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- 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 Aileen 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

patients, and extra work for staff, generated when a doctor develops rubella.

Since 1980 our occupational health department has screened all new employees for rubella antibodies and arranged vaccination (with repeated reminders if necessary) of those found to be negative. However, a newly appointed non-immune senior house officer in obstetrics and gynaecology slipped through the net by presenting with rubella before being vaccinated. The clinical diagnosis was confirmed by serological testing.

During the two weeks before the onset of the rash the doctor had helped at six antenatal clinics attended by 237 patients. The notes or laboratory records of all these patients were checked, a time consuming task made more difficult by the usual movement of patients and their notes between wards and clinics. Two non-immune patients in early pregnancy were discovered, neither of whom has seroconverted.

The doctor had recently arrived from the Indian subcontinent and this was his first post in the United Kingdom. He remarked that rubella seemed to be relatively uncommon in his home country. Women of Asian origin living in Britain are known to be more susceptible to rubella in pregnancy than non-Asians,^{1,3} but they are less likely to have been vaccinated. It would be interesting to know the prevalence of rubella antibodies in the populations of Asian countries. Should occupational health departments be particularly concerned to screen for rubella immunity in Asian doctors and nurses?

We thank the Sheffield Public Health Laboratory for confirmation of the rubella serology.

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- 1 Peckham CS, Tookey P, Nelson DB, Coleman J, Morris N. Ethnic minority women and congenital rubella. *Br Med J* 1983;287:129-30.
- 2 Collier LH, Hellyar A, Cefai C, Withers M. Ethnic minority women and congenital rubella. *Br Med J* 1983;287:498-9.
- 3 Miller E, Nicholl A, Rousseau SA, et al. Congenital rubella in babies of south Asian women in England and Wales: an excess and its causes. *Br Med J* 1987;294:737-9.

The new surgery

SIR,—Surgeons have welcomed the remarkable advances in diagnosis and treatment by endoscopic or non-invasive techniques, but Mr J E A Wickham (19-26 December, p 1581) is perhaps rather sweeping in some of his general comments and his forecasts. He should not underrate the advances in surgery in what he terms the second phase. It is hardly justifiable to suggest that surgeons over the past 20 years have given only "minimal thought" to the effects of operations on the patient. Modern methods of anaesthesia and resuscitation have allowed the surgeon to widen his repertoire greatly, but sound preoperative preparation and postoperative care are now the rule. The hurried and often rough methods of earlier years have given place to refined techniques by which shock is diminished and tissue damage minimised. Surgeons choose adequate incisions (large if necessary for good exposure) and avoid keyhole incisions (which may gratify the patient but often condemn the surgeon). For many years surgical training, based on the firm foundations of anatomy, physiology, and pathology, has produced something better than "butchers and carpenters."

May I comment on some of his forecasts about

abdominal surgery? If endoscopic cholecystectomy is "a short step away" will the danger area of the duct system and blood vessels be safely exposed and managed? Even with wide access, direct visualisation, and the sense of touch this may tax even the experienced surgeon. "Bleeding vessels in ulcers may be coagulated"—in some cases perhaps, but if large extravascular arteries are eroded open surgery will be required. "Indirect inguinal hernia may be repaired laparoscopically . . . the sac inverted by suction or traction and then ligated." This may prove feasible in the young, but a simple repair in the adult is all too likely to lead to recurrence. In any case, as I have discovered, it is not always possible to draw up the sac from within the abdomen. "An endoscopic bowel resection is feasible and should soon be achieved." It would be interesting to know how this is to be done without leakage of intestinal contents.

One of the most important aspects of surgical training is the long apprenticeship during which "live pathology" is observed, particularly in the abdominal cavity. An endoscopist without this experience is ill equipped to assess appearances. For this reason alone it will be important that specialised training of the type envisaged by Mr Wickham does not encroach excessively on existing surgical programmes. Already we have had warnings of the inherent risks of endoscopic surgery, with some disasters after attempted endoscopic tubal ligation—a relatively straightforward procedure compared with many now forecast.

I hope I am not laying myself open to the charge of denying the need for progress, like some Victorian surgeons who were bigoted enough to announce that the frontiers of surgery had been reached. Higher surgical education must constantly be the subject of review and must accommodate new advances. But the old and tried must not be discarded too precipitately for the new.

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SIR,—Mr J E A Wickham's editorial (19-26 December, p 1581) on the new surgery is certainly stimulating and as AD 2000 approaches it is hoped that mutilating operations with permanent morbidity will be passing into history. But the commonest abdominal operation is being performed with ever increasing frequency.

In an attempt to lower perinatal mortality as much as possible, to avoid litigation as well as the problems of difficult vaginal delivery, the caesarean section rate in the United Kingdom has increased so that in some units it is nearly 20%. This can be associated with serious morbidity and occasional mortality. In Wolverhampton in 1987 three women underwent hysterectomy to save their lives, which were endangered by complications of caesarean section. One had a continuing postpartum haemorrhage, one had sepsis associated with premature rupture of the membranes, and one had a bleeding, sloughing fibroid prolapsed into the vagina. Fortunately all survived. It is difficult to see how endoscopic surgery will remove the need for laparotomy to remove large lumps, and on occasion, that most fascinating creation of all, the unborn child.

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SIR,—Dr Tony Delamothe's report on the accident and emergency department of King's College Hospital (19-26 December, p 1628) must have

rung Christmas bells for many readers. Giving birth in a stable does not seem such a pre-welfare state idea when confronted by the evidence of his article.

His elegant description of a compassionate and dedicated staff working far beyond what can reasonably be expected of them and in conditions designed in 1910 to be adequate for a demand one third of current levels makes the case more eloquently than any official report. His day in the life of our accident and emergency department should blow away the misconceptions of both those in the regional health authority who think that King's College Hospital is doing too much for its community and those outside London who feel that its hospitals are overprovided. The report shows the irrelevance of those views to the health needs of the sixth most socially deprived district in Britain.

A substantial investment in the accident and emergency department was a top priority for King's College Hospital—until it became clear that a new theatre block would have to be built. The shortage of capital made a painful choice necessary: either renovate the accident and emergency department or build a new theatre block, but not both. How can one sensibly choose between the two? The demands for both clinical services are greater than ever. In the private sector if two successful elements of one concern were both popular and in demand then both would receive investment. With great regret Camberwell Health Authority had to relegate a new accident and emergency department behind investment in new operating facilities, conscious that this meant leaving the department to struggle on within decaying fabric.

Dr Delamothe is undoubtedly fair both in relating his tour of the department's corridors and treatment areas as well as in giving a feel for the highly diverse clientele of this inner city district. Certainly we welcome open discussion and debate about our problems. We part company from him, however, when he suggests that the hospital management were concerned with the department only because of a recent complaint. This does not fairly reflect what is in fact a cooperative and progressive relationship. The staff of the King's College Hospital accident and emergency department have the full support of the health authority and its managers. Continuing and close contact between the department and the hospital management ensures that we have care and not chaos despite adverse conditions.

The article highlights wider issues arising out of recent press and television coverage of the NHS. Like many other health authorities, Camberwell has maintained and improved hospital services despite a financial allocation broadly static in real terms. One way it has done this is to put funds previously destined for cleaning and maintenance of the fabric into keeping open wards and services. The results of this are plain to see. For this and related reasons Camberwell Health Authority decided in July 1987 to propose a fundamental change in its service strategy. The district agreed in principle to bring together all its hospital services on to one site. The proposal includes the complete renovation of the existing King's College Hospital, the building of a major new hospital extension on the adjacent site, and a range of developments in community and primary care services. A key element of the new King's will be a brand new accident and emergency department fit and fitted to treat the 80 000 people a year who look to it for care.

Dr Delamothe calls King's College Hospital the Liverpool of the NHS. If we are to turn the hospital into a health service garden city, then we will need substantial government support. We are