the denominator (the 95% confidence intervals for trimipramine are 1.7 to 3.1, for mianserin 1.5 to 2.9, and for moclobemide 1.2 to 2.3). Risk calculations including only cases with one single antidepressant detected did not differ from the results presented, but the confidence interval for moclobemide was then at the border of significance. Given that depression is a recurrent disease a relatively high rate of detection of other antidepressants among patients treated with the newly introduced drugs mianserin and moclobemide can be expected. Exclusion of cases in which more than one antidepressant is found would therefore make comparisons less valid.

Conclusion

Studies that have used the fatal toxicity index suggest that the risk:benefit ratios for newer antidepressants are better than for the older ones because of their lower toxicity. As intoxication with an antidepressant is a rare method of suicide, however, it is reasonable to include all methods in a risk analysis. The antidepressants of lower toxicity do not then seem to have lower risks than average, which suggests that therapeutic failure (relative benefit) may be of more concern than toxicity (relative risk) with antidepressants. Our most substantial finding, however, consistent with those of others is that few people are taking antidepressants at the time of suicide, although half of the people who commit suicides are depressed. This may be the reason why antidepressants have failed to reduce the suicide rate. Whether some drugs are relatively more effective in curing depressions or preventing suicide requires further studies.

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Provision of consumer health information in general practice

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The term "consumer health information" is relatively new and refers to information about healthy living, medical conditions, and health and other services that is provided direct to consumers. There are arguments for developing consumer health information independently of providers of primary care and other health care. It could then be seen as impartial and as a source of empowerment for consumers of health care. On the other hand, people have traditionally gone to their general practitioner for advice on their health and find general practice surgeries convenient and appropriate places to seek information on health.¹ Although there are several examples of innovations in the provision of health information to patients in general practice,^{2,5} there is no clear picture of the overall provision of consumer health information in general practices.

Method and results

A brief questionnaire about consumer health information (written, on video tape, or on audio tape) was sent in April 1993 to all 312 practices in the East Anglian region. The final response rate was 83% (n=258). Of the 312 questionnaires, 203 were completed

by the practice manager; 36 by a principal in general practice; and the remaining 19 by practice nurses, secretaries, or receptionists.

The table shows the types of information that were available for patients in general practice surgeries in East Anglia. Information about healthy lifestyles and medical conditions was available in most practices, but information about hospital waiting lists was available in less than a quarter. Information was usually given in a leaflet; in 98 practices books were available to patients, and in 60 practices videos were available. In addition to providing patients with leaflets produced by the health education authority and commercial companies, 91 practices said that they produced their own leaflets (as well as the leaflet about their practice); 36 had leaflets available in languages other than English.

Seventy four practices said that they had a library for

Consumer health information (written, on video, or on tape), according to subject, provided by 258 general practices in East Anglia

Subject	No
Healthy lifestyle	244
Life events (for example, the menopause)	239
Medical condition (for example, diabetes)	236
The practice and its services	226
Claiming welfare benefits	222
Self help groups	215
Charities and voluntary agencies	210
Support for carers	201
Community health services	168
Social services	163
Local hospital services	115
Hospital waiting lists	59

patients, with books, videos, or audio tapes for patients to borrow. One of us (JSP) carried out a follow up telephone survey of 30 of these practices; half of their libraries had between 20 and 100 books to lend to patients, six had between 100 and 500, and the rest had just a few books and tapes. Only seven practices, however, kept their library in the waiting room, where patients had direct access to the books.

We found little relation between the size or location of the practice and the type of consumer health information available. Urban practices, however, were more likely than rural practices to have leaflets in languages other than English, and fundholding practices were more likely than non-fundholding practices to produce their own leaflets and to have leaflets in languages other than English.

Practices were asked if they were planning any developments in health information services for patients in the coming year. The most popular development was the provision of videos. Other developments included setting up or improving a library for patients; producing leaflets and advice sheets within the practice; setting up a computer database; and producing a newsletter for patients. A few practices had some innovative ideas such as setting up a health information desk within the practice and having an annual health fair for patients. Four main types of problems with providing consumer health information were mentioned: lack of NHS resources; physical resources in the practice; concerns about the non-return of books, tapes, and videos; and a lack of suitable health information to provide to patients.

Comment

The availability of consumer health information in general practice surgeries in East Anglia varied greatly. Only a few practices had well stocked libraries where the books were readily available for patients to browse through and borrow. Many practices still relied on leaflets as the main way of communicating health information to their patients. Both the high response rate to the survey and the written comments about planned developments, however, show an encouraging enthusiasm for consumer health information in many practices.

We thank all the practices that participated in the survey; East Anglian Healthlink; and the family health services authorities of Cambridgeshire, Norfolk, and Suffolk that helped to send out the questionnaire. Special thanks are due to Mrs Sally Roberts, who entered the data from the questionnaires on to the computer. JSP was on study leave while the survey was carried out and received a grant from the East Anglian regional audit team.

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A PATIENT WHO CHANGED MY PRACTICE

Roger—my first patient with AIDS

In early 1983 I took up a research fellowship at St Mary's Hospital Medical School to work exclusively on AIDS. I had read about AIDS in *Newsweek* in 1982 and I was fascinated by the new disease, its mysterious arrival, and the unusual groups who seemed to be affected: homosexual men, Haitians, heroin users, and their heterosexual partners. I read all the publications describing this condition (about eight at that time, about 60 000 now). A friend came up with a free ticket to the United States, and I spent a few weeks in New York doing infectious disease rounds at Sloane Kettering and in the Bronx, where I was able to see many patients with AIDS. At St Mary's we had established a cohort of 100 asymptomatic homosexual men for immunological study and also a smaller group with persistent generalised lymphadenopathy. We suspected that this was part of the spectrum of AIDS, but had no idea whether patients with persistent generalised lymphadenopathy would progress to frank AIDS and over how long a period. The media were just beginning to become interested and the St Mary's group was attracting attention as a centre for AIDS research; all that we lacked were any patients with AIDS.

Roger was a waiter from a small town on the east coast and he came to the Praed Street clinic in March 1983. He had been referred by a dermatologist who had recognised that Roger had Kaposi's sarcoma. Quite by chance, the dermatologist had recently visited a United States army base in Texas where several cases of AIDS had been identified. He recognised AIDS associated Kaposi's sarcoma and wanted Roger to be seen in a clinic which was accustomed to dealing with this rare condition.

Roger was covered with violet plaques and had extensive infiltration of tumour into his gut, with lesions in his mouth, colon, and rectum. He had visited the clubs and

bath houses of San Francisco many times for holidays and had had casual homosexual sex for 10 years. He had heard about the AIDS epidemic and knew his diagnosis but not his prognosis. He seemed genuinely surprised when I admitted that we did not know how to treat his tumour. "Can't you just give me some pills to make it go away?" he asked. "How have you treated the others?"

I demurred, as I could not bring myself to admit that he was our first patient with AIDS. He was admitted, investigated exhaustively, and treated with high dose α interferon. We took innumerable photographs of his lesions, of every conceivable part of his body, and I (and many others) still use those illustrations. An image of his rectum graces several textbooks. After a promising initial response to treatment Roger died of disseminated Kaposi's sarcoma at the beginning of 1984.

Since Roger's admission there has never been a time at St Mary's without patients with AIDS on the wards; at present they occupy 28 beds. I think Roger knew that my clinical and research experience could be bought only at his expense, but his generosity was unlimited, as was that of the many patients who have followed him. While I had been personally convinced since mid-1982 that AIDS would become a clinical problem in Britain, the long wait for the first patient raised doubts about whether our premonitions were actually correct. After Roger there were no more uncertainties and we knew that the AIDS epidemic was real and among us.—JONATHAN WEBER is professor of genitourinary medicine and communicable diseases in London

We are delighted to receive submissions of up to 600 words on *A paper (or patient or book) that changed my practice, A memorable patient, The one message I would like to leave behind, or related topics.*