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### School students and general practice

Candidates for medical school are encouraged to investigate their chosen career by spending time in general practice prior to applying to university. To investigate the prevalence and nature of this practice I surveyed first year medical students at the University of Leeds during introductory week.

The response rate to an initial questionnaire was 63% (135 students). Of these, 59% (79) had spent time in a general practice while at school of whom the majority (61) had sat in during consultations, and 44 had gone on home visits. The amount of time spent in a practice varied from half a day to 200 days, with a median of six days. I asked the 69 students who had spent more than one day in a practice to fill in a second questionnaire and 46 (67%) replied. Of these, 18 students had spent time in the practice in which they were registered as patients. Issues of confidentiality had been discussed with 40 (87%) of these students, usually by a GP or practice manager, though for two students this had been carried out by a receptionist.

From conversations with some of the students it was apparent that not all patients were aware of the status of this person 'sitting in'. Some assumed the school student to be a medical student. Patients were asked to consent but sometimes not until they entered the consulting room.

I find this practice worrying for several reasons. Confidentiality is a complex issue discussed at length in the medical undergraduate curriculum before students interview patients. How much of this complexity can school students grasp when introduced to the issue in a short unstructured format, sometimes by receptionists? The Medical Protection Society suggests that patients should be given the opportunity of declining to have a medical student present both before entering the consulting room and again before the consultation begins. This does not always appear to be happening with school students. Previous studies have shown that the majority of

patients have either positive or neutral feelings about the presence of medical students<sup>1</sup> but 10% of patients said they had left without saying what they wanted to say and 33% found it difficult to talk about personal problems.<sup>2</sup> Given that community-based education of medical students is becoming more widespread, are we not in danger of losing our patients' goodwill by also expecting them to consent to the presence of school students?

J E THISTLETHWAITE

Academic Unit of Primary Care,  
University of Leeds, Leeds

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### Euthanasia in Northern Ireland

I was surprised to read in 'Research Papers this Month' (October *Journal*) that 'doctors... [in Northern Ireland]... approve of euthanasia'. Close inspection of the paper in question, however, does not bear out the Editor's assertion. A total of 70% of physicians responding to the questionnaire consider physician assisted suicide and voluntary active euthanasia to be wrong — hardly a majority. The only clear support was for 'passive euthanasia', a term which as defined may merely cover good terminal care, and not officiously striving, etc.

ANDREW CORDELL

Horfield Health Centre, Lockleaze  
Road, Bristol, BS7 9RR. E-mail:  
[cordell@gp-L81022](mailto:cordell@gp-L81022)

Thanks to Andrew Cordell for pointing out the error, and apologies to all readers for having misled them, even if it did have the desired effect of getting any of you to read the article —Editor.

### Complementary medicine

Philip White's discussion paper on complementary medicine rehearses some old arguments about what GPs might learn from complementary therapists. While some of the points he makes are probably quite valid, there is certainly not sufficient evidence to justify the schoolmasterish tone of the final paragraphs 'GPs must strive to provide holistic and patient-centred care', 'GPs must try harder to incorporate patients' own beliefs...'

When comparing conventional practice with complementary care, we are certainly not comparing like with like. Notwithstanding the cumulative effect of multiple consultations in terms of time spent with a patient, it is unreasonable to ask a GP to do in 10 to 12 minutes what a complementary therapist has an hour or more to do. I simply cannot be holistic to 30 or more patients in the course of a single day.

General practice is accessible and available free of charge. Complementary therapy, generally, is not. The GP is obliged to respond in an emergency, the complementary therapist is not. The constraints on general practice are considerable. Much complementary therapy is unregulated. It is hardly surprising that patients feel that complementary therapists are better communicators and have better bedside manners than GPs. This is particularly so in the context that White quotes — patients whose last contact with the GP was unsatisfactory. These patients clearly constitute a biased sample.

Are there any studies where patients were randomly allocated to GP or complementary therapy with identical consultation length and charge in each modality? Until there is good evidence from such trials, I doubt whether many GPs will take Dr White's strictures seriously. Most of us would be delighted to have longer consultation times and the opportunity to explore our patients' problems in depth, free from the pressure of a crowded waiting room. To suggest that we simply lack the will or skill to be 'patient-centred', to use the politically correct dogma, is rather insensitive.

At the same time, perhaps we should be aware of the advantages that complementary therapists have and of the many conditions in which conventional medicine is less than adequate, and be happy for our patients to use these therapists in a truly complementary and informed way.

JOHN VALENTINE

Limes Lee, The Street, Chilcompton,  
Bath, BA3 4HB

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## Sex, power and echos

Hood and colleagues raise important issues concerning gender differences in the management of CHD in primary care. Their study is particularly welcome since previous research is predominantly from North America and hospital-based to boot.<sup>1-4</sup> Their conclusion that systematic sex differences do not exist in the management of heart failure merits some comment.

The study sample size calculation was based upon detecting a 10% difference in the performance of echocardiography. The actual difference found on unadjusted analysis was 11% in favour of men. Age-adjusted analysis reduced this difference to 7% but a difference still persisted nonetheless. Because this difference is not statistically significant, it is suggested that gender differences in echocardiography are accounted for by the older age of women with heart failure. However, this study of 583 patients was not powered to detect a 7% difference. My sample size calculation (male echocardiography of 40% and a 7% sex difference) suggests that 740 patients would be required to avoid such an erroneous (type II) conclusion. It is therefore tantalisingly frustrating that the study was curtailed before the remaining practices participated and a further 160 patients were identified.

The study identified patients from either computerised disease registers or repeat prescriptions for loop diuretics (depending upon the practice set-up). If GPs are indeed less likely to refer women with heart failure for echocardiography, they may also be less likely to code women's heart failure on their computer system. Receipt of an echocardiography report may prompt a diagnostic entry of heart failure onto the clinical computer system. If this is the case, then the study results

may be confounded by the method of patient identification. The true sex difference in the use of echocardiography may be underestimated because women identified through disease registers are in fact on those registers as a result of undergoing echocardiography.

In those practices where patients were identified through diuretic prescribing, it would be fascinating to know if men and women with similar 'symptom combinations' suggestive of heart failure were equally likely to be referred for echocardiography.

MIKE CRILLY

Department of Primary Care, University  
of Liverpool, Liverpool

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## Job stress and mental health of GPs

Fletcher and colleagues (October *Journal*)<sup>1</sup> are not the first to suggest that co-operatives enhance GP well-being. Heaney *et al* showed that GP satisfaction increased following the introduction of a GP co-operative in Chester.<sup>2</sup> Charles-Jones and Houlker showed that GP stress declined following the introduction of an out-of-hours primary care centre in Midlothian.<sup>3</sup> Salisbury compared a GP co-operative with a deputising service in London and showed that co-op members were better satisfied with their arrangements for out-of-hours care and experienced less stress.<sup>4</sup>

Such improvements are self-evidently valuable and are given added importance when viewed against a background of high stress and mental ill health in the workforce. But is this actually the case? Fletcher and colleagues, like so many commentators, have been selective in reporting only the negative findings of previous research into the health of the GP workforce.

As Table 1 overleaf shows, job stress and mental health among GPs have been investigated in a number of studies in the past decade. Studies of GP stress vary considerably in their methodological quality, geographical coverage, and outcome measures making it difficult to draw any firm conclusions. The proportions of GPs reported as suffering from 'stress' varied from 30% to 50%. Although high, these proportions were often similar to those for other occupational groups within<sup>5</sup> and outside<sup>6</sup> the NHS. Moreover McManus *et al* suggested that, when subjects are aware that stress is the focus of research, reported levels may be exaggerated.<sup>7</sup> Thus the evidence that GPs experience higher job stress than other members of the workforce is surprisingly inconsistent and weak.

Studies of GP mental health in the past decade also vary considerably in their geographical coverage and outcome measures. Sutherland and Cooper noted an increase in measured levels of anxiety and depression from 1987 to 1990 following introduction of the new GP Contract.<sup>8</sup> However, subsequent studies show that rates of anxiety and depression among GPs are not consistently different from those found in other doctors or the general population. (Table 1)

It is time we stopped painting unrealistically gloomy pictures of the GP workforce as this serves only to encourage problems with GP recruitment and retention. GPs and others deserve a fair and balanced account of the available evidence. In this case, the evidence suggests that we should be neither complacent nor alarmed about the health of the workforce.

BONNIE SIBBALD

RUTH YOUNG

National Primary Care Research and  
Development Centre, 5th floor,  
Williamson Building, University of  
Manchester, Oxford Road, Manchester  
M13 9PL

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**Table 1.** GP Mental Health and Stress 1990-2000.

Reference	Study year	Type study	Outcomes (measurement tool)	Sample size and location	Results
Calnan et al <sup>9</sup>	1999?	Postal survey	Stress (GHQ)	n = 195 South Thames	30% stressed
Rout <sup>10</sup>	1998?	Postal survey	Mental health (Crown Crisp)	n = 203 North West	Males experience higher anxiety and depression than general population, while females resemble general population
Gilliand et al <sup>11</sup>	1996?	Postal survey	Stress (own design)	n = 905 N. Ireland	50% report high stress levels (as compared with 36% in Republic of Ireland)
Firth-Cozens <sup>12,13</sup>	1993-94	Cohort study	Mental health (SCL90) Stress (own design)	n = 131 National	17% depressed — same as for other doctors 33% stressed
Chambers and Campbell <sup>14</sup>	1994	Postal survey	Mental health (HAD)	n = 610 Staffordshire	19% anxious; 10% depression cases; similar to general population
Kirwan and Armstrong <sup>15</sup>	1993	Postal survey	Burnout (Maslach)	n = 245 Northamptonshire	UK GPs have higher levels of burnout than American doctors and nurses
Caplan <sup>5</sup>	1993?	Postal survey	Mental health (HAD) Stress (GHQ)	n = 257 N. Lincolnshire	30% depressed — similar to consultants and NHS managers; 11% anxious — higher than consultants or managers; 48% stressed — same as consultants and managers
Swanson et al <sup>6</sup>	1992/3	Postal survey	Job stress (OSI)	n = 547 Scotland	Stress levels lower among doctors than population norm.
Rout et al <sup>16</sup>	1992	Postal survey	Mental health (Crown Crisp)	n = 414 National	Males experience lower somatic anxiety and same level of depression as compared with general population; females experience lower somatic anxiety and lower depression compared with general population.
Chambers and Belcher <sup>17</sup>	1991	Postal survey	Well being (own design)	n = 704 Staffordshire	31% anxious; 13% troublesome depression; 39% exhaustion/stress
Sutherland and Cooper <sup>8</sup>	1990	Postal survey	Mental health (Crown Crisp) Stresses (own design)	n = 917 National	Somatic anxiety and depression in both men and women higher in 1990 than in 1989; 25 of 31 stresses rated more highly in 1990 than in 1989
Sutherland and Cooper <sup>18</sup>	1990	Postal survey	Mental health (Crown Crisp) Stresses (own design)	n = 917 National	Males have lower somatic anxiety and higher depression than general population; females have lower somatic anxiety and same levels of depression as general population. GPs higher than normative population on 6 job-related stress factors
Cooper et al <sup>19</sup>	1987	Postal survey	mental health (Crown Crisp)	n = 1928 National	Males have lower somatic anxiety and similar levels of depression compared with general population; Women have lower somatic anxiety and depression compared with general population

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## Breaking the silence

In her article 'Breaking the silence', Dorothy Logie wonders why behaviour is 'so slow to change' from cultural sexual practices of antiquity. She combines this wonder with the suggestion that lack of education may be a factor; speculating that literate women may stand better chances of protecting themselves from physical and sexual exploitation. She usefully further notes the machismo of some African cultures.<sup>1</sup> Colin Butler adds a helpful list of complex causes of HIV/AIDS epidemic in sub-Saharan Africa including debt, unfair trade, corruption, inequality, and the 'conceptually flawed economic models of development'.<sup>2</sup>

Both analyses, though quite important and helpful, miss some crucial ontological cultural aspects. In dealing with HIV/AIDS in the West, homosexuals were not asked to stop being homosexuals; they were provided with resources, interventions and empowered with information that enabled them to continue their lifestyles at safe levels.

In the case of Africa, if we wait for all that Logie and Butler accurately point out to be corrected before tackling HIV there may be few left to save. And yet, as the history of Christianity and colonisation shows, the western conception of development tends to be that of, to use short-hand, the 'westernisation' of sub-Saharan Africa. The colonial model may have caused an economic dependency but it has, so far, failed to economically or culturally 'colonise' Africa.<sup>3</sup> The medical model being proposed for dealing with cultural aspects of HIV, given its under-privileging of rural African cultures, is bound to be only partially successful. Many reasons can be advanced for this likely failure, the main being that the current cultures as practised have, from these Africans' point of view, historically served these communities satisfactorily. And lessons from previous 'epidemics'.<sup>4</sup>

Culture is after all a factor of socio-economic environment, and there are 'valid' reasons for women clinging on to what appear to us to be dangerous and archaic practices. In some of these customs, for example, reside the only social welfare systems available in these communities.<sup>5</sup>

But the HIV pandemic, like smallpox and other epidemics before it, is bound to change these cultures; all cultures respond to, or are abolished by, epidemics and rural Africa is no exception. But using the gay community analogy these communities can be helped to cope in more sustainable, practical, and realistic ways.

Therefore while the western model of HIV/AIDS health promotion is appropriate to urban and peri-urban dwellers, those in the rural areas need different intervention strategies. In the West, homosexuality was accorded a 'privileged status' that enabled the medical intervention to be given to the gay community in terms that did not aim to annihilate their lifestyles. Given the impossibility, or indeed the current unnessesity of changing rural African traditions, is it impossible to find models of making 'traditional' African lifestyles safer in terms of our current medical knowledge? For example, would it not be possible to persuade the *anankungwi* (the women responsible for organising the ritual deflowering of virgins) to insist on HIV testing and the use of condoms for their *fisi* (the men tasked with this deed); would it be impossible to suggest HIV testing for those wishing to practice *chokolo* (inheriting a dead brother's wife), etc.<sup>6</sup>

These proposed interventions may appear shocking but they are more practical and sustainable than expecting a rural dweller to afford the routine use of condoms which may cost as much as a weeks monetary wage each. Similarly, rural 'uneducated women' are capable of understanding the dangers of HIV/AIDS if the health promotion resources that are usually targeted at urban areas were offered them.

The failure to engage traditional medical practitioners at an early stage in the HIV awareness programmes is unfortunate. Many rural Africans continue to depend on traditional practitioners for their medical care.<sup>7</sup>

This failure is mirrored in the role that most major Christian religions have played in the HIV/AIDS debate; most have favoured abstinence and condemned the use of condoms. In the case of Malawi, the Malawi Council of Churches authorities stated in October 2000: '... our stand has been and remains abstinence. But sadly, we have not done much on this' and '... Church leaders have been thinking that HIV/AIDS is for sinners and outcasts, and because of this attitude, they have not been willing to talk openly about it or sensitise Christians on the dangers of the disease'.<sup>8</sup>

Given that 'public health is the meeting ground between politics and medicine' we need to be much more imaginative and realistic than the current paradigms permit.<sup>9</sup>

JOHN LWANDA

Centre of African Studies, University of Edinburgh, Edinburgh

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## Correction

In the letter entitled 'Why do some practices respond to an educational intervention?' by Michael Modell, Maren Khan and Bernadette Modell (October *Journal*, page 826), there was an error in one of the numbers in the second sentence of the letter. The correct form of the sentence should have read: 'We recruited and randomised 26 out of the 93 general practices that regularly sent screening requests to our laboratory'. We apologise for any confusion this may have caused.