consent to treatment rules that no one can give valid consent on a patient's behalf.⁵

An identified carrier's quality of life may be compromised by action taken to protect his fellow residents and would be further diminished should it prove impossible to maintain confidentiality in a long stay hospital over a long period. But if routine screening appears unethical the corollary is that the alternative seems unacceptable. It cannot be right to statutorily confine a group of men of limited intellectual capacity in close proximity over a prolonged period, promoting activities which have a 70% chance of transmitting an infection with a 30% mortality, without attempting to determine who carries the contagium.^{1 4 6}

We have asked for guidance from distinguished institutions, including the BMA, without receiving a wholly satisfactory answer. So long as the results show that the patient is seronegative no conflict of principle arises. Should one prove seropositive then critical decisions will need to be made balancing the interest of the patient with those of the other patients.

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The possibility of AIDS

SIR,—Compared with the great epidemics, such as typhus, smallpox, tuberculosis, bubonic plague, and syphilis, the acquired immune deficiency syndrome (AIDS), like serum hepatitis, has a long way to go. The total number of cases reported in the United Kingdom by 1987 was 610 (17 January, p 184), but, like the population predictions of the 1960s, the projection is exponential. The hypothetical epidemic dwarfs many of our other future horrors, but the following case emphasises the need for a sense of proportion.

A 34 year old married man had a five week history of odynophagia described as a fish bone in his throat. He was referred to a general physician when a neck lump appeared in his right mid-deep cervical region. After numerous investigations, including Venereal Disease Research Laboratory and hepatitis B serology (both negative), a general surgeon performed a biopsy on the patient's neck node. A long pathology report concluded "atypical Hodgkin's lymphoma." After the patient was referred to a radiotherapist ulceration of the right tonsil was noticed (as was a "query AIDS" diagnosis thrown on the end of one of the initial differential diagnoses). The genitourinary referral was made after the ear, nose, and throat referral, so it was during the case preceding the panendoscopy and right tonsillectomy that theatres were informed that the man may have been carrying human immunodeficiency virus (HIV) antibodies. Even though the consultant genitourinary physician thought it extremely unlikely that the man was a carrier, serology was performed, just in case. Within minutes full theatre precautions were in train. For many, particularly the operating department orderlies, the fact that the diagnosis had appeared in the notes was enough. A simple 20 minute procedure took two and a half hours and consumed many disposable gowns, gloves, towels, and plastic bags.

Clinically, the lesion resembled a T4 N1 squamous cell carcinoma of the tonsil extending into the postnasal space. Histology of the tonsil remained unclear but confirmed the previous report. No HIV antibodies were found.

The morals of this tale are ancient and modern. Firstly, neck lumps should be referred to a head and neck specialist. Secondly, the present AIDS information campaign behoves all doctors, including the desperate diagnostician, to be circumspect before raising the possibility of the disease or carrier state.

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HIV transmitted by sexual intercourse but not by kissing

SIR,—An essential element of the public education campaign about the dangers of the acquired immune deficiency syndrome (AIDS) is based on the view that human immunodeficiency virus (HIV) is transmitted primarily by sexual intercourse. Writing to the *Guardian*, Dr John Seale asserts that there are dangers in kissing and asks for evidence that the risk from semen is greater.¹ My letter concerns the scientific arguments and is written on behalf of the government's expert advisory group on AIDS, of which I am a member.

When a sexually active couple have intimate contact it can be difficult to be sure what activity led to the transfer of infection. There is no doubt, however, that semen can be infectious because transmission of infection has occurred after artificial insemination.² Gradations of risk have been described with different sex acts, receptive anal intercourse carrying the highest risk.^{3 4} The wearing of a condom seems to lessen the risk of infection.^{5 6} These lines of evidence support a direct role for semen in the transmission of HIV. It is also worth noting that most cases of HIV infection in the USA and Europe have entailed transfer of semen from an infected person.

Dr Seale uses a single case as evidence of salivary transmission.⁷ A woman of 61 was said to have been infected by her husband, who had been impotent for three years. It should be noted that the authors of that report did not claim that the patient in question necessarily contracted HIV through kissing; the purpose of their report was to describe cases in which the virus seemed to have been isolated from blood in the absence of antibodies. The woman in question lacked HIV antibodies or other features of HIV infection. Inadequate detail was given of the type and frequency of contacts between the woman and her impotent husband or of any other sexual contacts. Though it was assumed that the husband became infected through a transfusion during the surgical operation that rendered him impotent, no information is given in the paper about the infectivity of the blood donors concerned. The man might have been infected before becoming impotent. A single case report with incomplete information is an insufficient basis for the argument that kissing has resulted in the transmission of HIV.

In another brief case report one boy is assumed to have been infected by his brother, who had himself become infected through a blood transfusion.⁸ The method of transmission between the two boys was unknown, although it was speculated that saliva in a bite on the forearm might have been responsible. Inoculation of infected material is recognised as a method of transmission of HIV; this case is thus not directly relevant to the dangers or safety of kissing.

The accumulated evidence suggests that social

kissing is not associated with risk. We are reassured because, firstly, non-sexual family contacts of infected people have not caught HIV⁹; secondly, the age/sex breakdown of patients with AIDS and known carriers, with a lack of children aged 5-15 years, argues against transmission by non-intimate kissing; and, thirdly, there are no well documented cases where infection has been attributed to kissing. There is, moreover, no evidence of salivary transmission to health care workers such as dentists,¹⁰ and it has been suggested that there is an inhibitory factor for HIV present in saliva.¹¹ The sharing of drinking vessels such as cups and glasses seems to be completely safe.

Some forms of open mouthed kissing can be associated with considerable transfer of saliva. In epidemiological studies intimate kissing is confounded with sexual intercourse, which makes it difficult to be sure of the precise role of each in the transmission of infection. Apart from the arguments given above for the belief that semen and not saliva has been responsible for cases described to date, there is also indirect evidence from the relative safety of oral sex. Though semen can transmit infection when deposited in the rectum or vagina, the evidence suggests that it is probably not associated with risk by the oral route.^{3 4}

The precise mechanism of transmission of HIV is unclear, and the relative roles of cell free and cell associated virus are uncertain. Contrary to early reports,¹² HIV cannot be grown readily from saliva,¹³ although it can be detected fairly easily in semen from infected people.^{14 15} The difficulty in determining the relevance of such in vitro studies is evident in the reference quoted by Dr Seale on virus in saliva.¹² The method of culture employed in that study could not have differentiated between cell free and cell associated virus. Infectivity shown in cells in vitro may have little relevance to human transmission, where the site of challenge may be as important as the virus load of the fluid in question, as argued above in relation to oral sex.

Public health policy is formulated with the best consensus advice drawn from acknowledged experts. Their view is that there is no sound evidence that HIV has been transmitted by kissing. When questioned in detail, patients infected with HIV are almost invariably identified with one of the known risk groups linked to the well recognised methods of transmission.¹⁶ The real risk to most people is from sexual intercourse, where the clear advice is to restrict the number of sexual partners, preferably to one faithful partner, and if you are unsure of your partner to use a condom.

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State of the public health

SIR,—The suspension of Dr David Josephs by South Bedfordshire Health Authority for his remarks about the action needed to contain the epidemic of the acquired immune deficiency syndrome contrasts sharply with the freedom of the chief constable of Manchester to expound on the same subject. Taken together, these two examples provide a dramatic insight into the state of public health in Britain.

In the 1840s and 1850s there was widespread debate in Europe about the need for "medical police" to control public health hazards. Such an authoritarian style was never imposed, but in Britain we developed a systematic approach to the protection of public health based on technical skill and scientific knowledge rather than popular superstition about disease. This skill was housed in

the office of the medical officer of health in the local authority. Starting with Duncan of Liverpool in 1847, it came to be accepted that the medical officer of health could not be sacked for speaking out on contentious matters that might upset politicians or vested interests; he could be sacked only for professional incompetence. His powers were reinforced by the Public Health Act 1848.

Since the 1974 NHS and local government reorganisations this has changed, and the independent advocacy function of public health has been all but lost. Sadly, this has often occurred with the apparent collusion of community physicians, who have inherited the mantle of the medical officer. In Britain today the public health function is going by default; those who should be making their voices heard on behalf of the public health are all too often keeping their heads down in self imposed silence. Those few who are brave enough to speak out find themselves reprimanded or, like Dr Josephs, actually suspended.

So while a self proclaimed prophet trained as a policeman is free to offer public advice on public health problems a doctor with technical skill in public health who voices a legitimate opinion finds his livelihood threatened. David Player already looks set to be sacrificed for speaking out against the pedlars of ill health. We are certainly back in Victorian Britain with a vengeance (pre-1848) and increasingly seem simultaneously stuck in 1984; rationality seems to have bowed down to superstition on the one hand and intolerance and authoritarianism on the other. Surely it is time to stand up and be counted.

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Points

An assessment of the preregistration year experience

Dr R F Gledhill (Department of Internal Medicine, Kalafong Hospital, Pretoria 0001, South Africa) writes: Drs J E Elizabeth and S Hughes (13 December, p 1559) may have been too ready to accept the veracity of the self assessments provided by their Liverpool preregistration graduates. The known limitations of this evaluation method^{1,2} were strikingly illustrated in a report from the Mount Sinai School of Medicine,³ in which 78% of subjects (third and fourth year students and residents) felt confident in their ability to perform cardiopulmonary resuscitation, but only 2.9% could execute this procedure correctly on examination. In contrast to the figure of more than 95% at Liverpool, an average of only 37% to 75% of Cambridge University graduands felt competent to manage a seizure and acute presentations of left ventricular failure, asthma, and gastrointestinal bleeding.⁴ Furthermore, whereas two thirds of the Liverpool house officers considered themselves competent in performing a lumbar puncture and abdominal paracentesis, the figures for Cambridge were 30% and 12% respectively.⁴ With respect to medical emergencies the findings reported by Wakeford and Roberts⁴ accord with those obtained in surveys of graduates from McMaster University⁵ and interns from the University of Stellenbosch.⁶ Liverpool University Medical School may well conduct highly effective undergraduate and postgraduate programmes but there would also seem good reason to question whether the results of the survey are especially impressive because some of their respondents tended to overestimate their abilities.

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Man bites dog

Mr K HASHEMI (Accident and Emergency Service, Mayday Hospital, Thornton Heath, Surrey CR4 7YE) writes: I agree with Drs B Kirkpatrick and R Wise (13 December, p 1522) that potentially the most serious form of human bites and the ones most likely to cause complications are clenched fist injuries. These injuries are more prone to complications because doctors often fail to recognise the injury as caused by a human bite. This, coupled with patients' own reluctance to give a clear history of the cause of their injury, leads to delay in providing appropriate treatment. The only sure way of avoiding this problem is to treat every "knuckle" injury as a clenched fist injury. Although an aggressive approach is necessary, I do not, however, agree that inpatient treatment is usually needed. In my own practice exploration and irrigation of the wound with any necessary debridement are carried out at the time of first presentation. Swabs and irrigation samples are sent for bacteriological culture. The open wound is then dressed and the injured hand raised in a high arm sling. The patient is started on a course of antibiotics and my own personal choice is Augmentin (amoxycillin and clavulanic acid). Every patient is reviewed the next day, and those who show evidence of spreading cellulitis are given a volar plaster cast immobilising the injured hand from the finger tip to the point of their

elbow, and the hand is again raised in a high arm sling, and these patients are reviewed daily. Those who do not show evidence of spreading cellulitis are reviewed at lengthened intervals. I have found the above regimen extremely effective, and since its introduction more than three years ago there has been no case of serious complications or inpatient treatment.

Attitudes to prescribing iron supplements in general practice

Dr J J BANNISTER (Department of Surgery, Royal Hallamshire Hospital, Sheffield S10 2JF) writes: In the survey of Drs D G Waller and A G Smith most GPs usually prescribed iron on the basis of the full blood count (93%) or a blood film suggesting iron deficiency (81%), apparently without further investigation. The study does not delve into the reasons for the subjects being iron deficient. It should be emphasised that iron deficiency anaemia is not a disease in its own right, to be treated with iron supplements, but merely a sign of an imbalance between, on the one hand, the dietary intake and absorption of iron and, on the other hand, the body's losses of iron. In all patients, with the possible exception of women with heavy menstrual loss or the loss of iron associated with pregnancy, the finding of a microcytic and hypochromic anaemia should alert the attending doctor to the possibility of chronic bleeding from the gastrointestinal tract. Testing for the presence of occult blood in the faeces may be useful in confirming bleeding, but a full and prompt radiographic or endoscopic study of the upper and lower bowel is the only way in which symptomless and possibly remediable gastrointestinal lesions, such as caecal carcinoma or colonic polyps, will be detected.

Self help groups

Dr ELIZABETH BRYAN and Ms MARGARET HARRISON (Home-Start Consultancy, Leicester LE1 7JL) write: Many readers working with self help groups will have been delighted to see Dr Stephen Lock's valuable article about them (20-27 December, p 1596). But does not their role in preventive medicine deserve as much emphasis as that of supporting patients (and their families) suffering disease or disability? If an overstressed mother can be prevented from abusing her child or needing antidepressant treatment through the committed support of another mother there can be little doubt of the cost effectiveness, let alone human benefit. In recent years this has been clearly demonstrated by Home-Start, a voluntary scheme in which volunteers offer practical support and friendship to families with children under 5 in their own homes. There are now over 60 local Home-Start schemes. The role of the volunteer is, of course, complementary to that of the professional worker, and the organiser of each scheme always has close links with the statutory services.

Depression after stroke

Dr DAVID AMES (Academic Department of Psychiatry, Royal Free Hospital, London NW3 2QG) writes: Dr Allan House's otherwise excellent review (10 January, p 76) contains a common but incorrect assumption about the uses to which Hamilton's depression rating scale¹ may justifiably be put. Hamilton's depression rating scale is intended not as a diagnostic instrument, as Dr House seems to believe, but specifically to rate the level of depression in patients already diagnosed as depressed. Hamilton makes this point clear in his original paper. For patients over 65 with stroke the most useful standardised diagnostic interview is probably the geriatric mental state of Copeland *et al.*² This schedule is better suited to the diagnostic requirements of an elderly population than is the present state examination.

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