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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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 highet proportion of cases, followed by injecting drug use.

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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