Summary points

Infection with herpes simplex virus type 2 is mostly asymptomatic and cannot be cured

Prevalence by age differs between populations and geographical areas

Serology tests are commercially available with acceptable sensitivity and specificity

Use of the tests to screen low prevalence groups would give high rates of false positive results

Potential biotechnical, medical, epidemiological, psychosocial and ethical advantages and disadvantages must be balanced at both the individual and public health level

Screening cannot currently be ethically justified

their sexual relationships and also prevent transmission. Concern about infecting a partner is common among those diagnosed, although relationship issues and not infection control seem to be the main cause for this.[w1]

The chosen ethical principles for guidance should be intellectually and emotionally acceptable in the affected society, in our case primarily patients at an STD clinic, their partners, the clinic staff, and policy officials. We do not know whether this is the case, and more information is needed from social science research.

In our opinion, justice as solidarity (see bmj.com) should be paired with autonomy in ethical deliberations of preventive health interventions. If the goal is solidarity rather than conformity, patients must be free to decide what they think is right, because that is what moral responsibility is all about. Without professional truthfulness—the basic tenet of patient involvement in clinical decisions—solidarity could never be accepted as an argument by itself. Patients must understand and feel comfortable with the messages from health institutions. They must also be convinced that reasonable societal support will be available and affordable for those infected with HSV-2 as well as for their partners.

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Contributors and sources: IK is a specialist in infectious diseases and professor in epidemiology and public health with an interest in the ethics of public health. G-BL, IK, and BMA are part of a herpes research network in western Sweden. TN is professor in medical ethics. IK and TN had the idea for this paper, and IK wrote the first draft. All authors contributed to the final version from their special fields of competence. The article is based on sources from the Pub Med and medical ethics research literature. They are all guarantors.

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Corrections and clarifications

Scandals have eroded US public's confidence in drug industry

In this news article by Jeanne Lenzer (31 July, p 247) we wrongly said that one of the authors of a study on the sources of lead in children living near a smelter failed to acknowledge that her husband owned the smelter in question. In fact, her husband didn't own the smelter; he owned the consulting firm that advised the owner of the smelter.

How protective is the working time directive?

We appeared to slash the salaries of new doctors in this editorial by Rhona MacDonald (7 August, pp 301-2). In the fifth paragraph we dropped a zero by mistake: 12 550 additional UK doctors would cost up to £780m [not £78m] ($1420m; €1150).

Assessing the quality of research

One of the authors of this Education and Debate article by Paul Glasziou and colleagues has advised us that his published name was missing his middle initial (*BMJ* 2004;328:39-41). Jan Vandenbroucke is in fact Jan P Vandenbroucke.

UK health minister under pressure to ban smoking in public

In this news article by Claire Laurent (14 August, p 368), we said that a *BMJ* paper reinforced the findings of earlier studies linking passive smoking to coronary heart disease. Unfortunately, we inadvertently cited the wrong paper. The correct citation is: *BMJ* 2004;329:200-5. The web version and link have been amended.

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