who look after those in nursing or residential homes for the elderly.

Typically patients will be admitted to such homes at times of crisis, when the availability of medical information may be critically important. There is an additional problem when people are not certain that they will settle in a particular home and prefer to register temporarily with a new doctor at first. When they register permanently the transfer of records is delayed by the time spent as a temporarily registered patient. Meanwhile hospital reports and discharge summaries continue to be sent to the previous doctor.

I care for 21 patients in a nearby nursing home. One was previously registered with my practice, one is temporarily registered (two months), and I am waiting for the records of five (mean 4·2 months so far). For the remainder, who are permanently registered with me, there was a mean interval between registration and receipt of records of 5·1 months (range 2-8 months) with an additional temporary registration period in half of them of 3·7 months. Thus eight months or more can be spent caring for an elderly and often ill patient with no knowledge of his or her medical past. This is despite excellent liaison with the local family practitioner committee. I issue a questionnaire to all new patients, but the information gained is often vague and unhelpful. One patient mentioned problems with her neck and her blood, but not until her notes finally arrived did I appreciate her multiple myeloma. The last note by her previous general practitioner read, "Admit for terminal care."

What can be done about this heroic but dangerous business of treating patients blindfold? The idea of a summary card held by the patient is attractive but probably impractical. Who should have one? When does one become elderly? Why just the elderly anyway? If all patients have one why do they not simply transfer the entire record? While we wait for electronic "credit cards" containing medical information in a decipherable but secure form a simple solution suggests itself. When it is imperative to know about a patient's history a telephone call to the previous practitioner (why are doctors' telephone numbers not on medical cards?) could easily result in the summary card from the patient's notes or at worst a brief résumé of the history being sent directly to the new doctor. This would involve a minimum of time and effort but would at least provide some peace of mind to the legions of blindfolded doctors.

J K BYNOE

Medical Centre,
Sherburn in Elmet,
North Yorkshire LS25 6ED

Psychiatry: private and public provision

SIR,—Dr Greg Wilkinson (9 January, p 79) has failed to appreciate the implications of his own analysis. This may explain the bland tone of his homilies on the "mix" between NHS and private psychiatric care, which he seems to believe can be satisfactorily resolved "by market forces and empirical means."

He is doubtless correct in stating that "people with mental illness descend down the social scale," that insurance risks are so high that only the well off can afford to insure for genuinely comprehensive psychiatric treatment, and that private psychiatry is concentrated on "the outpatient treatment of patients with neurosis." A transfer of consultant commitment towards private practice in psychological medicine must, therefore, mean a shift of medical effort towards the higher social classes and those with less severe illness. This is "the inverse care law" squared. In this scenario severe psychotic illness would inevitably be neglected in favour of the "walking worried." Furthermore, history teaches us of the risk of an expanded private psychiatric sector bringing with it a burgeoning of dubious and unsupervised therapies. Because of the particular vulnerability of the mentally ill and their families there seems to be an unanswerable case for a divorce between treatment and personal profit.

A further and larger objection lies in the main thrust of psychiatric intervention today. This is at the community level and demands the participation of experienced consultants in assessing patients, supporting their clinical teams, liaising with general practitioners (who are increasingly asked to carry psychiatric responsibilities beyond their formal training), and coping with the complexities of the Mental Health Act 1983. Nor should one forget teaching, research, planning of services, and defending services against the deprivations of budgetary cuts. Even the most ambivalent of psychiatrists is not yet capable of being in two places at the same time. A growing proportion of the working week spent in private clinics must reduce a consultant's availability on NHS wards and risk a decline in the clinical standards on such wards.

We are not enthusiasts for the expansion of private practice in any specialty. The fairness, efficiency, and public acceptance of a properly financed National Health Service seems self evidently preferable. A return to market place psychiatry could be envisaged only by those not engaged in a clinical commitment to society's most underpriviliged victims, the mentally ill.

T H TURNER

Hackney Hospital,
London E9 6BE

DAVID WIDGERY

London E14

Viral infection, human papillomavirus DNA, and cervical neoplasia

SIR,—I was surprised that Dr J B Murdoch and others (6 February, p 381) infer from their data a good correlation between histological or cytological diagnosis of wart virus infection and the presence of human papillomavirus deoxyribonucleic acid (DNA) sequences.

Of 34 samples taken from women with either histological or cytological evidence of wart virus infection, 10 had no human papillomavirus DNA, whereas nine of 20 normal samples did have such DNA. That the correlation between histological or cytological diagnosis and the results of DNA hybridisation was better when the samples were taken from colposcopically abnormal areas reflects mainly on the correlation between colposcopic and histological abnormalities.

The increasing frequency with which human papillomavirus 16 DNA is found in normal tissues must surely suggest that the presence of human papillomavirus 16 DNA does not indicate a high risk of subsequent malignancy.[1-3] Indeed, the data from the matched internal controls in this Glasgow study suggest that the relation between human papillomavirus 16 infection and cervical malignancy is association rather than causation.

W P SOUTTER

Institute of Obstetrics and Gynaecology,
Hammersmith Hospital,
London W12 0HS

1 Cox MF, Meanwell CA, Maitland NJ, *et al.* Human papilloma virus type 16 homologous DNA in normal human ecotcervix. *Lancet* 1986;ii:157-8.
2 Walkinshaw SA, Cordiner JW, Clements JB, Mcnab JCM. Prognosis of women with human papilloma virus DNA in normal tissue distal to invasive cervical and vulval cancer. *Lancet* 1987;i:563.
3 Murdoch JB, Cordiner JW, Mcnab JCM. Relevance of HPV-16 to laser therapy for cervical lesions. *Lancet* 1987;ii:1433.

Variability in biothesiometry: an error of technique?

SIR,—Dr Gareth Williams and others (23 January, p 233) may underestimate the reliability of biothesiometry. They show wide variability between both contralateral sites and ipsilateral sites in 25% of non-diabetic and 24% of diabetic patients. It would be interesting to see the variability and scatter for the first readings at each site because, as in many other forms of sensory testing, the "fatigue" of the patient's sensorium is an important factor which may have clouded their results. Dr Williams and his colleagues discard the first 12 readings (three at each site) and then proceed to an additional two cycles of three measurements at each site—another 24. After 36 measurements it is not surprising that such variability is shown.

My own practice is to use one measurement of threshold starting from zero volts at each site, after an initial reference point—remote from the test sites—for example, clavicles or sternum—to familiarise the patient with the sensation and its initial perception. A comparison of standard deviations with this technique and with the multiple tests used by the authors might prove the point. Biothesiometry remains a valuable way of quantifying threshold, but neurologists have long been familiar with the dangers of using a single sensory modality as a "screen" for neuropathies, since impairment may result from root or posterior column lesions. It is a useful way of monitoring change.

J M S PEARCE

Department of Neurology,
Hull Royal Infirmary,
Hull HU3 2JZ

AUTHORS' REPLY,—We share Dr Pearce's concern about the need to strike a compromise between familiarity and "fatigue." We tried to develop a protocol for measuring vibration perception threshold which would allow the subjects to become fully accustomed to an unfamiliar stimulus without becoming bored and losing interest. We performed vibration perception threshold measurements in groups of three at each of the four sites in rotation, with a total of nine determinations at each site. Although this is a relatively large number of observations, the whole procedure took only four to six minutes and would be much less vulnerable to boredom and distraction than the three hour testing procedures used at some centres.[1]

We do not think that fatigue was an important contributory factor to the wide variability in vibration perception threshold among different sites, as the values at any given site were confined to a narrow range which showed no tendency to increase as more readings were taken. At the right big toe, for example, the first and last readings differed by >5 voltage units in only six of the 64 non-diabetic and 10 of the 110 diabetic subjects, and in each of these cases the last six values all fell within a range of five units. This does not suggest increasing variability, which would be expected with fatigue or failing concentration; indeed, it highlights the need for several estimations as the first may be unrepresentative. In most cases the final stable value was lower than the first, presumably because some time was necessary to "tune in" to the stimulus, whereas those subjects reporting a lower