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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1 Royal Colleges of Physicians and Psychiatrists. *Joint working party report: the psychological care of medical patients: recognition of need and service provision*. London: Royal College of Physicians and Psychiatrists, 1995.

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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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3 Secretary of State for Health. *The health of the nation: a strategy for health in England*. London: HMSO, 1992. (CM 1986.)

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

meaningless. Is it not better for people to know that they have an infection, have it treated in every way possible, be accepted as any other person with any disease should be, and live to the fullest that is possible but to be aware of the restraints imposed by the condition and so prevent unwitting spread to others? For most people infected with HIV the infection will manifest at some time. They may then have on their conscience the fact that they spread the disease unknowingly.

In most countries, submitting to HIV testing is considered to be blameworthy. In Saudi Arabia all expatriates are tested as a requirement before they are employed. Rather than be seen as an invasion of a person's privacy or an infringement of his or her rights an HIV test should become as routine as any other test carried out in the interests of health promotion.

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1 Evans JA, Marriage SC, Walters MDS, Levin M. Unsuspected HIV infection presenting in first year of life. *BMJ* 1995;310:1235-6. (13 May.)

Patients with a self diagnosis of myalgic encephalomyelitis

EDITOR,—Myalgic encephalomyelitis is most commonly related to an underlying psychological or psychiatric disturbance.^{1,2} Shonagh Scott and colleagues report that when general practitioners deal with symptoms consistent with those of myalgic encephalomyelitis their attitude is likely to be influenced by the patient's perception, expectations, and social class.³ It is not uncommon for patients to diagnose myalgic encephalomyelitis themselves before they seek a consultation; this can lead to disruption of the doctor-patient relationship, unsatisfactory consultations, and possibly failure to diagnose any underlying pathological process. We report on a patient with a self diagnosis of myalgic encephalomyelitis in whom hypopituitarism was diagnosed only after a protracted period.

A 65 year old man presented with a four year history of tiredness, lethargy, and loss of weight of 13 kg. He had attributed his symptoms to myalgic encephalomyelitis, and, although he was referred for a medical opinion, he defaulted, preferring to attend a popular herbalist. Over the next five years he took a series of remedies and concoctions with only limited success. The persistence of his symptoms persuaded him to seek confirmation of his self diagnosis, and a further medical consultation was arranged. When seen he was noted to have a sallow appearance, dramatic loss of body hair, gynaecomastia, and micro-orchidism.

Subsequent investigations confirmed hypopituitarism: the cortisol concentration was 48 nmol/l basally and minimal after tetracosactrin, rising to 160 nmol/l at 30 minutes. Thyroid stimulating hormone was undetectable, with a low free thyroxine index of 18.3 nmol/l (normal range 21-36). Serum testosterone concentration was <1 nmol/l, and gonadotrophins were undetectable basally and after stimulation. Computed tomography showed a large pituitary adenoma. His symptoms resolved dramatically within 24 hours of the start of hydrocortisone replacement treatment. He continued to take full hormone replacement and resumed his normal lifestyle after resection of his adenoma.

Support groups for people with presumed myalgic encephalomyelitis publish an extensive literature. In this, intestinal *candida albicans* is strongly implicated in the pathogenesis of myalgic encephalomyelitis, within "many people, probably over half, the yeast being out of control." Among the remedies suggested are anti-candida diets, garlic, homoeopathic doses of candida, and even colonic cleansing. Such polarised publications, while providing valuable support for patients with myalgic encephalomyelitis, also lead to self diagnosis and self treatment without appropriate investigation. The use of the above remedies may provide some relief but in this case would not be a substitute for steroid treatment.

When considering the diagnosis of myalgic encephalomyelitis it is important to remain objective and exclude any underlying remediable disease. Hypopituitarism should be considered in all patients presenting with non-specific symptoms.

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Review ignored biography of Sloane

EDITOR,—Christopher Booth's review of a biography of Sir Hans Sloane¹ overlooks a previous biography, by St John Brooks.² While the earlier book does not list Sloane's collections in detail, it has biographical merit. It seems a pity that it should be ignored.

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Guidelines to reduce x ray examinations in accident departments

Implementing guidelines may not improve outcome for patients

EDITOR,—Eugene McNally and colleagues report the effect of introducing guidelines on when to request radiographs for certain conditions presenting in an accident department.¹ Two aspects of this paper merit discussion. Firstly, the outcome measured and the data presented do not seem to support the conclusions. Secondly, one should not infer that use of the posters containing the guidelines will lead to clinical benefit for patients.

The outcome measured (the proportion of patients referred for particular series of radiological views) is not the same as the proportion of patients managed in accordance with the guide-

lines. The follow up of patients who did not undergo radiography seems inadequate: the reduction in the proportion of patients undergoing radiography may have been inappropriate. The reduction need not have been due to fewer unnecessary radiographs being obtained.

In two of the areas studied (radiography of the cervical spine and ankle) no significant change occurred. (It is not possible to calculate from the data whether a significant change occurred when all four areas are considered together.) One cannot necessarily extrapolate the results from these two areas to others. We would like to have seen data from areas not covered by posters: other factors, such as use of the Royal College of Radiologists' booklet,² may have caused the reductions seen.

The final point concerns the interpretation of such studies. These data do not show that using posters to promote guidelines benefits patients. Even if they did show increased adherence to the guidelines, we believe strongly that such data (concerning the process of care) should not be interpreted as showing improved outcomes for patients unless the guideline has previously been shown to confer benefit when followed. Increasing adherence to a flawed guideline may be harmful.

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- 1 McNally E, de Lacey G, Lovell P, Welch T. Posters for accident departments: simple method of sustaining reduction in x ray examinations. *BMJ* 1995;310:640-2. (11 March.)
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Radiology guidelines could be improved

EDITOR,—Radiologists' suggestions to help reduce unnecessary x ray examinations in patients prescribing to accident and emergency departments have been welcome. Eugene McNally and colleagues suggest that this reduction can be sustained by the use of posters.¹ I am concerned, however, about the content of the two examples of their posters shown in their paper.

The poster illustrating the guidelines for x ray examination of the skull states, "Do not x-ray patients who are to be admitted." A linear fracture is important chiefly as an indicator of potential secondary intracranial bleeding.² A patient with a head injury who is not oriented will be admitted for observation. If this patient has no skull fracture there is a 1 in 100 risk of a serious intracranial bleed. That risk is increased 25 times to 1 in 4 if a skull fracture is present.³

Reducing the threshold for performing computed tomography is one answer, but this has financial and workload implications that many units might not be able to afford. A skull x ray film can thus be a useful triage tool in determining which patients with head injury require computed tomography. It should, of course, be emphasised that patients with serious head injuries (for example, those with a score on the Glasgow coma scale of ≥ 8) need urgent computed tomography and not skull radiography.

Teaching of advanced trauma life support has greatly raised awareness of possible injuries to the cervical spine and highlighted the importance of lateral radiographs of the cervical spine in major trauma.⁴ It is thus disappointing that the poster on x ray examination of the cervical spine does not mention major trauma or multiple injuries. Similarly, the first indication on the poster is "Neck injury with pain." However, patients who are difficult to assess—for example, because of alcohol—may not always complain of pain. This and the mechanism of injury must be taken into account. If there is any doubt about a possible neck