SIR: Dr Thomas is indeed correct that the term 'dysmorphophobia' has mainly been used to describe patients who are deluded that a *visible* part of their body is defective. There seems no good reason, however, to restrict this term solely to visible delusions. Patients who believe that they smell and so request surgery to remove apocrine glands in the axilla are similar to classic dysmorphophobics in three ways: (a) their social avoidance; (b) their desire for surgery; and (c) their response to exposure therapy, at least in some cases. It thus seems logical to label as dysmorphophobics those patients who believe that part of their body is malfunctioning on evidence from any sensory modality.

As mentioned in our paper, delusional conviction was rated on a scale from 100% = total conviction to 0 = no belief at all. A delusion is not a black and white issue where somebody is either deluded or not deluded – there can be gradations from no belief at all to a totally fixed belief. Delusion-like ideas, overvalued ideas and primary delusions would score increasingly on such a scale. These phenomena shade into one another with no clear divide, and change with successful treatment – for example, exposure improves fixed beliefs and overvalued ideas in obsessive-compulsive disorder (Lelliott & Marks, 1986; Lelliott *et al*, 1988) and also improves abnormal cognitions in social dysfunction (Stravynski *et al*, 1982).

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Schizophrenic Thought Disorder

SIR: Cutting & Murphy (*Journal*, March 1988, **152**, 310–319) propose that schizophrenic thought disorder comprises four relatively independent components: delusion, intrinsic thinking disturbance, formal thought disorder, and deficient real-world knowledge. In order to determine whether the fourth component, real-world knowledge, is intact in schizophrenic persons, they devised tests of social and practical knowledge, using multiple-choice questions. The majority of schizophrenic patients tested had low scores.

How should one test practical and social knowledge? Should one not test practical activities and social behaviour, rather than asking questions about these things? I would suggest that one might possess this information, and be able to use it in a practical situation, but be unable to express it in a verbal form – or vice versa. It would be interesting to know how many of the schizophrenics tested would, for example, be unable to describe in detail (or answer detailed questions about) how to best cross the road, but would choose a pedestrian crossing and wait for traffic to stop before walking across to the other side.

Could there be any relationship between such a discrepancy in 'knowledge' and 'behaviour' and another, well-recognised discrepancy between thoughts and actions: the "double orientation" of patients with chronic schizophrenia? Here the patient is wholly convinced that a delusion is true, even though it may be clearly contrary to generally held knowledge about the real world, yet his behaviour is appropriate to his circumstances – i.e. his behaviour, but not his expressed beliefs, is in keeping with 'real-world knowledge'. Did the patient who was described giving his plan to go to Scotland after discharge to audition for a star part in "Fiddler on the Roof" actually leave for Scotland?

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Screening for HIV

SIR: Dr Davies expressed "astonishment" that a psychiatrist should have any qualms about determining the HIV status of patients admitted to psychiatric units (*Journal*, June 1988, **152**, 857). He went on to advocate the routine screening of all such patients. Dr Davies would appear to be ignorant of the legal, moral, epidemiological, clinical, and financial issues surrounding HIV testing.

The British Medical Association sought legal advice on HIV testing and were told that as it was not a routine test, testing without specific consent could constitute an assault. Even if consent were sought the disturbed patient, to whom Dr Davies refers, is likely to be psychotic and may be incapable of giving informed consent and unable to fully appreciate the implications of a positive result.

Dr Davies is on very shaky ground if he thinks that the Mental Health Act will provide protection against litigation. Everall (1987) described the case of a depressed patient admitted under Section 3 of the Act who refused all routine investigations. The Mental Health Commissioners stated that the Act did not cover performing such tests without the patient's consent, and a medical defence organisation advised the doctors not to proceed, as doing so would probably constitute a battery.

While no-one would argue that nursing a disturbed patient who is HIV positive is without risk, testing for the virus would not confer protection to the nursing staff, nor would it prevent the patient from biting or spitting at the staff. Taking a history from a patient is far more important than taking a blood sample. All patients who have put themselves 'at risk' should be treated as if they were positive, and the necessary precautions taken. Routine testing of all 'at-risk' patients could lull staff into a false sense of security. A negative result would not exclude HIV infection, as the period from inoculation to seroconversion, during which time the patient is infectious, may be anything from 3 months to well over a year. So even after testing, both positive patients and negative but 'at-risk' patients would still need to be managed with the same precautions.

The consequences of having had a test for HIV, even if the result is negative, can be far-reaching and may adversely affect the patient's future chances of taking out life insurance or a mortgage. The same cannot be said for the W.R. or measurement of the mean corpuscular volume.

Despite press hysteria and talk of a 'plague', both AIDS and HIV infection are still relatively uncommon in this country. Putting aside the legal and moral issues, routine testing of all psychiatric patients would be an expensive undertaking and would identify few cases. Even in Tybridge, South Devon I suspect that HIV infection has not yet reached epidemic proportions.

If a patient's history and presentation suggest HIV encephalopathy and the patient consents to testing, then the test may be undertaken in conjunction with pre- and post-test counselling. If the patient refuses or is incapable of giving informed consent, then the doctor should not proceed. The Mental Health Act would not appear to protect the doctor who overrides the patient's wishes, and since HIV testing is not a life-saving measure, common law is unlikely to do so either.

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SIR: To correct Dr Dunn, the categories of patients for whom I advocated HIV testing were: (a) those in whom HIV encephalopathy forms part of the differential diagnosis; and (b) those who are behaviourally disturbed. These constitute only a small proportion of psychiatric admissions, and certainly not all as he asserts.

Dr Dunn suggests that the position with regard to specific consent is clear-cut. This is not the case. All the authoritative statements on HIV testing make some provision for carrying out of tests in the absence of specific consent, but the details are, to say the least, complicated. To quote Mr Langley QC:

> "There is no simple answer: it is not in our opinion possible to say that fully informed consent is invariably necessary and it is certainly not right that it is never necessary. It normally will be required, but in each case must be considered in the light of its particular circumstances."

The General Medical Council statement would appear to condone testing without consent "where it is imperative in order to secure the safety of other persons than the patient ..." but "only in the most exceptional circumstances ...". Requirement for specific consent is the norm, but this *can* be overridden, and not just by common law. The debate therefore centres on the dividing line between normal and 'exceptional' circumstances. In view of the paucity of case precedent in this area, it is important that the psychiatric profession develops a consensus on this issue so that, in the event of litigation, the Bolam Test can be applied. With regard to the case reported by Everall, I am sure that much responsible medical opinion will consider it odd to be empowered to impose treatment upon a patient whose condition they are prohibited from investigating.

I quite agree that a negative HIV test with present techniques does not permit staff to relax precautions. The use of 'at risk' categories is, however, fraught with danger, as HIV penetrates the community at large: it is necessary to assume that all patients are HIV infectious. In the vast majority of cases, simple and unobtrusive measures will eliminate the risk of transmission of HIV. Disturbed behaviour requires more elaborate measures, including protection of all exposed areas of those attending on the patient. Even with all precautions and high levels of staff awareness and vigilance, incidents will still occur. Carriage of HIV significantly increases the dangerousness of