groups of people who are somehow recognisable. Is it any wonder that, as Smith asserts, "heterosexuals have simply not adopted safe sex in large enough numbers to prevent HIV spreading through the heterosexual population"?

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EDITOR,—To me the most important point in Richard Smith's editorial on promoting sexual health is that we are going to have to change a great many of the attitudes of people in Britain before we can possibly change their health habits.¹ So many are mealy mouthed when it comes to anything with a sexual content and squirm with horror at direct, honest language. As Smith says, "Use a condom" is a clear and simple message, but for far too many Britons it is made complicated by being put into words at all. Too many people in Britain believe that talking about sex is acceptable only if it's in the "dirty joke" mode, never if it's simple and direct.

I should know. I have been bombarded with complaints from women who think it is disgusting that I mention on television the fact that women menstruate and have to use sanitary towels. The commonest reason for complaint has been that the advertisements in which I appear have been screened at times when children were watching. "And how can I possibly talk about such things to my children? I shouldn't have to listen to even the mention of periods in front of my teenagers."

We're going to need all the help we can get in promoting honest talk about shared sexual experiences. Once we get that maybe we will be able to promote sexual health.

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Heterosexual transmission of HIV

EDITOR,—Richard Smith's editorial addresses the promotion of sexual health.¹ In Britain most mass health education regarding heterosexual transmission of HIV-1 infection has presented sex with casual partners as the main risk. But if most heterosexual intercourse involving infected people took place in stable relationships long term partners would be the most at risk from unprotected sex.² In Sweden 53 heterosexual partners of people with HIV infection were infected: 32 by steady partners and 21 by casual partners.³ In the United States, having a partner who used drugs, but not the number of partners, carried a significant risk of HIV infection.⁴ Of 35 women who acquired HIV heterosexually in Copenhagen, 10 were infected by a cohabiting partner; only one of the 25 women with partners in a high risk group was aware of the partner's risk activities when the relationship started.⁵

All cases of AIDS resulting from heterosexual transmission within the United Kingdom reported to the Communicable Disease Surveillance Centre

and the Communicable Diseases (Scotland) Unit were classified, based on the information in the reports, into transmission within long term sexual partnerships (marriage, cohabitation, and relationships of six months or more) or short term partnerships (lasting less than six months). Cases were also classified according to characteristics of the partner into first generation (partner infected through injecting drugs, receiving contaminated blood, or homosexual intercourse) and second generation (partner infected heterosexually). Where the type of partnership was known, 18 of the 21 first generation cases (86%) and 13 of the 31 second generation cases (42%) were presumed to have arisen in long term partnerships. There was a pronounced difference between the sexes, with 73% of the men having been infected in short term partnerships and 83% of the women in long term partnerships (table).

Heterosexual transmission of HIV in United Kingdom: analysis of reported cases of AIDS by duration of partnership to December 1991

Type of partnership	First generation transmission		Second generation transmission	
	Male	Female	Male	Female
Long term	4	14	2	11
Short term	1	2	15	3
Not known	1	4	16	3
Total	6	20	33	17

This information was not collected in a systematic way, and its completeness may be biased. Because of the long incubation period cases of AIDS may not reflect the present pattern of transmission. Data on AIDS, however, are not subject to ascertainment bias as most patients will seek medical care, in contrast to patients with HIV infection.

Further information is needed on the type and duration of partnership in which recent infections occurred and, for those infected by partners in a high risk group, whether they were aware of their partners' risk factors at the time of the partnership but still had unprotected sex or whether they were not aware. From the data available on cases of AIDS, however, heterosexual transmission of HIV in long term sexual relationships should not be ignored.

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Sexual contact in the doctor-patient relationship

EDITOR,—I was interested to read in D Wilbers and colleagues' report of their study of sexual contact between doctors and patients that the Dutch National Society for General Practitioners had withheld its approval for the questionnaire to

be sent to general practitioners.¹ The society's reason was that the specific importance for general practitioners was not evident. Wilbers and colleagues quote a previous finding that six out of 29 responding general practitioners (from 75 contacted) had had erotic physical contact with a patient. Kardener *et al*'s American study,² referred to in Thomas Fahy and Nigel Fisher's editorial,³ showed that half of 100 respondents thought it might be therapeutically beneficial to indulge in "non-erotic hugging, kissing and affectionate hugging" while a quarter thought that erotic contact may at some time be beneficial. Only 3%, however, admitted to having engaged in erotic practices.²

The media have given a lot of attention recently to claims about doctors making advances towards patients, and many doctors have experienced the reverse. General practitioners are particularly at risk because of more frequent contact and longer acquaintance with patients, the congeniality of surgeries and intimacy of home visits, and the greater likelihood of contact outside the professional relationship.

Though a few doctors may enjoy erotic involvement with patients, many fear it. This may lead them to avoid taking any interest in a patient's sexuality, to the potential detriment of the patient's health. Sexual dysfunction is common, and many would seek help for it if encouraged to do so by their physician.⁴ The family doctor may be the professional of choice.⁵ He or she needs to be comfortable with the subject. Nearly four fifths of gynaecologists in Wilbers and colleagues' study thought that more attention should be paid to sexuality during training.¹ Brief intensive exposure to sexual issues at undergraduate level has been shown to alter attitudes to sexuality favourably and encourage greater awareness.⁶ Problems of sexual dysfunction can often be helped without a great deal of extra training and should be addressed by all practitioners during undergraduate and postgraduate training.

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Site of injection for vaccination

EDITOR,—I agree with Mark Henley that BCG vaccination above the deltoid insertion should be avoided.¹ He is, however, incorrect in stating that the only vaccination for which a specific site on the upper arm is recommended is rabies. It is also recommended for hepatitis B vaccine. Both the Joint Committee on Vaccination and Immunisation in the United Kingdom and the Immunisation Practices Advisory Committee in the United States recommend that, although the anterolateral thigh is the preferred site for infants, hepatitis B vaccine should be given into the deltoid muscle in adults.^{2,3} In particular, the buttock must not be used: it is associated with a suboptimal response, probably because of injection into subcutaneous fat rather than into muscle.⁴ Injection into the thigh might prove unsatisfactory for the same reason, especially in overweight adults.

Vaccination of health care workers against