# BRITISH MEDICAL JOURNAL

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## LEADING ARTICLES



## CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED



## MEDICAL PRACTICE



## NEWS AND NOTES



## SUPPLEMENT




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# CORRESPONDENCE



Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

***Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.***

## "AIDS test" a misnomer

SIR,—In the article in the Medical News section (31 August, p 611) on testing blood donations for traces of the acquired immune deficiency syndrome (AIDS) the following phrases were used: "... all blood donations will be tested for traces of AIDS" and, "... tests showed the presence of AIDS antibodies in ... blood." At a time when many of us are criticising some lay journalists for misleading and unhelpful coverage of the AIDS problem, it is extremely unfortunate that the *BMJ* should perpetrate such nonsense as the two quotations above. I understand that the relevant press release from the Department of Health and Social Security was not worded as above, although its wording was not ideal.

Let us be quite clear: the test to be introduced into the transfusion service is a test for antibodies to human T cell lymphotropic virus III (HTLV-III)/lymphadenopathy virus (LAV). This retrovirus is indeed the causative agent of AIDS, but it undoubtedly can also cause milder illnesses, such as persistent generalised lymphadenopathy, and, in a significant proportion of those infected, no symptoms at all. The test only seeks evidence of prior infection with HTLV-III/LAV and is to be used by the transfusion service to reduce the risk of AIDS associated with transfusions; *it does not and cannot test for AIDS*. It is vital that the general public and medical profession understand this.

AIDS and related conditions are, of course, diagnosed by the conventional clinical diagnostic methods of history and examination, backed up by the judicious use of certain laboratory tests, particularly those that detect opportunist infections or tumours. HTLV-III/LAV antibody testing is superfluous when the diagnosis of AIDS is clear cut, may help in a few cases of genuine uncertainty, but can never be used to make the diagnosis in isolation. If a person is concerned that he or she may have AIDS then he or she should consult a medical practitioner to enable the profession to examine the problem by the usual diagnostic channels, whether by general practitioners or sexually transmitted disease clinics alone or via these to other specialists in the field, as judged on conventional clinical criteria. The use of HTLV-III/LAV antibody screening as a means of helping to reduce the spread of infection by sexual contact is controversial and outside the scope of this letter.

By the analogy of another infectious agent with several different clinical consequences, the hepatitis B antigen or antibody tests are not tests for "traces of fulminant fatal hepatitis"; nor do we call antibodies to *Streptococcus pneumoniae* the "pneumonia antibody test." Nobody should be fooled that there is a test for AIDS, let alone for traces of AIDS. If we are to educate the public on this issue through the lay press, as we must, then the standards of medical journalism must be impeccable.

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## Setting standards in general practice

SIR,—*Towards Quality in General Practice* is what it says, a consultation document, and the carping nihilism of Dr P D Campion's leading article (24 August, p 499) contributes little to the consultative process which he agrees is so important. The two assumptions which he challenges, whether quality of care can be assessed and whether it is synonymous with quality of doctor, are no longer the areas for debate.

Quality of care is being described and assessed every day by groups of doctors who review their performance in achieving various outcomes. They believe, for example, that the proportion of children receiving measles innoculation, the numbers of asthmatics having their peak flow recorded, and the percentage of patients on long term digoxin who have seen a doctor in the last year all reflect quality of care. I challenge Dr Campion to find colleagues who disagree with this.

For those who lose sleep worrying whether quality of care is synonymous with quality of doctor, I ask them, firstly, to note that the document is about general practice and not its practitioners and, secondly, to rephrase the question to, "What sort of doctoring?" and hope that they will not be misunderstood. The time is long past for arguments about whether we should be assessed. General practitioners both outside and within the college must address together the issues of how, when, and by whom.

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SIR,—There can be little doubt of what was in the government's mind when the green paper on general practice was first conceived two years ago. The open ended commitment to meet all patient demand on general practitioners' services was to go, and since the hospitals' solution of obstruction by queuing seemed impossible, some sort of price