I cannot see what the United Kingdom Central Council for Nursing, Midwifery, and Health Visitors in the shape of Mr Reg Pyne is concerned about when he says that complaints are difficult to initiate. There is no lack of letters of complaint flooding into hospitals, and this is usually the starting point. The consultant is then given an opportunity to reply; if this is not sufficient further action can be taken.

This further action normally involves the clinical complaints procedure. Having been at both the receiving and the adjudicating ends of this procedure, I think it fails entirely in its intial objective, which was to avoid unnecessary litigation. In my experience the convening of such a forum merely gives the patients another opportunity to vent spleen on the doctor for real or imaginary wrongdoings. It was originally intended that the conclusions of the inquiry through the medical officer would prevent litigation, but this was never binding. The patient could take the conclusion of the clinical complaints procedure and use it as evidence in a full blown judicial procedure.

The need for this review is timely, because consultants appointed since trusts were established will not have the right of appeal to the secretary of state as before. Therefore some external appeal procedure should be in place for both the patient and any consultant who feels aggrieved as a result of disciplinary action for the purpose of the appeal.

I suggest that two consultants from outside the region be appointed to consider the facts of the case and report. If this is still not satisfactory, clearly there must be recourse to the courts.

I G SCHRAIBMAN

Rochdale Health Care NHS Trust,
Birchdale Hospital,
Rochdale OL12 9QB

1 Warden J. Complaints process must put patients first. *BMJ* 1993;307:12. (3 July.)

Doctors need support and encouragement

EDITOR,—With calls for increasing ease of access for patients to make complaints[1] and new attitudes to expectations and demands being fostered by the patient's charter—without there being any increase in resources to meet these—general practitioners are going to have to adopt a new attitude to patients' complaints. We shall have to teach doctors that complaints are an inevitable hazard and part of normal professional life. Complaints will need to be viewed with no more emotion than inner city doctors like myself view a parking ticket: it does not mean one is a criminal; it does not incur penalty points on one's licence or risk imprisonment or deportation. On the other hand, serious motoring offences are not viewed any less seriously, and dangerous driving still attracts a suitably heavy penalty.

If complaints are to be used as a way of improving the quality of service, general practitioners will need to respond in an appropriate way, which will be very different from our attitude in the past. I am not suggesting that we should be striving for anything but the highest possible standards of care. No one should connive at serious lapses of professional standards, but the complaints procedure has been changed to a process unrelated to these few and relatively rare situations. No longer should it be necessary for decent men like Colin Waine to feel so guilty and embarrassed that they have to do the honourable thing and resign.

The environment in which doctors practise has changed and now all doctors are vulnerable in a way for which we are unprepared. Complaints induce distress and guilt and affect performance. What is needed is support, encouragement, and help to develop strengths and improve weakness. We must look to how we can develop this for us all, especially those who find themselves complained about. Such support needs to be available immediately and automatically to every one of us who feels threatened or is in difficulty.

L ALAN RUBEN

British Postgraduate Medical Federation Office,
UMDS Guy's Campus,
London SE1 9RT

1 Warden J. Complaints process must put patients first. *BMJ* 1993;307:12. (3 July.)

Transmission of HIV in prison

Prevention depends on enlightened approach

EDITOR,—Following the recent outbreak of hepatitis B and HIV infection in a Scottish prison[1] the *BMJ* has published an editorial[2] and an article[3] on the subject. The articles do not emphasise strongly enough the key issue in this matter—namely, that prisoners do not have the same rights of access to health care and preventive measures to combat the potential spread of hepatitis B and HIV as the general population does. This is not always the case—for example, in prisons such as Saughton in Edinburgh officers have volunteered to train as HIV counsellors. Enlightened though this is, it does not go far enough. The evidence clearly shows that the prison population needs access to means of reducing harm more than the general population does.[1-3]

The reasons for the denial of services to reduce harm, including condoms and needle exchange schemes, are loosely referred to in the articles. They include a lack of political will, lack of legal reform,[2] and the fact that to accept needle exchange schemes in prison would be to condone illegal drug taking. In addition, needle exchange schemes may be seen as a means of introducing potential weapons into prisons rather than as a means of preventing spread of HIV. There may also be resistance to counselling about HIV infection and to harm reduction techniques among prison staff in institutions with no practical experience of such problems.

I suggest that needle exchange schemes should be piloted in Saughton jail in Edinburgh and Polmont young offenders' institution in Falkirk: these two sites would be suitable because staff are experienced in HIV investigations and counselling services. The pilot scheme could be administered by prison officers who are HIV counsellors, such as those in Saughton jail, and needles could be exchanged, on a one for one basis to individual prisoners only after counselling. All prisoners in all institutions should be offered access to education about HIV infection, and condoms on request, as a matter of urgency.

I have misgivings about having an amnesty for the surrender of needles but no needle exchange scheme. This simply removes needles from the pool of equipment used without reducing the number of injecting drug users. Any reduction in injecting equipment can only increase needle sharing and hence the risks of spread of hepatitis B and HIV infection.

A reduction in the spread of hepatitis B and HIV infection in the prison population can be achieved only with the active cooperation of those infected—for example, drug injectors. Major efforts are being directed towards calculating the prevalence of hepatitis B and HIV infection in prison; it seems obvious that major efforts should also be directed towards preventing new cases of infection and reducing harm.

ANDREW RILEY

Edinburgh EH10 6ST

1 Christie B. HIV outbreak investigated in Scottish jail. *BMJ* 1993;307:151-2. (17 July.)
2 Gore SM, Bird AG. No escape: HIV transmission in jail. *BMJ* 1993;307:147-8. (17 July.)
3 Bird AG, Gore SM, Burns SM, Duggie JG. Study of infection with HIV and related risk factors in young offenders' institution. *BMJ* 1993;307:228-31. (17 July.)

Prisoners need condoms and clean needles

EDITOR,—Sheila M Gore and A Graham Bird seem to accept the present situation whereby prisoners are denied condoms and cannot disinfect any needles they might use; instead they emphasise the need for more research and measures to persuade prisoners to have tests for HIV so as to improve information about public health.[1] They seem to be saying that we should wait for an outbreak of HIV infection or hepatitis B in our prisons and then send in an army of epidemiologists and counsellors. It is not clear what advantages this would hold for individual prisoners at risk of HIV infection.

The risks of transmission of HIV can be reduced by treating drug users in prison, providing agents to clean needles and syringes or facilities for exchanging needles, and providing condoms. Declaring an amnesty and getting prisoners to surrender needles, if done in isolation, would just reduce the availability of injecting equipment. Counsellors, who can tell patients infected with HIV only not to inject drugs or not to have sex, in effect deny prisoners information and advice on the usual measures to reduce the risk of transmission of HIV.

The fact that non-medical staff have access to the HIV status of prisoners on a "need to know" basis is a disincentive to having the test. The viral infectivity restrictions, which lead to the identification and isolation of HIV positive and at risk prisoners are punitive and exacerbate this lack of confidentiality.[2]

The government's Advisory Committee on the Misuse of Drugs has recommended the abolition of viral infectivity restrictions; that the options for treating drug users should be considered, including the prescription of drugs such as methadone; that prisoners should have access to cleaning agents to sterilise needles; and the distribution of condoms.[3,4] The government, however, chooses not to act. We should challenge this intransigence and demand action.

JOHN DUNN

Community Drug Team,
Maudsley Hospital,
London SE5 8AZ

1 Gore SM, Bird AG. No escape: HIV transmission in jail. *BMJ* 1993;307:147-8. (17 July.)
2 Turnbull P, Dolan K, Stimson G. *Prisons, HIV and AIDS.* Horsham, West Sussex: AVERT, 1991.
3 Advisory Council on the Misuse of Drugs. *AIDS and drug misuse. Part 1.* London: HMSO, 1988.
4 Advisory Council on the Misuse of Drugs. *AIDS and drug misuse. Part 2.* London: HMSO, 1989.

Different aims, different strategies

EDITOR,—The editorial by Sheila M Gore and A Graham Bird was timely in view both of a press release by the World Health Organisation during the Berlin conference on AIDS and of media reports of transmission in a Scottish prison.[2,3] However, the authors failed to distinguish clearly the important, practical differences applicable to the three investigative situations to which they alluded. These were: (i) when the aim is to establish the prevalence of HIV infection in a general population (prison inmates, for example); (ii) when there is a need to determine someone's HIV status for essentially personal reasons; and (iii) when evidence presents of recent spread of HIV infection, such that a public health obligation arises to find cases (or carriers) in the relevant, exposed population and to institute control measures.

In the first situation, we agree that an anonymised and unattributable investigative procedure, based on voluntary sampling, is appropriate. Since this is likely to be applied primarily for the benefit of the community rather than of the individual, the full panoply of preparatory commitments is necessary, including prior ethical approval. Saliva