## LETTERS


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## Priorities for reducing the burden of injuries in sport: the example of Australian Football

Belinda J Gabbe, Caroline F Finch and Peter A Cameron

**To the Editor:** Safe sports participation has become a key national issue, especially in view of the potential for concerns about safety to inhibit sports participation,[1] in a nation where obesity rates are rising[2] and more exercise is recommended.

Australians participate in many sports, but the safety of the football codes is especially criticised by the media and the community because of the intense focus on injuries to players at the elite level. This is particularly the case for Australian Football (AF) and its elite game, the Australian Football League (AFL).

National reports released in 2006 have identified AF as the sport most associated with injury admissions to hospital[3] and with private health insurance claims.[4] These have sparked media commentary about the safety of AF. Response to these injury reports prompted an unprecedented media release[5] from the country's peak sports medicine body, Sports Medicine Australia, detailing issues with the report figures, urging caution in their interpretation and supporting the efforts of the football codes in improving participant safety.

The modified version of the game (Auskick), which is played by children, has been shown to be safer,[6] but there is a progression to adult rules by the under-15 age group, and the umbrella of safety provided by modified rules is eventually gone, raising the question of how safe the non-modified version is. Recently released AFL figures suggest that injury rates at the elite level are at a historical low,[7] but the report provided insufficient information to assess whether this represents a significant decline since 1997, and the data are already one season behind. Equivalent information for the more than 450 000 adult, non-elite participants is not available.

Published literature related to injury prevention highlights a dearth of knowledge relating to the causes of injuries in non-elite participants and a very small evidence base for ways to prevent injuries in AF. With AF played almost exclusively in Australia, the onus to provide evidence for improving the safety of participation clearly falls on the stakeholders of the sport here. Gains in reducing both the public health impact of football injuries and the fear of injury associated with participation will only come from substantial investment in large-scale trials at the non-elite level, and a multidisciplinary approach to safety and injury issues across *all* levels of play. This will require active and committed collaboration of key stakeholders such as clinicians, allied health practitioners, researchers, clubs, sports administrators, coaches and the participants themselves.

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## Folate and vitamin $B_{12}$ in older Australians

Victoria Flood and Paul Mitchell

**To the Editor:** The recent viewpoint by Kamien[1] and letter by Gunasekera[2] rightly highlight the benefits of folate fortification and the unlikely occurrence of masking pernicious anaemia. Food Standards Australia New Zealand recently submitted a proposal supporting the mandatory fortification of bread-making flour to increase folate intakes in women of child-bearing age, with the aim of reducing the risk of children being born with neural tube defects.[3] This proposal has had extensive public comment and will be considered by the Australia and New Zealand Food Regulation Ministerial Council. Several public groups and individuals continue to raise concerns that higher dietary folate levels could increase $B_{12}$ deficiency. Our data, collected from a population-based sample of 2596 older people in the Blue Mountains region, from 1997 to 2000, do not suggest that this is a likely outcome.

We recently reported the prevalence of low serum vitamin $B_{12}$ levels in the Blue Mountains Eye Study cohort of people aged 50

**Mean serum vitamin $B_{12}$ levels in a population of older Australians, for various folate intakes (from diet and supplements) ($n = 2596$)**

| Folate intake | Mean serum $B_{12}$ (95% CI) adjusted for age and sex | Mean serum $B_{12}$ (95% CI) adjusted for age, sex and $B_{12}$ intake (diet and supplements) |
|---|---|---|
| Folate (µg DFE) | | |
| Quintile 1–4 (< 571.8) ($n = 2077$) | 273 (263–289) | 278 (267–289) |
| Quintile 5 (> 571.8) ($n = 519$) | 316 (295–337) | 297 (275–319) |
| *P* | < 0.001 | 0.132 |
| Folate cut-points | | |
| < 500 µg DFE ($n = 1828$) | 273 (261–284) | 278 (267–290) |
| 500–1000 µg DFE ($n = 645$) | 294 (276–314) | 289 (270–308) |
| > 1000 µg DFE ($n = 123$) | 346 (303–389) | 300 (253–348) |
| *P* for trend | < 0.001 | 0.239 |

DFE = dietary folate equivalents. ◆

years and older. We found that 22.9% had low serum $B_{12}$ levels (< 185 pmol/L).[4] New data from this study show that higher intakes of folate (from diet and supplements) did not increase the likelihood of low serum $B_{12}$ levels; in fact, people whose diets included folate in the highest quintile of intake had significantly higher serum $B_{12}$ levels than those consuming lower dietary folate (Box), after accounting for age and sex ($P < 0.001$). After also adjusting for vitamin $B_{12}$ from diet and supplements, there was no significant difference in mean serum $B_{12}$ levels for the various quintiles of folate intake.

We also investigated older people who reported consuming high amounts of folate (> 500 µg dietary folate equivalents [DFE] [$n = 645$] and > 1000 µg DFE [$n = 123$]) and found higher mean serum $B_{12}$ levels in these groups than in people who consumed < 500 µg DFE, after adjusting for age and sex ($P$ for trend < 0.001). After further adjustment for vitamin $B_{12}$ intake, there were no significant differences in mean serum $B_{12}$ levels for these high dietary folate intakes (Box).

We also examined the frequency of macrocytic anaemia in our cohort ($n = 6$; 0.2%); two of these had low serum $B_{12}$ levels (0.3% of subjects with low serum $B_{12}$ levels).

In the United States, where mandatory folate fortification began a decade ago, a study of the presence of anaemia in people with $B_{12}$ deficiency found no significant change in the proportion with anaemia before and after the introduction of mandatory fortification.[5]

Although many older Australians have low serum levels of vitamin $B_{12}$, our data show that higher intakes of folate do not increase the likelihood of low serum $B_{12}$ levels. Given the relatively high prevalence of low serum $B_{12}$ levels among older people, it would seem reasonable for this to be monitored more frequently in this age group. We suggest that this is not a valid concern that should prevent moves to proceed with mandatory folate fortification of key foods in Australia.

*Competing interests:* Victoria Flood and Paul Mitchell received a Kellogg's Research Grant 1998–2000.

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## Exposure to environmental tobacco smoke in cars increases the risk of persistent wheeze in adolescents

Peter D Sly, Marie Deverell, Merci M Kusel and Patrick G Holt

**To the Editor:** The adverse health effects of environmental tobacco smoke (ETS) are well documented. Workplaces are increasingly smoke-free, and restrictions on smoking in restaurants, pubs and clubs are increasing. Paediatricians counsel parents to make their children's home smoke-free and to smoke outside if they can not quit. In Australia, attention is turning to ETS exposure in cars, in the belief that the confined space may result in increased exposure, even if the windows are wound down. However, few, if any, objective data on the health effects of ETS exposure in cars have been published.

We report here the risks of current wheeze at the age of 14 years in children exposed to ETS in their parents' car. Questionnaire data were available from parents of 1427 children taking part in the 14-year assessment of a longitudinal birth cohort in Perth. Characteristics of the cohort have been described elsewhere.[1] Information about current wheeze (defined as the occurrence of wheeze in the previous 12 months) and asthma risk factors, including ETS exposure in the house and car, was obtained. Standard spirometry, methacholine challenge and skin prick tests to local aeroallergens were performed in 1400, 1334 and 1308 children, respectively. Current wheeze was reported in 191 children (14.0%) at the age of 14 years, compared with 537 (38.2%) when they were seen at 6 years of age. Persistent wheeze, at both 6 and 14 years of age, was reported in 145 children (10.2%).

ETS exposure in the parents' car was common. The 14.6% of children who were exposed at 14 years had increased risk of both current wheeze (odds ratio [OR], 1.55; 95% CI, 1.02–2.35; $P = 0.038$) and persistent wheeze (OR, 2.14; 95% CI, 1.34–3.42; $P = 0.001$). These risks were higher than those for ETS in the home: for the 8.9% of children exposed in the home, the OR for current wheeze was 1.33 (95% CI, 0.80–2.22; $P = 0.27$) and the OR for persistent wheeze was 1.98 (95% CI, 1.12–3.50; $P = 0.016$). Those with current wheeze and ETS exposure in the car had increased methacholine responsiveness: $PC_{20}$ (provocative concentration required to produce a 20% fall in forced expiratory volume in 1 second) was 5.9 mg/mL in children with ETS exposure compared with 15.2 mg/mL in those not exposed ($P = 0.004$). These effects were independent of sex and atopic status.

These data provide evidence that the community needs to be educated about the adverse health consequences of ETS exposure in cars and suggest that health care professionals should include such education in counselling sessions for families of children with asthma. Teenagers can escape ETS exposure in the home, either by removing themselves or by their parents smoking outside. However, children of this age and younger have no choice but to travel with their parents in the car, especially given the phenomenon of "mum's taxi" transporting children to school and extracurricular activities. Smoke-free cars are important for all children.

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## Immunisation coverage in refugee children

Kylee J Parsons, Maggi Osbourn, David N Durrheim and Murray T Webber

**To the Editor:** Refugees are a particularly marginalised group, often originating from countries where immunisation coverage is low.[1] As vaccine-preventable diseases such as hepatitis B and measles are endemic in both their countries of origin and the countries in which they spend time in displaced persons camps, the potential burden of disease for refugees is greater than for Australians.[2] It is important to determine whether our health systems provide refugees with access to optimal health care, including vaccines.

From May 2004, refugee families arriving in Newcastle, New South Wales, have attended the Newcastle Refugee Clinic, where, with the assistance of interpreters, health screening is provided and catch-up vaccination regimens are commenced according to the Australian Standard Vaccination Schedule.[3] Vaccines administered are documented in an appropriate personal health record. All age-appropriate vaccines are registered with the Australian Childhood Immunisation Register (ACIR). Families are provided with a copy of the catch-up schedule and, through interpreters, are advised to complete their vaccination schedule through a general practitioner. In NSW, general practices can obtain free vaccines for refugees through public health units.

In March and April 2006, there was an outbreak of measles in NSW. A review of ACIR records of refugee children seen over the previous 12 months (May 2005 to April 2006) at our clinic showed that, of the 35 children aged under 7 years, all were overdue for subsequent vaccinations, and only two children had received any additional vaccines after their Refugee Clinic visit. By contrast, vaccination coverage for all children in the Greater Newcastle area is high, and exceeds 90% for scheduled vaccines. Older members of refugee families also required additional vaccines, highlighting concerns that refugee families are not attending general practices for this basic preventive health care measure. While the reasons for this are unclear and need further research, it is likely that multiple factors, including lack of knowledge of the health system, lack of transport, no local government or community vaccination services, and lack of bulk billing by general practices, all play a role. Further, a number of local general practices have closed their books and do not accept new patients.

Consequently, catch-up vaccination sessions were conducted at the Refugee Clinic, and transport was provided. Home visits were conducted for families unable to attend these clinics. Seventy-seven people were vaccinated and 209 vaccine doses administered.

A thorough assessment of refugees for important medical and psychological conditions is merited soon after they arrive in Australia.[4] It is also essential that early access to general practice is secured for continuity of care and completion of vaccination. It is the responsibility of all — the Department of Immigration and Citizenship, contracted resettlement organisations, proposers, public health services and general practitioners — to ensure that vaccinations are accessible to newly arrived refugees. We believe they deserve the same protection against vaccine-preventable diseases as other Australians.

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## Mistakes and misconduct in the research literature: retractions just the tip of the iceberg

Alison Poulton

**To the Editor:** Post-publication audits of the quality of medical research studies are vitally important. I support the conjecture of Nath et al[1] that the small number of retractions for mistakes and misconduct (about 20 per year for articles published between 1982 and 2002) represents the tip of the iceberg.

I recently wrote a systematic review of studies (published between 1972 and 2005) of growth in children taking stimulant medication for attention deficit hyperactivity disorder (ADHD), and I was astounded by the poor quality of much of the research.[2,3] Of the 22 studies reviewed, I felt that 11 were flawed, either because their conclusions were not fully supported by the data, or because of poor methodology, or both. Some had quite subtle mistakes or misinterpretations, such as failure to consider that a child's height velocity might vary with duration of treatment (two studies). Others were more obvious; for example, a study with a design that introduced systematic errors. Two studies had negative findings associated with inappropriate controls; however, in both of these studies the suitability of the control data was fully discussed. Two studies appeared underpowered, but a full assessment of this could not be made because some of the essential information was either insufficiently detailed or completely lacking. There were three studies lacking any rigorous comparison with control data on which to base their conclusions.

I did not detect any trend for studies with unsupported conclusions or flawed methodology to be published in journals with higher impact factors (median impact factor in both groups, 3.9), suggesting that, while these journals might report a higher rate of retractions (as found by Nath et al[1]), it may not necessarily reflect a higher rate of mistakes or misconduct among their authors. Likewise, the number of authors and level of funding — pharmaceutical industry or otherwise — appeared to be similar between studies whose conclusions were judged as valid or invalid.

Nearly all of the more rigorously designed studies showed statistically significant slowing of growth in height during the first 1–3 years of treatment with stimulant medication.[2] By contrast, the flawed studies as a group supported the notion that stimulant

medication does not have any statistically or clinically significant effect on growth in height, the individual studies varying in the extent to which this was emphasised. None of the studies has been retracted, and it is likely that poor quality research has had a substantial influence on clinical opinion in this area.

I do not think that my sample is representative of the quality of medical literature as a whole. I have to admit that my decision to write the review was based on my perception of the poor calibre of many of the studies of growth in children with ADHD. However, I have no reason to believe that the level of poor quality research in my area of interest is unique.

While retractions are important, the medical readership also has a responsibility to evaluate the scientific validity of published studies and, when necessary, correspond with the journals.

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## In the wake of hospital inquiries: impact on staff and safety

Gavin H Mooney

**TO THE EDITOR:** Aspects of the article by Dunbar and his colleagues on the impact of hospital inquiries are disturbing.[1]

The abstract states, "In the aftermath of the inquiries, common themes included loss of trust in management and among clinical colleagues, and loss of trust from patients and the community". Rather, the loss of trust in these instances arose from fundamental problems with the culture in the organisations involved. It was this that led to the inquiries.

In the case of King Edward Memorial Hospital (KEMH), the Douglas Inquiry was set up to investigate obstetric and gynaecological services at the hospital between 1990 and 2000, and sought "to identify and assess the deficiencies in the provision of those services, over that period".[2]

But when the final report of the Douglas Inquiry was originally published in 2001,[2] there was a chapter missing, which was only released under Freedom of Information legislation in December last year. I have seen a copy of this "missing chapter", courtesy of *The West Australian* newspaper, which gained its release. It revealed various problems with clinical practices at KEMH, many of which were described as "very unsafe" and which had been going on throughout the 1990s. Nearly 100 cases were covered in this missing chapter, but these were only a small selection of the total adverse outcome events, including several deaths, that occurred over the decade.

And the reason for not releasing this chapter? It was kept secret for 5 years because of intense lobbying of the state government by members of the medical profession — to quote *The West Australian*, "The current State Government [caved] in to the medical lobby and kept secret the most crucial chapter".[3] Just before it was released, the President of the Australian Medical Association (WA) was still arguing against its release and was quoted as saying, "I can imagine that it would be very painful to these families who were involved and I very much doubt there is anything in it that would serve the public interest by releasing it now".[4] What about accountability? Transparency? Trust?

Dunbar et al state that, "At … KEMH, there were longstanding problems that had not caused harm".[1] This is an extraordinary comment given that an inquiry was thought necessary, and the clinical problems revealed by this inquiry stretched back over 10 years — during which time no action was taken — until a newly appointed chief executive officer at KEMH, Michael Moodie, blew the whistle.

What concerns me most about Dunbar and colleagues' article is that in the wake of these inquiries, the authors, who "include the Directors of Medical Services who went into the hospitals following these events" (ie, the inquiries), now seek to argue that such matters are best left to be dealt with internally by "health service providers".[1]

We need transparency in such matters. The health service "belongs" to the Australian people — or at least it ought to. It is not the doctors' health service. These inquiries and the details outlined by Dunbar and colleagues show that, in addressing these sorts of problems, we cannot have trust in most internal reporting systems in hospitals. We cannot trust some of our doctors.

When will they ever learn?

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### Geoffrey J Dobb

***IN REPLY:*** Mooney makes assertions in his letter and elsewhere[1] that cannot go unchallenged.

He is wrong in stating that the "missing chapter" from the Douglas Inquiry report[2] "was kept secret for 5 years because of intense lobbying of the state government by members of the medical profession". To quote the then Minister for Health, "… sections of the [inquiry's] report were withheld on advice from the Crown Solicitor, mainly for the protection of patients".[3] Detailed reasons for information provided to the inquiry being kept private were published in 2001.[4]

I stand by my statement that "I very much doubt there is anything in [the missing chapter] that would serve the public interest by releasing it now". The report on the Douglas Inquiry made 237 recommendations. The reality is that Dr Bill Beresford, who stepped in as Acting Chief Executive Officer (CEO) of King Edward Memorial Hospital (KEMH), did an outstanding job in implementing the report's recommendations and making a good but under-resourced hospital much better.

Mooney is also wrong to describe Michael Moodie as a whistleblower. He was the CEO of the hospital and accountable for the services it provided. The only person he would be blowing a whistle to was himself, if *he* failed to act. True, the problems stretched back over 10 years; many of the issues were highlighted in a report released in 1990.[5] Among these were the findings that "King Edward is understaffed by 5.2 FTE [full-time equivalent] generalist obstetricians and gynaecologists" and "… the after hours cover is inadequate and poten-

tially unsafe" (Vol. II, p152). I believe it was the failure to act by successive state governments and health ministers, who had the ultimate responsibility for provision of health services, that led to the problems at KEMH.

For at least a decade now, the need to collocate Western Australia's tertiary obstetric services with adult tertiary services has been advocated, so the increasing proportion of mothers with significant comorbidities, including diabetes, heart disease and substance misuse, can have optimum access to services, including adult intensive care. While this principle appears to have been accepted,[6] there has been no indication as yet of its implementation.

Mooney and the community *can* trust doctors; the lessons from the Douglas Inquiry have been learnt, and its recommendations implemented.

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## James A Dunbar, Prasuna Reddy, Bill Beresford, Wayne P Ramsey and Reginald S A Lord

***In reply:*** We are grateful to Mooney for drawing our attention to the "missing chapter" of the Douglas Inquiry report, which came to light after we had submitted our article for publication. Open and fully public inquiries are necessary for all parties involved.[1] To the best of our knowledge, the Douglas Inquiry is the most thorough review ever undertaken of clinical standards in an Australian hospital.[2] It is difficult to know how other hospitals would have compared over the same period.[3]

Our article concentrated on how these hospitals recovered, as organisations, to improve patient safety. We called for "open, honest, and timely investigation undertaken within the organisation", which avoids prolonging the recovery that, paradoxically, can make hospitals less safe.[4] In the United Kingdom, the General Medical Council enforces a national system that puts patient safety first and makes covering up for a poorly performing colleague an offence.[5,6] It also requires Directors of Medical Services to act in patients' best interests. Concerns about a colleague's performance are handled locally, because experience has demonstrated that this works best for patients and doctors.

We would like to see the proposed national registration body for health professionals in Australia make reporting such concerns obligatory.

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## Hendra virus infection in a veterinarian

### Paul Prociv

**To the Editor:** In their report of Hendra virus infection acquired by a veterinarian from an infected horse, Hanna et al[1] mention that the likely reservoir for this virus is fruit bats (*Pteropus* spp.), and suggest that transmission of the virus to horses may be via contamination of pasture by birth products from fruit bats.

During 5 years of fieldwork in north-eastern Australia for my PhD thesis on *Toxocara pteropodis*, an intestinal roundworm of flying foxes,[2] which included hundreds of hours observing fruit bats in their natural habitats, not once did I come across a case of natural birth or abortion in fruit bats away from their communal roosts ("camps"), which were always within pockets of dense forest, such as mangrove, eucalyptus or melaleuca swamps. Furthermore, the three coastal fruit bat species exhibited a short, well defined birthing season, generally over 3 weeks from late October through to November. The birthing season of the wide-ranging, inland little red flying fox, *P. scapulatus*, is 6 months out of phase with this; it produces its young in May[3] in remote inland camps. During birth, which is a short pro-

cess lasting usually less than an hour, the mother bat remains alone, quite separate from and ignored by her neighbours.

All my observations of flying fox births were during daylight hours, and in the camps. While it is possible that an individual female might give birth away from her camp while out feeding at night, this would seem to be such an isolated event as to exclude it from being a reliable, and therefore major, transmission route for the virus. Moreover, the first recorded cases of equine and human infection occurred in the month of September,[1] further diminishing the likelihood of birth products being the mode of transmission from bats.

On the other hand, while feeding in mango trees or on other exotic or native fruits and blossoms growing in horse paddocks, these bats do defecate and urinate frequently; this, to my mind, may be a more likely infection route. Resting in camps, individual bats urinate indiscriminately, contaminating any neighbours roosting below. While out collecting flying foxes for my research, I found it impossible to avoid aerial contamination by their excrement — although I do not recall ever experiencing symptoms suggestive of Hendra virus infection.

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## The Australian Health News Research Collaboration

Simon Chapman and Ross MacKenzie

**To the Editor:** The enormous influence of the news media on health issues is widely acknowledged,[1] and health and medicine rank among the most frequent topics covered.[2,3] This influence extends from the setting of personal health agendas to shaping public health policy. Health and medical agencies have an obvious interest in how their areas of concern are depicted, and health interest groups can use the news media as a means of influencing government policy and legislation.

Much of the existing research into the portrayal of health topics in the news has been based on newspapers and other print media, yet television is the most popular mass communication medium for Australians.[4] A study underway at the School of Public Health, University of Sydney, is investigating how television frames health stories, and how this influences personal, institutional and political priorities.

Since May 2005, all news, current affairs and "infotainment" programs concerned with health or medicine on five free-to-air Sydney television channels have been digitally recorded. Recordings are then indexed by category (date, program, broad topic, specific issue, and sources quoted) and stored in a large digital archive that will be used by researchers to undertake critical studies of media content, audience response and deconstruction, and studies of the journalistic framing process.

Early returns of the project include a study of media narratives in coverage of Kylie Minogue's recent breast cancer diagnosis, and an assessment of the impact of this reporting on bookings for breast cancer screenings by mammography in four states.[5] Other studies include media depiction of obesity and notions of personal responsibility and a recently commenced analysis of news discourse on prostate cancer screening.

Currently, the nearly 9000 news items collected address a broad range of topics including cancer, cardiovascular disease, environmental health, mental health, nutrition, obesity and medical technology.

We are keen to collaborate with agencies and researchers who wish to draw on this unique resource for research purposes.

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## The adventures of an alienist

Bruce H Peterson

**To the Editor:** I read with great interest Ellard's article "The adventures of an alienist" in the Journal's recent Christmas issue.[1]

Few have equalled or surpassed Ellard's contribution to Australian psychiatry. However, as the only member of the College Committee still living, I must take issue with his statement, "In the 1960s, David Maddison created the College virtually single-handedly". He was, of course, referring to the Australian and New Zealand College of Psychiatrists (the "Royal" prefix not granted until 1978).

In May 1962, Dr J D Russell, President of the Australian Association of Psychiatrists, moved at the Council meeting that "Council resolve to take the necessary action forthwith to convert the Association into a College".

The Council appointed a College Committee, consisting of Dr Russell, as Chairman, with Professor David Maddison, Dr Ian Simpson and myself to plan the "necessary action". At the Council's annual general meeting in September 1962, members approved the formation of a College and its memorandum and articles of association, and, after legal approval, the College was officially incorporated on 28 October 1963.

David Maddison was able to attend only some of the many meetings of the College Committee, but he did make a major contribution to our deliberations. Nevertheless, it could hardly be said that he "created the College virtually single-handedly".

**Bruce H Peterson,** Psychiatrist (retired)
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1 Ellard JHT. The adventures of an alienist. *Med J Aust* 2006; 185: 642-645. ❑

John H T Ellard

***In reply:*** I have no difficulty in accepting Peterson's comment. My view of what happened at the genesis of the College arose from the fact that, at the time, Professor Maddison and I were close friends and had many conversations about academia and its institutions. This led me to greater awareness of his contribution and less of the contribution of others. I should have been more careful in reaching my opinion.

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## Characteristics of Australian women who test positive for HIV: implications for giving test results

Carol A Hopkins, Rosey A Cummings, Tim R H Read and Christopher K Fairley

**To the Editor:** Improving clinical efficiency helps sexual health services deal with the demands of increasing rates of sexually transmitted infections.[1,2] Many Australian sexual health centres require all clients to return in person to obtain their HIV test results; legislation only requires those who test positive to return in person.[3] Giving HIV test results by phone to low-risk clients may improve efficiency.

We determined the proportion of women testing positive for HIV infection at Melbourne Sexual Health Centre (MSHC) between 1 January 1996 and 1 January 2006, and reviewed the files of those who tested positive to determine their risk factors for HIV acquisition.

In this period, 16 655 women were tested for HIV and 48 (0.29%) tested positive. For 11 of these 48 women (0.07%; 95% CI, 0.027%–0.10%), this was their first positive test. Six had been born in a high-prevalence country[4] and had had sexual contact in those countries (two in South Africa, one in Ethiopia, one in Zimbabwe, one in Kenya, and one in Thailand); two had a sexual partner with HIV; one had had sex with a resident of a high-prevalence country (Thailand); one had had sexual contact in Australia with a man from a high-prevalence country (South Africa); and one had had sex with a bisexual man. All these risk factors were recorded in the patient's history at the time of initial testing.

Of the 37 women who tested positive and whose initial HIV test was performed elsewhere, risk factors were documented for 34. Thirty-one women (91%) had similar risk factors to the 11 who had first tested positive at MSHC. All three women without identified risk factors at the time of testing subsequently discovered their male partners were known to have HIV.

We found that fewer than one in 1000 women attending MSHC tested positive for the first time, and all who did had clear risk factors. The upper 95% CI for testing positive among those without risk factors (ie, none in 16 655) was also extremely low and in the order of 1 in 1000.

In the light of these findings, it is difficult to justify providing all results in person. MSHC now provides HIV test results by telephone to women without risk factors. Women with unexpected, indeterminate or positive results are recalled. This requires sensitive management to minimise stress and anxiety.

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## Prisons: mental health institutions of the 21st century

Gordon R W Davies

**To the Editor:** The recent editorial by White and Whiteford raises the important issue of the need to provide more extensive and more effective mental health services for the prison population.[1]

However, their discussion of the reasons for the increased level of need does not consider one important problem that often results in the inappropriate imprisonment of people with mental illness. This is the frequent refusal of acute psychiatric units to accept mentally ill people referred by the courts.

I recently reviewed a series of 102 referrals for medicolegal assessement from Legal Aid New South Wales between February 1999 and March 2006. The results were presented at the 2006 meeting of the Forensic Section of the Australian and New Zealand College of Psychiatrists.[2]

Of the 55 patients meeting the criteria for mental illness under section 32 or 33 of the *Mental Health (Criminal Procedure) Act 1990* (NSW), 27 (49%) were seen in custody. For 14 of these patients, their incarceration had resulted from the failure of the local area heath service to accept patients for admission if they had drug-related exacerbations of mental illness. Hospital registrars would return patients to court with a certificate saying that they had no mental illness, even though some of them were currently under a community treatment order recommended by other professionals from the same mental health service.

To some extent, this may be because of the strict application of the guidelines for compulsory hospitalisation. These are more stringent than the criteria for defining mental illness under the Mental Health (Criminal Procedure) Act, but one is left with anomalous situations such as the one described above.

Important issues leading to this situation appear to be the presence of dual diagnoses (10 of the patients reviewed had a combination of psychosis and substance misuse) and violent behaviour. The rejection of violent patients reflects both occupational health and safety considerations in the context of inadequate resources and an industrial stance (usually informal) taken by the nursing staff.

It is therefore important that some of the additional resources recently committed by Australian governments to the reform of forensic mental health services be directed towards the provision of acute hospital inpatient services for disturbed patients, so that the incidence of imprisonment in the acutely disturbed psychiatric population is reduced. This is more humane and may be more cost-effective than simply applying all the resources within the prison system.

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## Patient privacy and Latin: my father's story

Katherine A Haley

**To the Editor:** My father, a retired general practitioner now 86 years old, continues to lament the fact that Latin terms have fallen out of use in medical practice. Even today, he can still recite the conjugation of Latin verbs without a mistake, and he likes to tell the story of how Latin helped a young teacher in the 1950s.

Although World War II had made it acceptable for single and widowed women to work (but not for equal pay with men!), women who continued to work after getting married were considered to be "stealing jobs" from men who needed to support their families. Today, a pregnancy without a marriage certificate does not even cause a raised eyebrow, but, back then, it condemned a girl to a lifetime of discrimination and gossip. Single pregnant girls went to stay with distant relatives or went to religious homes for "wayward girls".

One day, a GP colleague of my father telephoned seeking advice. He had a young, single, very distressed teacher in his surgery and he had just confirmed her pregnancy. She had told an all too common story about being "unofficially engaged" to her university-student boyfriend and not having the money to get married. Apparently, on finding out about the suspected pregnancy, the boyfriend had decided that this was the time to end their unofficial engagement. The young teacher was still unsure whether to have the baby adopted, try to find a supportive relative, or bring up the child herself.

The patient, being a full-time teacher with the Department of Education, was one of the few "lucky women" for whom society considered it acceptable to work and earn a living while married or with children. It was therefore very important that she keep her job. The medical certificate for her employer was to be a very important piece of paper.

My father advised his colleague to put the following words on the patient's medical certificate: "The patient is suffering from non-pseudocyesis and will be unfit for work for 3 months". The colleague was delighted with this diagnosis.

The teacher came to see her GP a short time later and reported that departmental leave had been approved and that her teaching colleagues had wished her well in her recovery. My father's colleague continued to chuckle about the diagnosis and enjoyed providing the additional leave certificates until full-term delivery, when the non-pseudocyesis miraculously disappeared.

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