of the genital tract significantly increases the rate of transmission of HIV.⁴ Genitourinary medicine services have a pivotal role in preventing HIV infection by education, counselling, and the management of other sexually transmissible infections. It is thus of particular concern that many prisons in Scotland have no specific genitourinary medicine services, and the few existing services may be under threat.

Policies to reduce harm need to address all aspects of potential transmission of HIV and not to concentrate on injecting drug use to the exclusion of others. Furthermore, the provision of entirely confidential, high quality open access genitourinary medicine services to this group of people should be an important component of such policies.

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- 1 Taylor A, Goldberg D, Emslie J, Wrench J, Gruer L, Cameron S, et al. Outbreak of HIV infection in a Scottish prison. *BMJ* 1995;310:289-92. (4 February.)
- 2 Gore SM, Bird AG, Burns SM, Goldberg DJ, Ross AJ, Macgregor J. Drug injection and HIV prevalence in inmates of Glenochil prison. *BMJ* 1995;310:293-6. (4 February.)
- 3 Solursh LP, Solursh DS, Meyer CA. Is there sex after the prison door slams shut? *Med Law* 1993;12:439-43.
- 4 Clotney C, Dallabetta G. Sexually transmitted diseases and human immunodeficiency virus. Epidemiologic synergy? *Infect Dis Clin North Am* 1993;7:753-70.

What about the WHO guidelines?

EDITOR,—An editorial, two papers, and news from a dozen countries: the issue of 4 February certainly brings to readers' attention the major public health problem of transmission of HIV in prison. The reporting has one or two oddities: Switzerland is apparently reduced to a province of France, being included in Alexander Dorozynski's report from Paris and excluded from the summary table.¹ Dorozynski's napoleonic view of Europe troubles me less than the failure to recognise the pioneering work from 1985 onwards of the Swiss Federal Office of Public Health and prison doctors in several Swiss cantons in promoting the equivalence of measures to prevent AIDS in prisons to those in the community: condoms, non-discrimination, bleach, methadone maintenance, and recent trials of needle exchange. These initiatives are worthy of recognition. The report from Israel is also perplexing: "every prisoner is tested on arrival . . . voluntarily," and HIV carriers are segregated while results of tests are kept confidential.⁴ How do they do it? Or is the editor just a little gullible?

My main criticism of these contributions, however, is the failure to mention the World Health Organisation's guidelines published in 1993, which provide a comprehensive, public health based approach to managing HIV infection and AIDS in prison while respecting human rights.^{2,3} This omission is all the more surprising because the *BMJ* has subjected the WHO to intense critical scrutiny recently.

Policy concerning HIV infection and AIDS in prisons is part of a wider problem of health care in prison, as the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment has repeatedly emphasised after its visits to various countries, including Britain. The committee has condemned segregation of prisoners infected with HIV and non-respect of confidentiality as unnecessary and a violation of basic human rights.⁴

Sensible policies on HIV infection and AIDS will come about only when prison health services

are independent of prison administrations and the principle of equivalence of health care including preventive measures is recognised.

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- 1 Prison policies put inmates at risk. *BMJ* 1995;310:278-83. (4 February.)
- 2 World Health Organisation. *Guidelines on HIV infection and AIDS in prison*. Geneva: WHO, 1993.
- 3 World Health Organisation. *Statement from the consultation on prevention and control of AIDS in prisons*. Geneva: WHO, 1987.
- 4 Council of Europe. *European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment: 3rd general report*. Strasbourg: CE, 1993.

Testing in prison is uncommon

EDITOR,—We agree with O Noel Gill and colleagues that there are difficulties in measuring the incidence of HIV infection acquired in prison.¹ Reasons for this include the fact that acute HIV infection may be asymptomatic and that a pattern of repeated short prison sentences is not conducive to the detection of new infections. We appreciate the confidential nature of information about imprisonment and the problems associated with recording it accurately. We also appreciate that assessing the possible contribution of imprisonment to transmission of HIV at the national level is not easy as existing national voluntary confidential HIV and AIDS surveillance reporting systems, which safeguard confidentiality, cannot provide information about a history of periods in prison.

Our experience suggests that the frequency of diagnostic HIV testing in prison is low, although we recognise that efforts are being made to increase it. This laboratory serves one of Britain's largest prisons, catering for over 1000 prisoners, of whom nearly two thirds were serving sentences of less than four years in 1992.² A review of the source of 2562 specimens submitted for testing for antibody to HIV in 1994 showed that 50 came from the prison services. This represented an almost 100% increase on the numbers submitted in 1993. Of the 50, nine were positive for the antibody, and available information indicated that these tests were carried out to confirm a history of HIV positivity. Most of the remaining tests were carried out because of a history of injecting drug use.

We would caution against deriving any reassurance from the stable prevalence found in the unlinked anonymous studies of the prevalence of HIV among injecting drug users in England and Wales as a stable prevalence can mask an increasing incidence. We endorse the authors' sentiments and urge that every conceivable effort should be made to minimise the risk of transmission of HIV in prison, including minimising risk factors such as injecting drug use as well as sharing of potentially contaminated equipment.

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- 1 Gill ON, Noone A, Heptonstall J. Imprisonment, injecting drug use, and bloodborne viruses. *BMJ* 1995;310:275-6. (4 February.)
- 2 Home Office. *Report of an unannounced short inspection by HM Inspectorate of Prisons. HM Prison Wandsworth*. London: HO, 1993.

Management of ventricular fibrillation by doctors in cardiac arrest teams

Guidelines do not discount change according to clinical circumstance

EDITOR,—The audit of the management of cardiac arrest by T M Cook and J Handel agrees with many others in showing that doctors do not consistently apply guidelines on resuscitation.¹ The interpretation of this as unacceptable seems to misunderstand the nature of guidelines generally and those of the European Resuscitation Council in particular.

Guidelines suggest a course of action but do not discount change according to clinical circumstance; the European Resuscitation Council's handbook, *Guidelines for Resuscitation* (1994), states that "guidelines are not set in tablets of stone."² One of the hidden rules of medical audit is that the standard being compared with actual practice has been validated. The guidelines of 1992 represent a valuable and important consensus view, but there is no claim that they would make any difference to outcome. This is not scientific nihilism: the universal and rigid application of such guidelines does real harm to patients and their families. It follows that the fact that the guidelines are intuitively reasonable and based on the best available evidence is not sufficient to validate them for the purposes of such audit. More selective use of the arrest call makes clinical and ethical sense, and Frenchay Hospital's guidelines for "not resuscitating" as outlined in the European Resuscitation Council's handbook set a high standard. Testing such a selective approach might be a self fulfilling prophesy (and an arrest call cannot properly be designated appropriate or not after the event), but the reluctance of clinicians to make this difficult decision is clearly bad practice.

The broader issues here are the priorities of resuscitation training teams, the concept of consensus statements from expert committees, and the adoption of guidelines and protocols in general—subjects of much debate in anaesthesia. With the advent of the Cochrane Collaboration, clinicians should be able to distinguish between guidelines based on double blind placebo controlled trials, "best possible evidence," and elaborate anecdote.

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- 1 Cook TM, Handel J. Management of ventricular fibrillation by cardiac arrest teams. *BMJ* 1995;310:466. (18 February.)
- 2 European Resuscitation Council. *Guidelines for resuscitation*. London: Resuscitation Council (UK), 1994.

Anaesthetists are tested under examination conditions

EDITOR,—P F S Prior-Willeard and J David report their finding that skills in advanced life support are little improved since their preliminary study one year ago.¹ We agree that there is a fundamental problem of incentive and that postgraduate medical examinations must provide this incentive by including resuscitation skills as a component of practical testing. This has been firmly endorsed by the Royal College of Anaesthetists, which includes a compulsory testing station in its new objective structured clinical examination. Candidates are asked to demonstrate their skills at single rescuer basic life support for about two minutes and are subsequently examined in their ability to recognise rhythms and their theoretical knowledge of advanced life support.

Anaesthetists generally perform resuscitation to a high standard. Despite this, we believe that the inclusion of compulsory testing in the fellowship examination has provided an additional stimulus