

caused by HBV worse.² Acute hepatitis A in patients with chronic HCV seems to carry a higher risk of acute liver failure than hepatitis A alone.³ In both of these examples, acute superinfection is associated with transient suppression of the other, already existing, viral infection. More recently it has been observed that co-infection with GB virus C (also known as the hepatitis G virus) seems to be associated with a more favourable outcome in patients infected with HIV.⁴ The molecular or immunological mechanisms by which these viral infections interact is unknown. Confirmation of this novel observation—that SEN virus infection inhibits antiviral activity—may lead to new insights into the mechanisms of action of interferon and ribavirin. Clearly this finding deserves attention, and further study, at least for now.

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“Dangerousness” and dangerous law

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In December last year the UK government published a white-paper for a new mental health act.¹ The intention is that the act will provide a new legal framework for mental health services that reflects “major changes” in patterns of care. It will also provide new powers for compulsorily detaining those with mental disorders who are thought to pose a threat to the safety of others. Included in this group will be people with dangerous severe personality disorder (DSPD), a neologism that has no legal or medical status. Detention would occur whether or not the person was treatable, and would extend to those who have committed no criminal offence. Pilot assessment centres for DSPD are operating at Whitemoor Prison and at Rampton Hospital, and a new centre at Frankland Prison is about to open. At these centres, those with a disorder that has yet to be defined, and for which there are no treatment programmes in existence and no firm evidence base, are undergoing exploratory assessment.

The key word in the new term DSPD is “dangerous”. The proposal in the white-paper is to incarcerate people according to the opinions of others as to their propensity to behave dangerously at some point in the future. Would-be clairvoyants engaged in this form of assessment exercise will make use of “tools” in the form of actuarially-based checklists, which give spurious scientific value to estimations that perform less well than chance.^{2,3} In today’s *Lancet* Alec Buchanan and colleagues shine further the light of reality upon these shadowy notions. Examining the published studies of the accuracy of dangerousness assessments, both clinically based and statistically derived, they conclude conservatively that six people with DSPD would need to be detained in order to prevent one person from acting violently, if government estimates of the prevalence of DSPD are correct. This finding should not

come as a surprise. The forecasting of dangerousness remains like that of the weather—accurate over a few days, but impotent to state longer-term outcome with any certainty.

Psychiatry has already become more coercive, with the number of compulsory admissions from the community increasing by 70% over the 10 years from 1986 to 1996.⁴ It now threatens to assume an Orwellian air, as the socially undesirable risk indefinite incarceration in psychiatric (or pseudopsychiatric) institutions. Where does this trend leave the role of the doctor, and what are the ethics of his/her position? Doctors are used to treating patients for the patients’ sake. Now they will be required to pretend to treat the untreatable for the sake of a third party. The Hippocratic injunction to do no harm to a patient is replaced by a responsibility to make sure that the patient himself does no harm to anyone else. The medical role is changed from treating the sick to one of social control. There is conscious deception,⁵ as a policy driven by a public-protection agenda is pushed through in the guise of a health-care intervention.

Apologists for the new proposals point out that money is now being spent, in anticipation of the new law, on high-quality well-resourced assessment facilities for a group that has received shamefully little attention from health services in the past—that is, the personality-disordered. This position ignores the abysmal standards of mental health care for the 67 000 in prisons in the UK,^{6,7} where the rate of imprisonment now surpasses Portugal’s as the highest in the European Union. The government has shied away from bringing prisoners’ health care into the National Health Service, and opted for a partnership between the prison and the health services,⁸ which is heavy on rhetoric and, as yet, low on substance. It is hard not to conclude that the large sums set aside for DSPD would better be targeted at improving health care for those already legitimately detained, suffering from illnesses for which proven treatments exist.

These changes are not taking place in isolation. They reflect a gradual transformation over the past two decades in criminal justice and social policy, as the “culture of welfare” is replaced by the “culture of control”.⁹ It is not difficult to see where such changes will lead: one has only to look across the Atlantic to the USA. With more than 2 million people in prisons, and dangerousness used as a criterion for execution as well as preventive detention, society is no safer, and liberty dies a little.

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