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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

base our clinical decisions on imperfect clinical evidence, basic sciences, and common sense.

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Primary care of patients with schizophrenia

Sir,

The policy paper by Burns and Kendrick (August *Journal*)[1] highlighted the need for mental health research in primary care, and I would wish to suggest some important priority areas.

Assessment. The Care Programme Approach (CPA) achieves multidisciplinary assessment for complex needs among patients receiving secondary care. In our experience of commissioning psychiatric care in Manchester, GPs wish to access thorough assessments of patients with chronic mental illness at periods of vulnerability, often not necessitating referral for psychiatric opinion.

In our own practice population of 13 000, 14 patients with chronic schizophrenia are not receiving CPA levels of care, and only receive medical perspectives on their condition via the GP, practice nurse, and occasional outpatient psychiatry assessments.

If GPs are to reflect improvements in management for patients with schizophrenia, they need access to other, non-medical disciplines working closely with them in practice.

In 1995, we introduced a mental health social work service into primary care,[2] which has opened up more primary care management options for patients with chronic severe, non-psychotic illness. We plan to extend the application of GPs' skills at the level of primary care management of psychosis. Primary care and preventive mental health promotion activities may be performed by different professionals, and liaison has certainly broadened our management options in primary care for all patients with chronic severe mental illness.

Often the important assessment for the GP is that of a patient's vulnerability and functioning at an early stage of deterioration. Many chaotic patients do find general practice accessible, although doctors find it increasingly difficult to assess patients who are not well known to them, who have complex needs, and who are often deluded even when well. The process of subsequent contextualization of any consultation, usually through telephone calls to carers and involved professionals, is time-consuming but informative in triggering further action.

This skill in acute assessment and crisis management by GPs, and the subsequent response of the secondary services, needs further research.

User views. There is a need for research into the perceptions of primary care provision for patients with schizophrenia, particularly in a climate where community residences are established with little discussion with local practices, which may not have the experience or skills required.

The importance of involving users in the design of future services is particularly relevant in encouraging compliance in schizophrenia. Some patients use the GP for limited activities, e.g. acquiring sick notes; others enjoy total general practice care. We need to respect issues of choice while acknowledging some variation in quality and availability across the sectors. This has implied training and resource consequences for primary care teams and for primary care-led purchasing of comprehensive mental health services. Furthermore, the increased empowerment of those patients best able to monitor their own therapy[3] may give rise to improvements in care. This trend for increased patient involvement is likely to be further assisted by the continued introduction of the newer antipsychotics, which are more acceptable to many treatment-resistant patients.

If users want GPs to undertake levels of care for schizophrenic patients, the quality of that care should be reflected and resourced to enable close working with our psychiatric colleagues. Practices must be better supported by other disciplines and resourced for training in the future. Our research programme should reflect these changes in the process of care of primary, secondary, and independent sectors, and should evaluate and engage the user prespective in any planning.[4]

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Provision of care for alcohol and drug misusers

Sir,

I enjoyed reading Deehan *et al*'s original paper (November *Journal*) examining GPs' attitudes towards providing care for alcohol and drug misusers.[1] I agree that this is an important area requiring further study.

The authors conclude by asking what can be done in real terms to encourage GPs to work with drug misusers. Perhaps the question, when so many GPs fail to respond to incentives to become involved, is where should this population of patients be cared for?

From personal experience, I found it impossible to meet the needs of my other patients while caring for members of this group, who present with great frequency and expect fast access. The nature of their problem requires a service configuration that is not found in most general practices. Additional resources for additional services, many of which are not within the power of primary care to deliver, need to be found.

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