environment that they inhabit is banal and undistinguished, but both films contain masterly sketches of sympathetic characters getting on with life in a humble part of New York. They are also very funny.

Although in *Smoke* the tobacco store is the catalyst for interaction, it is subservient to the main themes of the film: the meaning of relationships. The star of *Blue in the Face* is Brooklyn. Studded with video clips of real life

residents describing their lives, the film is up front about the crime, the noise, and the decay, while taking delight in the human spirit that survives. The films are too rich and complex to deserve condemnation merely because they give a central role to tobacco. In *Smoke*, smoking is not glamorous or evil: it's just something some regular people do. Submitting the habit to such neutral examination is so unusual in an American film that it feels like an act of subversion.

While the characters in *Smoke* and *Blue in the Face* do not make anti-smoking propaganda, neither do they derive much pleasure from tobacco. It is precisely the unremarkable and undramatic manner of their smoking that makes it clear that they are hooked. Viewed in this cool light, smoking is rather effectively deglamorised.—DOUGLAS CARNALL, *general practitioner and freelance journalist, London*

PERSONAL VIEW

"Coming out"—a personal dilemma

Sandy Logie

See p 1625

I retired four years ago, aged 53. This was not through ill health or burn out, nor as a protest against the NHS reforms. It was prompted by the 1988 offer of early retirement on full pension to senior consultants, part of a solution to the problem of too many time expired senior registrars in Scotland. My wife and I had worked in the Gambia in west Africa in the late 1960s: this exerted a strong formative influence which made us both wish to return to Third World medicine when domestic commitments permitted. The offer of early retirement was too good to refuse.

One year later, in Zambia, I sustained my first needle stick injury, and this was closely followed by two further exposures to blood which was HIV positive. Six weeks after this I had a non-specific pyrexial illness which lasted one week. Back in Britain I tested positive for HIV.

We were numbed by this misfortune, but 10 days later my wife managed a short break from her work as a general practitioner and we went camping in the Lake District. The great beauty of our surroundings and the perfect weather had a wonderfully healing effect, helping us to come to terms with our situation.

A thorough medical checkup was reassuringly normal, although my CD4 count was undesirably low, and I learnt that people of my advanced age fare less well with HIV than younger patients. Medical advice, forcefully expressed, was that I should not return to work in the tropics. "Too much antigenic stimulation of your fragile immune system." The unavailability of sophisticated diagnostic facilities and of intensive care were other considerations. This advice, while undeniably sound and sensible, constituted a major blow to our plans for the future.

There were two immediate problems: whom to tell about my diagnosis and what to do with the rest of my life. The advice of the

AIDS team of my local health board was didactic: the fewer people who knew, the better, and provided that I did not perform any invasive procedures there was no reason why I could not continue to practise as a physician—and, perhaps controversially, there was no need to inform employing authorities of my HIV state before doing short term consultant locum posts.

I have had several such locum appointments without disclosing my state (but feel guilty about it). I have closely followed the advice of the Department of Health's Expert Advisory Group on AIDS so I am confident that no patients have been placed at any risk. We have enjoyed three brief consolation visits to Africa—to Kenya and South Africa for conferences, and to Uganda to help set up a project on the effects of economic structural adjustment programmes on health.

For two and a half years I kept well, but last October's visit to South Africa marked the start of a prolonged pyrexial illness, with profound anorexia, dramatic weight loss, pronounced weakness, and malaise. Fortunately, symptoms did not worsen until my return to Britain. No firm diagnosis came to light, despite thorough investigation, including screening for all known tropical diseases.

"It is increasingly difficult to field questions about my health, my recent illness, and our future plans."

During the long watches of nocturnal insomnia, I sometimes feared that I was at the start of a slippery slide into chronic ill health, and that my days were numbered. Things are always worse at night, but these intimations of early mortality proved quite a test of my professed agnosticism.

My pessimism proved unfounded. Restored to restless health, I now have to plan for an uncertain future. My Presbyterian work ethic precludes my giving up medicine completely and devoting more time to such delights as music, literature, and, for as long as I am able, hill walking. One option is to resume consultant locum work. This is agreeable and it is interesting to observe how different hospitals are organised. Merely look-

ing after patients with no administrative responsibilities and no committees is enjoyable but I suspect that it will lack longer term fulfilment. Non-clinical research does not greatly appeal, and a spell doing phase 1 clinical drug trials was frankly boring.

So why am I writing this? There are several reasons. Firstly, as a means of "coming out" and no longer trying to conceal my HIV state, which has been a big strain. My wife and I have told no lies, but it is increasingly difficult to field queries about my health, my recent illness, and our future plans. "When are you going back to Africa?" is a frequent question, and "So have you retired completely, then?" is another, in slightly disapproving tones, to one who seems relatively young.

Secondly, in the light of recent exciting advances in treatment for HIV it is possible that I may survive in a fit state for longer than I had feared, and I would not wish, at some unspecified point in the future, to look back on time spent unprofitably, in effect waiting to fall ill. I would like to pursue more permanent employment, and I will be happier if I can be completely open about my health.

Thirdly, some family members and close friends have urged me to declare my state, both for my personal peace of mind and because I can then be in a position to help others less fortunate.

I do not foresee strong adverse publicity, but my wife and I realise that we may have to face some of the prejudice, ignorance, irrational fear, and aggression which other health care workers who are HIV positive have experienced.

Any momentary lapse into self pity responds to a comparison of my position with that of many patients with AIDS, who suffer severe, unsupported illness and die lonely, distressing deaths at less than half my age. During my time in Zambia I was often upset by my therapeutic impotence and inability to provide more than the simplest palliation to terminally ill young men and women, many of whom, especially women, had been cruelly rejected by their families and communities, and even separated from their children. In contrast, I know that I can continue to rely on excellent medical care and all necessary support to help me through whatever may lie ahead. I do not glibly declare myself fortunate, but truly I have much to be thankful for.—A W LOGIE is a retired consultant physician from Melrose