

Recording HIV status on police computers

Too softly, softly?

Doctors go to considerable lengths to maintain the confidentiality of their patients' HIV status.^{1,3} The fact that decisions have been taken to store people's HIV status on police computers is therefore of medical interest.

In an attempt to determine the extent of the practice I contacted a sample of chief constables by questionnaire; in the event, composite replies were provided by the chairman of the Association of Chief Police Officers' working group on data protection and the honorary secretary of the Association of Chief Police Officers in Scotland. No comparable records are held in Northern Ireland. My inquiries show that centralised computerised records, which may include a person's HIV status, are stored in the police national computer and in the computer of the Scottish Criminal Records Office. Some local systems in England and Wales hold duplicate records. Records are held in Britain on people convicted of recordable offences; in England and Wales records may also be held on people wanted for specific offences. No person is listed on the police national computer purely because of his or her HIV status: the entry must have been made for a police purpose.

In most cases the information has been provided by the person concerned. If information comes from an outside source the subject's consent to it being entered in the computer is not sought; the police believe that refusal would defeat the purpose of the warning markers. Any entry must be factual; the officer who originates a warning notice must justify and validate the information before it is computerised. Validation must be repeated every five years.

A flagged warning is non-specific and is only one of 13 admonitory signals. In Scotland HIV seropositivity is subsumed under the heading "contagious," which applies to several conditions, including, for example, hepatitis B infection. Further access to the computer records is needed to discover the precise nature of the "contagiousness."

Thus police computer records of people's HIV status are centrally controlled and have strictly limited objectives. These are based on the assumption that it is desirable for the relevant police officers to have full information as early as possible to enable them to discharge their responsibility for the wellbeing of people in their custody. The police consider it important that they are aware of any information that may affect how they deal with a person or how they handle a given situation; they also regard it as their duty to ensure, as far as possible, the safety of other prisoners and of the public.

For these reasons immediate access to the computer is available to police "at the scene"—such access being limited

to those with an operational need to know. Individual police officers do not have to justify each access—the number of computer inquiries made each year is said to run into millions. Random checks are made to verify that access was gained for legitimate purposes.

The system is thought to be accurate; the results reported in this issue by Sadler and his colleagues⁴—which indicate a relatively high rate of inaccuracy in the police records of drug addicts—were not, in fact obtained from the computer records of the Scottish Criminal Records Office. The HIV status of a person is considered to be personal data and is subject to the provisions of the Data Protection Act 1984, which gives the subject access to his or her records unless certain exclusions apply. It is unlikely that any exemptions relating to the prevention of crime or to the prosecution of offenders would be relevant in the circumstances under discussion. There is also no doubt that a person listed in the computerised police data could be eligible for compensation for any damage or distress caused by the storage of inaccurate information—for example, by having been held in isolation.

The holding of sensitive personal data in police computers therefore seems tightly regulated. The question, however, still remains: should the police be keeping HIV records at all? The modern judicial approach to confidentiality in many spheres is based on performing a balancing act between the demands of personal privacy and the public's right of access to matters of general interest.^{5,6} Few would deny the police, who are a particularly vulnerable group, a right to know if they have been or are being exposed to contagious disease. Although HIV infection is not very infectious, the results of infection may be catastrophic.

The basic question thus becomes: does a person's right to privacy justify the exclusion of HIV infection from a general warning applied to infectious disease? The reasons for the very high priority given to maintaining the confidentiality of people infected with HIV have been well established,⁷ and the principle has been upheld in the courts.⁸ Such considerations apply, however, mainly to medical records; the status of information volunteered by the subject, which seems the main issue here, may be wholly different. Doubts may be expressed about the origin of the apparently small minority of police warning signals coming from sources other than the person concerned. Inevitably, these are diverse and include information provided by the prison service or a close and credible relative supported by factors such as the subject's lifestyle or documentary evidence carried by the subject at the

time of his or her arrest. There is no evidence that medical records are included.

As long as the purpose of storing knowledge about contagious disease affecting a convicted person or one suspected of having committed a crime is limited to the objectives outlined above, there can be little antipathy to the policy on grounds of principle. Moreover, it could be argued that the police service has not discharged the duty of care it owes to operational police officers if it fails to provide warnings of contact with known infective people. Although the police understand that having such knowledge may not protect them against infection, it allows them to be counselled and possibly given prophylaxis with zidovudine when their work has put them at risk.⁹

The situation is comparable to that of forensic pathologists performing necropsies on victims of violence.⁴ No one would deny them the advantages of knowing whether they were at risk of infection before proceeding. The police are entitled to

the same protection; there is no reason why they should not receive it provided that offenders' rights to privacy are protected at the same time. On current evidence, this balance is being achieved.

J K MASON

Professor (Emeritus) of Forensic Medicine
University of Edinburgh,
Old College,
Edinburgh EH8 9YL

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Treatment of elderly patients with breast cancer

Tamoxifen alone is no longer justified

Over one third of all breast cancers occur in women over 70. Although these elderly women have often been excluded from breast cancer trials, women aged 70 have a life expectancy of 14 years.¹ Despite a widely held view that breast cancers in elderly women are less aggressive there is little evidence to support this.^{2,3}

Uncontrolled studies published in the early 1980s suggested that tamoxifen as the sole treatment was effective for elderly patients with breast cancer.^{4,7} Since then increasing numbers of elderly patients have been treated in this way. Follow up has usually been short, and one study, which followed up patients for at least five years, has cast serious doubts on the efficacy of tamoxifen alone in these elderly patients.⁸ In that study tamoxifen did not control local disease in 62% of patients to the time of death or most recent follow up. Only patients whose cancers responded completely to tamoxifen achieved a satisfactory rate of local control at five years.

Although immunocytochemical assays can predict the response to tamoxifen,⁹ deciding with certainty which patients will have a worthwhile response is not possible. Other markers of response, such as epidermal growth factor¹⁰ and transforming growth factor β 1,¹¹ are currently being studied.

Two prospective trials compared tamoxifen with surgery in elderly patients and came to opposite conclusions. In a study of patients randomised to surgery or tamoxifen, Gazet *et al* reported no difference in time to disease progression between the two groups and concluded that tamoxifen was effective as first line treatment.¹² This study has been criticised because of its small numbers and large proportion of inoperable tumours and because most patients randomised to surgery had wide local excision. This is probably inadequate local treatment, particularly for large tumours. Robertson *et al* randomised patients to receive either wedge mastectomy with excision of affected nodes or tamoxifen alone.¹³ Significantly more patients receiving tamoxifen required a change of management for local progression of disease.

Only one published trial compared tamoxifen alone with surgery and tamoxifen.¹⁴ At a median follow up of 42 months patients who had received the combination of surgery and tamoxifen had a small but significant survival advantage. Most patients undergoing surgery had wide local excision;

one in four had a mastectomy. After 34 months local recurrence rates were more than five times higher in the patients treated by wide local excision than in those undergoing mastectomy.¹⁴ A study comparing modified radical mastectomy with wide local excision and tamoxifen reported a survival advantage for the mastectomy group.³ This study also showed more local recurrences after wide local excision. Contrary to some proposals¹⁵ these trials suggest that wide local excision without postoperative radiotherapy is not satisfactory local treatment for elderly patients with breast cancer.

What are the results of mastectomy in these elderly patients? The average mortality in elderly patients undergoing mastectomy is less than 1%,^{3,16-18} which has led some authors to suggest that elderly patients should be treated by surgery. Simple mastectomy alone in these elderly patients seems associated with an unacceptable rate of axillary relapse when compared with a modified radical mastectomy.^{3,18} Importantly, modified radical mastectomy does not seem to be associated with a higher postoperative mortality than the lesser operation.³ Little justification therefore exists for the continued use of simple mastectomy alone in managing these patients. There are few data relating to treatment of elderly patients with radiotherapy because of the reluctance to treat these patients with this method.² There is no evidence, however, to suggest that they tolerate radiotherapy less well.

Clearly, elderly patients with breast cancer should receive treatment that effectively controls disease long term. The unselected use of tamoxifen alone in such patients is therefore no longer justified. Patients with operable breast cancer who are fit should have either wide local excision and radiotherapy¹⁹ or a modified radical mastectomy. They should also receive adjuvant tamoxifen as it has been shown to improve the control of local disease and survival in postmenopausal women.^{20,21}

In patients unfit for a general anaesthetic tamoxifen alone is satisfactory treatment for those whose tumours test positive for oestrogen receptors. This assay is now widely available and can be performed on the same fine needle aspirate as that taken to establish the diagnosis.⁹ Where this assay is not available or when the tumour is negative for oestrogen