

have decreased unilateral decision-making on the part of some doctors.^{3,4}

If the premise that the interests of the patients' loved ones is a consideration in the duty of care,¹ then we are risking the loss of patient autonomy in an unprecedented way. As a practising clinician, the majority of requests that I receive to hasten death are from relatives, not patients. These relatives ask that they be put out of their own misery by ending the patient's life prematurely. To do something to a patient for a third party, however concerned or distressed, is an unacceptable action for clinicians.

For the profession to credibly engage in the debate about end-of-life care, we must accept that we are part of the community and hence governed by its laws. There are reference points external to the profession by which we will be judged.

1. Hunt RW. Intention, the law, and clinical decision-making in terminal care [commentary]. *Med J Aust* 2001; 175: 516.
2. Douglas CD, Kerridge IH, Rainbird KJ, et al. The intention to hasten death: a survey of attitudes and practices of surgeons in Australia. *Med J Aust* 2001; 175: 511-515.
3. van der Wal G, Dillmann RJ. Euthanasia in the Netherlands. *BMJ* 1994; 308: 1346-1349.
4. van Thiel GJ, van Delden JJ, de Haan K, Huibers AK. Retrospective study of doctors' "end of life decisions" in caring for mentally handicapped people in institutions in The Netherlands. *BMJ* 1997; 315: 88-91. □

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IN REPLY: The survey by Douglas et al¹ indicated that, under the current criminal code, about one in three Australian general surgeons are at risk of prosecution for murder because of the way they treat their dying patients. It is likely that many other Australian doctors are similarly at risk of prosecution. This is a serious problem that raises important questions: Why are so many doctors breaking the law? Should these practices be kept covert or brought out into the open for audit and discussion? Is the law serving the needs and interests of dying patients, those who care for them, and the wider community?

Rather than argue that doctors are above the law, I have argued that the practice of medicine should be congruent with the law.² Laws have been established and refined over time so doctors can help their patients (eg, with procedures and the administration of drugs) in ways that are illegal for others. An integral part of the medical role involves the negotiation of life-death decisions. I believe murder laws should be refined to reflect the reality that some terminally ill patients want death as a release from suffering and seek the help of their doctor to provide this. Just as there are

differences between rape and making love, I see obvious differences between common murder and the hastening of death that doctors provide for terminally ill patients out of compassion, mercy, and respect for their wishes. Unfortunately, the ethics of current practices are difficult to elucidate because the existing law makes investigations problematic.

The current crude law does not reflect community values — Morgan Gallup polls indicate about 80% of Australians are in favour of allowing voluntary euthanasia in certain circumstances.³ As Currow observes, these widely held values are sometimes expressed by the relatives of dying patients. In my experience, however, these relatives are usually advocating for the patient's wishes and interests, rather than undermining patient autonomy. I support the established hospice tenet that "the family is the unit of care" and there is a duty to address the concerns not only of patients but also of their loved ones.

I think it is only a matter of time before politicians introduce the reforms that render the legal framework for terminal care more congruent with community values, the wishes of patients and their families, and current medical practices. These reforms should enable research, audit and the better regulation of end-of-life care.

1. Douglas CD, Kerridge IH, Rainbird KJ, et al. The intention to hasten death: a survey of attitudes and practices of surgeons in Australia. *Med J Aust* 2001; 175: 511-515.
2. Hunt RW. Intention, the law, and clinical decision-making in terminal care [commentary]. *Med J Aust* 2001; 175: 516.
3. Morgan poll. Finding No. 2933. *The Bulletin* 1996 Sep 17. □

HIV among injecting drug users of Indo-Chinese ethnicity in Victoria

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TO THE EDITOR: Australia has been successful so far in maintaining a low prevalence of HIV infection among injecting drug users (IDUs). This has been achieved by adopting a harm-reduction approach to the prevention of bloodborne virus transmission, including needle and syringe programs, methadone maintenance and peer-education. Sharing of needles and syringes has declined markedly: cross-sectional surveys among users of needle and syringe programs across Australia have

shown a decrease in the prevalence of reported sharing from 31% in 1995 to 15% in 1997.¹

However, there is evidence that among some subpopulations, especially those of Indo-Chinese origin, unsafe injecting practices remain common. In a survey of Indo-Chinese IDUs in Sydney and Melbourne, Maher et al reported that 22% of those surveyed had shared needles and syringes in the preceding month.² Although the Indo-Chinese community is becoming increasingly aware of issues related to drug use, IDUs are under-represented in drug treatment programs.³ There is also evidence that parents send their children back to their country of origin to escape the Australian heroin scene. In a Melbourne survey of Vietnamese IDUs, Kelsall et al reported that 19% of their sample (38 of 200) had returned to Vietnam during the previous five years for drug-related reasons. Of these, 24 reported using heroin in Vietnam, a disturbing finding given that HIV prevalence among IDUs in parts of Vietnam is greater than 50%.⁴

We analysed HIV surveillance data in Victoria to investigate whether there was an over-representation of Indo-Chinese-born IDUs. Country of birth has been collected as part of HIV notification in Victoria since January 1996. Since then, there have been 38 notifications of HIV infection in individuals reporting intravenous drug use as a risk factor. Of these 38, 11 (29%; 95% CI, 15%–46%) reported an Indo-Chinese country of birth — a higher proportion than expected given the 1996 census finding that 1.5% of Victoria's population was born in an Indo-Chinese country.⁵ These 11, all men, were significantly younger than other IDUs notified in this time (mean, 23.3 years v 31.3 years, respectively; $P < 0.05$).

Although these numbers are small, they highlight a group at increased risk of HIV who are not currently being effectively reached by prevention services. These data also suggest a hidden route for spread of HIV from Asia into the Australian community. There is an urgent need to provide culturally relevant education and harm-reduction programs to prevent transmission of HIV within this group. The Victorian Department of Human Services is allocating additional resources to working with culturally and linguistically diverse communities on prevention activities to address this issue.

1. MacDonald MA, Wodak AD, Dolan KA, et al. Hepatitis C virus antibody prevalence among injecting drug users at selected needle and syringe programs in Australia, 1995–1997. *Med J Aust* 2000; 172: 57–61.

2. Maher L, Sargent P, Higgs P, et al. Risk behaviours of young Indo-Chinese injecting drug users in Sydney and Melbourne. *Aust N Z J Public Health* 2001; 25: 50–54.

3. Reid G, Crofts N, Beyer L. Drug treatment services for ethnic communities in Victoria, Australia: an examination of cultural and institutional barriers. *Ethn Health* 2001; 6: 13–26.

4. Kelsall J, Higgs P, Crofts N. The Vietnamese Harm Reduction Project: Stage 2. Melbourne: Centre for Harm Reduction, Macfarlane Burnet Centre for Medical Research, 2001.

5. Australian Bureau of Statistics. 1996 census of population and housing. Canberra: AGPS, 1997.

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Detecting and reducing hospital adverse events: outcomes of the Wimmera clinical risk management program

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TO THE EDITOR: On reviewing the results of the Wimmera clinical risk management program,¹ we are prompted to ask whether the model can be generalised to a tertiary hospital. The program outlined by Wolff and colleagues is a good model for local quality improvement and provides a foundation for developing a model for tertiary hospitals. However, in considering its applicability to tertiary hospitals, a number of issues must be addressed.

The number of separations and emergency department presentations at tertiary hospitals does not lend itself to review of all medical records. Such review is time- and resource-intensive and probably unrealistic in a tertiary setting. A sampling strategy might be more suitable, but would introduce the possibility of sampling error and missing adverse events.

The availability of medical staff to review records is also limited, with clinicians often having public, private and teaching commitments. It would also not be feasible for a medical director to be involved regularly in the day-to-day tasks of the process. Nevertheless, these issues could be addressed by allocating the review process to a dedicated, trained team. Development of a review pathway would ensure participation of senior medical or management staff when necessary.

The interface between tertiary hospitals and local general practitioners is broader and less defined than in rural areas, making the involvement of GPs difficult.

The clinical mix and complexity of patients requiring tertiary care differ significantly from those at a rural base hospital, and restricting screening criteria for adverse events to eight items, as in the Wimmera program, would likely result in adverse events being missed. In addition, the clinical structure of tertiary hospitals is not uniform, and specific criteria may need to be developed to address the clinical specialties of the hospital.

Lastly, in this era of cost containment in healthcare, Wolff et al did not address the cost of its clinical risk management program. While this is not a fault in the study, cost would be an essential consideration in generalising the program to a tertiary hospital.

The model used in the Wimmera program has limitations when considering adaptability to tertiary hospitals, because of issues of scale and day-to-day practicalities. Further examination of the costs involved in ongoing operation of the program and a cost-benefit analysis are required. In addition, investigation is needed into feasible options that deliver *useful* results in a tertiary setting before a quality improvement model can be developed that is relevant, appropriate and cost-effective for tertiary hospitals.

1. Wolff AM, Bourke J, Campbell IA, Leembruggen DW. Detecting and reducing hospital adverse events: outcomes of the Wimmera clinical risk management program. *Med J Aust* 2001; 174: 621–625. □

Correspondents

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