even genocide: ministers secretly agreed to "tilt" towards Iraq with regard to exports related to arms in December 1988, only eight months after the bombing of Kurdish villages with poison gas—part of a definitive attempt to eliminate Kurdish life and culture—had been in the news worldwide. Ministerial acknowledgment of this was limited to a concern with presentation and meant that the full facts were kept from the Commons and wider public.

In the 1990s the strategic tilt is in the reverse direction and Britain seeks warmer relations with Iran. What of the experiences of the Iranian refugees in my current caseload?

A 28 year old woman was strung up, whipped, and raped in front of her 4 year old son by officials seeking her husband. The boy was tortured in front of her: long cuts were made with razor blades. She fled in 1993.

A 47 year old Kurdish woman fled in 1991. Her husband, daughter, and son had been detained and tortured. She had been summoned to be told that her daughter and, later, son had been extrajudicially executed. When she protested her son's innocence, officials assured her that if they had made a mistake he would go to paradise.

A 29 year old medical student in her final year was accosted by a revolutionary guard outside the teaching hospital; after a verbal altercation he shot her classmate dead in front of her. No protest was possible, and the university authorities were pressurised to expel her. She hid in her parents' home for three months and fled in 1992.

A 37 year old man was tortured; this included mock executions and being burnt with a hot skewer. His 70 year old mother was allowed to visit only if she humiliated herself by stripping naked. He was moved from Evin to Gohadasht prison, where he heard firing squads every night. Young girls there were raped by guards before being shot or hanged. He fled in 1992, but his brother was arrested and may be under sentence of death to force him to return.

A 32 year old Kurd spent four years in prison under an extreme brutal regime. His job was to wash the bodies of executed prisoners; he estimates that he saw 10 000 in this time. He fled in 1992.

Reports by Amnesty International confirm the systematic and institutionalised nature of these acts, affecting thousands of new victims every year.¹ For how long will this continue to weigh so little with decision makers in the West?

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1 Amnesty International. *Annual report*. London: Amnesty International, 1992:144-6.

Salt and asthma

EDITOR.—Alan J Knox has reviewed evidence suggesting a relation between a high salt intake and worsening of asthma in men¹ and discussed two hypotheses to explain this—namely, Blaustein's hypothesis and the hypothesis that the deterioration in asthma is due to the fall in circulating catecholamine concentrations that occurs during salt loading. We and colleagues have published findings that may provide a much simpler explanation.

We have shown that a reduction in salt intake from 200 mmol/day to 50 mmol/day over two weeks causes up regulation of β_2 adrenoceptors on lymphocytes (as well as concomitant down regulation of α_2 adrenergic receptors on platelets).^{2,3} These changes in the densities of adrenoceptors are reversible: a subsequent high salt diet (200 mmol/day over two weeks) causes a decrease in β_2 adrenoceptors and an increase in α_2 adrenoceptors. Receptor affinities remain unchanged. These

changes in adrenoceptors are more pronounced in subjects whose blood pressure falls when they have a low salt intake (that is, those who are sensitive to salt). In a subsequent study we showed that subjects who are sensitive to salt have a decreased expression of β_2 adrenoceptors on cultured fibroblasts, which presumably is determined genetically.⁴

If our findings also apply to airway smooth muscle cells a high salt intake would lead to reduced bronchodilatation mediated by β_2 receptors. A body of literature exists in favour of the so called β adrenergic theory of asthma, which postulates disturbed β_2 adrenergic function as a cause of asthma.⁵ It would be interesting to measure β_2 adrenoceptors on cultured fibroblasts of patients with asthma as this might give evidence for a possible genetic background. It would also be interesting to test our findings regarding adrenoceptors on lymphocytes in patients with asthma during high and low salt diets.

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Incentives in the internal market

EDITOR.—Neil Goodwin is right that success in the internal market should be reinforced.¹ But the incentives must be to the trust as a whole and not to individual people. A successful trust can reward outstanding groups or departments by supporting and developing their budgets. That way the morale of all who work in the department is raised. Individual performance related pay is a sick joke—as much for managers as for clinicians—and is divisive and destructive of team loyalty.

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- 1 Goodwin N. Making the internal market work. *BMJ* 1994;308:206. (15 January.)

Use of a telephone advice line in an A and E department

EDITOR.—Conor V Egleston and colleagues report the use of a telephone advice line in an accident and emergency department.¹ We acknowledge that there is public demand for medical advice over the telephone, but the authors report that inappropriate information was given on two occasions during their study, one occasion being after accidental poisoning.

The accident and emergency department at Leeds General Infirmary has developed strong links with the National Poisons Information Service, which is a valuable source of information. The service provides a 24 hour telephone inquiry answering service to members of the medical profession and will give specialised advice about the management of poisoned patients. We recom-

mend that a poisons centre should be contacted whenever information about a specific poisoning is required. (The numbers of all the poisons centres are listed in the inside front cover of the *British National Formulary*.) The use of this service would reduce the risk of inappropriate advice or treatment being given to patients, which could jeopardise an otherwise worthwhile scheme.

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- 1 Egleston CV, Kelly HC, Cope AR. Use of a telephone advice line in an accident and emergency department. *BMJ* 1994;308:31. (1 January.)

Bed sharing and sudden infant death syndrome

EDITOR.—We agree with R Scragg and colleagues that the role of bed sharing in the sudden infant death syndrome needs further clarification.¹ Our view is based on our experience in South Australia, which has a population of about 1.46 million and where virtually all postmortem examinations in cases of the syndrome are carried out at Adelaide Children's Hospital.

Since a large publicity campaign in South Australia in 1991 regarding the increased risk of the sudden infant death syndrome associated with the prone sleeping position the incidence of infants dying of the syndrome has fallen considerably (table). At the same time there has been a rise not only in relative terms but also in the absolute numbers of infants whose death was attributed to the syndrome and who were found dead in bed with one or both parents.

In July 1988 one of us (SMB) conducted a postal survey of the usual sleeping environment of 220 consecutively registered infants in South Australia when the infants had reached the age of 12 weeks; 197 replies were obtained. The results were: bassinet 89 infants; cot 59; crib 39; pram 4; parent's bed 3 (1.5%); capsule 1; other unspecified 2. The survey indicated that even at that time infants sharing the parental bed were overrepresented in the population dying of the sudden infant death syndrome.

Despite Scragg and colleagues' conclusion our own experience suggests that consumption of alcohol by the parent sleeping with the infant on the night of death may be a factor and is worthy of further study.

Clearly, more multi-centre studies are needed to determine with certainty whether bed sharing by

Number of cases of sudden infant death syndrome (SIDS) and number in which infant shared bed with parent in South Australia, 1983-93

	No of cases of SIDS	No in which infant shared bed
1983	31	2
1984	40	4
1985	42	1
1986	40	4
1987	52	3
1988	31	5
1989	35	1
1990	35	3
Total	306	23 (7.5%)
1991	23	6
1992	25	8
1993	17	7
Total	65	21 (32.3%)

itself or in conjunction with other factors is a risk factor for the sudden infant death syndrome. This is particularly so given that some groups have actively promoted bed sharing.

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1 Scragg R, Mitchell EA, Taylor BJ, Stewart AW, Ford RPK, Thompson JMD, *et al*. Bed sharing, smoking, and alcohol in the sudden infant death syndrome. *BMJ* 1993;307:1312-8. (20 November.)

Prostitution: would legislation help?

EDITOR,—Mary Hepburn cited the views of the English Collective of Prostitutes.¹ This group represents only a small section of the prostitute population; relatively little is known about the views of prostitutes in general, in particular those working on the streets. Accordingly, we conducted a survey of a sample of street working women to elicit their opinions about aspects of legalisation.

At the Glasgow Drop-in Centre, a health care and social work facility for female street prostitutes,^{2,3} a short questionnaire was administered to a sample of prostitutes. Over four nights in August 1992 we invited 52 women, sequentially coming into the centre, to participate in the survey; only one refused. Of the 51 respondents 44 were injecting drug users. Their age range was 17-62, the median age of injecting drug users being 24 and that of non-users 40. Forty five of the women thought that prostitution should be legalised, three disagreed, and three did not know. One of those who disagreed thought that legalisation might encourage more young girls on to the streets, which would be undesirable as street prostitution was a dangerous way of life; another stated that more young girls on the streets would provide too much competition for existing prostitutes. Thirty four said that they would work in "brothels" if they were legalised (mainly for increased safety), 13 said they would not, and four did not know. When asked if they would continue working on the streets if prostitution were legalised, 22 said yes, 25 said no, and four did not know. All of the sample said that they would submit to regular medical examinations if that were a condition of legalisation. Finally, the women were asked if they would pay taxes if required by law. Twenty six said yes, 13 said no, and 12 were undecided.

This survey showed that most of the Glasgow street workers questioned were in favour of legalisation of prostitution, would work in "brothels," and would cooperate with medical examinations. It is encouraging to note that over half said they would cooperate in paying taxes.

These views differ from those expressed by some of the more eloquent prostitutes' rights groups, thus highlighting the importance of obtaining a wide cross section of prostitutes' views when any changes in the law are debated.

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GP facilitators and HIV infection

Heterosexual infection less common than other routes

EDITOR,—Peter Saunders rightly draws attention to the fact that an increasing proportion of newly diagnosed HIV infections in Britain is attributable to heterosexual intercourse; his statement that this is now the commonest mode of spread in Scotland merits comment.¹ Since 1985 the Communicable Diseases (Scotland) Unit has maintained a register, based on laboratory reporting, of all people known to be infected with HIV in Scotland. As it is based on voluntary testing this register cannot be seen as an indication of incidence or prevalence, but it remains the most reliable source of data on HIV infection in Scotland and is used in resource allocation under the AIDS (Control) Act and in official predictions of the course of the HIV epidemic.

The table shows the distribution of newly diagnosed HIV infections by probable category of transmission and by year of specimen (since 1985) according to the Scottish HIV register.

Distribution of newly diagnosed cases of HIV infection in Scotland by category of transmission. Values are numbers (percentages) of cases

Year	Homosexual or bisexual	Heterosexual	Injecting drug use	Other	Total
1985	71 (26)	3 (1)	162 (59)	39 (14)	275
1986	73 (22)	19 (6)	206 (63)	27 (8)	325
1987	64 (26)	28 (11)	124 (50)	32 (13)	248
1988	42 (30)	32 (23)	51 (37)	14 (10)	139
1989	44 (39)	28 (25)	34 (30)	8 (7)	114
1990	53 (40)	40 (30)	27 (20)	14 (10)	134
1991	56 (35)	42 (26)	51 (32)	13 (8)	162
1992	50 (36)	52 (38)	26 (19)	9 (7)	137
1993	56 (37)	38 (25)	49 (32)	10 (7)	153

Overall, the decreasing predominance of injecting drug use as a category of transmission and the increasing predominance of heterosexual transmission are clearly apparent, but in only one year (1992) has heterosexual intercourse been the commonest mode of spread. In 1993 sexual intercourse between men accounted for the highest proportion of cases, followed by injecting drug use.

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1 Saunders P. GP facilitators and HIV infection. *BMJ* 1994;308: 2-3. (1 January.)

Shared care better for GPs and specialists

EDITOR,—We agree with Peter Saunders about the importance of general practitioners providing more of the care for HIV positive patients,¹ but facilitators are not the only means of achieving this. The departments of primary health care and genitourinary medicine at University College London Medical School have collaborated in setting up a formal shared care protocol for asymptomatic HIV positive male patients. The aim of the study is to ascertain whether shared care is appropriate for these patients.

Patients attending the genitourinary clinic at the Middlesex Hospital are invited to participate in the study. Once a patient has agreed, his general practitioner is contacted and asked if he or she is willing to provide the necessary care; if the answer is yes the patient is enrolled in the study. The patient holds a "co-op card," which contains a summary of the relevant medical history, a record of any drug prescribed, and a chart for completion at each consultation. All baseline investigations are done at the clinic; subsequently the patient attends

his general practitioner at three monthly intervals for a check up and is reviewed at the hospital annually.

We believe that the advantages of this approach include the opportunity to form a therapeutic doctor-patient relationship early on, when the patient is still well; the possibility of continuity of care for the patient from his own general practitioner, which relieves the pressure on appointments at the hospital and allows specialist physicians to concentrate on patients most in need of their skill; and the fact that the general practitioner can gain both confidence and competence in caring for patients with HIV infection through a structured protocol of care.

An initial questionnaire indicated that about half the patients would be interested in increasing the involvement of their general practitioner in their care.² Recruitment of patients has, however, been slower than was suggested by the results of the questionnaire—reflecting perhaps both the reluctance referred to by Saunders and the strength of the doctor-patient relationship already established in the genitourinary clinic at the Middlesex Hospital.

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GPs should be involved early

EDITOR,—Peter Saunders highlights the importance of general practitioner facilitators in the context of HIV infection and indicates that the role of these facilitators will vary depending on the prevalence of HIV infection in the area they serve.¹ In areas of low prevalence the emphasis will be on prevention; in areas of higher prevalence clinical management and organisation of care at home become increasingly prominent.

The statement that "on average every general practitioner may . . . expect to have one HIV positive patient on his or her list" must, however, be qualified. In reality, most patients are concentrated in large cities. Even within these cities the prevalence of HIV infection varies considerably. This unit is in contact with several hundred general practitioners, but the 31% of our patients who are known to be registered with a general practitioner are registered with just 20 practices. In our experience, many patients move to be closer to our unit as they become more sick. This further concentrates the workload related to HIV infection into a small number of practices.

In London the care of people with HIV infection was initially provided in genitourinary clinics and community services were marginalised.^{2,3} Increasingly, more care is being provided in the community, partly by specialist teams organised by hospital units and partly by general practitioners and district nurses. One of the problems with hospital based teams is that they may continue to marginalise generic services, including those provided by general practitioners,³ despite a stated aim of increasing general practitioners' participation in these patients' care.^{4,5} Although contact with a home support team increases registration with and disclosure to general practitioners, it also reduces use of general practitioners by about a quarter of the people using the service.⁴

The community liaison team at Chelsea and Westminster Hospital does not itself provide any home care as we firmly believe that the best people to provide medical and nursing care in the community are general practitioners and generic district nurses. Instead we seek to involve those