with England and Wales, where only 7000-8000 are notified to the Home Office yearly (though the actual number may be five to 10 times greater), is dangerous if we assume that experience of issuing its needles, syringes, and opiates to drug takers is relevant to us. Thirdly, Dr Moss seems unaware that intravenous drug misusers in this country have encountered few, if any, barriers in obtaining needles and syringes. In many areas of the country needles and syringes may be bought from chemists at a cost that is insignificant when compared with the expenses of drug misuse generally.

I would argue that there is a considerable risk that issuing free needles and syringes will increase this mode of self administration of drugs in the United Kingdom. If schemes are designed to restrict the issue of needles and syringes to established intravenous drug takers we would miss the most vulnerable intravenous misusers: those just starting to inject themselves. Though I share the concern of the government and many other agencies about HIV infection and the acquired immune deficiency syndrome, I would question the value of current proposed countermeasures and wonder whether we would be better to debate more pertinent issues, such as the compulsory treatment of the population at risk, as occurs elsewhere.¹

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Who may give blood?

SIR,—Controversy surrounds the selection and testing of blood donors. We write to provide details of our case, which was cited by Dr Marcela Contreras (17 January, p 176) and has been the subject of considerable speculation elsewhere.

The donor gave blood in April, August, and October 1986. The October donation was shown to contain antibody to human immunodeficiency virus (HIV) by competitive electroimmunoassay (Wellcozyme) (confirmable by Western blotting). An archive aliquot from the August donation was examined in the reference laboratory but contained no antibody to HIV as shown by competitive electroimmunoassay, Western blotting, or assay for specific antibody to the HIV envelope and core (Abbott Laboratories). A test has recently become available for p24 antigen, but a borderline result was obtained. Two patients had received the donation. One showed seroconversion to HIV and the other had antibody to HIV 14 weeks after transfusion, although he was not a member of a risk group. There seem to be only two published reports of transmission of HIV by blood definitely negative for antibody to HIV to recipients with no other risk factors,¹ though other cases are apparently under investigation.

No evidence of either HIV antigen or antibody was found in the April donation by the same techniques. Both recipients subsequently died, but an archive specimen from the platelet recipient 52 days after transfusion was negative for antigen and antibody. Accordingly, we have no evidence that this donation was infective.

Subsequently, after an interview, the donor was assigned to a recognised risk group. This incident would not have been prevented by Dr Dawson's proposals to extend the risk groups. Before a test for HIV antigen may be regarded as a useful additional screen it will need much shorter incubation times and must give clearly positive results with infective blood like the August donation.

Marlink *et al* showed the usefulness of Western blot in early seroconversion,² but even the Western blot yielded negative results for the infected donation. This finding must not be used to justify the use of insensitive screens for antibody to HIV as specimens from other patients have reacted weakly to electroimmunoassay during seroconversion.

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AIDS and life years lost: one district's challenge

SIR,—Health authorities are being told that combating the acquired immune deficiency syndrome (AIDS) should be made a priority. Therefore resources are going to have to be diverted, particularly to the traditionally underfunded services of genitourinary medicine and health education. How big this transfer should be raises the question of how important AIDS is compared with other threats to health. We tried to answer this question objectively by calculating Lewisham and North Southwark's expectations of life years lost because of AIDS and other conditions over the next five years.

tion and of the disease's incubation period.⁴ We used a combination of the first two methods.

McEvoy and Tillet's log-linear model may be used with confidence only to 1988 (H E Tillet, personal communication). American predictions to 1988 (Coolfant planning conference, 4-6 June 1986) may be used to predict figures for the United Kingdom from 1989 on the basis of a three year time lag and 1:4 population ratio.³ The proportion of cases in the United Kingdom attributable to our district was assumed to remain the same as up to 1985, when our 10 cases represented about 2% of the national total. The death rate was taken as 28% during the year of presentation and 55% in the following year,¹ with a further 6% and 3% in subsequent years, to approach the four year mortality of 92%.⁵

Life years lost for AIDS and seven other conditions were calculated, with a life expectancy of 70 years being assumed. Years lost equalled 70 minus the age of death if under 70 years. Deaths over 70 were disregarded. The number of deaths and age at death for conditions other than AIDS were taken from district figures for 1985. The average age at death from AIDS was assumed to remain at the present level of 37 years.

The table shows the seven leading causes of life

Seven leading causes of life years lost in Lewisham and North Southwark in 1985

Condition (ICD No)	No of deaths	Life years lost (to age 70)
Ischaemic heart disease (410-11)	948	2340
Respiratory tract cancer (140-9, 161-2)	314	1365
Suicide (E950-9)	39	915
Road traffic accidents (E810-9)	35	900
Cerebrovascular disease (430-8)	397	670
Breast cancer (174)	87	550
Chronic obstructive airways disease (490-2, 494-6)	220	545

Leading causes of life years lost and AIDS in Lewisham and North Southwark 1986-90. The life years lost for AIDS are based on predicted numbers of deaths from AIDS in the district of 7 in 1986, 15 in 1987, 32 in 1988, 57 in 1989, and 79 in 1990.

A combination of two methods was used: the fitting of epidemic predictions to AIDS cases nationally and locally and the calculation of life years lost for AIDS and other conditions. Nationally, three main methods of predicting the numbers of cases of AIDS have been described: the fitting of an epidemic curve,^{1,2} the application of the United States experience with a time lag,³ and the use of estimates of the existing infected popula-

tion and of the disease's incubation period.⁴ We used a combination of the first two methods. American predictions to 1988 (Coolfant planning conference, 4-6 June 1986) may be used to predict figures for the United Kingdom from 1989 on the basis of a three year time lag and 1:4 population ratio.³ The proportion of cases in the United Kingdom attributable to our district was assumed to remain the same as up to 1985, when our 10 cases represented about 2% of the national total. The death rate was taken as 28% during the year of presentation and 55% in the following year,¹ with a further 6% and 3% in subsequent years, to approach the four year mortality of 92%.⁵

The current leading causes of premature death

have been stable since at least 1974. This pattern is about to be altered quite abruptly by AIDS.

Our predictions make several assumptions. They will be overestimates if the current educational programme dramatically changes sexual habits or if an effective vaccine or treatment is found. They will be underestimates if the disease continues to spread unchecked through the large uninfected pool of heterosexuals, if there has been much underreporting, or if the incubation period is longer than 52 months.⁶ Given the evidence for the heterosexual spread of AIDS and the years taken to discover a vaccine for other viral conditions, we believe these predictions to be reasonably conservative.

Two issues arise from the picture shown by our figures. The current preponderance of ischaemic heart disease, lung cancer, and chronic obstructive airways disease stands out clearly. All of these conditions have a major smoking component, yet this preventable cause has been the subject of masterly inactivity for many years. Secondly, because AIDS will rank with the top causes of premature death within the next few years there is a massive need for preventive resources now. This need is being heeded to some extent by national advertising and the specific allocation of £20m. But such specific allocations tend to lead to the assumption that AIDS needs only these marginal resources. The pattern of premature death described here could well be used to change that thinking and encourage the local transfer of mainstream resources, ever frozen into traditional patterns of use.

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HIV antibody testing

SIR,—In their report of Henoch-Schönlein purpura associated with legionnaires' disease (24 January, p 220) Dr P W Bull and colleagues say that in view of the patient's social history skin biopsy was postponed pending the result of a test to determine whether he was positive or negative for antibody to human immunodeficiency virus (HIV). By the time they knew that the test had yielded negative results the skin eruption had faded, so a specimen could not be obtained for histological examination.

There are two important points to make about this report. Firstly, a negative test result for antibody to HIV should not be regarded as evidence of freedom from infection with that virus in a patient with a relevant social history; three months or more may elapse after infection before the test result becomes positive. Secondly, a patient should not be deprived of any necessary investigation pending the result of an HIV antibody test. In this particular case lack of a skin biopsy did not affect the patient's treatment and eventual recovery. In other circumstances, how-

ever, lack of one or more diagnostic tests could seriously impair diagnosis and treatment.

HIV is likely to spread. All doctors, nurses, and laboratory staff must therefore learn to look after patients and to handle their specimens safely without detriment to the care of patients. Experience in the United States and elsewhere in the past five years has shown that the risk to health workers of acquiring HIV from patients is exceedingly small. The recent publication by the health services advisory committee of the Health and Safety Commission on the labelling, transport, and reception of specimens, which should be read by all concerned, emphasises that there is a need to ensure that all specimens are safely contained and transported from the patient to the laboratory.

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Dally, O'Donnell, and the GMC

SIR,—I have no doubt that Dr Michael O'Donnell's article (14 February, p 451) will cause some anxiety. As I was not sitting on the professional conduct committee on the occasion to which he refers I cannot comment on the events he describes, which would, in any case, be improper, but I would like to comment on the principles.

Though it may not be clear to anyone reading the article, the professional conduct committee goes to considerable lengths to prevent any confidential matter used during its hearings being related to an identifiable individual unless a witness assures the committee that he or she has no objection. In some instances this can be achieved effectively by the committee allowing the witness to write down his name and address and thereafter referring to him by an initial. Alternatively, if the identity of the witness cannot be concealed in this way, the committee willingly goes into private session to hear sensitive evidence. There is no question of the committee treating confidential matters casually.

A more difficult problem arises, however, when evidence to be put before the committee derives from case records or other confidential sources. It is essential, for obvious reasons, that the respondent doctor must be able and willing to identify to those at the hearing the person to whom the records refer, and clearly, in the absence of the patient's consent, this constitutes a breach of confidentiality. In no such case will the public be aware of the patient's identity. It is the normal practice of the committee to insist that consent for disclosure should be sought from the patient concerned, but there are circumstances in which this may be impossible.

If the matter before the committee concerns the alleged improper prescribing of controlled drugs hundreds of patients may be affected, which makes it impracticable to contact every one, even if they can be found and are willing to consent to disclosure, which is less than certain in a case of this kind. It is, of course, quite untenable to suggest, as Dr O'Donnell does, that problems of confidentiality could be averted by changes in the drafting of charges. How could a matter relating to improper prescribing be considered without reference to the condition for which prescription was alleged to be necessary? Similarly, difficulties over consent may arise when a doctor is subject to a complaint from one of his patients, who will almost certainly refuse to allow the disclosure of medical information that would call into question the validity of his evidence against the doctor. In circumstances such as these the committee is faced with the choice of failing in its duty to ensure that

justice is done or accepting evidence of a confidential nature without the appropriate consent.

The blue book is not a statutory document but advice to the profession on how to conduct itself, which indicates that certain actions or omissions may render the doctor liable to a charge of having committed serious professional misconduct. At no point does it suggest that such a judgment is automatic, and a valid defence, such as serving the interest of the patient, may be acceptable. The same applies to the work of the professional conduct committee. It rarely admits evidence that would breach professional confidence, but it must retain the right to do so should the interests of justice demand it. In all circumstances such information will remain with the committee and its immediate associates, whose procedures are designed to prevent it from becoming public property.

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SIR,—May I suggest that in honour of Ms Wendy Savage a new verb be introduced into medical terminology: "to be savaged." In my view Dr Ann Dally has just been savaged by the General Medical Council (GMC).

It has been an open secret that the Home Office has been concerned about Dr Dally for some time as she is a private practitioner in drug dependence and she still prescribes injectable methadone. This is still an acceptable treatment but has recently been held to be less orthodox. (I would draw attention to the *Guidelines of Good Clinical Practice in the Treatment of Drug Dependence*. These guidelines are now apparently recognised, by the GMC at least, as a code of practice. In my opinion these guidelines are a useful first draft but would need much more work and much wider consultation before they would be suitable for anything approaching a code of practice, even supposing that we should have such codes in clinical practice.)

Until five years ago the state did not see that drug use was rapidly growing. Then, when the government did so, in a moral panic it embarked on a war against drugs. Sadly, the first victims of war are truth and justice. The government quite forgot and has still forgotten the need for adequate treatment facilities, including access to a clean, legal, and well regulated supply of drugs. Dr Dally continued to prescribe such drugs and met a very real need, which was not being served by the NHS.

The tribunals set up under the Misuse of Drugs Act, which could have prevented Dr Dally from prescribing controlled drugs, would not have been able to find her practice unacceptable. The GMC has taken a different view and for the second time found against Dr Dally.

I gave evidence for Dr Dally and was present to hear the end of her own evidence. I was asked about the ethics of treating privately patients dependent on drugs who did not seem to be able to afford such care. I had already been in correspondence with the GMC on this issue before I had any idea that I was to give evidence for Dr Dally. The chairman did not seem to appreciate the subtlety of my argument and asked me not to continue as there were reporters present and he did not wish my views to be attributed to a doctor or to the tribunal. I was and am still puzzled by his argument.

It struck me that the GMC is prosecutor, judge, jury, and executioner. The medical profession is as a whole hostile to drug dependent patients, and, as will happen with such an attitude, the carers are stigmatised as well. In cases where the care of drug dependent patients is at issue the GMC reflects this