PRACTICE OBSERVED

Contemporary Issues

In aid of doctors suffering from complaints about AIDS

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In the autumn of 1984 a young man died soon after admission to hospital where he had been diagnosed as having the acquired immune deficiency syndrome (AIDS). He had been registered with one of my partners for three years and during that time had been seen by several doctors in the group practice, including two trainees. Not one of us had ever suspected that AIDS was the cause of his symptoms.

After his death his mother, with whom he lived, complained formally to the family practitioner committee that her son had been "most poorly served" by the doctors in the practice, who were said to have displayed "a low level of medical skill, incompetence, and gross negligence." More than 18 months later I was called before a hearing of the Medical Service Committee. The issues raised included: the failure to recognise AIDS as the underlying cause of the patient's various symptoms, failure to diagnose the terminal illness of pneumocystic pneumonia, and an allegation that I refused to respond to a request for a home visit. The various arguments and counterarguments are set out below.

The non-diagnosis

COMPLAINT

"There has been ample and extensive publicity over the past two years about the condition. By November 1984 there had been considerable exposure of the disease and its symptoms and causes in the national press." "There is a wide lay awareness and one would expect that a medical practitioner would consider it paramount to keep himself apprised of the most recent developments in the diagnosis of this condition."

Response—1. By November 1984 fewer than 100 cases of AIDS had been identified in Britain.[1] 5 had occurred in London, which is served by several thousand general practitioners.

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2. The first circular from the Department of Health and Social Security about AIDS was not issued until January 1985. It referred to "The emergence of AIDS as a newly recognised disease."

3. A later circular in May 1985 stated: "Probably the most important factor in making a diagnosis of AIDS is to think of it. By far the largest proportion [of cases] has occurred in homosexuals."[2]

4. None of the doctors in my practice was aware of this patient's homosexuality and consequently did not think of AIDS as a possible cause of his symptoms.

5. In October 1985 an expert on AIDS declared: "From now on GPs must be on the alert for AIDS at all times . . . there are so many gays around."[3]

6. A general practitioner, who had encountered a case of AIDS, wrote in July 1986: "I will obviously have to increase my level of suspicion when seeing single, young male patients."[4]

COMPLAINT

"I have been aware for some years that my son was homosexual, and I find it incredible that this was not known to the doctor." "It never occurred to me that the doctor could have been my son's GP for three years without becoming aware of his homosexuality." "My son was always quite open about this."

Response—Not once did the patient or his mother mention his homosexuality to the doctors. Furthermore, he concealed from us the fact that he had repeatedly referred himself to a special clinic for sexually transmitted diseases where he had been treated for, among other things, anal gonorrhoea.

COMPLAINT

"In December 1981 the patient developed hepatitis . . . eventually diagnosed as hepatitis A. Some forms of hepatitis are sexually transmitted. The doctor might have asked the patient whether he was a homosexual." "It does not seem improper for a GP to question a patient suffering from facial dermatitis and diarrhoea as to his personal circumstances, including his emotional and sexual life."

Response—The average family doctor would not have considered this the thing to do before 1985.

COMPLAINT

"The symptoms exhibited in January to May 1984 were very different to those of previous years."

Response—The facial abscess was the only new symptom. The patient's diarrhoea, sore throat, dry cough, conjunctivitis, and facial rash were indistinguishable from the symptoms presented in previous years, which cleared spontaneously. Only by applying hindsight could a pattern have been discerned.

COMPLAINT

"The boils were very severe . . . yet no effort was made to ascertain the underlying pathology." "The doctor did not seem concerned about the boils or to discover their cause."

Response—This is untrue: for in addition to repeated physical examinations, the urine was tested, a blood count done, a swab taken, and referral made to the outpatient department of a teaching hospital. The report subsequently received from the hospital told of satisfactory results of the investigations, the lesion settling, and some residual scarring.

COMPLAINT

"Despite a series of warning illnesses and repeated visits to the surgery over a period of more than a year the doctors failed to diagnose or treat the fundamental condition, which was that of progressive damage to the immune system."

Response—The failure to make an early and correct diagnosis of AIDS is not inconsistent with the provision of proper, relevant, personal medical care required of general practitioners by their terms of service, and of the kind that was customary two years ago. It is important that the diagnosis of AIDS was made neither by the teaching hospital, to whom we had referred the patient, nor by the special clinic for sexually transmitted diseases, where he had repeatedly referred himself.

The final illness

COMPLAINT

"The absence of visits by the patient from June to September is significant as it reveals his disillusionment with the treatment he received from the practice. He felt it was futile to go back."

Response—In May a letter to my trainee assistant from a hospital consultant stated: "I have offered to see him again should his lesion not settle rapidly but he tells me he would prefer to be followed up by you." At a consultation in October the patient inquired about the whereabouts of my previous trainee and when told he was no longer with the practice the patient asked if we knew whether he was practising in the neighbourhood. This suggests the presence of a doctor-patient relationship, not disillusionment.

COMPLAINT

"The doctor did not examine him in any way on 25 October but simply prescribed a cough suppressant."

Response—A dry cough was the sole symptom presented. Despite a relaxed and unhurried exploration, in the presence of a newly appointed trainee, not one other symptom was elicited. It is possible that cerebral changes induced by AIDS might have influenced the patient's behaviour.

COMPLAINT

"In the 10 days before the patient's death the doctor failed to make the simple diagnosis of bronchial pneumonia." "I certainly knew he had pneumonia, a diagnosis which totally escaped the doctors."

Response—The atypical pneumonia from which the patient died was not accompanied by exceptional pulmonary signs. On his admission to hospital, just 36 hours before he died, the only physical signs detected in his lungs were "a few scattered rales at the left base."

COMPLAINT

"The doctor does not state whether the trainee was a qualified GP." "Hospital experience does not develop the specific diagnostic skills so necessary in general practice." "The visit to the surgery on 30 October was a desperate cry for help. That it went unnoticed reveals the inability of an insufficiently experienced doctor to cope with a case of this kind."

Response—My trainee assistant had already had extensive hospital experience, including an appointment to a chest clinic. Before he began seeing my patients by himself I had assessed his clinical competence and satisfied myself that he was most conscientious.

This patient's condition was not a subtle, psychosocial type of general practice case but an acute illness of the respiratory tract for which the trainee's previous hospital training was totally appropriate. The trainee's detailed clinical notes testify to the thoroughness of his history taking and of his physical examination.

The patient was given treatment appropriate to the findings, including a course of erythromycin for suspected throat infection. What the trainee did not realise was that he was witnessing the beginning of the end of a lethal illness, the seeds of which had been sewn long before, and which had not been recognised by any of the doctors in attendance, whether in hospital or in our own group practice.

The non-visit

COMPLAINT

"On 31 October at 9 30 am I was still very worried and rang another National Health Service doctor in the area to see if she would come and give me a second opinion. She felt unable to, as it would have been a breach of ethics." "At 5 pm I rang the medical centre and eventually at 6 45 pm was able to speak to the doctor." "The doctor declined a request by me to visit my son on the evening of 31 October."

Response—1. It is not true that the complainant requested a visit that evening.

2. Requests for visits are recorded by the receptionist or by the caretaker at night and weekends before being passed on to the doctors concerned.

3. The complainant knew perfectly well the procedure for obtaining home visits and had in fact requested one only three days before.

4. On the evening in question a Wednesday a partner of mine was responsible for home visits, not I.

5. When she first phoned at 7 pm the complainant did not mention to the receptionist her wish for a visit but asked to speak to me.

6. On being told I was consulting, she was prepared to wait a further two hours until I had finished my surgery.

7. Even on her final phone call at 6 45 pm she said nothing to the receptionist about a visit. This was certainly not a straightforward request for a visit.

8. In her conversation with me she seemed genuinely to be seeking my advice. Her son had been seen the day before and was due to be followed up in two days' time. I advised that he ought to be seen earlier and would arrange for a visit to be paid the following morning. This seemed to be accepted by the complainant.

9. A few days earlier, according to the complainant, she had rung the practice at 10 30 pm "to see if I could speak to a doctor to discuss whether the antibiotics should be taking effect."

10. Had a request for a visit actually been made to me, or even some indication of anxiety at having to wait until the next morning, I should have immediately transferred the call to my receptionist to record the routine details and then inform the partner who was on call for visits that evening.

11. My judgment that it was appropriate to plan to visit the patient the next morning was based on the following factors. *a*: I knew the patient well, the more so before, after an absence of five months, he had come to see me for a dry cough, which I had diagnosed as tracheitis. *b*: He then developed influenza like symptoms for which he was seen at home by my trainee assistant and was prescribed erythromycin for an inflamed throat. *c*: He actually came to the surgery for follow up two days later; some improvement was noted in his symptoms and his chest remained clear; he was asked to return in three days. *d*: Now I was informed by his mother that he was feeling less well, and trouble with his breathing had returned; he was still taking erythromycin, a visit was not being requested, and there appeared to be no great urgency; my advice was apparently sincerely being sought after she had waited for two hours. *e*: In discussion on the telephone I asked in detail about his condition; I advised that he ought to be seen earlier than had been planned and that I would arrange for him to be examined at home the following morning. This appeared to be acceptable to the complainant, and no reservations at all were expressed. *f*: Had I been speaking to someone who was unintelligent, uneducated, or inarticulate as some of our patients are, I should not have relied on information over the telephone.

12. Many of the complainant's assertions have been shown to be unsupported and to contain discrepancies and inconsistencies. This may be attributable to unrealistic expectations, to being confused or ill-informed, or to simple lack of knowledge. None of these factors, however, can explain the complainant's allegation of refusal to visit. The complainant was directly involved and did not have to rely on hearsay.

Summing up

This unfortunate patient succumbed to a rare, incurable illness, whose true nature was unsuspected by us; but this does not warrant accusations of clinical negligence, carelessness, and disdain. Fault finding on such a scale often reflects the need to offload troubled personal feelings, which is understandable, and indeed the tone of some of the allegations suggests that the complainant was perhaps guilt ridden as well as grief stricken. The complainant felt that if only we doctors had been more competent her son might have survived a few weeks longer, but behind this might be the bitter thought that if only he had not been homosexual he would have been alive today. Be that as it may, the fact remains that although we did not succeed in prolonging the patient's life, given all the circumstances the standard of care he received is not to be disparaged.

Final note

The decision reached by the Medical Service Committee, and adopted by the Camden and Islington Family Practitioner Committee, was announced in September 1986:

"The committee recommend that the complaint in respect of the failure to diagnose AIDS should not be upheld, but that the respondent should be held in breach of his term of service for not recognising the serious nature of the patient's condition and for not visiting the patient as requested. The committee therefore warn the respondent to adhere more closely to his terms of service."

References

1 Department of Health and Social Security. *AIDS—interim guidelines*. London: DHSS, January 1985.
2 Department of Health and Social Security. *AIDS—general information for doctors*. London: DHSS, May 1985.
3 Gazzard B. GPs must be on the alert for AIDS at all times. *General Practitioner* 1985 Oct 18: 1.
4 Anonymous. Week in the surgery. *General Practitioner* 1986 July 25: 19.

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Practice Research

Medical facilities used by heroin users

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Abstract

There is little information about the extent of contact between heroin users and medical facilities. In this study of heroin users from general practice we found an increase in the attendance of patients after the onset of heroin use and that a high proportion of appointments were made at general practices compared with hospital departments.

Introduction

It has been reported that many doctors are reluctant to become involved with drug users, who conventional wisdom describes as troublesome and unrewarding to treat, and who often remain undetected by the conventional health establishment.[1] Recent Department of Health guidelines, however, state that all doctors have a responsibility to provide care for the general health needs and drug related problems of heroin users.[2] This requirement can only become more urgent because these patients now represent the group most affected by the human immunodeficiency virus (HIV: AIDS-related virus) infection in some areas of Britain.[3] To plan and establish effective intervention strategies it is necessary to know what use is made of medical facilities by heroin users.

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Method

Data were collected retrospectively from the case records of patients who were known to be, or to have been, heroin users who were attending a large general practice. The practice, situated in a deprived area of north Edinburgh, takes a clinical and research interest in the large numbers of heroin users attending.[4] but for several years has followed a policy of not prescribing opiates to heroin users and does not encourage attendance of users from outside a specific geographical area.

The total number of appointments at medical facilities during the period from the onset of each patient's heroin use to the last medical contact, and an equivalent period before the onset of use, were recorded. Genitourinary and obstetric and gynaecological data were excluded because they were incomplete. Dates of the onset of heroin use were available because they were requested and recorded in the case records at the time of the first drug related general practice appointment. Where possible, these were corroborated by clinical examination and by comparison with similar information in communications with hospital departments in the case records. The low mobility or local stability of this group, contrary to popular belief, has been described, and the resulting long term contact with the patients is reflected in the completeness of their case records.[5]

Results

Of a population of 164 heroin users previously described,[5] 103 had complete case records and were included in the study. There were 76 (74%) men and 27 (26%) women, with a mean (SD) age of 23·2 (4·18) years, range 16·8-33 years, and a mean (SD) duration of heroin use of 3·2 (1·97) years, range 0·2-13·8 years. Reflecting practice policy, patients presented to general practice for various reasons, including specific help for drug dependence usually during the acute phase of voluntary withdrawal; but more commonly for drug related problems such as those caused by septic injection techniques. In addition, patients attended for general health needs—women, for instance, for contraception or obstetric and gynaecological conditions, much like any other patient.

The table gives the total number of attendances at general practice and hospital facilities. A pronounced rise in the number of general practice appointments (×5·5) was noted after the onset of use, though this was less at hospital departments (×2·0). Interestingly, however, the relative proportion of surgery visits, house calls, and defaulted appointments did not alter appreciably, but general practice appointments rose from 67% to 85% of all medical contacts, and the relative proportion of appointments at most hospital departments remained stable. Perhaps contrary to expectations defaulted appointments accounted for similar proportions of all contacts before (9%) and after (13%) the onset of use.

Discussion

Though we acknowledge that these data represent the experience of heroin users from a single Scottish practice with a longstanding involvement with drug users, it is clear from other recent reports that there is extensive, though little described, contact between drug users and general practitioners throughout the United Kingdom.[6] Our data therefore confirm that general practice is the main interface between the drug users and the medical establishment even accounting for selecting the study group through general practice.[7] This has not been recognised, however, in recent advisory reports. In particular, the historical emphasis placed on intervention based in hospital (normally psychiatric) for the education and general management of drug users appears to be inappropriate.

Our data were collected before the recent awareness of the risk of AIDS (acquired immunodeficiency syndrome) to injecting drug users, and therefore indicates the pattern of presentation before the influence of this additional health problem. As the awareness of this risk among the users increases, and as those who are already infected become ill, consultation rates at all medical facilities will almost certainly rise. Whether or not this transpires, the established and extensive interface between general practice and drug users should be recognised and exploited when new services are provided for those at risk from HIV infection.

Finally, the assumption that drug users attend only to receive alternative drugs, such as methadone, is clearly erroneous. In the community at least there is no justification for using this to engage heroin users in some form of treatment. In addition, the mean attendance rate of drug users of once every 5·5 weeks over more than three years indicates the need and the opportunity to progress from the unrealistic model of a "cure" for heroin dependence to the more pragmatic "risk reduction" approach to the management of drug misuse.

Medical attendances of 103 heroin users at general practice and hospitals: mean duration 3·2 years before and after onset of use

	Before onset of heroin use			After onset of heroin use		
	Total No	%	Patient mean per year	Total No	%	Patient mean per year
General practice						
Surgery	544	64	1·65	9126	85	9·19
House call	54	6	0·10	83	1	0·26
Default	68	11	0·21	436	12	1·32
Total	666 67	100	1·96	9549 85	100	10·78
Hospitals						
Accident and emergency	158	50	0·48	289	46	0·88
Infectious diseases	4	1	0·01	53	10	0·19
default	2	1	0·01	12	2	0·04
General surgical	96	31	0·29	63	10	0·20
default	5	2	0·02	44	8	0·15
Psychiatric	30	10	0·09	82	13	0·25
default	7	2	0·02	35	6	0·11
Presenting unit	32	4	0·04	52	4	0·20
Total	314 33	101	0·95	626 15	100	1·90
Total	960 100		2·91	4175 100		12·68

100 YEARS AGO

The bulk of your readers will not be surprised to hear that the cholera not only lingers in certain parts of this peninsula, but is actively invading others, causing great havoc in certain towns, and leaping on to others far distant from them. After leaving this province, it swept into La Mancha, then into Alicante, Murcia, and Granada, etc., lingering on the south coast, and last month getting so far west as Marbella, Alora, etc., where it was severe, although the population is sparse. Within the last week, it has invaded Tarifa, the most southern town in Spain, where, out of a population of 3,000, fifty were struck down in one day, and the proportionate number of deaths still goes on. As Tarifa lies midway between Gibraltar and Cadiz, I daresay our people at the former stronghold are fully on the alert, but it is quite clear that the Spaniards are not, as long ere this it might have been stamped out. "*Estamos en el pais de non posemus.*" Yesterday we had the news that it had got as high up as Oviedo, and that several towns in Asturias have got the "*empermadad sospechosa.*" I fear very much that we shall have another outbreak this year, perhaps more fatal and general than the last, as I see no measures taken to prevent its return. We have lapsed into accustomed normal neglect and apathy in connection with preventive hygienic measures, as our drains, sewers, and unventilated streets and houses, and filth and refuse of all kinds piled as it used to be, foul clothing washed at the same centres of infection as of yore; and so we are contented, but not happy. *British Medical Journal* 1886;i:324.