patients. Where our two approaches differ is in deciding whether specialist advice on management is needed. Our local general practitioners do not believe that all patients with heart failure need specialist management; they believe that, with guidelines, most patients with uncomplicated disease can be managed in the community. Direct access to diagnostic testing is not a problem if the condition sought can be managed by the doctor using the test, whether he or she is based in a hospital or in the community.

Mark Wallace and Mark Levy believe that our conclusion was misleading. We actually said that a change in treatment was recommended in almost 70% of those patients who were already treated. We did obtain input from general practitioners at the design stage of our study. It is feasible to recommend changes in treatment on the basis of echocardiographic findings. Severe left ventricular dysfunction indicates that use of an angiotensin converting enzyme inhibitor should be considered; diuretic treatment should be reconsidered in obese patients with normal left ventricular function. Our recommendations were, however, only advisory, and the final decision on treatment was left to the general practitioner. Though only 93 out of about 550 general practitioners attended our launch meeting, one representative of virtually every practice in Edinburgh was present.

Epidemiological surveys suggest that 1% of the population, or, in our area, 11 000 patients, have heart failure. Many will already have been diagnosed and treated or referred to other hospitals in the area. It is therefore impossible to know how big an impact our service will have on heart failure. It is also difficult to comment on asymptomatic left ventricular dysfunction as the prevalence of this is unknown. We agree with David I Slovic, however, that many doctors in hospital and in the community do not appreciate the importance of heart failure and its treatment. With our echocardiography service we have shown to our local general practitioners, in a practical way, that we take this problem seriously.

In response to Robert J MacFadyen and colleagues' comments, the treatments we suggested stopping were diuretics and calcium channel antagonists, neither of which improve systolic function. While having grave doubts about the concept of heart failure with normal systolic function, we did not advise stopping a diuretic when there was a history of breathlessness and "congestion" (or if there was another indication). We agree that many patients with breathlessness and normal left ventricular systolic function have other important problems, which in our population are most commonly obesity, chronic lung disease, atrial fibrillation, and myocardial ischaemia manifest as breathlessness.

Philip J G Kirby and Jeffrie R Strang are correct to point out that the "effectiveness" of our service depends on whether recommended changes in treatment are implemented by the general practitioner. While formal follow up has not yet been carried out, we are confident that one of the most important recommendations, to start treatment with an angiotensin converting enzyme inhibitor, was carried out because most general practitioners opted for such treatment to be started in hospital.

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Generalists neglect psychiatry

EDITOR,—The recent report by the Royal Colleges of Physicians and Psychiatrists highlighting the psychological care of medical patients emphasises the importance of general doctors being able

to detect and assess the presence of common psychiatric disorders.^{1,2} Most patients with psychiatric illness are not seen by psychiatrists, with only just over a quarter of psychiatrically ill patients actually being diagnosed.³ There must therefore be an increased emphasis on the detection of psychiatric illness by general hospital doctors. For this to occur, their skills and knowledge need to be enhanced. If the emphasis on a full physical, psychological, and social assessment is to gather momentum then active steps must be taken to implement the findings of the report.

The trainees of today are the consultants of tomorrow. A recent survey found that 94% of 50 house officers in three general hospitals never or rarely considered depression in their clinical assessments; when depression was found, less than half (46%) felt confident in assessing it and only 8% felt confident in treating the patient (C J Williams and S Wilson, annual meeting of Royal College of Psychiatrists, July 1995). These skills are advocated as being core topics by the General Medical Council.⁴

A major textbook of medicine devotes only 59 out of 3350 pages to psychiatry. This compares with 403 pages devoted to the cardiovascular system, 639 to infectious diseases, and 99 to skin. The psychiatry section is placed right at the end of the second (and final) volume and is followed only by sports medicine, medicine of old age, and terminal care. What does this say about the place of psychiatry in medicine?

One practical way of highlighting the psychosocial assessment is to include it as a routine part of the clinical examination for membership of the Royal College of Physicians and to specify that questions on common psychiatric conditions will be included in the written exams. The Royal College of Physicians has no formal course syllabus, although one is being prepared. This is an opportunity to emphasise the importance placed on these skills—the skills of a good doctor. This offers the chance for long term changes in the practice of medicine with benefits for doctors, patients, and the efficiency of the health service.

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Unsuspected HIV infection in first year of life

Obstetric and perinatal staff should provide sound, unbiased information on HIV tests

EDITOR,—J A Evans and colleagues report five cases of unsuspected HIV infection presenting in the first year of life.¹ As the number of HIV positive young women continues to rise this will be the first of many papers reporting the effects of the HIV epidemic on the perinatal period.² The authors highlight the current deficiencies in screening for HIV antibodies among pregnant women, but these exist in screening of all adults who may be at risk of infection. An HIV test is not a simple blood test, and the decision to have the

test must lie with the patient after pretest counselling and be based on an understanding of the implications of taking the test.

Several simple measures can influence the voluntary uptake of screening for HIV in pregnancy. There must be a good working relationship between the obstetric and perinatal staff and the local genitourinary medicine clinic where HIV testing and counselling are routinely carried out. Genitourinary medicine clinics have medical staff and health advisers who are trained to counsel patients who seek testing. If necessary, link workers must also be involved with any counselling for the test, as in this series three of the five neonates were non-white.

Any HIV testing service in the hospital should be widely advertised—for example, in antenatal clinics—and, most importantly, obstetric staff should have a basic knowledge of the procedure entailed in having an HIV test, including the social and ethical implications of a positive result. This is vitally important as these staff are primarily responsible to pregnant women and a sympathetic, knowledgeable, unbiased view on HIV testing will influence the uptake of screening. The government has recently funded facilities for same day HIV testing and outreach clinics for those patients who feel unable to use the local genitourinary medicine clinics, and it is hoped that this will increase the uptake of screening further.³

The impact of the HIV epidemic on perinatal medicine remains unknown. Increasing the uptake of screening by pregnant women who may be at risk of HIV infection will help prevent the vertical transmission of HIV from those infected. It is up to obstetric and perinatal staff to provide patients requesting an HIV test with sound, unbiased, factual information so that the patient can make the decision. The impact of this on screening for HIV remains unknown, but this is the best method we have to offer.

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Minority with HIV infection must be identified

EDITOR,—We fully support the conclusions of J A Evans and colleagues.¹ In Saudi Arabia, where we practise, all antenatal patients are tested for HIV. Current philosophy emphasises respect for the human rights of people infected with HIV. The associated policies give little consideration to the rights of those who are not infected—and who is more innocent than the unborn child? Present policies concerning anonymity, confidentiality, and the rights of people infected with HIV are based on muddled thinking, ignorance, and fear and will be unsustainable for much longer. HIV infection affects a minority of populations. That minority should be identified and given every care and consideration possible. Fear of the unknown is greater than fear of the known. Those who suspect that they have been infected would be encouraged to come forward if they were not to be stigmatised, shunned, made redundant, or treated as lepers used to be.

Our role as doctors is to prevent disease when possible, diagnose disease where it exists, treat to the best of our abilities, and always comfort the afflicted. If we are prevented from identifying infectious disease it will spread relentlessly and the human rights of the unaffected will become