In the Discussion section of the paper we inadvertently distracted the attention of the reader from the high level in the TA sample by drawing comparison with the levels for young married Thamesmead women and for women in the same age range as the Thamesmead women recorded in Camberwell by Bebbington *et al* (1981); two population samples with relatively high 'caseness' levels. Dr Bebbington has kindly produced for us 'caseness' levels for subjects under the age of 50, which would correspond with the age-range of the TA subjects. These are 5.6% for men, 17.5% for women, and 12.0% for the sexes combined. The corresponding levels for the TA sample, using a DSI cut off point of 13+, were 8.9% for men, 35.8% for women, and 21.3% for the sexes combined. The levels using the BDI and the GHQ were comparable. Thus the level for TA women was particularly high, although one should remember that a high proportion of these women would be in the vulnerable age-range of 25–34. We would not wish to comment further on this finding at this stage, but we do have further data on the TA sample which we intend to publish in due course.

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Screening for HIV

SIR: Davies (*Journal*, June 1988, **152,** 857) apparently sees no distinction between the investigation of a full blood count in suspected alcoholics, which may help consolidate the diagnosis, if the MCV is raised, and HIV screening in a psychotic patient from the known high-risk groups. Once treatment has been instigated, alcoholics, if motivated, can abstain, and providing no irreversible neuronal or liver damage has occurred have a reasonable chance of survival. AIDS is lethal. No known cure exists at present.

I cannot agree with Dr Davies when he suggests that certain psychotic patients should be routinely screened for HIV status. Diagnosing AIDS in a psychotic patient benefits neither the patient, his or her family, nor the medical staff, for the following reasons:

(a) The treatment of the psychosis is symptomatic. Knowledge of HIV status does not affect treatment outcome, in contrast to syphilitic infection for which a specific treatment exists.
(b) If the test is not made, the patient and his or her family are spared the devastating effects of such a diagnosis.
(c) If adequate precaution is taken with every patient, staff are at minimal risk of contracting the disease.

Many patients who are not of high-risk groups and who have no symptoms typical of HIV infection may carry the virus – therefore it is mandatory that patient carers exercise due caution when dealing with all patients. Patients with AIDS may perhaps on occasions "spit and spray blood", but this I believe is more likely to happen when they are labelled as HIV positive. With the expected increased prevalence of AIDS, HIV encephalopathy will probably increase significantly and educated staff should feel comfortable in caring for these patients. Are these people, if disturbed, not entitled to proper treatment? Knowledge of HIV status does not provide staff with any extra protection.

AIDS is a transmissable disease, but the public via the mass media have been educated regarding the HIV virus and the modes of transmission, and this would appear to be the most reasonable means of controlling the spread of the disease. I do not believe that screening plays an important role in helping to control the spread of this virus. In conclusion, therefore, I have great reservations about the value of HIV screening. Generally, when dealing with a lethal illness such as AIDS and its accompanying social stigma we in the medical profession should use common sense and treat these patients with the compassion they need.

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SIR: Dr Davies' astonishment (*Journal,* June 1988, **152,** 857) is matched by my own. I am astonished at Dr Davies' whole approach towards the AIDS problem. He makes a number of assertions which need to be challenged.

1. There is essentially no justification to the position that routine screening for HIV should not occur, given that there is no effective treatment. However, the guidelines for screening for any disease adopted by the WHO states: "There should be an accepted and effective treatment for patients with recognised disease" and "The test or examination should be acceptable to both the public and to professionals" (Wilson & Jungner, 1968). Neither of these conditions can be said to obtain at present.

2. Dr Davies paints a rather fantastic picture of behaviourally disturbed patients infecting nursing staff. This scenario is certainly not supported by the studies on professionals engaged in the care of AIDS and HIV infected patients (one awaits Dr Davies' review with interest); for example, in the UK a prospective study of 150 health care workers accidentally exposed to HIV through needle-stick injuries, splashes, and other means found no evidence of seroconversion (McEvoy *et al*, 1987). Larger scale studies in the USA have similarly indicated that the risks facing workers in health care settings are very low (McCray, 1986). This does not mean that high standards of clinical practice with respect to hygiene should not be followed. These measures would be effective in protecting staff from both HIV or hepatitis B infection.

3. The considerable social stigma attached to being HIV positive or having AIDS, and the financial penalties incurred through, for example, uninsurability and the inability to obtain a mortgage are not mentioned by Dr Davies. However, the failure of countries to confront the social impact of AIDS is a leading barrier to an effective public health campaign to combat the disease (Rosenbrock, 1987). Dr Davies admits he is "unable to fathom why there is so much furor about HIV".

This may be understandable if we were to accept his implication that HIV positivity is equivalent to alcoholism. But this equivalence is entirely fictional. Thompson (1988) has enumerated the evidence on psychological reactions to HIV positivity; perhaps this review might lead Dr Davies to a greater understanding of some of the reasons for the 'furor'.

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SIR: I have recently (*Journal*, October 1988, **153**, 569–570) covered certain issues raised by my letter to which Drs O'Neill and Connelly refer. Others brought forward by these correspondents have been eloquently addressed by Grant (1988). I shall therefore confine myself to what remains.

Both doctors appear to have confused analogy with equivalence; my use of the blood count analogy was to illustrate the problems associated with the doctrine of specific consent, and the same test is referred to in Grant (1988) in similar fashion, although with a better example than mine. Unfortunately, my attempt at *reductio ad absurdum* seems to have been pre-empted by paragraph 13 of the General Medical Council statement on HIV testing (Simmons, 1988) with potentially dire consequences for psychiatric research (Davies & Rigby, 1988).

Dr Connelly dismisses my worries about the transmission of HIV to staff and other patients as 'fantastic'; I doubt if this view would be shared by the phlebotomist who seroconverted after a vacuum tube implosion and the apheresis technician who contracted HIV via an area of aural dermatitis (Center for Disease Control, 1987), or indeed by the nurses who seroconverted after superficial needlestick injuries (Neisson-Vernant *et al*, 1986; Oksenhendler *et al*, 1986). He asserts that the risks of transmission to health care workers are "very low" – this is a subjective statement. The Center for Disease Control currently estimates the probability of seroconversion following a needlestick injury at 0.5% (Anon, 1988). Using a simple binomial model, for 100 such injuries there is a 40% probability of at least one seroconversion, and for 1000 this probability rises to 99.3%, with an expectation of 5 cases. I can do no more than leave it to the reader to decide whether this is an acceptable risk, bearing in mind that the risks with regard to blood contact with open skin areas and cornea, not to mention patient–patient sexual intercourse (Davies, *Journal*, June 1987, **150**, 881–882) remain unquantified.

Both doctors raise the issue of treatability as a prerequisite for screening. This has been dealt with,