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-