by repeat tests.² At Brixton HIV positive prisoners, who are segregated because of their infection, occupy better accommodation, which thus encourages prisoners to claim that they are positive for the virus. Retesting shows that some of them are indeed negative.

Injecting drug use undoubtedly occurs in prisons, particularly among remand prisoners, and sharing of equipment is inevitable. Although cases of acute hepatitis B in prison have been recorded, so far there has been no evidence of acute HIV seroconversion illness. In an American custodial prison HIV testing on admission and release has not shown significant changes in seropositivity.³ Long term prisoners are much less likely to abuse drugs.

Identification of those prisoners infected with HIV, with guaranteed confidentiality, will permit targeted advice on reducing the risk of transmitting the virus and on maximising current health, including detoxification of drug users. Tests to evaluate the immune system will enable appropriate prophylaxis to be prescribed to those who are vulnerable to sudden life threatening opportunistic infections.

Multidisciplinary committees should be established to plan, implement, and monitor systems for managing HIV infection in British prisons. Sensitive and effective handling will benefit public health in general and the prison population in particular, including staff.

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- 1 Farrell M, Strang J. Drugs, HIV, and prisons. *BMJ* 1991;302:1477-8. (22 June.)
- 2 Wool RJ. Drugs, HIV, and prisons. *BMJ* 1991;303:118. (13 July.)
- 3 Horsburgh CR Jr, Jarvis JQ, McArthur T, Ignacio T, Stock P. Seroconversion to human immunodeficiency virus in prison inmates. *Am J Public Health* 1990;80:209-10.

Sexual behaviour in Scottish prisons

SIR,—Dr K G Power and colleagues report that during the course of their interviews with Scottish prisoners only a tiny minority (one man and three women out of a sample of 559) admitted to sexual behaviour in jail.¹ This may not surprise many who work in the Scottish Prison Service; what will surprise them is Dr Power and colleagues' assumption that such behaviour is therefore correspondingly rare.

In the course of my work as a clinical psychologist with prisoners during the past year three men have told me that they participate in sex with their fellow prisoners, one of whom claimed to have many partners. I do not imagine that any of them would have disclosed this information at a first interview, but this seems to be what Dr Powers and colleagues were expecting. It is a common experience among those who counsel prisoners that their stories change over time and that they sometimes gradually edge nearer to unpalatable truths. Dr Power and colleagues argue that the prisoners they interviewed had no reason to fear disciplinary repercussions from any disclosures they might make, and they note that a higher proportion of prisoners were prepared to admit to the equally illegal use of intravenous drugs while in prison. This misses the point that illegality itself carries no stigma in this population whereas homosexuality is strongly disapproved of. During a face to face encounter few people are happy to confess to behaviour that shows them in a bad light. Why should this be expected of convicted criminals, who are likely to be especially well practised in pleading not guilty to undesirable behaviour?

Dr Power and colleagues point out that reports of widespread sexual activity in jail are always anecdotal, as is my own. To remedy this they carefully select a random stratified sample representing the different categories of prisoners in Scottish jails. Unfortunately, this impressive sample of prisoners (11.7% of the total population of Scottish prisons) may be telling us more about their behaviour during interviews than their sexual behaviour. There can be no justification for the authors' suggestion that "The results of our study should be taken into consideration when discussing whether condoms should be provided to inmates of prisons."

Estimates of the prevalence of behaviour that is both private and socially unacceptable are always difficult and require more sophisticated methods of inquiry than an uncorroborated personal interview.

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SIR,—In their report on sexual behaviour in Scottish prisons Dr K G Power and colleagues probably underestimate the extent of sexual activity in prison.¹ They make no reference to data on the sexual behaviour of women in prisons in the United Kingdom² or to extensive American work on sexual behaviour in prisons for men and for women.³ American data suggest that 17-69% of prison inmates reported sexual experiences with people of the same sex during imprisonment.

The authors' work has methodological drawbacks. A single cross sectional interview provides unreliable data on sexual behaviour when compared with systematic participation and observation over time, as in standard anthropological fieldwork. Clemmer found 40% of male prisoners to be sexually active in prison.³ His research included 30 000 conversations with prisoners, 50 biographies, 200 essays by prisoners, and 174 questionnaires.

Furthermore, their study does distinguish between consensual sex and sexual assault. Sexual violence is acknowledged as a problem predominantly of prisons for men in the United States.⁴ Davis found that 200 of 60 000 inmates had been sexually assaulted after arrest.⁵ A survey of the prison system in New York reported that 28% of 89 men had been victims of sexual aggression during incarceration, often with physical assault.⁶ Given the current issues of control in prisons in the United Kingdom, this is a matter of considerable concern.⁷

Lastly, Dr Power and colleagues suggest that the number of prisoners per cell is connected to sexual behaviour but neglect to consider how the issue of "banging up" affects patterns of association and supervision to a great extent.

Dr Power and colleagues' study highlights the relative failure of researchers in the United Kingdom to produce reliable data on sexual behaviour in prisons for men and for women compared with data from the United States. This would be of mere academic interest were it not for the practical consequences. Firstly, the implications for sexual spread of HIV infection in the prison population are essentially unknown. Secondly, the distinction between consensual sex and sexual assault is important both for transmission of HIV and for the protection of possible victims. Thirdly, the Home Office can continue in its morally blinkered attitude to the realities of prison existence such that safe consensual sex is virtually impossible in custody. It remains to be seen whether the Home Office will permit independent in depth research of subcultures in prisons, research that is crucially relevant to both the humane management of prisons in general and

the sexual and non-sexual spread of HIV infection in particular.

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- 1 Power KG, Markova I, Rowlands A, McKee KJ, Anslow PJ, Killefder C. Sexual behaviour in Scottish prisons. *BMJ* 1991;302:1507-8. (22 June.)
- 2 Ward J. Telling tales in prison. In: Frankenberg R, ed. *Custom and conflict in British society*. Manchester: Manchester University Press, 1982.
- 3 Mawby RI. Women in prison: a British study. *Crime and Delinquency* 1982;28:24-39.
- 4 Propper AM. *Prison homosexuality*. Lexington: Lexington Books, 1981.
- 5 Clemmer D. *The prison community*. New York: Holt, 1958.
- 6 Scacco AM. *Rape in prison*. Springfield, Illinois: Charles C Thomas, 1975.
- 7 Davis AJ. Quoted in: Propper AM. *Prison homosexuality*. Lexington: Lexington Books, 1981.
- 8 Lockwood D. *Prison sexual violence*. New York: Elsevier, 1980.
- 9 Woolf H, Tumin S. *Prison disturbances April 1990*. London: HMSO, 1991.

New deal for old hearts

SIR,—Dr N A Boon discusses the treatment that should be available for elderly people with heart disease.¹ Next to cardiac pacing, restoration of sinus rhythm by electrical cardioversion of atrial fibrillation must rank as one of the most cost effective ways of preventing disabling morbidity in otherwise well subjects because as many as a third of strokes are associated with this arrhythmia in those aged ≥ 70 .² Given that this arrhythmia is significantly related to age³ and that a risk of embolism is evident even in subjects without coexisting "clinical heart disease,"⁴ it is ironic that old age should even be considered to be a relative contraindication to electrical cardioversion in "asymptomatic" subjects⁵ because it is precisely this type of patient who stands to lose the most if denied the benefits of the procedure.

Notwithstanding these spurious considerations, success rates obtained within 12 months⁶ or even within 36 months⁷ after the onset of arrhythmia are gratifyingly high in all age groups,⁸ and complications of the procedure are acceptably few. Furthermore, encouraging results have been obtained with drug prophylaxis against relapse after cardioversion.^{7,8}

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- 1 Boon NA. New deal for old hearts. *BMJ* 1991;303:70. (13 July.)
- 2 Wolf PA, Abbot RD, Kannel WB. Atrial fibrillation: a major contributor to stroke in the elderly: the Framingham study. *Arch Intern Med* 1987;147:1561-4.
- 3 Boston Area Anti-Coagulant Trial for Atrial Fibrillation Investigation. The effect of low-dose warfarin on the risk of stroke in patients with non-rheumatic atrial fibrillation. *N Engl J Med* 1990;323:1505-11.
- 4 Lundstrom T, Ryden L. Chronic atrial fibrillation: long term results of direct current conversion. *Acta Med Scand* 1988;223:53-9.
- 5 Szekely P, Sideris D, Batson G. Maintenance of sinus rhythm after atrial defibrillation. *Br Heart J* 1970;32:741-6.
- 6 Dalzell G, Anderson J, Adgers AAJ. Factors determining success and energy requirements for cardioversion of atrial fibrillation. *Q J Med* 1991;78:P85-95.
- 7 Karlson BW, Herlitz J, Edvardsson N, Olsson SB. Prophylactic treatment after electroconversion of atrial fibrillation. *Clin Cardiol* 1990;13:279-86.
- 8 Juul-Møller S, Edvardsson N, Rehnqvist-Ahlberg N. Sotalol versus quinidine for the maintenance of sinus rhythm after direct current conversion of atrial fibrillation. *Circulation* 1990;82:1932-9.

"Heartstart Scotland"

SIR,—Professor Stuart M Cobbe and colleagues' paper shows the value of out of hospital defibrillation. The use of the semiautomatic defibrillator avoids the need for expensive training, making this a very cost effective scheme. The organisers of

"Heartstart Scotland" are to be congratulated on having introduced such an efficient programme, over a wide area, in a relatively short time.

One disappointing aspect of this study is the lack of benefit from cardiopulmonary resuscitation. There are many possible reasons for this. Delay in calling for help, delay in initiating cardiopulmonary resuscitation, poor ambulance response times, and ineffective performance of cardiopulmonary resuscitation may all be contributing factors.

A programme known as "Operation Heart Start" was initiated in north east Fife in February 1988 (the model referred to in Professor Cobbe and colleagues' paper). From the outset it was considered that providing early defibrillation on its own was not enough, and training citizens in cardiopulmonary resuscitation formed an integral part of the campaign. Some 2000 citizens have been trained, and analysis of the records of the first 600 shows that mean scores for accuracy of around 70% can be achieved in both compression and ventilation (assessed with the Laerdal Skillmeter), with two hours of training. These scores are similar to the minimum standard set by the Royal College of General Practitioners for its membership examination.

The proportion of arrests in which a bystander performed cardiopulmonary resuscitation in Professor Cobbe and colleagues' study indicates a high degree of willingness on the part of the general public, and this enthusiasm needs to be captured. Many people may have received first aid training at some time, but this does not necessarily mean that they are efficient. Of those trained in north east Fife, 28% indicated that they had had some previous training, yet their scores were not significantly different from the scores of those with no experience.

Eisenberg *et al* showed that up to 43% of patients will survive if early defibrillation is supported by early access to the patient, early cardiopulmonary resuscitation, and early advanced cardiac life support.² Early access and efficient cardiopulmonary resuscitation by bystanders can happen only if investment is made in public education. Basic instruction in cardiopulmonary resuscitation must be given to all children before they leave school, and local campaigns for instructing citizens need to be established throughout the country. If Heartstart Scotland does nothing more than provide defibrillators only half the job has been done.

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- 1 Cobbe SM, Redmond MJ, Watson JM, Hollingworth J, Carrington DJ. "Heartstart Scotland" — initial experience of a national scheme for out of hospital defibrillation. *BMJ* 1991;302:1517-20. (22 June.)
- 2 Eisenberg MS, Bergner L, Hallstrom A. Cardiac resuscitation in the community. *JAMA* 1979;241:1905-7.

Impaired glucose tolerance and height

SIR,—Dr D R Rhys Williams and colleagues report that the seven subjects with impaired glucose tolerance detected in a population survey in East Anglia were significantly shorter than controls matched for age, and they speculate about

the possible influence of early development on β cell function.¹

This association was not present in our larger population survey of glucose tolerance in Europeans and South Asians aged 40-69 in west London.² The table shows the age adjusted mean heights for men by ethnic group and glucose tolerance. For the difference in average height between the 39 European men with impaired glucose tolerance and the 1393 European men with normal glucose tolerance the 95% confidence interval is -1.1 to 3.5 cm. The difference of -7.6 cm in average height reported by Dr Williams and colleagues may result from chance or from some unusual characteristic of the population studied.

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- 1 Williams DRR, Byrne C, Clark PMS, Cox L, Day NE, Rayman G, *et al*. Raised proinsulin concentration as early indicator of β cell dysfunction. *BMJ* 1991;303:95-6. (13 July.)
- 2 McKeigue PM, Shah B, Marmot MG. Relation of central obesity and insulin resistance with high diabetes prevalence and cardiovascular risk in south Asians. *Lancet* 1991;337:382-6.

Perinatal bereavement

SIR,—Dr Deborah J Sharp is right to emphasise the role of primary care workers in perinatal bereavement and the need for training and liaison.¹ For those who can get to London the Tavistock Clinic runs weekly seminars for general practitioners (Balint groups) as well as regular courses, of six afternoons, on understanding perinatal bereavement, which are attended by all the professions concerned, ranging from community midwives, health visitors, and paediatricians to psychiatrists and genetic counsellors.

Our brief editorial² was primarily to take stock of and to welcome the invaluable new guidelines for professionals published by the Stillbirth and Neonatal Death Society.¹ Regarding Mr Michael J Turner's comments,³ however, we were also trying to warn of iatrogenic problems due to confusion about early miscarriages. Having been in the vanguard of those calling attention to the way stillbirth used to be systematically blotted out as a non-event, we consider ourselves to be responsible for some overreaction now to miscarriage. Stillbirth is always lacerating; we have never met a woman who took it lightly, and there is something wrong if an obstetric unit is not rocked when it happens. Stillbirth and neonatal death are liable to be psychologically pathogenic for the parents, for their other children, and for grandchildren in years to come. By contrast, most people manage miscarriage as a private grief, many people are not badly bruised for long, and we think it harmful to respond with exaggerated concern, however well meant.

We differentiate, however, those cases in which bad omens or an exaggerated reaction call for special understanding and, possibly, trained psychological help. As we suggested, the quality of grieving may be more important than the overt level of distress—for example, clinging to grief and grievances are ominous. We should re-emphasise some factors that point towards trouble: recurrent miscarriage, the last chance for an older couple, a bad obstetric family history repeating itself, or a

miscarriage coinciding with another bereavement or an important anniversary. It is counterproductive to approach all cases with the expectation of grave reactions whereas, of course, normal sympathy is entirely appropriate.

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- 1 Sharp DJ. Perinatal bereavement. *BMJ* 1991;302:1465. (15 June.)
- 2 Bourne S, Lewis E. Perinatal bereavement. *BMJ* 1991;302:1167-8. (18 May.)
- 3 Stillbirth and Neonatal Death Society. *Miscarriage, stillbirth and neonatal death; guidelines for professionals*. London: SANDS, 1991.
- 4 Turner MJ. Perinatal bereavement. *BMJ* 1991;302:1465-6. (15 June.)

Enduring powers of attorney

SIR,—Ms Clare Dyer's article on enduring powers of attorney raises questions other than the one directly addressed.¹

A 79 year old woman in whom Alzheimer's disease had been diagnosed was recently referred to us. Her daughter had executive powers under the Court of Protection, on the strength of which she had disposed of her mother's home, placing her mother in residential care. On assessment an alternative diagnosis of pseudodementia due to underlying major depressive disorder was made.² Treatment with fluoxetine 20 mg daily and electroconvulsive therapy resulted in a complete recovery of cognitive and social functions. The patient's dilemma (and ours) is that she now wants to return to her own home and her daughter is unwilling to relinquish her executive powers.

The Court of Protection requires a medical practitioner to examine the patient, diagnose the nature of the incapacity, and give a prognosis. Without such safeguards who knows what catastrophes might ensue for those who sign an enduring power of attorney?

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- 2 Arie T. Pseudodementia. *BMJ* 1983;286:1301-2.

Blame is not the point

SIR,—In her review of the BBC1 programme "The Fight for Alexander" Ms Susanna Fischer, a barrister, seems to show signs of muddled thinking, which apparently is not the exclusive domain of politicians.¹ She asks us, "Yet what of babies born with congenital disabilities? Are they not as deserving of care and support as those injured by the fault of others?" She then suggests the usual catchphrase solution of a no fault system of compensation for medical negligence. By definition, however, this would exclude babies born with congenital disabilities. It is only in those cases in which injury can be proved to be iatrogenic that a no fault system will help.

We should be looking at wider, less exclusive reform. I thought the most telling section of Ms Rosie Barnes's letter² was where she said: "Unless one introduces a general disability compensation scheme, compensating individuals on the basis of need and not on the basis of how they acquired their disability, there will always be a need to prove causation." Let us have such a scheme. I can see no logical reason why victims of medical accidents should gain priority from the public purse over other victims. The debate should focus on the need

Mean (SEM) age adjusted heights of men in west London by ethnic group and glucose tolerance

	European		South Asian	
	No of men	Height (cm)	No of men	Height (cm)
Normoglycaemic	1393	174.3 (0.2)	1056	169.8 (0.2)
Impaired glucose tolerance	39	175.5 (1.1)	101	170.3 (0.6)
Diabetic	72	173.0 (0.8)	251	169.5 (0.4)