NEWS

Prison service agrees to BMA talks

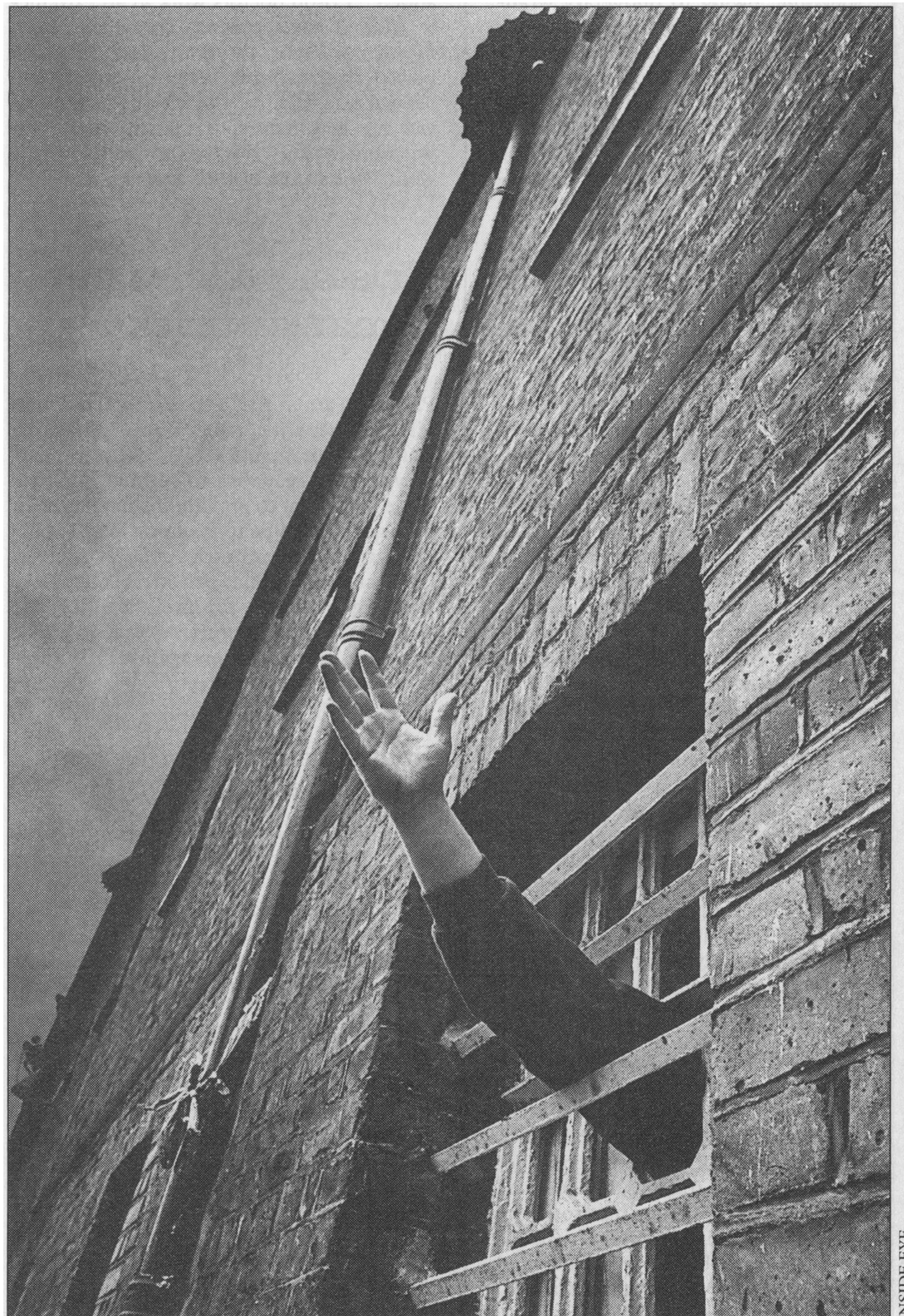
The prison service has finally agreed to undertake a detailed review of the terms and conditions of service for part time prison doctors. The move follows a threat from the BMA to "black box" future *BMJ* advertisements for these jobs.

The BMA says that morale among prison doctors has reached crisis level and that it has spent two years trying to persuade the prison service to discuss a major overhaul of part time prison medical officer posts. After an unsatisfactory meeting last autumn with prison service representatives the association announced that if a "serious package of proposals" was not forthcoming it might black box future job advertisements in the *BMJ*. This would mean that the journal would continue to carry the advertisements in the normal place, but that applicants would be recommended in the journal's Important Notice section to consult the BMA first.

A prison service survey last September established that eight prisons in England and Wales had been without a full time or part time medical officer and had to rely on locum help. In addition, the survey listed 30 vacancies for full time doctors and 30 part time vacancies. The BMA spoke of a "crisis of morale" and said that the large number of vacancies showed doctors' reluctance to accept what was seen as an "unattractive" package. A spokeswoman for the prison service said that the situation had since improved and that there were currently only 20 vacancies overall, covering full time and part time posts. The BMA's head of private practice and professional fees, Frank McKenna, said: "I think the prison service finally realised that they would have been left with a haemorrhage of medical officers and severe difficulties in maintaining the services provided to prisoners."

Members of the prison service last week agreed to begin talks with the BMA immediately on six key areas of concern for part time prison medical officers: the overall level of pay; the absence of any pay progression; the level of payment for night visits; the lack of pensions; the level of compensation for annual leave; and the level of on call payments.

The on call allowance is £717 a year and is for 365 days a year. The BMA wants a reduction in the overall number of potential days on call and better pay. Prison doctors are also keen to ensure that facilities in the service are equal to those in the NHS and that, allowing for the constraints of security, inmates are given privacy for consultations, examinations, and treatment.



INSIDE EYE

Prisoners need medical services

The prison environment is generally accepted to be an unusual and a stressful one. Many general practitioners who work part time in the prison service fear physical attack. One wrote to the BMA saying that doctors "resent the personal hostility shown by many inmates. Personal physical protection and a commitment by the governor to deal with such events is essential."

Dr Eric Godfrey, who recently resigned after 30 years as part time medical officer at Styal Prison for women, said: "There are enormous demands on one's time for example, to prescribe psychotropic drugs which are not medically indicated. An act of parliament says you have to go to the prison every single day. In addition, I was getting called on the phone almost every night. You need very sympathetic partners indeed for that."

Headlines

European Medicines Evaluation Agency opens: The European Medicines Agency is open for business in London one month behind schedule, owing to budgetary wrangles between the European institutions. The agency has set itself a target of 300 days to make a decision on new drugs submitted to it for centralised community licensing.

Britain will not end animal quarantine: The British government has said that it will not end the quarantine system whereby imported cats and dogs spend six months in confinement after entering Britain. This goes against a recommendation of the House of Commons agriculture committee that quarantine should be replaced by vaccination and blood testing for animals from European Union and other approved countries.

House of Commons starts inquiry into breast cancer services: The House of Commons health committee is inviting evidence for its inquiry into the quality and availability of breast cancer services in Britain. The inquiry will consider the progress made towards reducing mortality from breast cancer by 25% by 2000 and the role of clinical trials in evaluating new treatments.

Egypt releases female circumcision figures: The Egyptian Organisation of Human Rights says that up to 3600 girls are circumcised each day in Egypt, where the practice is legal if carried out by a doctor. The organisation says that 95% of girls under 16 in rural areas and 73% in Cairo have been circumcised.

Nurse dismissed for removing appendix is reinstated: Mrs Valerie Tomlinson, the British theatre nurse who removed a patient's appendix in an operation for which she had not received formal training, has received a final written warning from the Royal Cornwall Hospital Trust but will keep her job. She was supervised by a surgeon, Mr Tahir Bhatti, who has been suspended while South and West Regional Health Authority decides on disciplinary action.

Doctors' helpline launched: A national 24 hour helpline for doctors was launched in Britain this week. It will be staffed by more than 100 volunteer general practitioners and psychiatrists. The telephone number is 01623 491000.

The current pay structure also means that locum doctors are paid more than permanent part time prison medical officers. As a result, says the BMA, a "large number of part time prison medical officers have resigned their positions to work as locums, and some have left the service altogether."

Mr McKenna said that the BMA welcomed the latest agreement to talks, and added: "Prison doctors work in an extremely difficult environment. There have been major concerns about the lack of value placed on their professional experience and clinical expertise. As a result, the prison service has had increasing difficulty in attracting high quality doctors to perform this work."—CLAUDIA COURT, *BMJ*

Prison policies put inmates at risk

Prisoners are at risk of being infected with HIV and hepatitis, either through injecting drugs or homosexual activity. Governments vary in their response to combat this risk: some argue that to provide clean needles for prisoners would be to condone illegal activity. But in some countries such as Switzerland and Australia prisoners are given cleaning materials for their needles and syringes. In most countries people in prison are given less protection against HIV infection than non-prisoners.

England and Wales: Testing with consent

Testing for HIV among the prison population in England and Wales is voluntary, and no precise figures exist for prevalence of the virus. According to Her Majesty's Prison Service, however, about 35 prisoners are known to be HIV positive at any one time. An anonymous screening programme is currently under way.

In England and Wales 8% of the prison population is known to carry hepatitis B antibodies, and the figure rises to 18% among known drug users. No figures exist for the prevalence of hepatitis C in prisons.

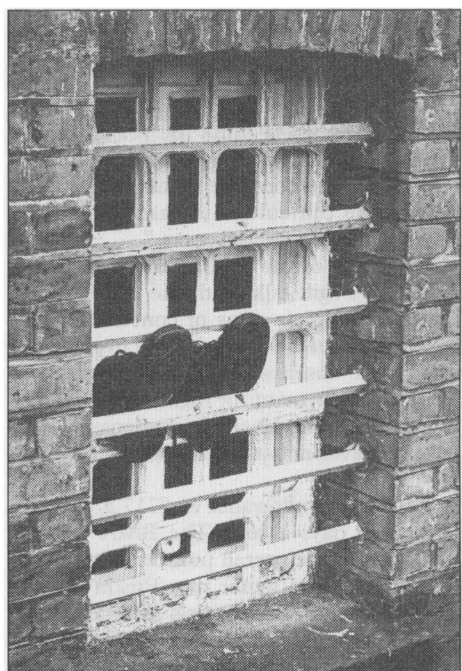
Both the prison service and the Prison Reform Trust accept that the illicit sharing of needles in prisons presents the biggest risk factor for cross infection of both HIV and hepatitis B. The prison service says: "Injecting drug misuse is one of the major factors because prisons receive a high proportion of those in society who have injected drugs at some time. The proportion of homosexuals would be no higher than in the population outside."

Testing for HIV is offered to inmates with their informed consent and after counselling. Those found to be HIV positive are not supposed to be treated differently, provided that they are healthy, but difficulties can arise if other prisoners learn about a person's HIV status. The prison service says that staff are not supposed to be told of a prisoner's HIV status because of medical confidentiality.

Attempts to minimise the spread of HIV and hepatitis B virus in prisons are made largely through education. All new prisoners can view educational videos on HIV and AIDS. Each prison has trained HIV counsellors, and inmates found to be infected are offered advice and help. Prison medical staff are trained in infection control and pass on their knowledge to staff in general, the service says. Vaccination against hepatitis B is currently offered to all staff and prisoners. Many recommendations have been made to reduce the spread of HIV, including those of the prison service's AIDS advisory committee, which are currently being considered. "The committee has made a thorough review of HIV procedures, including prevention of the spread of infection," the prison service says.

Several proposals have been for a needle exchange system in prisons, but none has been accepted. The prison service says: "There is evidence to suggest that many of those who have injected drugs before entering prison stop doing so once in prison. It is a question of balancing the risk of increasing injecting within a prison by providing needles, against the risk faced by the small number of inmates who continue to inject." Methadone maintenance is offered in prisons "as a matter of clinical judgment as to when and how it is used. The prison service is developing a new strategic approach to drug use in prisons, which will be implemented shortly, including enhanced treatment for drug users and increased security."

No general policy exists on dealing with prisoners with AIDS. Each case is considered on its merits, "and every effort is made to allow prisoners to spend their last days with dignity, which usually means transfer to an outside hospital or hospice," the prison service says. If a prisoner in the advanced stages of AIDS prefers to stay in prison then this wish is considered.—STEVE CONNOR, science correspondent, *Independent*


INSIDE EYE

British prisons are carrying out anonymous screening

Scotland: Learning from experience

A range of measures has been introduced in Scottish prisons in response to an outbreak of HIV infection that was spread by the sharing of contaminated drug injecting equipment in one of Scotland's jails. Thirteen prisoners who shared injecting equipment with an HIV positive inmate at Glenochil jail in 1993 have been found to be infected.

This is the first recorded incident of HIV infection being transmitted inside a British jail, and it led to prisons throughout Scotland being supplied with sterilising tablets to allow inmates to clean needles and syringes. Every prisoner is now given information on admission about the risks of injecting drugs. Detoxification and rehabilitation projects, based on the provision of methadone, have also been established at some jails.

Scotland has a high proportion of HIV positive injecting drug users, and fears had been expressed long before the Glenochil incident that the virus could spread within prisons. Despite attempts by prison staff to restrict the supply of drugs, injecting has continued in jails. Almost a third of prisoners who responded to a survey conducted by Strathclyde University's Addiction Research Group in 1991 said that they had injected while in prison.

Three quarters of this group said that they had shared injecting equipment. Eight of the 12 HIV positive inmates in the study group of 234 inmates were sharing needles. The researchers found that two of these men hired out their injecting equipment. The study concluded: "It is widely acknowledged within the prison system that drug free prisons are not a realistic goal; to suggest otherwise, and to develop a future strategy on such a basis, would be misleading and detrimental to ensuring stability within the prison population."

Another study, carried out by a team from Stirling University, found that the greatest risk of transmission of HIV infection came from sharing needles, since penetrative sexual intercourse in Scottish jails was "almost non-existent." It concluded that condoms were not widely needed but that the prison service must ensure greater use of programmes for needle sterilisation and substitution to limit the spread of infection. Tests for HIV infection are offered to prisoners on a voluntary and confidential basis, and testing programmes at Edinburgh's Saughton jail have shown that 4.5% of inmates are infected.

Scotland has never followed the policy set in England and Wales of segregating known HIV positive prisoners. But it does not offer the same services in prisons as are available outside. Prison authorities believe that needle exchanges in prison could increase rather than decrease drug injecting.

A project developed at Edinburgh's Saughton jail before the outbreak at Glenochil jail is being copied across the country. At Saughton an eight bed rehabilitation unit has been created where methadone is used to wean inmates off drugs.—BRYAN CHRISTIE, health correspondent, *Scotsman*

SCOTTISH DAILY RECORD AND SUNDAY MAIL

Glenochil prison : had the first recorded incident of HIV infection being transmitted in a British jail

Australia: Climbing the political agenda

The spread and management of HIV and hepatitis B and C in prisons has been high on the political agenda in Australia since researchers reported the first confirmed case of a prisoner contracting HIV through needle sharing. Federal health minister Dr Carmen Lawrence has asked each of the states of Australia, which administer separate prison systems, to ensure that prison inmates receive the same protection from AIDS as the rest of the community receives. She said that states had resisted introducing educational prevention schemes and providing condoms. But she stopped short of proposing a needle exchange scheme, which many AIDS organisations and experts want but which prison authorities and staff are strongly resisting.

The issue intensified when the Human Rights and Equal Opportunity Commission ordered the West Australian prisons department to stop discriminating against HIV positive prisoners by segregating them. A tribunal awarded two such inmates £5000 for hurt and humiliation.

Although medical policies and practice in prisons vary from state to state, New South Wales has the largest and certainly the most controversial jail system. It has a methadone programme for injecting drug users, provides bleach for cleaning needles, and is likely, following prisoners' legal action, to begin distributing condoms.

Dr Phillip Brown, chief executive officer of the state's Corrections Health Service, says that at any one time between 30 and 50 inmates among the prison population of 6500 are known to be HIV positive. Nationally the prevalence is less than 0.4%. Dr Brown puts the prevalence of hepatitis B and C as high as 50% because more than 75% of the state's prisoners are jailed for drug related crimes, and some continue to share needles in jail.

New South Wales is about to drop its obligatory HIV testing on entry and exit of the state's 28 jails and replace it with a voluntary scheme. HIV positive prisoners are not segregated but can anonymously move into a special "lifestyles" unit at Sydney's Long Bay Jail.

A confidential register of HIV positive prisoners is available, open only to those with a legal authority to know. Traditional educational schemes for prisoners and prison officers and peer support programmes are two methods used to minimise the spread of infection.

The intergovernmental committee on AIDS recommended in 1992 that all jails provide syringes, condoms, and bleach. But the New South Wales minister for justice, John Hannaford, said that there was no chance of a needle exchange scheme ever being introduced. His spokeswoman said, "What you're basically doing is giving prisoners a weapon. It's just like giving them a gun." Condoms are more likely to appear in New South Wales prisons following court action by prisoners who claim that the ban on condoms is a breach of the duty of care and an improper exercise of power by the department.

New South Wales is the only state with a methadone programme, currently serving 600 prisoners. Ms Dolan says that the programme reduces needle sharing and the spread of disease, but a further 2000 prisoners are not able to benefit. "It is very hard to get on the programme. Basically, if you do not come into prison on methadone you do not get on it," she said.

The state operates a compassionate release programme for prisoners in the terminal stages of AIDS. Dr Brown said that such inmates were usually chronically debilitated and admitted to a nursing home or other place of care.—CHRISTOPHER ZINN, Australian correspondent, *Guardian*

India: Campaigners urge check on spread of HIV

Prisoners in India are not tested for specific infectious diseases, although all prisoners undergo a medical examination when they begin their sentence. No studies of the prevalence of viral infections among prison inmates have been done at a national level.

Studies in selected state prisons over the past two years, however, have prompted health authorities and lawyers in India to campaign for medical policies to check the spread of HIV. India's National AIDS Control Organisation has a committee that is looking into the legal and ethical aspects of HIV infection and is also expected to release guidelines for policies in prisons.

India's HIV positive population is growing fast and is projected to reach at least four million by the end of this year, according to an estimate by the Indian Health Organisation, a non-government doctors' group.

A group of independent doctors sparked off a controversy in a prison in New Delhi last year over the supply of condoms to prisoners to prevent the homosexual spread of HIV. The doctors say that there is reason for concern about the spread of HIV infection and other sexually transmitted diseases through homosexual acts among inmates. But jail authorities claim that homosexuality is "virtually non-existent." A spokesperson for the Tihar jail in New Delhi said that the overcrowded and cramped conditions in jail were deterrents to homosexual activity.

Police officials also point out that prisoners in India cannot be legally provided with condoms because homosexuality is an offence under the Indian Penal Code of 1860. Any move to supply condoms to inmates could be interpreted as "aiding and abetting" this offence.

Prisoners in poor health and those who lose weight for no apparent reason are periodically examined by prison doctors. "But we cannot force a prisoner to be tested for HIV, hepatitis, or other infections," said Mahadu Naravane, inspector general of prisons in India's Maharashtra state. The 20 or so inmates who have been found to be positive for HIV so far from among Maharashtra's 25 000 prisoners are lodged in separate cells.

India's prison manuals provide for the segregation of prisoners suspected of having contagious diseases. Doctors and non-government organisations are campaigning against this. A few jails have established informal contacts with medical and social organisations for counselling of inmates to prevent the spread of infections.

Injecting drug use is not regarded as a problem in Indian prisons except in the north eastern state of Manipur, where at least several hundred injecting drug users lodged in state jails have been found to be positive for HIV. But no prison in India supplies syringes to its inmates. "The stress is on de-addiction, and many inmates are sent on de-addiction programmes in neighbouring hospitals," said a senior police official. —MEENAL MUDUR, freelance writer, New Delhi

Strategies to prevent the spread of HIV and hepatitis in prisons

	Methadone maintenance	Condoms provided	Needle exchange	Education and training	No segregation of HIVpositive prisoners	Voluntary HIV tests
Australia	Some	Some	No	Yes	Yes	Yes
Denmark	Some	Yes	No	Yes	Yes	N/A
England	Some	No	No	Yes	Yes	Yes
France	Some	Yes	No	N/A	Yes	Yes
Germany	Some	Yes	N/A	Yes	No	Yes
India	N/A	No	No	Some	No	No
Israel	Some	No	No	Yes	Some	Yes
Netherlands	Some	Some	Some	Yes	N/A	Yes
Scotland	Some	No	No	Yes	Yes	Yes
Thailand	No	No	No	N/A	Some	Some
US	Some	Some	No	Yes	N/A	Some

Yes   Some   No

Denmark: Opinion is divided

The spread of HIV infection and hepatitis among prisoners in Denmark is a serious problem, according to the chief physician in the prison service, Dr Knud Christensen. The guiding social principle that there should be no compulsory screening for such infections, no formal registers, and no totally unlinked testing means, however, that there are no reliable figures on prevalence.

There is a division of opinion over how to deal with the problem, and prison warders are currently opposing a proposal to make chlorine disinfectant available in prisons. Between a quarter and a third of prisoners are drug users.

Dr Christensen, in what he emphasises is a "very conservative" estimate, calculates that there are about 250 new cases of HIV infection among prisoners a year—about 7% of the total prison population.

The incidence seems to be almost entirely connected with drug misuse: the percentage of homosexuals in prison is probably low compared with that in the general population, and condoms have been freely available for several years. Dr Christensen believes that the incidence of hepatitis is probably greater.

Prisoners who declare themselves to be HIV positive are treated the same as other prisoners and can, for example, work in kitchens. "The Danish 'principle' is that we should behave towards everyone as if they were potentially HIV infected," said Alette Reventlow, deputy head of division in the Danish prison service.

The major difference is that prisoners do not have any access to the needle exchange and free syringe programmes that are widely available outside. The National Health Board has recommended the introduction of such services but is philosophical about the problems in doing so.

"It is hard to convince many members of prison staff to accept the double morality that, when drugs are forbidden, prisoners should be provided with the means that make it less dangerous to use them," said Reventlow. "Many Danish people find this inconsistent and unacceptable."

The authorities are concerned that making needles more readily available could encourage some new inmates to start injecting drugs for the first time, at a stage when they are particularly vulnerable.

Health information leaflets dispensed to prisoners warn of the risks of infection and recommend that syringes should be washed in water.

A working party is currently discussing the introduction of chlorine dispensers, in accordance with the World Health Organisation's guidelines. About 200 of the total of 3500 prison inmates are currently on methadone maintenance programmes, but these programmes are unlikely to be offered to people serving sentences of more than a year because of the requirement that there should be extensive social follow up.

Two prison inmates have died of AIDS to date, and both chose to remain in the prison hospital, where they had become close to the staff.—MARGARET DOLLEY, freelance journalist, Copenhagen

US: Injecting drug misuse is rare in prisons

Several different prison systems exist in the United States: a federal prison system, 50 state systems, and more than 3000 local jail systems (for short term imprisonment). Overall estimates of health care are therefore sparse. Some estimates do exist, however, about the state and federal systems of long term prisons.

Last June 1 012 851 Americans were recorded in state and federal prisons, according to the US Justice Department. About 90% were in state prisons. By March 1993, 11 565 cases of AIDS had been reported in those prisons, but the total is cumulative, as reporting of the disease began in the early 1980s. Thus AIDS is almost 10 times more common among prisoners than in the US population. No estimates exist of the extent of hepatitis B and C.

Sixteen of the 50 states and the federal government carry out mandatory HIV testing when inmates enter prisons. In one survey 77% of prisons reported that they offer voluntary testing. While many prisoners are at high risk of being infected with HIV before they enter prison, there is little transmission of HIV once prisoners are incarcerated, according to B Jaye Anno of the National Commission on Correctional Health Care, a non-profit making, private agency that develops standards for health services in prisons. Seroconversion rates in prisons run at about 0.5%, but Anno said that much of that reflects seroconversion of prisoners who were infected before they were jailed.

While there have been no formal studies of drug use in prisons, Anno said that injected drugs are rarely used in state and federal prisons because of higher security. No US prison supplies needles to prisoners. Although many local, short term jails allow methadone programmes, the prison systems do not, said Anno. Withdrawal is managed, however, through other treatments.

Sexual activity therefore remains the likeliest source of transmission of HIV, and five prison or local jail systems make condoms available to inmates: Mississippi, Vermont, New York City, San Francisco, and Philadelphia. A few states have laws that allow "compassionate release" of prisoners with terminal diseases, but few use them, so many AIDS patients die behind bars, according to Anno.—JOHN ROBERTS, North American editor, *BMJ*

France: one in five prisoners rejects voluntary HIV test

The latest survey indicates that 2.8% of the French penal population is infected with HIV. Carried out last July, it established that at least 1620 people out of a total of 57 000 were HIV positive, and 221 of them had clinical symptoms of AIDS. The survey is known to underestimate the prevalence of HIV infection because testing is carried out on a voluntary and anonymous basis and one in five prisoners refused to be tested.

In spite of a possibly wide margin of error, it is believed that the prevalence of infection, after reaching a peak of 5.8% in 1990, has declined, probably because of increased awareness of the risk of transmission from contaminated syringes and during unprotected homosexual relations. According to Erwan Le Garlantezec, a spokesman for the Ministry of Justice, the decrease is probably real and a result of information campaigns for the public at large as well as in prisons.

Condoms are issued in prison pharmacies and wards, and since last year their delivery to inmates who ask for them is mandatory. But no syringes are issued, nor is cleaning material such as chlorine offered because injecting drug use officially does not exist.

Screening for all infectious diseases, inside and outside prisons, is carried out on a voluntary basis and anonymously. Prison administrators have no statistics on the prevalence of hepatitis B and C, although it is known to be higher than in the general public.

Inmates who are known to be infected with HIV but are asymptomatic are followed up by a doctor but are not moved to special quarters.

Very sick or terminally ill patients with AIDS may be transferred to a hospital. In fact, says Le Garlantezec, it is beneficial for prisoners, particularly if they are not French nationals, to stay in prison because their treatment is fully covered by the Social Security's health insurance branch.

Until last year only those prisoners who were on methadone maintenance programmes before their imprisonment could continue such treatment in jail, but now such a programme can be initiated in prison.

Switzerland is the only European country where an experimental syringe exchange programme is available in prisons. The scheme was started at the Hindelbank women's penitentiary in Berne and at a prison in the small town of Oberschöngrün. In other Swiss prisons condoms are distributed and chlorine is made available together with instructions about cleaning needles.—ALEXANDER DOROZYNSKI, medical journalist, Paris

DAG OHRLUND/REX FEATURES

AIDS is 10 times more common among US prisoners than in the population

Netherlands: Potential HIV epidemic feared in jails

Researchers fear that there is the potential for an epidemic of HIV infection in the Netherlands' prisons, where each year up to half of the roughly 23 000 prisoners have a history of drug misuse. There is no compulsory testing for infection, but the Ministry of Justice estimates that between 800 and 1200 prisoners are HIV positive. This is based on the number of prisoners who admit to misuse of cocaine or heroin plus conservative estimates of injecting drug use and HIV infection among this group. Almost a third of Amsterdam's injecting drug users are believed to be HIV positive.

Results of voluntary testing showed 156 cases of HIV infection, 44 cases of AIDS, and 52 cases of hepatitis B in 1993. Few prisons have needle exchange schemes or methadone programmes. Normally prisoners undergo detoxification within two weeks of arrival.

Yet both officials at the Ministry of Justice and experts at the Dutch National Institute for Alcohol and Drugs accept that in reality drugs are injected and needles exchanged in Dutch prisons. Dr Hans de Man, the medical inspector for prisons, argues that all drugs can be eradicated only if all visitors are searched, cells are inspected daily, and urine testing is carried out.

It is hoped that the increased use of drug free wings in prisons will help to prevent the transmission of HIV. The idea is that long term convicted prisoners with a history of drug misuse can opt for a therapeutic programme in return for daily urine tests. There are 450 drug free cells in 14 different prison wings, and a three month waiting list. Amsterdam's drug treatment organisation Jellinek is proposing to build its own private drug free prison with 120 cells. —TONY SHELDON, freelance journalist, Utrecht

Germany: Approach varies widely between states

Estimates suggest that between 1% and 3% of prisoners in Germany may be HIV positive and that many of those probably became infected while in jail. Prisons in Germany are not supervised by the federal government but are managed by the 16 German states. Medical policy and practice therefore vary considerably.

Health experts from all the German states met for the first time in Bonn last year to discuss a common approach to dealing with drugs and infectious disease in prisons. Their report has not yet been published.

Only sporadic data are available on the prevalence of AIDS in German prisons. Last year 115 out of 4000 inmates in Berlin's prisons were registered as HIV positive, while in München-Stadelheim prison 11 out of 1700 were.

Out of about 60 000 prisoners in Germany, between 600 and 2000 may be HIV positive, and most of these are thought to have contracted HIV or hepatitis B virus, or both, in prison.

The sharing of needles by drug addicts is seen as the main transmission route of viral infections in prisons. The justice minister, Sabine Leutheusser-Schnarrenberger, estimates that about 15% of Germany's prisoners misuse drugs while in prison.

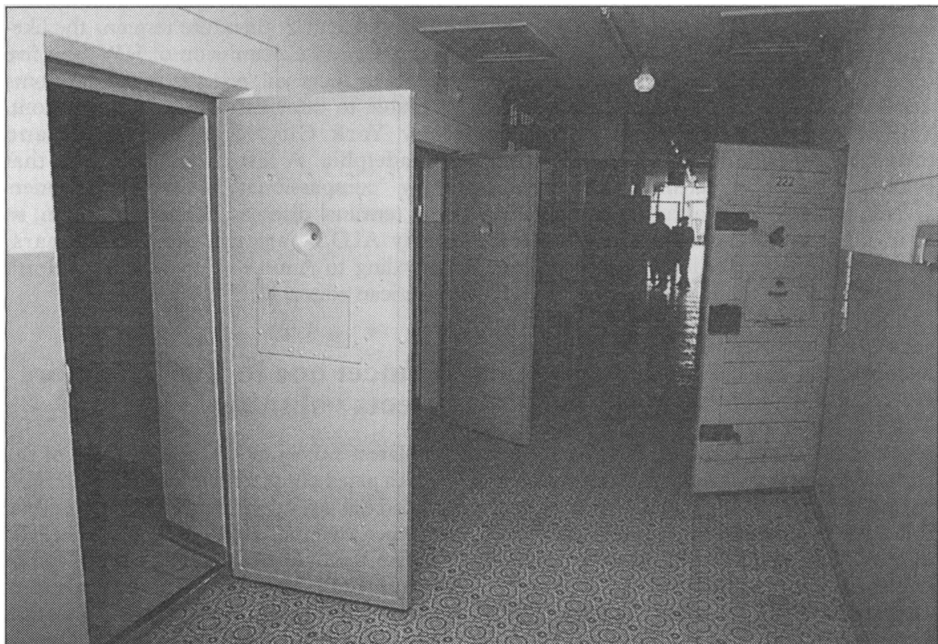
Prison authorities have been handing out instruction sheets on AIDS and offering routine HIV testing to consenting prisoners since 1985, when HIV tests became available. Participation in screening tests for HIV and hepatitis B and C, however, still varies between 40% and 96%.

In 1988 a special AIDS commission of the lower house of parliament (Bundestag) in Bonn recommended handing out disposable syringes to prisoners. But some prison doctors, like Dr Hermann Braun of Munich, see this as a "capitulation" of efforts to clean up prisons.

In Berlin a pilot study is being carried out, in which kits for cleaning syringes, but not syringes themselves, are issued to prisoners. All prisons in Germany already provide condoms.

All prisoners known to be HIV positive are housed in single cells. This does not necessarily mean that their HIV status becomes obvious to others, because single cells are common in German jails. Prisoners with AIDS, as all other ill prisoners, are treated in prison wards and can be discharged prematurely from prison in the terminal stage of the illness.

There are still wide variations between German states in their approach to methadone treatment for drug misusers. The most advanced maintenance programme was developed in Hamburg, where health insurers, family doctors, medical associations, and social services work together to provide methadone treatment for users. Seven other states provide methadone treatment on a more limited scale, and eight others, including the five new German states, do not allow it at all. —HELMUT L KARCHER, medical writer, Munich


FABRIZIO BENSCH/IMPACT

Prisoners in German jails often have single cells

Thailand: One hospital for HIV positive prisoners

Efforts to control the spread of viral diseases among prison populations in Thailand are centralised at a special 300 bed hospital at the main jail in Bangkok. The hospital, built at Klong Praem Prison on the outskirts of the Thai capital in the mid-1970s, now takes all HIV positive convicts from jails around the country as well as other seriously ill prisoners. Thailand has an estimated jail population of 100 000.

A special unit adjacent to the main hospital, which was built more recently and was intended for the strict segregation of all HIV positive prisoners, now accommodates 250 HIV infected prisoners who volunteer to stay apart from non-infected prisoners. This development reflects the fact that the Thai government introduced a policy of non-discrimination against HIV infected prisoners in the early 1990s.

A nationwide study of HIV infection that was conducted in the late 1980s and has since been discontinued included testing of prison inmates as part of an effort to characterise infection among the wider population. But the hospital director at Klong Praem Prison, Dr John Lerwitworapong, said: "We still can't estimate the prevalence of HIV, hepatitis B or C among the prison population as we have never performed a comprehensive testing programme. However, we do blood tests if there are medical indications or if the doctor who refers the prisoner to the hospital advises that we test for HIV infection. Most prisoners referred to us already have symptoms of AIDS or AIDS related conditions. The incidence of HIV infection among our inpatient population based on these test results runs at 20-30% (70 to 105 patients out of 350 inpatients in the 300 bed hospital)."

Dr Lerwitworapong said that rates of HIV infection at certain prisons—such as Banbud Prison, which was set up to take injecting drug users, including users of heroin—would be much higher. A group of prisoners at Klong Praem Prison who volunteer to give blood are tested for hepatitis B, and the incidence of this infection also stands at around 20-30%.

Dr Lerwitworapong said that the strict regime and the crowded conditions in Thai prisons—often one dormitory serves 20-30 people—help to prevent needle sharing and homosexual activity among injecting drug users. At Klong Praem only one case of HIV transmission in prison has been proved.

No programmes exist to distribute syringes, needle cleaning equipment, or condoms in Thai prisons. Dr Lerwitworapong said that with one member of staff to 16 prisoners in most Thai jails, implementation of such policies would be difficult. The Thai authorities say that they cannot afford to operate a methadone maintenance programme and that in any case it could lead to a prison black market.

Many prisoners with AIDS are granted early release owing to royal pardons.—PAUL HUNT, freelance journalist, Bangkok

Israel: All prisoners have voluntary HIV test

Since 1988, 72 inmates in Israel's prison system have been shown to be positive for HIV by tests carried out soon after their incarceration. So far no inmates have been found to have contracted HIV infection during their time in prison.

Dr Jacob Zighelboim, chief medical officer of the Israel prison service, says that there are currently 6000 offenders in the country's jails. The chief medical officer says that every prisoner is tested for HIV on arrival in prison. Tests for hepatitis B and C are performed only on prisoners who are at high risk of the disease.

Dr Zighelboim says that those who are infected with HIV mix freely with other prisoners during the day: "But at night, when certain behaviours such as covert drug use

and sexual encounters could occur despite our monitoring, we keep carriers together in a single cell or group of cells." The results of HIV tests are kept strictly confidential, he says. "But most carriers speak of it openly to fellow inmates and prison staff; they think they'll be treated more carefully and with more consideration."

Although some 80% of all criminal prisoners have a history of drug misuse, only about one in 10 have injected drugs; the rest swallowed pills or sniffed or smoked hard drugs. In addition, the chief medical officer maintains that, aside from homosexual prisoners, few heterosexual inmates are involved in homosexual acts. Thus the Israel prison service does not distribute either condoms or clean syringes to inmates. "We don't want to legitimise homosexuality or drug misuse, and in fact prisoners have not asked for them."

All new inmates receive pamphlets about HIV infection and hepatitis B and C. They also periodically attend lectures and workshops on these diseases and how to avoid them.—JUDY SIEGEL-ITZKOVICH, medical correspondent, *Jerusalem Post*

Emergency delays need urgent attention

Nearly one in five patients needing emergency treatment in British hospitals experience a delay in admission, says a report from the Clinical Standards Advisory Group published last week. In just over 40% of cases the delay was due to a lack of beds, but in one in six cases it was due to no doctors being available. In some hospitals only a third of patients seen as emergencies were admitted to a bed within four hours. The worst delays were seen in the four Thames health regions and the three regions bordering Greater London.

The Clinical Standards Advisory Group, an independent expert body set up to advise the government on standards of clinical care, found that hospitals that admitted most of their emergency patients within two hours had a lower mortality at 28 days.

The group carried out a study looking at urgent and emergency admissions to 38 hospitals picked at random from a stratified, representative sample of district health authorities. Teams of doctors and nurses spent a week in accident and emergency departments and admitting wards monitoring patients from their arrival to the start of definitive management. The group looked at nearly 8000 admissions.

Nearly 60% of emergency patients were seen by a doctor within 30 minutes, but the time taken to see patients varied twofold between the slowest and fastest hospitals. Most often the delay was due to doctors seeing other patients—delays were most common for patients referred by general practitioners as opposed to those arriving as emergencies by ambulance. The report suggests that such delays may be due to poor organisation of on take teams, with doctors in theatre or outpatient clinics.

The start of initial treatment, such as the administration of nebulisers for patients with acute asthma, was delayed in nearly one in 10 patients. Delay, which was defined as a wait of over one hour, was more common in patients with orthopaedic problems (13%) than in sick children (5%).The main reason in nearly half the cases was that no doctor was available.

The group makes over 30 recommendations for improvements. It notes that many accident and emergency departments are too small and that there are shortages of consultants and senior staff in these departments.

Nearly half of all admissions to hospital are urgent. The report accuses the NHS reforms of creating inequalities of funding whereby money is spent on elective procedures at the expense of emergency admissions. It says, "A more satisfactory balance in the funding formula should be struck so that hospitals are rewarded rather than penalised for treating urgent and emergency patients." It recommends that contracts should take into account the activity and quality of emergency services and that hospital managers must give these services the necessary priority.

The report is adamant that national guidelines for emergency services must be incorporated into local protocols and contracts. They should include time standards: more than 80% of patients should be seen by a doctor within one hour or more than 90% should be admitted within four hours. They should also incorporate issues of availability, and quality of treatment.

The Department of Health said that its new patient's charter advises patients admitted as emergencies that they can expect a bed "as soon as possible and certainly within three to four hours."—LUISA DILLNER, *BMJ*

Urgent and Emergency Admissions to Hospital is available from HMSO bookshops, price £10.

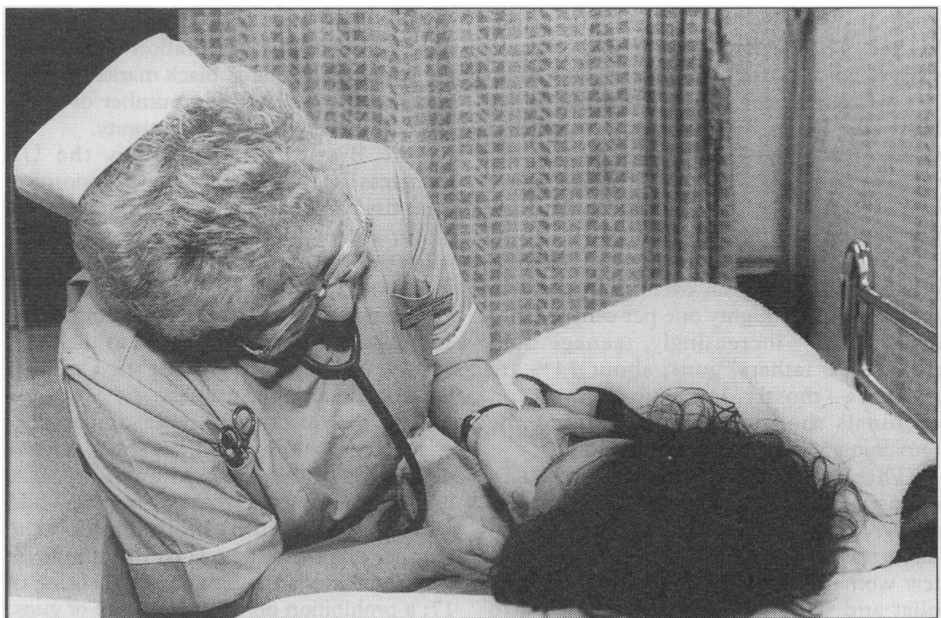
Wellcome waits for white knight

The future of the drug company Wellcome hangs in the balance this week as the company's board seeks a "white knight" bidder that can better Glaxo's £8.9bn offer. John Robb, chairman and chief executive of Wellcome, said that the bid had undervalued his company, which had hidden wealth in the form of new products. To underline this position Wellcome brought forward the launch of a new antiviral treatment for herpes, valcyclovir, the successor to its best seller acyclovir. The drug received regulatory approval in Britain and Ireland last week and was launched on Monday. On the same day the company said that it would bring forward publication of its annual results by more than a month to entice potential buyers.

Wellcome's board was unable to persuade the trustees of the Wellcome Trust to withdraw their "irrevocable commitment" to sell their 40% holding to Glaxo. But this commitment may be revoked if a better offer is made within 21 days of the posting of the document outlining the offer from Glaxo. The trust's decision will have to be cleared by the High Court, but this is unlikely to prove a problem as all trusts have a duty to maximise their income.

Mr Robb and his directors can take some comfort from the reaction by financial analysts in the city to Glaxo's proposals. After initial euphoria at the prospect of Britain's biggest ever takeover some analysts have decided that Glaxo's immediate prospects are not as rosy as the company claims, and the share price took a beating last week. Glaxo's biggest profits come from the antiulcer drug ranitidine, the world's biggest selling medicine, but the US patent on ranitidine expires in July 1997, leaving it open to competition from cheaper generic drugs.

Glaxo has admitted that sales of raniti-



The time taken to see patients varies twofold

dine have fallen for the first time over the past six months.

Acyclovir also loses its US patent in 1997. But the launch of Valtrex (the proprietory name of valcyclovir) makes Wellcome's position look far healthier. Whatever Wellcome's hidden value may be, the offer is well above the market's recent valuation of the company, which is about £6bn.

Glaxo's £9.4bn offer (including £500m in employee share options) represents 19 times its profits in 1994. Such offers are not unusual in drug industry takeovers: Roche bought Syntex last year for $5.3bn—27 times the target company's annual profits.

Unfortunately for Wellcome, there has been so much wheeling and dealing in the global drug industry lately, with over £30bn spent on takeovers in the past two years, that few of the big companies have the capital or the inclination to absorb another producer. The drug industry is under pressure worldwide as governments and medical institutions take action to protect themselves from spiralling health costs. The drugs industry has responded by massive restructuring: companies aim at reaching a critical mass, at which they will either be big enough simply to survive or big enough to buy up the middle companies that eat into their profits or to reach consumers direct by introducing drugs that will be approved for over the counter sale.

Glaxo is Britain's biggest drug company and the world's second biggest after Merck, with a 3.6% share of the market. The acquisition of Wellcome would make it a clear world leader with a 5.3% market share. —OWEN DYER, freelance journalist, London

Britain will not ban baby milk adverts

Campaigners for breast feeding in Britain are angry at the government's refusal to implement new regulations on the promotion of infant formulas. Health and food ministers have retreated from their earlier agreement to ban advertisements for baby milks directed at mothers and pregnant women. Advertisements will continue to be allowed in publications distributed through the health care system. A European Union directive last year stated that such advertisements should be restricted to professional and scientific journals.

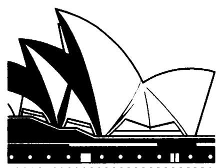
The government's decision not to implement the directive fully comes after a year's consultation and is seen as a victory for the baby food companies. The regulations that the government has agreed to will become law on 1 March. They cover the composition, labelling, and marketing of infant formula but are less strict in dealing with follow on formula. The Department of Health says that under the new law pharmacies will not be regarded as part of the health care system. It is not clear if the law will stop pharmacies giving advice or distributing booklets produced by manufacturers.

Rosemary Dodds, policy officer of the National Childbirth Trust, said: "We are very disappointed. It is a lost opportunity." Patti Rundall of the pressure group Baby Milk Action said that the government had ignored the BMA, the British Paediatric Association, and the Royal College of Midwives and had taken account only of the demands of the baby food industry.

The Ministry of Agriculture, Fisheries and Food received 210 letters in favour of an advertising ban and only 13 against, of which 10 were from baby food companies and advertising agencies.—JOHN WARDEN, parliamentary correspondent

Focus: Sydney

Gun control: bang or whimper at March election?



During New South Wales's elections in March the usual phalanx of single issue parties will be hoping to join the three independents, two Democrats, and two Call to Australia Christians who between them hold the balance of power in the two parliamentary houses. The performance of two of these parties holds particular interest for public health workers: the new No Aircraft Noise Party (see Focus 3 December, p 1464) and the Shooters' Party. Only 144 000 votes will win the Shooters' Party a seat in the upper house, where they may be able to frustrate gun control reform.

Around 600 people die in Australia from gun wounds each year, over 150 more than die from AIDS. Eighty one per cent of these are suicides—increasingly, teenage boys using their fathers' guns; about 14% are murders—mostly domestic killings and criminals shooting each other; and the remaining 5% are accidental shootings.

The Shooters' Party was formed to oppose a gun control programme that has massive popular support. The typical Shooters' Party spokesman (it seems to have few women) regularly holds forth on populist and country radio about arming to defend his family from burglars, rapists, and invading Asian armies. He distinguishes between criminals and ordinary, law abiding gun owners. His idea of gun control is for doctors to report all "mentally unbalanced" patients to a central register of loonies who would not then be able to get a gun licence. He virulently opposes the registration of firearms (which has routinely occurred with cars, boats, and even dogs for decades). And he embraces a popular antibureaucratic rhetoric that effectively disguises the real concerns: that gun registration would ruin the huge, tax avoiding, black market in guns and reveal the disturbing number of mini-arsenals throughout the community.

The Brady Bill, passed by the US Congress in 1994 after massive opposition from the National Rifle Association, provided for a cooling off period of seven days, when the criminal records of handgun applicants could be checked. The National Rifle Association saw this as the beginning of the end. The Shooters' Party views in the same way the charter for reform of the Coalition for Gun Control in Australia.

The charter calls for national, computerised registration of all firearms; stricter definitions of the "need to own" a gun; a ban on private ownership of automatic and semiautomatic guns; limitations on the number of guns to be owned by an individual; a minimum age for shooter licensing of 17; a prohibition on the private sale of guns; and the confiscation of guns where an aggravated violence order is issued. Some members also want a ban on the storage of guns in urban homes.

The most likely person to be shot by a gun in a home is the owner, followed by members of his family. The shooting of intruders is rare. The gun lobby's equation of gun violence with criminality doesn't allow it to see how reducing access to guns can lower the suicide rate. There is good evidence that when accessible means of suicide are denied (as in the detoxification of town gas in the UK) the overall suicide rate goes down. When suicide is attempted with a gun it is usually successful. Parasuicide is far more common in women than men, largely because women tend not to use guns. Consequently, suicide rates among women are far lower.

Although "routine" domestic violence and suicides comprise most deaths from guns, it is dramatic sieges and shopping centre rampages that accelerate community and political concern to tighten gun laws. There have been a dozen or so of these in the 1990s around Australia, and most of them have been carried out by men who would never have been registered on any proposed "loony list."

It is certain that more will occur. The gun lobby must be praying that the next one doesn't happen before March.—SIMON CHAPMAN, associate professor of community medicine, Sydney