concentrations in the cerebrospinal fluid necessary for success. Alternative treatments for these forms of meningitis are therefore much needed, and good clinical results are being reported with the newer cephalosporins. In the United States moxalactam has been extensively studied,^{18,19} and is being evaluated in a multicentre study by the Neonatal Meningitis Cooperative Study Group using a loading dose of 100 mg/kg followed by 50 mg/kg four to 12 hourly depending on the baby's age. One drawback of this compound is its relatively feeble action on Gram positive cocci, making it unsuitable for single drug therapy in meningitis of unknown cause. Experience with cefotaxime is also accumulating rapidly.^{14,20} Individual susceptibility testing remains essential in choosing the correct drug for meningitis but the newer cephalosporins are now important additions to the drugs available for Gram negative bacillary meningitis.

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Doctors and the police

Britain is almost unique in having no written constitution. Among the advantages of our "elective dictatorship"¹ is the relative ease with which public health legislation has been introduced—though the prolonged opposition by Members of Parliament to legislation on drinking and driving and seat belts suggests that they do not always need a written constitution to remind them of human rights and personal freedom. The disadvantage is that parliament can legislate on such issues without the restraining hand of the courts as guardians of the constitution. In the United States, for example, President Reagan's Bill requiring doctors to notify the parents of girls under 18 attending for contraceptive advice was promptly ruled unconstitutional by the courts. Amendment of a written constitution takes much more time and justification than parliamentary legislation, and a two party system committed to issues such as the closed shop and the abolition of private practice on the one hand and law and order on the other can place human rights and freedom in jeopardy.

The Police and Criminal Evidence Bill, currently completing its committee stage, has revived these issues in that it authorises the disclosure of confidential information to the police and the carrying out of intimate body searches without the consent of the person concerned. It is therefore important to go back to the report of the Royal Commission on Criminal Procedure,² on which the government claims that the Bill is based, to see what are the justifications for introducing these new powers. No reference to medical records or doctors is to be found in the section dealing with disclosure of information, and it is difficult to believe that the commission intended such powers to extend to medical records without having referred to the most sensitive information of all.

The commission was concerned that where "information is held on a confidential basis the holder may be unwilling to disclose it for fear of being sued in breach of duty by the person from whom he received it." In other words the commission was dealing with the legal consequences of disclosure and there is no evidence that the ethical constraint was considered. Even so, the commission emphasised that the power "should be granted only in exceptional circumstances and in respect of grave offences," and "only as a last resort." Both this power and the powers relating to intimate body searches and the taking of intimate body samples are subject under the Bill to cases where there is suspicion that a "serious arrestable offence" has been committed. The definition is obscure and is left to the discretion of a police officer "of at least the rank of superintendent." The royal commission concluded that such searches should be carried out "only by a medical practitioner and only in respect of the most serious offences." The Bill provides that where the purpose of the search is to obtain evidence of a serious arrestable offence (as opposed to the prevention of injury to the suspect) an immediate search can be made by a medical practitioner or a lay person of the same sex when the police officer concerned believes that any delay in carrying out the search for the purpose of providing legal advice might compromise the evidence, alert other suspects, or hinder the recovery of property.

The ethical position of a doctor invited to carry out an intimate body search for the purpose of providing evidence in support of a criminal prosecution is that it should be done only with the full, free, and informed consent of the suspect. If a suspect is told that he is going to be examined anyway his

consent to examination by a medical practitioner rather than the station sergeant falls a long way short of full, free, and informed consent. In the case of intimate body samples the Bill does provide that consent must be given and the sample has to be taken by a medical practitioner. Nevertheless, the Bill refers simply to "written consent," and this does not leave the doctor the discretion to satisfy himself that the suspect has given full, free, and informed consent to the sample being taken. This should be a required precondition to taking intimate body samples for the purpose of providing evidence for a criminal prosecution.

The most unsettling aspect of the powers affecting the doctor-patient relationship in this Bill is that no case has been made out for their justification. No evidence has been provided that the police have experienced any serious difficulty in securing the cooperation of doctors when circumstances justify it. So far as the disclosure of confidential information is concerned, an informal agreement reached between the

Association of Chief Police Officers and the BMA was in the process of being adopted nationwide and had already provided the police with important information in some well known cases. The procedure worked speedily and effectively. The possibilities of abuse of the powers provided in this Bill are considerable, and, as a joint letter to *The Times* from the secretaries of the BMA and Law Society pointed out recently,³ the police themselves are not adequately protected against the consequences.

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¹ Hailsham of Saint Marylebone, Quintin McGarel Hogg, Baron. *The dilemma of democracy: diagnosis and prescription*. London: Collins, 1978: ch 20.

² Royal Commission on Criminal Procedure. *Report*. London: HMSO, 1981. (Cmnd 8092.)

³ Havard JDJ, Bowron JL. Concern at proposed body searches. *The Times* 1983 Feb 17: 11 (col 5-6).

Regular Review

Acquired immune deficiency syndrome

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New patterns of infectious disease are always interesting and sometimes alarming. The appearance of a syndrome with a high mortality and including not one but a whole range of infections is both interesting and alarming.¹⁻³ The interest is heightened by the syndrome including an unusual manifestation of an uncommon form of cancer, Kaposi's sarcoma.⁴ The syndrome occurs principally in homosexual men and first surfaced about 1979 in the form of major foci in the urban United States, particularly in New York and California.⁵⁻⁷ Of the first 300 patients described, 291 came from the United States and only nine from six other countries, but several of these had recently been in the United States.⁸⁻¹² More recently new reports have shown that the disease is now no longer confined to the United States nor entirely to homosexuals, nor to the male sex.¹³ Pathologically its essential basis is an acquired cellular immune deficiency, but the cause of this deficit at present eludes investigators, and, perhaps for this very reason, the malady excites an interest far beyond the columns of the medical press.¹⁴

The clinical picture is difficult to describe, or even to define, because of the diffuseness and incoherence of the syndrome.¹⁵ Of the first 300 patients, 290 were men, of whom over four fifths were under 45, and most were homosexuals.³ The 10 women were predominantly heterosexual. Patients may present with a pneumonia eventually diagnosed as due to *Pneumocystis carinii* or with Kaposi's sarcoma, or with both. Many patients, however, appear to have had fever, lymphadenopathy, loss of weight, and diarrhoea before the principal illness, especially before the pneumocystis pneumonia. Of the 300 patients mentioned above, 135 had pneumocystis

pneumonia as the principal illness, 115 had Kaposi's sarcoma, and 28 had both. The remaining 22 had various opportunistic infections.³ Some two fifths of the earlier patients are now dead, and the overall mortality is expected to reach 70%. A few patients have presented with autoimmune disease, particularly thrombocytopenic purpura, with antibodies directed against the platelets.¹⁶ These patients have reduced helper: suppressor T cell ratios. This may be a clinical pathway alternative to the main syndrome, which seems to end in Kaposi's sarcoma if the patient has not been picked off on the way by a fatal opportunistic infection, of which pneumocystis pneumonia appears to be the commonest. Either pneumocystis pneumonia or Kaposi's sarcoma may be accompanied by various other infections.

The cardinal feature is the occurrence of infections which test the host's cellular rather than humoral immunity and which are normally seen only in patients who are naturally or artificially immunocompromised—since their common denominator is the dependence of the host on an effective cellular immunity to combat them. Abnormal or florid forms may also be seen of infections which occur in a more usual guise even in normal people. A striking feature is the range of infectious agents that have been identified. These include protozoa (for example, *P. carinii*¹⁷⁻¹⁹ and *Entamoeba histolytica*; yeasts (for example, *Candida albicans* and *Cryptococcus neoformans*); bacteria (for example, *Mycobacterium avium-intracellulare*)²⁰; and viruses (for example, *Herpesvirus hominis*, genital warts, and cytomegalovirus). Even Kaposi's sarcoma²¹ is not entirely out of step with this pattern, because there is growing evidence for its association with a virus,