Soutar and Ginsberg cite the 18% cross reactivity noted for Org 10172 in the series of Chong *et al*,⁵ but they have not appreciated that this study used a panel of stored serum samples, which represents a totally different situation. Any positive reactions found under these circumstances or by pretesting serum from a patient with heparin induced thrombocytopenia would preclude that patient from receiving the cross reacting drug, thus minimising the chances of a clinical disaster. It is these patients who show cross reactions, and those for whom doubt exists because a test was not done, who can alternatively be treated with ancrod or perhaps prostacyclin or hirudin analogues. Long term use of these drugs—for example, for renal dialysis or haemofiltration and in pregnancy—is usually, however, not possible.

In a continuing study of 350 named patients with heparin induced thrombocytopenia, of whom about three quarters had a thromboembolic complication or required urgent anticoagulation for a vascular operation or invasive procedure, over 93% were successfully treated with Org 10172. Five patients developed a cross reaction on testing, with thrombocytopenia persisting or recurring after one to six days' treatment. Only one of these patients suffered a non-fatal thrombotic clinical event. Two other patients developed thrombotic events soon after starting Org 10172, but testing for cross reactivity was not possible and the causal relation with the drug is unclear.

At present there is no absolutely safe replacement treatment for patients who develop heparin induced thrombocytopenia. All possible alternatives have one or more drawbacks. But even without prior testing for cross reactivity, which is always recommended but often not possible in the time available, Org 10172 is at least as safe and effective as ancrod and can be used in a wider variety of clinical situations.

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Anabolic steroids in sport

EDITOR,—John Gunn asks for scientific evidence of the benefits of anabolic steroids for people participating in competitive sport.¹ Haupt and Rovere reviewed published studies examining the effects of anabolic steroids.² They concluded that they showed no improvement in aerobic performance and were inconsistent with regard to the effects on strength; strength did increase if there was intensive training before and throughout periods when anabolic steroids were used. Landry and Primos drew similar conclusions in a more recent review.³

The most carefully conducted research was probably undertaken at the Sports Institute in Leipzig under state plan 14.25. The BBC *Horizon* documentary "A Question of Sport," transmitted on 8 June 1992, stated that some data avoided destruction around the time the Berlin Wall came down (a transcript is available from PO Box 7, London W3 6XJ). To our knowledge the surviving evidence has not been published. In our opinion

the political sensitivity of the issue, and the reputations of the athletes concerned, should not preclude publication.

All published studies examining use of steroids have been seriously flawed. Given the worldwide epidemic of use of anabolic steroids among athletes at all levels of competition, Perry *et al* have argued that controlled, double blind studies of the efficacy and dangers of high dose anabolic steroids are now ethically justified.⁴ The doses used by bodybuilders and others in Britain probably greatly exceed those needed for optimum benefit (if there is any benefit). Showing this might result in a reduction in doses and the risk of side effects. As belief in the efficacy of anabolic steroids has been reinforced by the fact that a user won an Olympic gold medal, only clear evidence of ineffectiveness is likely to deter current and future users.

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HIV and insurance

Catch 22

EDITOR,—The question of HIV testing and insurance gives rise to Catch 22. A spokesman for Commercial Union is quoted as saying, "The vast majority of people who are willing to go and have a test would do so because they feel that they had put themselves at risk in some way."¹

I applied for an income protection scheme recommended through BMA services and was told that I would have an HIV test. I said that although I was perfectly happy to have a test I must decline on the grounds that I would never again be able to answer that question asked by all insurance companies—"Have you ever had an HIV test?"—in the negative. I therefore do not have this form of insurance.

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- 1 Insurers inconsistent over HIV. *BMJ* 1993;306:1495-8. (5 June.)

Just say no

EDITOR,—I believe that the situation concerning HIV and insurers in Britain is actually far worse than is portrayed in a recent news article.¹ As a member of a low risk group who applied for life insurance recently and who honestly answered "no" to the standard screening question—"Have you ever had an HIV test?"—I was amazed that my wife and I were both automatically expected to take an HIV antibody test as a condition of possible cover. An obligatory test for all those asking for cover above a certain value was not mentioned on the application form.

The form I was expected to sign agreeing to the test contained a few paragraphs of information concerning HIV illness, which apparently took the place of any counselling. I was also expected to provide the name of a doctor to whom the insurers should write if HIV antibodies were found in the sample. Further investigation by my broker elicited the fact that illness related to HIV infection was in any case excluded from the cover offered.

This situation seems to me to be outrageous as people applying for cover are expected, without

warning or counselling, to undergo an investigation that is both potentially catastrophic to them and superfluous to the insurers. I now plan to obtain insurance from another firm, which does not demand a test for the amount of cover I require.

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- 1 Insurers inconsistent over HIV. *BMJ* 1993;306:1495-8. (5 June.)

Insurers don't penalise if test result is negative

EDITOR,—The news article entitled "Insurers inconsistent over HIV" unfairly criticises the British insurance industry.¹ The British industry is certainly consistent on its stance on AIDS and HIV, in no small measure because of the chief medical officers of life insurance companies.

The Association of British Insurers has stated unequivocally that a person will not be declined cover or charged more solely on the basis of a negative result of an HIV test, any more than he or she would be on the basis of a negative result of any other medical test such as intravenous pyelography, electrocardiography, or a blood glucose test for diabetes. Every doctor knows that a negative result does not guarantee that a disease or the potential for a disease to occur has been precluded; it is the underlying reason for any test, be it routine or clinical, that has to be assessed, and the same applies to HIV tests.

If an applicant who has had a negative HIV test result is charged an extra premium or is declined for life assurance cover, it will always be because of the presence of risk factors—be they risks of disease, lifestyle, or occupation—and not because of the negative result. If there are no other conditions than the negative HIV test result, that is the end of the matter.

Although the recent report by Day, which is the latest in a series of predictions, states that earlier projections regarding the increase in cases of AIDS and HIV infection have not been borne out,² this does not remove the difficulties for life insurance companies, which are writing business for the long term, where the future for HIV infection is still largely unknown. Insurers have a duty to look to the long term interest of policyholders. This duty extends to the assessment of the risk to ensure that, while it is equitable to all, it takes account of the fact that an insurer cannot alter the terms of a life insurance contract, which may run for 10, 15, or 20 years or more once it has been issued. Even with this careful selection, less than 1% of people are declined life insurance cover and only about 4% pay an additional rate of premium because of an increased health risk.

More and more people are having an HIV test for a wide range of reasons. In cooperation with the Department of Health, the Association of British Insurers advised its members that when there is a negative result of a routine HIV test—for example, during antenatal screening—the person can spell out clearly the circumstances surrounding the test. If it was a routine test and the result was negative no further information will be sought.

The article attempts to compare life insurance practices with regard to HIV in several countries, but medical practice varies considerably throughout the world. Insurance differs similarly, not only in the types of business sold but also because of the legal framework of the countries and the differing medical practices, which are reflected in insurance practice. Comparisons between countries can be made only after consideration of all the facts, otherwise the true picture is not given.

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- 1 Insurers inconsistent over HIV. *BMJ* 1993;306:1495-8. (5 June.)
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Confidentiality for doctors with AIDS

EDITOR,—A recent article in the *Independent* gave not only the name of a doctor dying of AIDS but what amounts to a précis of his entire curriculum vitae.¹

Under the new set of guidelines issued last month by the Department of Health the employer has a duty of confidentiality to the HIV positive employee in such cases. The employer has no legal right to release the employee's name without consent unless it is deemed to be in the public interest. If the doctor concerned was so sick that he was not able to assist the investigation was he really in a fit state to give such consent? Perhaps public interest amounts to what is likely to sell a tabloid.

How can Greater Glasgow Health Board justify its action in releasing the man's name? This action can hardly be expected to encourage doctors who suspect that they might be HIV positive to come forward, especially as it comes so soon after the release of the guidelines.

The newspaper quotes a BMA spokesperson as trying to allay public anxiety. Quite rightly. But isn't it time that the profession did something to allay the anxiety of sick doctors? Insisting that confidentiality is respected as it would be for any other patient would be a positive start: we would deplore it if any other patient was treated in such a way. Sadly, it seems that a medical degree takes away such rights and the need for compassion.

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- 1 Cusick J. Hospital doctor dying of AIDS. *Independent* 1993; May 27:10.

Doctors' HIV risk difficult to quantify

EDITOR,—In their editorial on the revised guidelines for health care workers infected with HIV A Graham Bird and Sheila M Gore recommend that studies should be carried out in which trained observers record hazardous exposures in operating theatres and these records are then compared with self reporting by staff.¹

To quantify risks of exposure to blood and body fluids for operating theatre staff we undertook a detailed survey in 1991, which highlighted the difficulties in estimating risk that such studies may pose. Theatre staff self reported incidents involving likely exposure to blood or body fluids during 2341 consecutive procedures over two months. Sixty five procedures were observed directly by an occupational health nurse or doctor. Surgeons also completed an anonymous questionnaire recalling the number of exposures during the second month of the survey, and 1737 used surgical gloves were collected after 293 consecutive routine procedures and tested for perforations. The variation in rates of apparent exposure produced by surveying the same population over the same period by different methods (table) made it impossible to quantify the risk to staff and raises questions about the value of these methods of assessing risk.

During our survey it became apparent that staff modified work practices while being observed, and it was difficult to observe effectively surgery performed in abdominal or pelvic cavities or done by several operators. In addition, the response rate

Rate of incident or injury involving likely exposure to blood or body fluids according to method of survey

	Method of survey		
	Self reporting	Observation	Retrospective questionnaire
No of procedures	2341	65	1142
Type of incident (no/100 procedures):			
Contamination of intact skin	2.5	8	23
Contamination of mucous membrane	1	1	4
Sharps injury	0.4	0	8
All exposures	4	9	35

to the questionnaire was low (55%)—a recurring problem found in questionnaire surveys of health care workers. Perforation of a glove occurred more commonly than other types of incident (29 perforations/100 procedures), but it was not possible to assess how many perforations resulted in the wearer being exposed to the patient's blood.

It has been difficult to compare our results with those of other surveys^{2,3} as there are differences in the specialties surveyed, the types of procedure undertaken, operating techniques, and protective clothing worn.

We recommend that surgeons should be encouraged to report to their occupational health departments, confidentially if necessary, those procedures that regularly place them at risk of exposure to blood. Occupational health professionals should work closely with theatre staff to devise and encourage use of appropriate preventive measures in reducing risks of cross infection despite the limitations of currently available methods of evaluation.

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Do we need more hospices?

EDITOR,—Claud F B Regnard criticises the continuing proliferation of inpatient hospices, arguing that they are an inefficient use of resources and that the present number of hospice beds—for patients with cancer at least—probably exceeds demand.¹ Most terminally ill patients with cancer wish to die at home, with only 15% wishing to die in a hospice.² The reality, however, is that almost half spend their last days in hospital, often in a busy acute ward.² As hospital doctors we often see terminally ill patients brought in by distressed relatives who are no longer able to care for them at home. Unfortunately, all too often there are neither hospice beds available nor the facilities in the community to provide the extra support required.

Regnard argues for a limited number of regional hospice centres, which could educate carers both in the community and in hospitals and direct resources effectively into the community. We agree with this in principle. Though the public will donate money to hospices in their local area, however, they may be reluctant to do so for a large

regional unit with little direct link with them. Also, can it be guaranteed that all the local government funding that would have gone to local hospices would find its way to these larger units? Finally, who would provide the extra funding required to buffer this transfer of resources from existing small hospices to larger units?

The expectations of the public for good quality palliative care will, rightly, continue to increase. We in the caring professions must endeavour to meet these demands. The trend for a continuing proliferation of hospices is not the ideal solution but will be difficult to reverse.

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Working part time is rewarding and fun

EDITOR,—I am one of the fortunate 200 people who have had a part time career registrar post created for me under the EL(91)5 scheme. This was indeed a simple (albeit long winded) process, as Trish Groves suggests.¹ I was fortunate in the support and encouragement I received from both the personnel department of my regional health authority and my supervising consultant.

I have never enjoyed a job so much, perhaps because I am not too tired to reap the benefits fully. Learning is fun, and life as a junior doctor in training should be a rewarding educational experience. But there is a service commitment to fulfil, and this should be integrated into, and not in direct competition with, the education of a junior doctor. When I was in full time training I, like all my colleagues, relied on precious evenings off and weekends to study for postgraduate examinations, to read the medical press, and, if I felt really enthusiastic, to write some papers. This "overtime" is an essential element in any doctor's continuing education, but it does not mix well with family life.

I am contracted to work seven sessions a week. I "work" from 9 am to 6 pm five days a week and am on call about once a fortnight. Within this framework I use the spare time to do what most full time doctors do in their overtime. My overtime is spent with my partner and children. As a result my life, like that of Trish Greenhalgh, is "happy, fulfilling, and mostly stress free."² It is said that one has to work part time to achieve this enviable goal of satisfaction in one's professional and personal lives. It is also regrettable that three quarters of my salary is used to pay a full time nanny.

Once we can eliminate the stigma of part time work and persuade the royal colleges that seven sessions with ample time to educate oneself and keep up to date are worth well over half the training gained in a full time post, we will be in a strong position to reverse the current attrition of women from 50% at medical school to 16% at consultant grade.¹ To achieve equal numbers of men and women consultants, however, we must await the unlikely scenario of government sponsored creche facilities at work.

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