committee and from A G Elder, in which in clear terms are laid out the case for screening after admission[3] and that against screening before admission.[4] My only slight disagreement with Elder is that if he does not believe hepatitis B is the thin end of the wedge, he should look again at the lack of compelling arguments on which these current guidelines have been introduced and at Richards and Harries comment that hepatitis B may only be the "tip of the iceberg"—presumably as a criterion for exclusion from medical school.

Richards and Harries are at pains to underline the concept of responsibility. The point here is that the Committee of Vice-Chancellors and Principals has a massive responsibility. It has a responsibility to the medical student who is now halfway through his or her course, having been accepted and been held in limbo for the two years which the committee has taken to debate the matter. This student's future has now been significantly affected by the guidelines, and whereas a modified clinical course was in prospect, he or she is now being pressured to leave or change course.

The responsibility of the committee pertains particularly to medical schools, some of which are continuing their policy of screening after admission. The fear is that, in view of the justifiably high regard in which the committee is held, some schools will, against their own better judgment, exclude or dismiss outstanding students on the sole grounds that to admit them would be to go against one of the committee's pronouncements.

Admission to medical schools should be on the basis of merit and suitability to become a doctor, not on grounds of infinitesimal risk factors which are preventable. The concept of accepting an applicant who is less suited for medicine on grounds of intellect, attitude, and personality rather than someone who is more suited but is positive for hepatitis B antigen—possibly temporarily—is not in the best interests of the profession or the public, whereas constructive use of able individuals and creation of an appropriate training programme for them is. I believe the debate should continue and the Committee of Vice-Chancellors and Principals should re-evaluate its position in the light of responsible opinion, such as that provided by the BMA medical students committee.

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Guidelines apply to dental students too

EDITOR,—A M Lever highlights the problems of implementation of the recently issues guidelines for universities regarding medical students.[1] These guidelines also apply to dental student admission. The aim of courses for dental students is to produce a graduate with academic and clinical knowledge and skills, ready for independent practice as a dental physician and surgeon. Therefore as part of these courses all students are required to carry out a wide range of treatment procedures. By the Department of Health's guidelines virtually all dental procedures are "exposure prone" in that the operation takes place within a body cavity. On qualification virtually all graduates will continue to perform clinical work as there are few jobs in dentistry which do not include clinical work.

It is appropriate to screen dental students and start hepatitis B vaccination during the first term of training as they are unlikely to perform exposure prone procedures then. Dental schools can avoid pre-admission screening. Lever suggested that one in 5000 medical school applicants could be infectious, which would suggest that one carrier of e antigen might be accepted to dental studentship every six years—surely a surmountable problem. The cost of the vaccination programme to dental schools or students is considerable—vaccination by the student's own general practitioner necessitates travel and time costs. This is accepted as necessary to protect the patients and the dentist.

We considered the problem of the HIV positive dental student at a European Community Working Party[2] since employment opportunities in dentistry would be very limited for such students. On admission to dental school, students should be informed of the occupational risk and consequences for employment of becoming HIV positive. There is one reported case of a dental undergraduate who was found to be HIV positive.[3] Testing should remain on a voluntary basis but once a student is identified as positive a sympathetic approach by the dental school, university, and General Dental Council should allow a clinical student to complete the course and be examined while avoiding exposure prone procedures. The graduate could then seek research or administrative work or obtain graduate entry to a non-dental course.

A recent report indicated that "over 70% of hospital ward doctors had been accidentally jabbed by 'sharps' during a two year period."[4] The emphasis in dentistry has, for some years, been to prevent injury and possible contraction of HIV. Risk assessment[5] has led to modification of techniques and so reduced the danger to the operator and assistant. Anecdotal evidence points to a reduction in injuries, but only time will tell how effective these changes in techniques have been in preventing dentists from contracting HIV infection.

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General practitioners and necropsies

General practitioners are welcome at necropsies

EDITOR,—Recent articles on necropsies written by the non-forensic community are muddled and consistently omit to mention crucial differences between the coroner's necropsy (under the Coroners Act 1988 and the Coroners Rules 1984) and the hospital necropsy (under the Human Tissue Act 1961, as amended by the Anatomy Act 1984).[1-3] The relevant cofactors that merit consideration by those indulging in medical jurisprudence are stated elsewhere.[4,5]

The comment that a deterrent to general practitioners requesting necropsies is their belief that a necropsy is needed only if the cause of death is not known[1] is wrong. When the cause of death is unknown the case is referred to the coroner and a request from the general practitioner for a necropsy is redundant.

Although the coroner's investigation of a death primarily serves statutory requirements and medicolegal interest, modern forensic pathologists endeavour to find a medical reason for the death for the benefit of clinical colleagues and the bereaved family. All too commonly, and to the detriment of clinicopathological answers that may be gleaned from a necropsy, no clinical history is available.

The general practitioner is welcome at the necropsy (under rule 7 of the Coroners Rules 1984) and entitled to be notified when practicable of the time and place. It is constructive and of mutual benefit for doctors to liaise with the coroner's pathologist before the necropsy. More communication and greater rapport should be encouraged.

The financial burden of a medicolegal necropsy falls on the coroner or the police authority and is relieved by public funds. A prescribed fee (if any) for the necropsy report (under rule 57 of the Coroners Rules 1984) is a reasonable token payment. It may selectively control properly interested applicants. The report and other evidence before the coroner may be inspected without charge.

A proposal that a copy of every necropsy report should be readily available to the general practitioner is inappropriate under current legislation. In practice, the information in many medicolegal cases can be given in a telephone call, and in certain cases premature disclosure is inadvisable, particularly if legal proceedings or criminal charges are likely and the case material is sub judice. The disclosure of information without the coroner's prior authorisation is forbidden (under rules 10 and 13 of the Coroners Rules 1984) in coroner's cases.

A necropsy should not represent failure for a doctor but should be regarded as vital to the process of continuing postgraduate education and valuable to medicine.

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May harm relationships with relatives

EDITOR,—K B Thomas and R O Weller suggest that general practitioners hesitate to request necropsies because the death of a patient starkly highlights their failure as doctors[1]; the general practitioner can be seen as attempting to bolster his or her flagging self confidence by denying that the death happened. I challenge this view and suggest that the reluctance of general practitioners to request necropsies stems from two main factors.

Whereas hospital pathology departments have little to do with dead patients' relatives, these relatives are often the patients of the general practitioner concerned, who may have developed a close relationship with them. A desire not to hurt a relative's feelings may seem a trivial reason not to press for a necropsy when viewed from the point of view of a hospital (or even a university department of general practice). But to a general practitioner, pressing unwilling relatives for permission to perform a necropsy may mean knowingly causing further stress and hurt to