services in that country. Perhaps it is easier to define the problems of the communities and the care that should be provided when these people can be identified as recent immigrants or from a clearly different minority culture than when the discrimination is built into a society (such as that practised against the harijans in India).

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Sir,

The quotation from David Hume — 'I am apt to suspect the negroes ... to be naturally inferior to whites' — made me blush for this flaw in the judgement of the great Scottish empiricist. Paradoxically, Hume's scepticism was combined with extreme credulity. Once an exasperated friend of his is said to have expostulated 'Man Davie! You'd believe anything, anything, except in the Almighty!'

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Introduction to psychosexual medicine

Sir,

As the editor of *Introduction to psychosexual medicine* I have read the correspondence about it with great interest (March *Journal*, p.126; June *Journal*, p.263). Perhaps one or two points of fact might clarify the arguments for your readers.

Five of the 13 chapters were written by general practitioners and one by a nurse. Dr McDonald states that, it 'does not easily relate to the practicalities of their [general practitioners] everyday practice life.' Yet the chapters are illustrated by cases taken from the everyday practice life of the authors.

The book describes a specific form of psychosomatic medicine and is thus relevant to the work of generalist doctors and other health care professionals, notably some nurses and physiotherapists. These workers are licensed, and indeed expected, to examine their patients physically, including genitally, as part of their everyday work. This licence confers responsibilities and also offers opportunities for care of the body and mind that is not available to psychologists. The expectations of patients and the setting where they choose to ask for help alter the work that can be done.

The degree of unhappiness and ill health caused by sexual problems is great, and there is more than enough work for everyone. Any busy general practitioner will welcome the help and specific skills offered by a psychologist. However, much time and money will be wasted on unnecessary visits and investigations if general practitioners do not pick up the clues in their own consultations, and use the opportunities provided at that moment to explore the patient's problem. Such a 'here and now' approach can save time for the doctor in the long run, as well as relieving much suffering.

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INFECTIOUS DISEASES UPDATE: AIDS

UK sex survey

To date, Alfred Kinsey's data on sexual behaviour gathered in the late 1940s remain the most widely quoted. However, in the era of the human immunodeficiency virus (HIV) with an estimated 6.5 million infected individuals worldwide, many such surveys are now being conducted. In the UK a national study of sexual attitudes and lifestyles[1] surveying 20 000 persons at a cost of £900 000 should make its first results available within two years. Once collected and analysed the information will provide knowledge of current sexual attitudes and practices and should help to identify specific areas which could be focussed on by health campaigns.

Progression from HIV to AIDS

The average time from infection with HIV to the development of the acquired immune deficiency syndrome (AIDS) is more than eight years, with the upper limit still undetermined. However, McLean and colleagues[2] describe a case which may represent the most rapid progression to severe HIV disease reported to date other than in patients treated with immunosuppressive agents or infected by blood transfusion. They describe a 35-year-old homosexual who developed *Pneumocystis carinii* pneumonia within four months of an acute illness associated with documented HIV seroconversion and who, in spite of therapy with zidovudine, died six months later.

Prophylaxis with zidovudine after HIV exposure

The average risk of transmission of HIV per episode of percutaneous exposure to HIV infected blood is approximately 0.4%. Following such an exposure some physicians and institutions are now offering zidovudine as prophylaxis.[3] However, at present data from animal and human studies are inadequate to support or reject the hypothesis that zidovudine may be effective prophylaxis for those who have been exposed to HIV occupationally. As part of an ongoing open trial of zidovudine prophylaxis, three people have been enrolled following 'massive exposure' to HIV. Two had broken/abraded skin exposure to high concentrations of HIV and so far remain seronegative (after three months and 11 months, respectively). The third case received an HIV infected blood transfusion and was culture positive for HIV four months after completing six weeks of chemotherapy.

Needle and syringe exchange

It is now widely accepted that making available needles and syringes to injecting drug users is an important and effective way of limiting the spread of HIV infection within and from this high risk group. Thus, the general trend, particularly in Europe, is towards establishing a wide range of needle and syringe exchange facilities. It is therefore astonishing that in New York, a city which has more HIV infected injecting drug users than any other in the world, the exchange programme, set up in 1988, has now been closed down. Only 300 people enrolled in the programme possibly because the exchange was sited opposite a criminal court building thus discouraging many drug users from attending.

References

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