Commission on Euthanasia put forward a proposal suggesting that immunity from prosecution for doctors performing euthanasia should be subject to a number of criteria: the patient must be in an untenable situation with no prospect of improvement; the patient's request must be voluntary, rational, and consistent; the patient must have been informed of his or her condition; there must be no other way of escape from that condition; a second doctor must be consulted. These criteria are closely mirrored in the guidelines on euthanasia issued by the Dutch Medical Association.

Recent polls have shown that 68% of the Dutch population is in favour of legalising euthanasia in accordance with the criteria as defined by the state commission.

In a series of judicial decisions since 1973 court criteria have been developed which closely correlate with the criteria of the state commission and the Dutch Medical Association. If a doctor fully adheres to these criteria in performing euthanasia he will usually not be prosecuted.

The present government, which will remain in office until 1990, has not adopted the proposals of the state commission. It recently proposed a bill to keep euthanasia performed by a doctor as a criminal offence under the penal code. The public prosecutors, however, will probably continue their practice of dropping charges against a doctor who has strictly adhered to the criteria mentioned earlier.

There is thus no formal legalisation of euthanasia in The Netherlands, nor will there be in the near future. Dutch doctors performing euthanasia in accordance with the criteria mentioned above, however, expect to remain protected from prosecution by the jurisprudence that has developed over the years.

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Doctors with AIDS

SIR,—Anyone wishing for an illustration of the practical value of counselling sick doctors with blood transmissible viruses should read the report by Grob and others.[1] This shows that a general practitioner with hepatitis B infected 41 patients over four and a half years. When this was discovered he was counselled on how to reduce transmission and no new cases occurred for several months. When cases of hepatitis B began to recur investigation showed that he had become so ill with oesophageal varices that he was unable to put counselling into practice.

Since it appears that hepatitis B is 20 times more transmissible than human immunodeficiency virus (HIV) it is reasonable to assume that had this general practitioner been carrying HIV he would have infected only two patients in four and a half years, a risk which is slightly greater than negligible for patients.

As Professor Michael Adler points out (21 November, p 1297), hepatitis B transmission is more usually associated with surgery, and surgeons are not asked to stop operating until an outbreak of hepatitis B has been traced to them.[2] The problem with adopting this approach for HIV is that the "incubation" period is five years, not 150 days, and by the time infected patients become ill they will have infected subsequent sexual partners, obscuring the true source of infection. This may explain why no health care worker has yet been proved to have transmitted HIV to a patient. Similarly, a surgeon carrying HIV is unlikely to realise this and seek testing and counselling until he or she feels unwell. Since surgeons' gloves are holed in up to 30% of major operations it is not impossible that several patients could be infected in five years. We should also remember that the consequences of HIV infection are far more grave than those of hepatitis B.

If we leave aside the possibility of HIV transmission, people with the acquired immune deficiency syndrome (AIDS) by definition have opportunistic infections, most of which can be suppressed but not eradicated by treatment.[3] Some of the organisms are pathogenic for normal people (salmonella, shigella, mycobacterium), others for the elderly (legionella) or for the fetus (cytomegalovirus); all are potentially pathogenic for the immunocompromised among a doctor's patients. The task of microbiological and neurological monitoring of such doctors is too much to ask the counselling physician.

A patient who may well have impaired resistance to infection has a right to expect not to put himself at additional risk when consulting a doctor. Doctors go into medicine in full knowledge that there must be some additional risk to health from infectious disease.

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1 Grob PJ, Bischoff B, Naeff F. Cluster of hepatitis B transmitted by a physician to a patient. *Lancet* 1981;ii:1218-20.
2 Colindale CDSC. Acute hepatitis B associated with gynaecological surgery. *Lancet* 1980;i:1-6.
3 Armstrong D. Opportunistic infections in the acquired immune deficiency syndrome. *Semin Oncol* 1987;14 (suppl 3):40-7.

Testing for HIV

SIR,—Ms Clare Dyer (10 October, p 871) advises that doctors risk civil or criminal proceedings if they test for human immunodeficiency virus (HIV) antibodies without the patient's consent and refers to the detailed legal opinion from Messrs Michael Sherrard QC and Ian Gatt (10 October, p 991). This legal opinion provides an informative review of related legal decisions and issues.

The matter of greatest practical importance to doctors is whether a patient who has given consent to the obtaining of a blood sample must give further specific consent to HIV testing on that sample. Messrs Sherrard and Gatt deal with this matter by introducing the concept of a "routine" test and comment, "The taking and testing of a sample, though it may be commonly carried out, would not, in our opinion, be considered 'routine' by the courts. Given the far-reaching implications of a positive result . . . it is equally unlikely that the courts will decide that an HIV test should be classified as routine. Accordingly a medical practitioner is under a duty to ensure that the patient's explicit consent to the testing is obtained."

The authors do not offer any definition of a "routine" test and offer no guidance as to what tests, if any, apart from HIV testing, will come into this category. If the authors' views are correct it becomes a matter of some importance to define a "routine" test and to establish what additional tests fall outside this category. Logically all these "non-routine" tests will require exactly the same specific consent as HIV testing and failure to follow this procedure will carry the same risks for doctors. It would be most helpful if the BMA would now obtain further legal advice for its members on these specific issues.

The following comments attempt to put the issues in a practical context.

The *Concise Oxford Dictionary* defines "routine" as "regular course of procedure, unvarying performance of certain acts."

The number and scope of blood tests performed routinely has expanded progressively as advances in technique have enabled large numbers of analyses to be performed cheaply on a single small blood sample. This expansion will almost certainly continue as further investigations become more widely available. Currently, at this psychiatric hospital, a blood sample is routinely taken from patients on admission and analysed in a way which screens for the following conditions, among others: anaemia, blood dyscrasias, syphilis and other venereal diseses, renal and liver disease, and common endocrine and metabolic disorders. Except in the most unusual circumstances, consent to the blood sampling is obtained but the patient is not usually informed of, or asked to consent to, specific diagnosic investigations. If these procedures are correctly regarded as "routine" in what way do they differ from HIV testing?

The acquired immune deficiency syndrome (AIDS) is infective, stigmatising, usually fatal, and novel. The conditions listed above may all, in some people, be fatal. Hepatitis, syphilis, and gonorrhoea are infective. Some diseases, particularly venereal diseases, are stigmatising. It must thus be concluded that AIDS is unique only in its novelty. The other unpleasant characteristics commonly occur singly and sometimes together. The novelty has contributed to an emotional reaction on the part of the profession and the public which has placed the disease in a singular category—somewhat as leprosy was regarded in the Middle Ages. More specifically, "novelty" and "routine" are incompatible adjectives. It is thus little more than tautological to assert that what is new cannot be immediately routine, although it often becomes so with a little time and established practice.

Much more is at stake than the definition of words or even the hypothetical civil liability of doctors. As AIDS spreads in the general population infective and HIV positive people will increasingly require medical attention, although they will not necessarily be recognisable members of any "high risk" group. Correct diagnosis, epidemiological and public health measures, and the protection of staff and patients will be impossible without widespread use of HIV testing. Such testing will be seriously hampered if there is insistence on specific and informed consent.

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Control of HIV infection with confidentiality

SIR,—Doctors diagnosing human immune deficiency virus (HIV) infection are in a dilemma between maintaining strict confidentiality about their patients, who may not want anyone else to know, and the need to alert certain others for purposes of controlling infection. Dr P Gerber (7 November, p 1205) suggested that a failure to inform colleagues might, in some circumstances, even be culpable in law. Many consider that the patients' own general practitioners at least should know, not just for safety purposes but to appreciate the deeper significance when illness occurs.

To preserve confidentiality yet achieve control of infection in this district we have for the past two years used the term high infection risk to alert staff. We apply this to a group of diseases—HIV and other human lymphotropic virus infections (HTLV I and II), hepatitis B, and hepatitis non-A non-B—with such similar epidemiology that a single set of control arrangements covers all satisfactorily. The management of these patients is built into all the district's hygiene and nursing policies, staff have been widely educated to know what the term means, and case notes are marked with it. In this way all the necessary steps can