

That duty includes making sure the patient's consent is properly informed. The Sidaway case confirmed that the patient does not need to be told everything,¹ but the patient must understand the nature of the procedure the doctor proposes to carry out and the real risks attached. On this principle it would be hard to argue that a consent to the doctor's taking blood "for tests" would be a sufficient consent to allow a doctor to test for antibodies to HIV. With the severe consequences that could follow from a positive test result—for instance, the destruction of personal relationships and the refusal of life cover—the patient must be allowed an opportunity to refuse the test, particularly since identifying the infection will not enable the doctor to give lifesaving treatment.

Some lawyers might argue that since a responsible body of medical opinion favours testing without the patient's consent—that is, the doctors at the annual meeting—no doctor doing so would be held to be negligent. The law lords in the Sidaway case confirmed accepted medical practice as the test of whether or not a doctor has been negligent but affirmed the court's position as the final arbiter. Where there is a grave risk of serious consequences, the law lords said, doctors alone should not determine what a patient should be told. Doctors will thus be well advised not to test for antibodies to HIV without the patient's consent.

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¹ Sidaway v Governors of Royal Bethlem Hospital (1985) 2 WLR 480.

Consensus on preventing osteoporosis

Osteoporosis is sometimes compared to hypertension; in both conditions irreversible damage is likely to have occurred if the doctor waits until symptoms have developed before starting treatment. Recently women (especially in the United States) have become aware of the need for preventive treatment for osteoporosis, but often their doctors have been reluctant to provide it. And the treatment offered varies enormously from one country to another, with some favouring hormones, others calcium, and yet others calcitonin or vitamin D.

Last week an international symposium on osteoporosis was held in Aalborg, Denmark, and at the end of the meeting

a panel of experts from Europe, the United States, and Australia debated and drew up a consensus statement on preventing and treating osteoporosis. This is published in full at p 914.

Postmenopausal osteoporosis in women seems to be multifactorial in its aetiology; it is not just caused by loss of secretion of oestrogen at the menopause, since natural aging, the more sedentary lifestyle of the elderly, and inadequate nutrition all contribute.

Prevention may be primary or secondary. Primary prevention attempts to get the woman's bone mass as high as possible before the menopause. Two factors that are known to help are a high calcium intake in childhood and adolescence (which means persuading adolescent girls to drink skimmed milk rather than carbonated water) and exercise. Excess athleticism may be dangerous, however; distance runners who become amenorrhoeic quickly become osteoporotic.

Secondary prevention is with oestrogens. The meeting was unanimous and emphatic on this issue. No other treatment "stops the disease in its tracks." Prolonged analysis by the experts on the consensus panel convinced them that the overall effect of oestrogen treatment on mortality is likely to be beneficial rather than harmful. Hormone treatment given for about 10 years will delay by about 10 years the onset of symptoms of osteoporosis, such as fractures of the hip, and in practice this will delay their onset until close to the end of the expected life span.

The crunch question remains—which women should be treated? The consensus panel did not tackle this question, even when asked for advice from the floor during its press conference. One of its members, Dr Claus Christiansen, suggested that recent work by his own group was leading to a simple method of predicting women at high risk using biochemical tests and measurement of body weight.¹ For now women and their doctors will have to continue to rely on the traditional risk factors—slender, small build, early menopause, and family history.

Even though many of the answers to doctors' questions are not yet in, the consensus statement covers much ground. The participants accepted that their conclusions had to be interim; another meeting will be needed before long. But consensus meetings of this kind are proving a useful balance to the excess claims of enthusiasts, providing as they do a clear division between what is known (on the basis of well designed research studies) and what is only surmised.

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¹ Christiansen C, Riis BJ, Rødbro P. Prediction of rapid bone loss in postmenopausal women. *Lancet* 1987;i:1105-7.