my haste to dress, pack, and get out of the hospital. As he walked into my room his eyes lit up and he started to look happier than he had for weeks. I wanted to cry, for him not for me, but instead I shouted, "No, it's not good news. I've got it but let's get home." Without being oversentimental I will try to tell you about that weekend. It is almost more relevant to my present good health and positive mental state than all the drugs, both allopathic and holistic, that I have swallowed since.

We arrived home and we fell into each other's arms and we cried. We cried for many reasons. Because we'd hurt each other in the past, because we needed to reconfirm our love, because we needed the outlet, because we were frightened, and, lastly, because I had AIDS. Afterwards, as things looked a little brighter, I vowed I would never cry for myself again. That would be a difficult decision to keep, so I mentally enumerated all the good things in my life. I knew that they would outweigh anything bad, including AIDS.

We went out to dinner that evening with two close friends. We told them and they cried, but we had a marvellous dinner. The following day I went to tell my mother while John went to tell his parents. Some of you may have seen my mother on TV with me; her common sense, strength, and love are a huge part of my fighting determination. Obviously my relationship with Lil had been growing for 41 years and still is—just as it is with my sisters and with all my friends. I never experienced rejection—just unconditional support, sometimes from surprising sources.

No regrets

On the Sunday John, my mother, and Karen, my young sister, who has Down's syndrome, went to Leeds Castle for the day. It was a fabulous day—not the weather, it rained on and off all day—but the joy of living just filled me. I couldn't be dying. I had so much to live for, so much to do. How could I cause John and Lil so much grief. I didn't know how but I knew very early on that I had decided to fight and if I did die I would do it fighting and with dignity *but not yet*.

All that was 10 months ago, and each minute has been wonderful. I even enjoyed admitting on a TV programme that I had AIDS. Knowing that my mother was there with me, that my lover and my sisters were in the green room, gave me the strength that made me want to help other people with AIDS in a worse situation than myself. I have only been in hospital once and have discovered homoeopathy. Scoff if you like, but do you have any of the real answers either? I feel good in myself and about myself, and I keep taking the pills and reject no offer of help without discussing it with all the people who are trying so hard to help me and others in the same position. My relationship with John is growing daily, and our sex life, although completely safe, is good and frequent. I live with myself better than in the past. I've never had many problems with being gay and I now think I'm quite a well adjusted human being. As my doctor once commented, many people with AIDS become what they always wanted to be. Perhaps, but I still worry about the black bag at the end, and then I have to remind myself that I won't be there to feel the zip being done up. Occasionally I worry about becoming demented and then again remind myself that I wouldn't know much about that either, so that's another problem solved.

Things are moving forward, not slowly but really quite quickly. People with AIDS are admitting it and not hiding away, lying to friends and relatives. I personally cannot regret being homosexual, and therefore I can't be negatively regretful about having AIDS.

Conference Report

Inner city medicine: off the back burner

TONY DELAMOTHE

One of the more affecting sights of recent English summers has been that of Lord Scarman, making his way through the aftermath of some inner city riot, searching for a polite equivalent of I told you so. It was Lord Scarman who reported on the Brixton riots in 1981[1] and who ever since has been condemned to see his predictions come true—in St Paul's, Brixton (again), and Tottenham.

In the same year another aspect of inner city life, primary health care, was the subject of a report.[2] Six years later few of its 115 recommendations have been adopted. Has any progress then been made at all? A conference devoted to inner city medicine, organised jointly by the Royal College of Physicians and the Royal College of General Practitioners, suggested that there has been.

The conference's introductory address was given by Sir Donald Acheson, whose study group was responsible for the original report. He listed some of the problems of inner cities. Economic changes have led to their steady depopulation. Compared with other areas, inner cities now have a higher proportion of drug abusers, single parent families, the elderly, the mentally ill discharged from old poor law hospitals, ethnic minorities, and the young, mobile, and unemployed. Many sleep rough. The prevalence of illness is greater and so is use of the health service: inner city residents are admitted to hospital more frequently and stay longer, often because of poor conditions at home. They bring low expectations of the health

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service with them, and when poor service is given they usually accept it uncomplainingly.

New initiatives

The bulk of the conference was devoted to describing attempts to tackle these problems. These initiatives shared several common characteristics. The use of services was improved by taking them away from hospitals and out into the community. There was greater sensitivity to the desires of consumers—who were often consulted in the planning stage of a new scheme. Inflexible structures, imposed "top down," were avoided. "Non-medical" health workers played a large part in the management of "medical" conditions.

Professor Sir Malcolm Macnaughton, president of the Royal College of Obstetricians and Gynaecologists, and Dr J Langan, a general practitioner in Glasgow, described a programme of antenatal care in the east end of Glasgow. There, combined clinics of midwives, general practitioners, and hospital consultants are conducted in health centres rather than hospitals, with patients visiting hospital only for ultrasound examination and delivery. A comparison of mainly community with mainly hospital care showed no difference in outcome between the two groups, with women preferring community care because they saw fewer doctors, wasted less time, and spent less money on transport.

Dr L Polnay, a community paediatrician, and Dr J Temple, a general practitioner, described the child health services in the socially deprived area of Nottingham in which they work. Medical services are just one component of a highly integrated health care team. According to Dr Temple, health visitors play the key part in his practice team's care of children. They are often the first point of contact for acute minor illness and family problems. Health visitors are the practice's main link with speech therapists, the school nursing service, and community resources such as nurseries and mother and toddler groups. At the child health clinic, which is situated in the middle of the area it serves, English classes are run for non-English speaking parents at the same time as children's playgroups. Parent held records have been introduced recently, involving parents more directly in their children's health care and having an educational function as well.

Details were also given at the conference of two primary care development projects in London, both supported by the King's Fund. In Tower Hamlets the project was intended to establish whether an independent lay worker (Nancy Dennis) working with general practitioners, community health staff, social services, and statutory and voluntary organisations could facilitate improvements in the delivery of primary care. In Camberwell Dr Roger Higgs, Ms Virginia Morley, and Dr Tyrrell Evans are working from the department of general practice studies at King's College School of Medicine and Dentistry to facilitate developments in primary health care. As an antidote to the isolation experienced by many inner city general practitioners they have emphasised teamwork—between general practitioner and general practitioner, between general practitioner and health visitor, and between general practitioner and the local hospital.

Professor Elaine Murphy described the community psychogeriatric service in Lewisham and North Southwark. This is a totally open referral system, which is widely advertised to general practitioners, hospital consultants, social services, home care services, voluntary organisations, and the general public. The open referral system was created to deal with the alternative ways that dementia presents in the community—through its social impact on relatives, neighbours, and the general public rather than as an illness through the usual general practitioner route. Her multiprofessional team has reduced the number of patients with dementia entering long stay psychiatric care by half.

The way in which accident and emergency departments in inner cities have become surrogate general practices, accounting for almost half of all primary patient-doctor contacts taking place out of hours, was described by Dr D J Williams, president of the Casualty Surgeons Association. He reported the successful use of experienced nurse practitioners to conduct triage in accident and emergency departments.

Next stage

The steering group that set up the conference will probably be releasing a statement soon. A monitoring system will be set up jointly by the two royal colleges to report back in one year's time on the progress of these initiatives and to decide what further steps are required.

The inner cities, which have been slowly fighing their way up the political agenda, look as if they may finally have made it on to the medical agenda as well.

References

1 Lord Scarman. *The Brixton disorders 10-12 April 1981*. London: HMSO, 1981.
2 Study Group. *Primary health care in inner London*. London: London Health Planning Consortium, 1981. (Acheson report.)

DOCTORS IN SCIENCE AND SOCIETY

Science and technology

What is contributing to our lack of success? There appear to be a number of factors, which include British attitudes to technology, unsatisfactory relationships between industry and academe, a relatively small home market, and the influence of budgetary constraints in the National Health Service.

It is platitudinous to say that one of the major contributing factors remains the attitude to technology and applied science, but it must still be said. Medawar has pointed out that "Britain suffers from that most dangerous form of snobbism in science . . . which draws distinctions between pure and applied science . . . and which is at its worst in England." In our schools any one who is "any good" is encouraged to do academic things, and engineering and applied sciences are regarded as lesser pursuits. This carries forward into university life and later into professional careers. It is a viewpoint reflected by the comment of a certain medical scientist that the award to Hounsfield of the Nobel prize for the introduction of computed tomography had been given for "mere technology." One is reminded of the immortal reply made to Brunel when he told a lady that he was an engineer, and she commented that she had mistakenly thought that he was a gentleman.

In recent years populists have sought to sow a mistrust of scientists and technology in the public mind. This has been accompanied by assaults on modern medicine by writers such as Illich and the BBC's Reith lecturer for 1980, Ian Kennedy, as well as by doctors themselves. McKeown, among others, has argued that medical science and technology have been given too much credit for the improvements in the nation's health during the past century and in particular that the decline in mortality from infectious disease is due more to social change than to science and technology. By constrast, he might now reflect that it is social change that has led to the current world epidemic of sexually transmitted disease and, in particular, to the tragedy of AIDS. Since epidemiologists are unlikely to succeed in changing sexual behaviour, it must be emphasised that it is only science that has anything to offer to the unfortunate sufferers from these unpleasant and sometimes fatal conditions, as is illustrated by the discovery that a specific retrovirus is associated with AIDS.—CHRISTOPHER BOOTH.

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