will offer a single leisurely consultation, and broadly psychological treatment, involving their families if necessary. The doctors are in the happy position of being able to prescribe drugs if they are needed to facilitate the psychotherapeutic process, without diluting the therapeutic relationship.

What Colin Brewer fails to address, of course, is the vital argument about cost. If he is correct that few patients need drugs, then the competitors come cheaper for nearly as good a service. Using part of his own thesis, surely the cost-benefit analysis of different therapists is the crucial question, and one just as amenable to critical enquiry? Nevertheless the repeated plea for health workers to question their own cherished beliefs is important and applies as much in general practice as in psychiatry.

(D.J.)

Source: Brewer C. Doctors heal the parts ordinary health professionals cannot reach. *J R Soc Health* 1988; **108:** 15-19.

Contributers: R. Jones, A. Bichard, N. Stott, D. Hannay, D. Jewell.

INFECTIOUS DISEASES UPDATE: AIDS

The role of the general practitioner

As a testimony to how important we consider the role of the general practitioner in dealing with human immunodeficiency virus (HIV) infection the *British Medical Journal* recently devoted one leading article and three research papers to the subject.[1-4] The consensus was undoubtedly that our ability to control the spread of HIV infection depends much on the efforts of the primary care team.

One paper revealed a strong commitment of general practitioners to solving the practical problems of infection with HIV.[2] Indeed 90% of practitioners responding to a questionnaire revealed they were giving advice on risk reduction. If this were to be reflected nationwide, the practitioners' present role in prevention would justify full recognition. However, another survey of a group of practitioners[3] revealed that only half of those who responded to a questionnaire showed interest in health education being part of a training programme for managing the acquired immune deficiency syndrome (AIDS), and only just over one quarter had even raised the question of AIDS with a patient unprompted. These findings are worrying as they suggest regional differences in the practice of AIDS prevention.

Another finding likely to cause concern was an uncertainty about methods of transmission for HIV. Forty-five per cent of one group of practitioners[3] considered oral sex to be a high risk activity (the evidence for transmission via this route is minimal) and 48% considered deep kissing to be a low risk activity (no significant evidence exists at present for this being a mode of transmission). In addition, there was an apparent underestimate of the risks of heterosexuals as opposed to homosexuals. It is therefore clear that practitioners who are not fully aware of the facts regarding transmission will need to address this problem quickly if uniform and accurate messages are to be delivered to the general public. The general practitioner's role in curbing the AIDS epidemic cannot be underestimated.

Risk of heterosexual HIV transmission

A recent study by Peterman and colleagues of the risk of HIV transmission for the heterosexual contacts of individuals infected via blood transfusion[5] showed two (8%) of 25 husbands and 10 (18%) of 55 wives testing positive for the virus. Although one of the seropositive women had had only a single sexual contact with her infected husband and another had had only eight, 11 wives remained uninfected after more than 200 sexual contacts. Thus heterosexual transmission of HIV does occur in both directions, can occur with only one sexual contact and may not occur with hundreds of contacts. Other studies reviewed by Peterman revealed transmission to wives of infected haemophiliacs (10/48 in one study and 2/21 in each of three others), to female sexual partners of bisexual males (8/43), and to female sexual partners of intravenous drug misusers (32/76).

In a recent Edinburgh study[6] of heterosexual transmission, out of 123 subjects with no apparent risk factor for infection other than heterosexual intercourse with a subject either infected or at high risk of being infected with HIV, seven were found to be seropositive.

References

1. Hodgkin. HIV infection: the challenge to general practitioners. *Br Med J* 1988; **296:** 516-517.
2. Anderson P, Mayon-White R. General practitioners and management of infection with HIV. *Br Med J* 1988; **296:** 535-537.
3. Milne RIG, Keen SM. Are general practitioners ready to prevent the spread of HIV? *Br Med J* 1988; **296:** 533-535.
4. Boyton R, Scambler G. Survey of general practitioners' attitudes to AIDS in the North West Thames and East Anglia Regions. *Br Med J* 1988; **296:** 538-540.
5. Peterman T, Allen J, Jaffe H, *et al.* Risk of human immunodeficiency virus transmission from heterosexual adults with transfusion associated infections. *JAMA* 1988; **259:** 55.
6. France AJ, Skidmore CA, Robertson JR, *et al.* Heterosexual spread of human immunodeficiency virus in Edinburgh. *Br Med J* 1988; **296:** 526-529.

Contributed by Dr D. Goldberg, Research Associate, AIDS Surveillance Programme Scotland, Communicable Diseases (Scotland) Unit, Ruchill Hospital, Glasgow G20 9NB.

AIDS and suicide

A number of reports have shown that certain medical conditions, such as chronic renal failure and Huntingdon's disease are associated with very high rates of suicide, although suicide rates among cancer patients are only modestly elevated compared with the general population. A study from New York has reviewed all cases of suicide in New York City during 1985, to establish how many of the victims had been diagnosed as having AIDS.

The total number of suicides in 1985 in New York City was 668, with a rate for men between 20–59 years of 18.75 deaths per 100 000 person years of life. In the same year there were 3828 New York city residents with a diagnosis of AIDS; the suicide rate for men with AIDS in the 20–59 year age group was 680.56 deaths per 100 000 person years of life. This represents a relative risk of suicide over 36 times that of men in this age group in the general population. When women with AIDS are included in the analysis, the relative risk rises to over 66 times that of the general population.

These are important and alarming figures; there is tendency for these suicides to occur early in the course of the illness so that evaluation of suicide risk soon after diagnosis must be considered carefully. Although the illness is terminal, the authors argue that attempts at suicide prevention are appropriate. These results are particularly important in view of the recent advocacy of mass population screening for HIV antibody. They also suggest urgent prospective research into the associations between AIDS-related neurological and psychiatric syndromes and suicide risk.

(R.J.)

Source: Marzuk PM, Tierney H, Tardiff K, *et al.* Increased risk of suicide in persons with AIDS. *JAMA* 1988; **259:** 1333-1337.