intraepithelial neoplasia,[3] and evidence of HPV infection has been demonstrated in over 90% of invasive cervical cancers.[4] Further exploration of the causative hypothesis raises complex design issues, since women's exposure status may change throughout the duration of a cohort study.[5]

Clinicians whose day-to-day experience is with high-risk individuals are rightly cynical of advice issued by epidemiologists and derived from the average outome in a heterogenous population. In one study of 212 women attending sexually transmitted disease clinics with anogenital warts, all subjects were offered colposcopy and histological examination in addition to a cervical smear. Over half the subjects had cervical epithelial abnormalities detected by cervical cytology, but histologically confirmed high-grade cervical lesions (CIN II or III) were rare in those without cytological evidence of dyskaryosis. The authors concluded that early colposcopy is indicated in women with anogenital warts and an abnormal smear, but that, in those without dyskaryotic changes on the smear, the value of early colposcopy is uncertain and warrants larger, more long-term trials.[6]

The results of several ongoing studies in this field are awaited; meanwhile we must