Recording HIV status on police computers

SIR,—J K Mason's editorial on recording people's HIV status on police computers cries out for correction.¹ I have been a police surgeon in London for nearly 17 years and have seen over 9000 people at the request of the police; most have been prisoners in custody. From time to time the custody officer says, "Doc, be careful, he's got HIV." I always ask how the officer knows, and the reply is invariably, "It's on the computer"; I have never heard of any validation. Equally often, the prisoner angrily denies being HIV positive or having provided the information.

I am the first to admit that people in custody do not always tell the truth and often change their stories. My experience, however, is so much at variance with the comfortable official line that Mason quotes with approval that I am not comforted by the editorial's conclusions. In fact, in the short report from which Mason quotes three of the seven people (57%) thought by the police to be HIV positive were not.²

I can see no reason for the police to record this information at all. In practice, the infection will be spread by only two activities, neither of which should occur in police stations. In my experience contamination of wounds with infected blood is exceedingly rare; all blood should be treated as infected anyway, whatever is on the computer. The label "HIV positive," whether true or not, serves only to increase tension in an already tense situation.

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1 Mason JK. Recording HIV status on police computers. *BMJ* 1992;304:995-6. (18 April.)

2 Sadler DW, Pounder DJ, Urquhart GED, Porter-Boveri M. Prevalence of HIV antibody in forensic cases. *BMJ* 1992;304:1027-8. (18 April.)

SIR,—As an occupational physician and a forensic medical examiner I share J K Mason's views on recording people's HIV status on police computers.¹ There is, however, room for improvement.

On several occasions I have seen the fact that a prisoner is positive for HIV recorded on the board commonly found in the charge rooms of the Metropolitan Police to facilitate the requirements of the Police and Criminal Evidence Act. This is to remind custody officers of the hazard, but the board may be read by anybody in the room; this may include other detainees as well as police staff. I regard this as too public; an indication outside the cell door would be more appropriate and would restrict the information to officers and others on a need to know basis.

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SIR,—As a doctor who has researched into HIV infection and the risk of exposure for health care staff, I was dismayed by J K Mason's editorial on recording people's HIV status on police computers.¹

Firstly, under international law people with HIV infection and AIDS have the right of liberty and security of person and the right to privacy.² Both of these rights are violated when police store information concerning a person's HIV status that may then be accessed. More outrageous is the fact that when such information is obtained from a third party the person concerned is not subsequently asked for his or her consent for it to be stored on a computer. This raises many ethical questions about how this has been allowed to occur without public debate.

In contrast, medical professional bodies insist on maintaining confidentiality and obtaining proper informed consent and counselling subjects before HIV testing. Only recently an ethics review committee failed to approve a protocol for a clinical trial that included HIV testing of volunteers, on the grounds that such information could expose the volunteers to potentially punitive actions from several sources.

I agree that the police are at risk, but how many documented cases exist of transmission of HIV to police compared with figures obtained for health care workers? Reports state that in a medical setting the maximum risk of acquiring HIV infection after sustaining a puncture wound or splash injury is 0.5% or 1 in 500 exposures, so in real terms the risk to a member of the police force must be marginal.³ To minimise their risk of exposure to HIV health care staff have adopted good laboratory safety practice. Could the police not minimise their risk by treating all people as potential sources of infection?

Mason states that knowing a person's HIV status allows police who may have been exposed to the virus to be counselled and given prophylaxis with zidovudine. Surely, it is adequate for a HIV test to be performed in cases in which exposure may have occurred, as is current practice among health care staff.

In conclusion, why are doctors going to such lengths to protect their patients' rights when police have access to sensitive personal data via a computer screen, and in some cases such access may be without the subject's consent or knowledge? Should such inconsistencies be tolerated in our society?

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1 Mason JK. Recording HIV status on police computers. *BMJ* 1992;304:995-6. (18 April.)

2 UK declaration of the rights of people with HIV and AIDS. *BMJ* 1991;303:541.

3 Seef LB, Wright EC, Zimmerman HJ, Alter HJ, Dietz AA, Selscher BF, et al. Type B hepatitis after needle-stick exposure. *Ann Intern Med* 1978;88:285.

SIR,—In the editorial on recording people's HIV status on police computers J K Mason assures us that "offenders' rights to privacy are protected . . . on current evidence. . . ." The author fails, however, to present any evidence that convincingly supports this assertion.

Firstly, Mason states that "the holding of sensitive personal data in police computers therefore seems to be tightly regulated." Can this be true when millions of inquiries are made each year? Random checks are made, we are told, but data on how often these are performed and how often access is found to have been gained without good reason are lacking. Are any sanctions taken against

officers found to be abusing the system? This crucial information is lacking.

The fact that most information is volunteered is beside the point; some is not and may be placed on record without the person's knowledge or consent. Furthermore, as David W Sadler and colleagues point out, this information may be in error.¹ To dismiss this worrying observation as immaterial because it was not based on the computer records is fallacious; the data in a computer are only as good as the data entered into it, which presumably are the same as those held by the police (albeit in an unspecified way) in Sadler and colleagues' article.

The issue of risk to police officers needs to be justified by some data. How common are events that might pose a risk of infection? Are these documented? Given that most such events must surely involve people who are not listed on the police computer or whose records cannot be accessed before the event occurs, how many such events does flagging records really prevent? Police officers need to treat all people as potentially infectious if they are to protect themselves. Mason suggests that informing a pathologist before a necropsy that a body may be HIV positive is comparable in terms of HIV testing. This is clearly not true: the subject of a necropsy has little to lose, whereas the suspect (not "offender" as stated) does.

Surely the real issue is whether the fact that the police may hold, and have readily available, medical information such as HIV status may prejudice the just and fair treatment of those with HIV infection. I fear that it might and find no evidence in Mason's article to reassure me.

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1 Mason JK. Recording HIV status on police computers. *BMJ* 1992;304:995-6. (18 April.)

2 Sadler DW, Pounder DJ, Urquhart GED, Porter-Boveri M. HIV antibody prevalence in forensic fatalities. *BMJ* 1992;304:1027-8. (18 April.)

Cholera: getting the message across

SIR,—Bernard Dixon appeals to medical microbiologists to redirect efforts towards simple measures to control cholera.¹ Similar thinking lay behind the innovative campaign against cholera led by the Centro de Investigación de Enfermedades Tropicales, an international centre for the epidemiology of tropical diseases in the faculty of medicine of the Universidad Autónoma de Guerrero in Acapulco, Mexico. Although the centre is one of the leading Latin American centres in immunoepidemiology and uses modern research techniques like the polymerase chain reaction, its approach to cholera included mobilising university students in a community based education programme and establishing a network of inexpensive diagnostic facilities throughout the state of Guerrero.

At the request of the university's rector, and without any additional funding, the centre mobilised and trained 23 000 university students, who travelled to hundreds of remote communities to give advice on preventing cholera and on low cost or no cost techniques to treat all diarrhoeal