ate, since we believe that this would be a statistically dubious approach in a study with 14 events and 13 variables. We agree, however, that what is most urgently required is effective assessment of risk for the patients at moderate risk, who make up the bulk of our practice; conventional indices of risk have not met this need,^{1,2} and in a recent study we found the Detsky scoring system to be inadequate at predicting risk (N Mamode *et al*, XVIIIth congress of the European Society of Cardiology, Birmingham, August 1996).

Further to Howell and Foex's comments on other risk factors, we can clarify that female sex was associated with perioperative infarction. Both the type and urgency of surgery were taken into account; the risk was 6% for elective or urgent procedures and 12% for emergency surgery, and the type of procedure was clearly stated in table 1 in our report. Although neither of these factors reached significance, this does not mean that they are not important and underlines the need for larger studies.

We are interested in Constantinos G Missouris and colleagues' findings. We are unaware of any studies showing improved perioperative morbidity resulting from preoperative renal or carotid artery screening. Four perioperative cerebrovascular accidents occurred in our study, only one of which occurred after carotid surgery. Coexistent carotid artery stenosis may certainly be an important cause of perioperative morbidity. In our recent work we found that, in 328 patients who had 21 perioperative cardiac events, the two most important clinical predictors of a perioperative myocardial infarction were age and raised preoperative urea concentration (χ^2 test, $P = 0.001$; XVIIIth congress of the European Society of Cardiology).

Whether poor renal function itself contributes to the risk of perioperative infarction or is simply a marker of severe, generalised atheroma is unclear. Nevertheless, we hope that such findings stimulate more research.

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HIV antibody testing should be routine investigation

Suggestion is appalling

EDITOR,—G M Scott's letter about HIV testing in the investigation of undiagnosed pneumonia raises important issues.¹ Scott contends that a clinician's freedom to investigate an illness may be compromised by the requirement for informed consent to HIV testing. This view fails to acknowledge that a clinician's responsibility to investigate and treat can be reconciled with the patient's right to information.

HIV testing is important to help confirm or exclude suspected diagnoses. In the case cited, Scott implies that the clinicians were unable to test for HIV because they felt restricted by the General Medical Council's guidelines.² Scott fails, however, to tell us why they felt restricted.

Time and experience may limit a clinician's inclination to offer adequate discussion before an HIV test, but clinicians can easily ask a health adviser from their department of genitourinary medicine for help (indeed, Scott's hospital is linked to one of the largest HIV testing units in Europe). Health advisers deal daily with HIV testing, including that of urgent inpatient referrals. Their involvement is often pivotal in helping patients cope with their diagnosis and future treatment and in the notification of partners. In my experience, patients very rarely withhold consent for HIV testing if adequate medical explanation is given.

So does HIV infection warrant being a special case? Those working in HIV infection would argue that it does and welcome the General Medical Council's guidance *HIV Infection and AIDS*.² Although Scott draws parallels with leukaemia and syphilis, there is no other condition that currently combines limited treatment and poor prognosis with length of infectivity and sexual transmission. The implications of HIV infection cannot be overstated, even though medical advances bring some optimism. At present our only truly effective weapon against HIV is the prevention of transmission. Control of HIV infection requires patients' cooperation, not alienation.

Scott advocates that a doctor "should not be required to tell a patient that he or she had an HIV antibody test." This view appals those of us who have to deal with the consequences when patients are given positive results of HIV tests without adequate prior discussion. Although HIV infection needs to be considered proactively in the differential diagnosis of many conditions, including undiagnosed pneumonia, HIV testing cannot at present be considered a routine investigation. Obtaining informed consent should be viewed as an essential and beneficial process and not an unnecessary barrier to testing. Colleagues in genitourinary medicine are more than willing to help.

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"HIV exceptionalism" has been harmful

EDITOR,—G M Scott's report of an avoidable death associated with the current restrictions on HIV testing provides yet another argument against HIV exceptionalism.¹ The policies that have arisen in response to lobbying by AIDS activists have been harmful in other ways.

Firstly, there has been the damage to public health measures based on contact tracing. Landis *et al* reported that only 14% of 534 HIV positive people agreed to notification of their partners and that tracing was successful in only 7% when the best methods were used.² Secondly, the AIDS lobby pressurised the regulatory authorities to relax the normal requirement for establishing the safety and efficacy of new drugs. The first product, zidovudine, was licensed for use at an unnecessarily high dose. It is known to cause dose dependent toxicity to bone marrow, and many patients have probably died as a result. More recently, 21 198 patients received didanosine on "compassionate release," with 63 deaths from acute pancreatitis.³ A proper sequence of controlled clinical trials could have minimised the problem. Death in the

cause of political correctness may or may not have been a compassionate release.

Surely the time has come to change the policies and treat HIV infection in the same way as other infections, as urged by Bayer⁴ and Amiel.⁵

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GMC's guidance on HIV infection and AIDS is useful

EDITOR,—Gilles de Wildt and Helen Sweeney express concern¹ about the General Medical Council's recent guidance on HIV infection and AIDS.² The points they make about confidentiality form only part of the guidance. The authors give the impression that doctors will break the confidentiality of any health care worker whom they know to be infected with HIV. The guidance should be taken as a whole, and it explicitly states that doctors who are HIV positive should seek specialist advice on the extent to which they should limit their practice. It also states that it is unethical for doctors infected with HIV to put patients at risk by not seeking advice or by failing to act on the advice.

With regard to breach of confidentiality, the guidance says that when a doctor is aware that a health care worker who is infected with HIV has not sought or followed advice to modify his or her professional practice, then that doctor has a duty to inform the worker's employing authority. In this situation the health care worker clearly represents a risk of infection to other people and appropriate action to control the risk (modification of practice) has not been taken. It is only in this rare situation that doctors should inform the health care worker's employer. De Wildt and Sweeney state that this situation is not comparable with that of a professional driver who has developed epilepsy, but the issue is exactly the same: the patient represents a clear risk to the health of other people in doing his or her work, and the reason to breach the patient's confidentiality is this risk to others. Obviously, in any circumstances the doctor must first exhaust all other routes to persuade the patient to take advice (in the case of a health care worker) or to give consent (in the case of a professional driver). Only then should the doctor consider breaching confidentiality.

Another issue raised in the article concerns HIV testing and insurance. The Association of British Insurers modified its guidelines in 1994 to require information only on applicants who have had a positive result of an HIV test or treatment for HIV infection.³ Therefore, people should have no concerns about subsequent insurance proposals if the result of an HIV test is negative.

The General Medical Council's new guidelines are useful and clarify a situation that is never easy to handle—namely, when confidentiality can be breached. They also, how-

ever, caution that doctors may be required to justify their actions when confidentiality may be breached.

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Needle exchange programmes should do more to prevent transmission of hepatitis C virus

EDITOR,—The debate on whether asymptomatic people at high risk of hepatitis C should be screened shows that, whether we agree with screening or not, until more effective treatment becomes available the most appropriate strategy is prevention.¹ The largest group of people who are at risk of hepatitis C are those who continue to inject drugs. Needle exchange programmes may have reduced the risks; however, a project in Amsterdam found no change in the seroprevalence of hepatitis C among drug users over a five year period when it introduced needle exchanges to prevent the transmission of HIV.

Hepatitis C virus can probably survive for much longer in dried blood outside the body than can hepatitis B virus or HIV. It has been identified (in the form of viral RNA, because the virus cannot be cultured) from needles and injecting paraphernalia for up to three months after use.² Evidence from studies of accidental needlestick injuries suggests that the amount of virus required for infection to occur is small.³

As the seroprevalence of hepatitis C among drug users is high, at about 80%, and the rate of chronic carriage of the virus is high⁴ a user may need to use drugs only once before he or she is exposed to the virus. Many users, when using drugs for the first time, are indoctrinated by someone else. Only one episode of sharing is needed to be potentially exposed to the virus. At present, most needle exchanges provide only clean needles and syringes. Water for injection, filters, or other paraphernalia needed for clean injecting cannot be supplied.

In the light of the increasing knowledge, should we look again at what needle exchanges can provide now that hepatitis C (and perhaps infections due to as yet unknown viruses) has become such an enormous threat?

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Testing to check success of treatment to eradicate *H pylori*

EDITOR,—Two letters¹ comment on our paper assessing the use of dyspeptic symptoms as a test for eradication of *Helicobacter pylori*² and cite work that is supposedly at variance with our results.^{3,4} The authors fail, however, to appreciate important differences between these studies and our paper. Both of the quoted studies inves-

tigated patients with duodenal and gastric ulceration,^{3,4} whereas we studied only patients with uncomplicated duodenal ulceration. Patients with haemorrhage and perforation were included in one of the studies,⁴ while no data on these patients were provided in the other.³

The study by Reilly *et al*³ differs from ours in several other ways, which makes direct comparison of results difficult. Firstly, the patients were assessed after a variable interval, the lower limit being 85 days. Thus sufficient time may not have elapsed for dyspeptic symptoms to resolve after successful eradication of *H pylori*. Secondly, it is not known how the recurrence of dyspeptic symptoms correlated with recrudescence or reinfection with *H pylori* as the carbon-13 labelled urea breath test was not repeated.

Although Powell *et al* reported that 12-18% of patients with peptic ulcer used ulcer healing treatment in the year after successful eradication of *H pylori*,⁴ they also showed that only three (3%) patients were using such treatment for a recurrence of ulcer symptoms. Of 66 patients with peptic ulcer who were positive for *H pylori* and were followed up for 12 months,⁴ two developed bleeding and two were admitted to hospital with abdominal pain. Importantly, a quarter of these patients had a history of ulcer haemorrhage and were therefore at high risk of rebleeding. We specifically excluded such patients in our study. K Bodger and R V Heatley state that excluding patients with a history of complications will not remove the possibility of patients presenting with severe symptoms or complications.¹ Even after eradication is confirmed by conventional tests, however, this possibility cannot be entirely excluded.

Most patients with uncomplicated duodenal ulcer disease in whom *H pylori* is successfully eradicated will gain a remission of their ulcer symptoms, and we maintain that there is little point in these patients undergoing testing to confirm eradication. Symptomatic patients should be allowed to use antacids or H₂ receptor antagonists as required; their wellbeing does not need to be compromised.¹ If they remain symptomatic six months after eradication treatment then their *H pylori* status can be verified with conventional tests.

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General practice fundholding has improved services

EDITOR,—Sarah Stewart-Brown and colleagues should have given more thought to their description of the methodology used by the Audit Commission for its report on general practice fundholding.¹ Far from visiting "a large number of fundholding practices, family health services authorities, district health authorities, and trusts to collect qualitative data," the commission's staff visited only 56 of the 2200 practices that

were fundholding practices at the time (there are now 3600), 15 family health services authorities, and 12 trusts. This very small sample is a major criticism that my association has of the report. Other survey data were collected in 1993-4 and 1994-5. In short, the report reflects the situation 18 months ago and therefore does not include the latest wave of fundholders. In the meantime, fundholding has moved on and practices have broadened the scope of purchasing and management of their patients' care.

The National Association of Fundholding Practices conducted its own survey among general practice fundholders between September and October last year. Altogether 539 responses were received (60% of the total membership). A précis of that survey has just been published.² It showed, among other things, that 437 respondents had developed new services, 431 consulted patients over purchasing plans, 426 had improved quality, 361 were providing more treatment than originally planned, 334 had moved a contract away from a traditional provider, 330 thought that their ability to deliver general medical services had improved, and 216 complained that changes in providers' prices were made after their budgets were set.

Our survey shows that general practice fundholding is improving the number of services and the quality of care for patients. The aims of the NHS reforms were to put patients first. Fundholding is achieving that objective. Indeed, this is acknowledged by the Audit Commission in the many positive comments that it makes in its report.

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Reduction in sudden infant death syndrome may be due to parents checking their babies more often

EDITOR,—Christine M H Hiley and Colin J Morley show that the continuing fall in the incidence of the sudden infant death syndrome in Cambridge in 1993 was strongly associated with the increased proportion of babies who slept in the supine position.¹ In the same issue A S Douglas and colleagues speculate about why prone sleeping is a risk factor for the syndrome, linking it with less exposure of the eyes to light and interference with the maturation of mechanisms of the photoneuroendocrine system.² Is there a simpler explanation for the protection associated with supine sleeping?

Two years ago, one of us (DPD) suggested that publicity to place babies to sleep on their backs could be having another effect on parental behaviour—that babies were being checked more often and left alone much less than previously.³ Perhaps these practices would enable signs of illness to be detected earlier and provide a richer sensory environment to help the baby through any difficult transition in the control of breathing.⁴ The benefit of these practices, it was suggested, could even be a proxy for back or side sleeping.³ (In many populations in which the syndrome is uncommon not only are babies laid on their backs but they are also looked after in rich sensory environments.) Hiley and Morley found that in 1993 a greater proportion of babies slept in their parents' bedroom at later ages and slept in the parental bed, which suggests that mothers could have been observing their babies