

Dr Davies is on very shaky ground if he thinks that the Mental Health Act will provide protection against litigation. Everall (1987) described the case of a depressed patient admitted under Section 3 of the Act who refused all routine investigations. The Mental Health Commissioners stated that the Act did not cover performing such tests without the patient's consent, and a medical defence organisation advised the doctors not to proceed, as doing so would probably constitute a battery.

While no-one would argue that nursing a disturbed patient who is HIV positive is without risk, testing for the virus would not confer protection to the nursing staff, nor would it prevent the patient from biting or spitting at the staff. Taking a history from a patient is far more important than taking a blood sample. All patients who have put themselves 'at risk' should be treated as if they were positive, and the necessary precautions taken. Routine testing of all 'at-risk' patients could lull staff into a false sense of security. A negative result would not exclude HIV infection, as the period from inoculation to seroconversion, during which time the patient is infectious, may be anything from 3 months to well over a year. So even after testing, both positive patients and negative but 'at-risk' patients would still need to be managed with the same precautions.

The consequences of having had a test for HIV, even if the result is negative, can be far-reaching and may adversely affect the patient's future chances of taking out life insurance or a mortgage. The same cannot be said for the W.R. or measurement of the mean corpuscular volume.

Despite press hysteria and talk of a 'plague', both AIDS and HIV infection are still relatively uncommon in this country. Putting aside the legal and moral issues, routine testing of all psychiatric patients would be an expensive undertaking and would identify few cases. Even in Tybridge, South Devon I suspect that HIV infection has not yet reached epidemic proportions.

If a patient's history and presentation suggest HIV encephalopathy and the patient consents to testing, then the test may be undertaken in conjunction with pre- and post-test counselling. If the patient refuses or is incapable of giving informed consent, then the doctor should not proceed. The Mental Health Act would not appear to protect the doctor who overrides the patient's wishes, and since HIV testing is not a life-saving measure, common law is unlikely to do so either.

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Reference

EVERALL, I. (1987) Consent to investigation. *British Journal of Psychiatry*, 151, 869-870.

SIR: To correct Dr Dunn, the categories of patients for whom I advocated HIV testing were: (a) those in whom HIV encephalopathy forms part of the differential diagnosis; and (b) those who are behaviourally disturbed. These constitute only a small proportion of psychiatric admissions, and certainly not all as he asserts.

Dr Dunn suggests that the position with regard to specific consent is clear-cut. This is not the case. All the authoritative statements on HIV testing make some provision for carrying out of tests in the absence of specific consent, but the details are, to say the least, complicated. To quote Mr Langley QC:

"There is no simple answer: it is not in our opinion possible to say that fully informed consent is invariably necessary and it is certainly not right that it is never necessary. It normally will be required, but in each case must be considered in the light of its particular circumstances."

The General Medical Council statement would appear to condone testing without consent "where it is imperative in order to secure the safety of other persons than the patient ..." but "only in the most exceptional circumstances ...". Requirement for specific consent is the norm, but this *can* be overridden, and not just by common law. The debate therefore centres on the dividing line between normal and 'exceptional' circumstances. In view of the paucity of case precedent in this area, it is important that the psychiatric profession develops a consensus on this issue so that, in the event of litigation, the Bolam Test can be applied. With regard to the case reported by Everall, I am sure that much responsible medical opinion will consider it odd to be empowered to impose treatment upon a patient whose condition they are prohibited from investigating.

I quite agree that a negative HIV test with present techniques does not permit staff to relax precautions. The use of 'at risk' categories is, however, fraught with danger, as HIV penetrates the community at large: it is necessary to assume that all patients are HIV infectious. In the vast majority of cases, simple and unobtrusive measures will eliminate the risk of transmission of HIV. Disturbed behaviour requires more elaborate measures, including protection of all exposed areas of those attending on the patient. Even with all precautions and high levels of staff awareness and vigilance, incidents will still occur. Carriage of HIV significantly increases the dangerousness of

such incidents. It is current practice to treat those whose behaviour is dangerous in special settings, although the threshold for the use of such facilities is much higher than it used to be. HIV carrier status may be a critical factor in deciding whether a secure treatment environment is appropriate. Just as threats of violence are insufficient to warrant secure provision, so is supposed HIV carrier status. Assumption of innocence is a fundamental principle of English Law, and therefore when measures that involve significant infringement of liberty are to be taken, there must be proof of dangerousness. A positive HIV test combined with disturbed behaviour would constitute such proof. A general lowering of the threshold for secure provision would, in my opinion, be a greater evil than imposing HIV testing on disturbed patients. There are other benefits to be had from testing of disturbed patients, but as, individually, they would probably not warrant institution of testing, I shall not enumerate them here.

Dr Dunn asserts that HIV infection is relatively uncommon in this country. How does he know? Where are the valid epidemiological studies? What is certain is that the principal vectors, promiscuous homosexuals and intravenous drug abusers, are highly mobile groups, and even in our idyllic surroundings within the Dartmoor National Park we have seen several. The 'gay plague' hysteria has produced a quite violent backlash, and I fear this has gone too far. While it is quite right to disabuse the public of the notion that HIV can be contracted by merely being in proximity with a positive individual, it is wrong to understate the risk of infection by means other than sexual intercourse and transfusion, and this, unfortunately, is currently the case. It is only now that the problems of behavioural disturbance in HIV patients are being addressed – as a measure of the paucity of literature on the subject, I have received some 30 reprint requests from 12 different countries concerning two *letters* on the subject!

I hope that Dr Dunn's letter will go some way to initiating a debate on the subject out of which a professional consensus will emerge. In the last analysis, however, it is the physician who determines whether a disturbed patient may be admitted, and the nurse who bears the brunt of the behaviour, and is therefore at risk. It is to the medical profession that the Courts turn for advice on ethical matters when there is a lack of precedent, and clearly psychiatrists will have a voice in determining the circumstances under which HIV testing can be undertaken in mentally disordered patients. Our profession has always accepted a responsibility which is more general than

that to the patient alone, and it ill becomes us to retreat from this general reasonability to the safe isolationist position that Dr Dunn suggests. I would deny ignorance of the moral dimension of this problem; perhaps, rather, I am more aware of the complexities than Dr Dunn would appear to be.

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Molecular Genetics and Human Disease

SIR: Baron & Rainer's review (*Journal*, June 1988, 152, 741–753) side-steps, once again, the most important aspect of recent and potential advances in molecular genetics. It seems increasingly likely that genetic markers will be identified which indicate increased vulnerability to subgroups of the functional psychiatric disorders. Despite the undisputed importance of environmental factors in the development of these illnesses, it is implicit in the writing of psychiatric geneticists that these advances could lead to prenatal diagnosis with selective termination of foetuses. This prospect has been explicitly advocated on at least one occasion (Wallace, 1986).

This issue is separate from the tragedy of individual women who feel unable to raise a severely ill child and therefore request prenatal diagnosis. The careful cost-benefit analyses of amniocentesis programmes (Chapple *et al*, 1987) and evangelistic approaches to these new methods of prevention (Milunsky, 1986) indicate, in my opinion, a hegemonic view within the profession that prenatal diagnosis should be encouraged for improvement of the public health and, indeed, the genetic pool. In the United States, the grotesque compensation claims against obstetricians for wrongfully permitting the birth of the plaintiffs (Shaw, 1986) emphasise the pressures in Western society to avoid the existence of handicapped or genetically abnormal people.

If predictions of advances in molecular biology are correct, the widespread acceptance that it is better for imperfect people never to have been born will provide an opportunity to reduce the frequency of disturbances of mood and behaviour by eugenic means. I would like to stimulate discussion of this difficult topic before we are overtaken by technological breakthroughs, as was the case with Huntington's disease.

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