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MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
- *We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.*
- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

Doctors with HIV infection

SIR,—On 16 November I was buying another paper when I saw on the newsagent's shelf a copy of *Today*, which displayed on its front page a life size photograph of a man whom I am proud to have called my friend, in the proper sense of that currently abused word. Under the caption "AIDS DOCTOR WHO DIED" the article stigmatised a man who had earned the respect of nephrologists and other colleagues, and the gratitude of countless patients with kidney disease. For good measure there was a picture of his house and a laconic statement that his wife "was in hiding with her children." After some hesitation I bought and opened the paper, to find therein a leading article which advocated compulsory testing of all doctors and disclosure of the results, and which went on to advise Mr Moore to "fire his own chief adviser, Sir Donald Acheson."

Now the principles of consent, confidentiality, and absence of stigmatisation are generally acknowledged, even if in the case of particular individuals grounds may be found for departing from them. But it now appears that not just exceptional individuals but a whole class of persons can no longer rely on protection from public invasion of their privacy. I refer to doctors in renal units, and by extension to nurses and other staff, whose very work exposes them to danger from hepatitis and the acquired immune deficiency syndrome. It is in fact sensible that testing for hepatitis virus and for the human immunodeficiency virus should be offered them, and that carriers should be counselled, as the chief medical officer in fact recommended. But compulsory testing, disclosure, and publicity even after death are surely different matters. Normally I resent being troubled by what I see or read; after all, today's publicity is tomorrow's garbled memory and the next day's oblivion. But this seems to me a peculiarly flagrant example of unfair criticism of individuals and of a profession, who deserve better treatment.

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Five year cervical screening policy

SIR,—The recurrent debate about whether cervical screening should be carried out at five yearly or three yearly intervals (31 October, p 1156) seems usually to be conducted without recourse to the relevant evidence.

A substantial body of reports exists whose principal burden is that the important requirement of a successful screening programme would be that it screened all sexually active women regularly.[1] If that were achieved in England and Wales a five year screening interval would prevent about 4000 cases of cervical cancer at a cost of about 3·5 million smears each year (the present volume), while increasing the frequency to three yearly screening would prevent a further 300 cases at an additional cost of just over 2 million examinations. The more important requirement, however, is that all women at risk should be examined. If the present volume of resources were deployed to achieve one yearly examinations for only one fifth of the women at risk the result would be the prevention of only about 750 cases at a cost of 20 000 examinations per case.

The priority in improving our present cervical screening performance in Britain is to screen all the women at risk. Until we get somewhere near that objective all discussion about the frequency of screening is largely academic.

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1 Smith A, Chamberlain J. Managing cervical screening. In: *Information technology in health care*. Issue 4, Institute of Health Services Management. London: Kluwer, 1987.

Child abuse and osteogenesis imperfecta

SIR,—The excellent review by Dr L Taitz of fractures in babies and young children draws attention to the fact that they occur more frequently from non-accidental injury than from osteogenesis imperfecta (31 October, p 1082). He concludes by encouraging medical witnesses in legal cases to take account of such odds.

His comments highlight two important points. Firstly, because legal decisions are made on a balance of probability, whenever there is more than one possible diagnosis the more common one will be accepted. This approach differs from medical practice, which is to seek an accurate diagnosis in all cases, however rare the condition. A number of parents have suffered as a result of their child being thought to be the victim of abuse until later events revealed the correct diagnosis.

Secondly, it is because osteogenesis imperfecta is a rare condition that many medical witnesses are unfamiliar with its different manifestations, especially the more subtle features. For example,