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Markers of HTLV-III in patients with end stage renal failure treated by haemodialysis

SIR,—The risk in those undergoing dialysis of acquiring human immunodeficiency virus (HIV) infection is not well defined. Dr Michel Goldman and others (19 July, p 161) reported a 5% incidence of HIV infection in patients undergoing haemodialysis at a centre in Belgium. Neumayer *et al* also reported a 2% incidence of HIV antibodies in patients who had received kidney transplants or were undergoing haemodialysis in centres in West Berlin.¹

We would like to report our data on the incidence of HIV antibodies in the dialysis population of a United Kingdom centre. Antibodies against HIV were measured by Ortho Diagnostic Systems/Litton-Bionetics HTLV-III bioenzymic test and Wellcozyme enzyme linked immunosorbent assay as previously described.² HIV antibodies were not detected in any of the 137 patients who attended our unit regularly. They included 84 patients undergoing haemodialysis and 53 undergoing peritoneal dialysis. The only patient with HIV antibodies was attending our dialysis unit on a temporary basis. He had been receiving home haemodialysis in Hong Kong and came to our centre to seek further medical treatment for aluminium toxicity. He was also an e antigen positive carrier of hepatitis B.

There has been some controversy over whether or not all patients on renal replacement therapy programmes should be tested for HIV antibodies. We think that it is important to establish the true incidence of HIV infection at regular intervals as a means of ensuring that routine infection control procedures are in fact preventing transmission of this virus. Furthermore, the HIV results may have direct implications for the routine management of patients undergoing dialysis and their suitability for renal transplantation.

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Manpower

SIR,—Discussions on manpower within the profession are often divorced from the requirements of patient care. This impression was further enhanced by the batch of letters published in your issue of 16 August (p 448), where only one letter addressed the problems of patient service. Unfortunately the provision of an "adequate" patient service was referred to as the third of the three objectives mentioned.

In the United Kingdom in 1986 we should be aiming to provide the highest standards of patient care within a National Health Service. To provide

the high standards of care required this service needs to be provided by the trained—that is, consultants—part of whose job will be to train their successors.

Anyone considering hospital staffing and manpower problems must start by looking at the needs of our consumers, customers, and eventual paymasters. Consultant practice will undoubtedly undergo considerable changes in the future, with a considerable increase in numbers to provide a good service. The preservation of the status quo should not be allowed to cloud our judgment of what is required. The cost implications are enormous but are not insurmountable. If we compare the United Kingdom with countries whose standards we could perhaps look to as an example, the British public are getting an unsatisfactory service at half price. It beholds us as physicians and surgeons to strive for a first rate service, realistically funded, and to achieve this we must support and develop the proposed changes in our manpower structure.

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SIR,—The consultant staff in the Basildon and Thurrock district debated *Hospital medical staffing—achieving a balance* in mid-August and again in early September, resulting in a rare unanimity of resolve: all 32 staff present (out of a total of 75) rejected the report.

Members were concerned that sections of the document appeared vague on important issues which could turn out to be either a negotiator's dream or a nightmare. We recognise that it goes some way to reducing the bulge in senior registrars in some specialties, and this is warmly welcomed. On the other hand, there are many anxieties and unanswered questions about the scheme in general and the new grades in particular. Colleagues who had made inquiries outside the district had been met with "reassurance" and this has largely been reflected in your journal and the *Lancet*. We fear that silence will be interpreted as acceptance and feel obliged to record our reservations.

"Acute specialties" are not defined. We presume that general medicine, general surgery, and orthopaedics are foremost, yet acute work pervades many other specialties. In our district, with a population of 290 000, there are two main centres of population with two district general hospitals and attempts to reduce junior staffing levels are likely to lead a serious reduction in provision of services. The transfer of the bottleneck at senior registrar/consultant level to SHO/registrar level has some advantages but may prove a further deterrent to junior doctors wishing to remain in hospital practice, especially as junior doctors can now obtain relatively well paid posts in general practice within a few years. This compares with an uncertain and indeterminate hospital career structure with delayed financial reward. The implication of major change in consultant practice in the future, as outlined in the document, will add to the present uncertainty for juniors. There is insufficient detail about how staffing levels will be reviewed. The United Kingdom has long benefited from immigration and there must be ways by which overseas doctors can join our medical establishment. At present the proposals appear to make this much more difficult. While we welcome attempts to introduce rational planning into manpower proposals, we note that within the finite pool of medical graduates there is no control over retirement age in general practice and we believe this to be desirable.

There is inadequate explanation of how early or

partial retirement will be made available to consultants and how health authorities will afford such a programme. The proposed increase in the number of consultant appointments would result in fewer than one additional consultant per district, and makes no mention of the recognised costs of employing consultants, particularly surgeons. In this district all moves to appoint "Short" types of consultants will be opposed. We seek assurance that senior registrars will rotate to district general hospitals as well as teaching hospitals so that they have appropriate experience in a setting in which most of them will perform their lifetime's work.

We believe that the proposals to reduce the number of registrar posts will mean that SHOs will perform registrar duties for less pay. We will accept the concept of regional and district registrars only if there is at least one regional registrar post in each specialty in each district and district registrars are distributed equitably between teaching and non-teaching hospitals. The district registrar's training must be seen to be useful for that overseas individual and related to the setting to which he will return. If inadequate attention is given to this there is little likelihood that there will be many applicants. There must also be measures that ensure that applicants are of adequate calibre.

The proposals for an intermediate level service grade caused considerable anxiety. Looking at the bright able individuals in, and emerging from, medical schools we found it difficult to see who would wish to enter such a grade. The level of remuneration is indeterminate between SHO and consultant levels and thus gives no guide.

In the next few months we will look with interest at the districts selected to pilot the proposals, but for the time being as a group we remain unconvinced and withhold our support.

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SIR,—It is interesting to read the consultative document *Hospital Medical Staffing—achieving a balance* in conjunction with Dr Eva Lester's plea for more flexibility in attitudes to part time medical work (2 August, p 331).

Nowhere in this official document is the concept of part time work or job sharing even acknowledged. Its concern that the number of training posts should more closely relate to the number of consultant posts available is obviously justified and welcome. However, the two tier system which it proposes, with a clear distinction between the single higher training grade and the new non-training intermediate level service grade, has serious implications.

Would it be too cynical to suggest that this latter scheme is being offered as a substitute for a scheme of part time training posts? That the underlying attitude is that women and men not able or wanting to take up full time training posts would and should be satisfied with such an arrangement? It would be reassuring to believe that the higher training grade posts are not intended solely for strictly full time workers.

Much prejudice exists towards part time medical work. A recent survey of part time registrars and senior registrars in community medicine (6.5% of the total) found that fewer than half were satisfied with the training¹ and that negative attitudes towards part time work were common. The fact that only 12% of consultants in obstetrics and gynaecology are women is a result of such attitudes. Only by integrating provision for part time work in overall manpower planning will attitudes change.