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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.*

Testing for HIV: the non-medicolegal view

SIR,—The medicolegal aspects of testing for human immunodeficiency virus (HIV) without consent have recently been clarified, but less emphasis has been given to the psychological aspects of this debate. As the case below illustrates, an unexpected positive HIV result, in the absence of pretest counselling, may severely compromise subsequent management owing to a destruction of the patient-doctor relationship, quite apart from the risk of litigation.

We have recently seen a young woman with sickle cell disease and severe progressive cervical and axillary lymphadenopathy. No risk factors for HIV were identified from the initial history, and an extensive battery of investigations was performed. HIV serology was performed as a "last resort" when other investigations, including lymph node biopsy, failed to produce a diagnosis. In this case the test was done without the patient's knowledge or consent, as it was considered unlikely that the result would be positive.

Three serum samples were, however, repeatedly positive by several enzyme linked immunosorbent assay techniques and immunofluorescence. The patient was questioned further about possible risk factors for HIV. During a two year stay in the United States (1984-6) she had received no blood transfusions, but she did recall a three unit transfusion in the United Kingdom in 1984. The three donors were subsequently shown to be HIV negative. Drug abuse was denied, and both sexual partners were negative for HIV more than three months after the last exposure.

The absence of pretest counselling and perceived risk factors in this case has made her subsequent management very difficult. To date, 12 months after the initial positive HIV result, she has refused to accept the diagnosis, requesting repeat second opinions and serological analysis and failing to attend for outpatient follow up.

We are therefore left with a dilemma. In the absence of identifiable risk factors from the history should we have tested the patient for HIV at an earlier stage, avoiding multiple investigations but, with pretest consent and counselling, causing possible "unnecessary anxiety," or should HIV tests be performed as part of the routine diagnostic investigations, with counselling only for those patients in whom a positive diagnosis is made? Although the second course of action is in line with previous medical practice—for example, tests for syphilis and hepatitis B—the more serious and far reaching implications of HIV infection make pretest counselling advisable. Such a policy, which accords with the medicolegal view, will also facilitate further patient care in the event of a positive result.

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HIV screening in an emergency department

SIR,—In a recent issue (7 November, p 1205) the necessity of obtaining consent before testing for human immunodeficiency virus (HIV) was discussed. This need not be an important problem if, as we think, most people will give consent when asked.

We are planning a long term systematic study of the prevalence of HIV in all patients seen in the emergency department of our hospital. Most patients admitted to our hospital pass through the emergency department, which is thus a strategic location for systematic testing. The purpose of the study is to gain knowledge about the prevalence of HIV in the community and also to define better those groups in whom precautions should be taken against accidental transmission of HIV. Swiss regulations prohibit testing for HIV without the patient's consent; we therefore conducted a short pilot study to investigate the feasibility of systematic testing.

During a 30 hour period 84 consecutive patients seen in the emergency department were asked to consent to HIV testing. Twenty patients were unable to give informed consent (three patients died, 16 were confused or comatose, and language barriers made communication impossible in one). Among 64 patients asked 60 (94%) responded favourably. The four patients who refused were interviewed by one of us: only one was in a high risk group for HIV infection. Testing for HIV was negative in all but two patients, who were already known to be HIV carriers.

The high acceptance rate is encouraging if screening is to be done in a facility—for example, an outpatient clinic—where almost all patients are conscious and orientated. In a general purpose emergency department, however, many confused or comatose patients will be unable to give informed consent. We hope to gain permission to perform anonymous testing in these patients to determine how many are HIV carriers.

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Doctors and rubella

SIR,—We support Dr Aideen Fogarty's plea (21 November, p 1348) for vaccination of non-immune doctors, both men and women, against rubella. An incident here last year emphasised for us the risk to