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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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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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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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.)
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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

for trainees to acquire the necessary skills. It remains to be seen if the proficiency in resuscitation skills among those taking anaesthetic examinations is higher than that among candidates taking the examination for membership of the Royal College of Physicians. The resuscitation training officer has a valuable role in ensuring that these skills are retained.

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1 Prior-Willeard PFS, David J. Resuscitation skills of MRCP candidates: one year on. *BMJ* 1995;310:195. (21 January.)

In future, cardiac arrest teams may require current evidence of their skills

EDITOR,—We agree with P F S Prior-Willeard and J David that resuscitation skills fall short of satisfactory standards, even in those who are members of cardiac arrest teams.¹ A recently completed audit of cardiac arrest procedures at our hospital showed that the guidelines issued by the European Resuscitation Council in 1992² were unavailable at 25 of 77 (32% (95% confidence interval 22% to 44%)) cardiac arrest calls. Furthermore, these guidelines were followed in only 55 of 68 (81% (70% to 89%)) cardiac arrests for which they were applicable. We also found that early management of the airway in cardiac arrests was ineffective in 38 of 76 cases (50% (38% to 62%)).

The anaesthetic department in our hospital is leading the way in resuscitation training and is shortly to require each of its members formally to demonstrate proficiency in basic life support. In North America the possession of a certificate confirming skills in basic life support is a prerequisite for employment in many hospitals. The Royal College of Anaesthetists has also set high store by the demonstration of adequate resuscitation skills. A resuscitation station is now a mandatory part of the objective structured clinical examination in the examination for part 3 of the fellowship of the college.

Will we yet see the day in Britain when all members of cardiac arrest teams will be required to possess current certificates confirming their skills in advanced life support?

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2 European Resuscitation Council Working Party. Adult advanced cardiac life support: the European Resuscitation Council guidelines 1992 (abridged). *BMJ* 1993;306:1589-93.

Skills and knowledge should be tested in postgraduate exams

EDITOR,—Recent correspondence has highlighted the deficiencies of various groups attending cardiac arrest.^{1,2} We believe that doctors are motivated to practise basic life support skills and learn guidelines on advanced life support mainly when these are required for career advancement. One example of this is the fellowship of the Royal College of Anaesthetists: life support is included in the curriculum for the examination for parts 1 and 3, and candidates know that they will be tested on this subject.

We surveyed 43 anaesthetic trainees in our region by questionnaire to assess their knowledge

Effect of study for examination on score for knowledge of cardiopulmonary resuscitation and pass rate

Group	No	Median score (interquartile range)	No (%) who passed
1	14	10 (9-11)	9 (65)
2	16	9 (8-11)	3 (19)

of the European Resuscitation Council's advanced cardiac life support guidelines of 1992.⁴ Each trainee could score a maximum of 13, and a pass was awarded if intravenous access and intubation were attempted at the appropriate time, the correct energy level and sequence of DC shocks were indicated, the correct number of sequences of cardiopulmonary resuscitation was known, and drugs were used with appropriate doses and timing.

The overall median score was 9, and 15 trainees passed. Senior house officers (n=22) scored significantly better than senior registrars (n=13) (median score for senior house officers, 10; median for senior registrars, 7; P=0.01). The effect of study for examinations was assessed by looking at senior house officers and registrars. Group 1 (n=14) had successfully passed part 1 or 3 of the fellowship of the Royal College of Anaesthetists in the previous year, while group 2 (n=16) had not. Group 1 had a significantly higher pass rate (P<0.05), but scores were similar.

In this small sample of anaesthetists we have shown that a pass in an examination is not enough to equip them for the rest of their careers. Similar shortcomings have been shown in other groups.^{1,2} If the general standard of resuscitation is to be improved we agree with other correspondents³ that leaders of cardiac arrest teams should be certified providers of life support techniques. We also believe that life support skills and knowledge should be tested as part of the postgraduate examinations of all the acute specialties and that other motivation is needed beyond this, such as competence on regular testing as a condition for employment at all grades in these specialties.

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1 Tham KY, Evans RJ, Rubythorn EJ, Kinnaird TD. Management of ventricular fibrillation by doctors in cardiac arrest teams. *BMJ* 1994;309:1408-9. (12 November.)

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Local training also has major impact

EDITOR,—T M Cook and J Handel raise several important points concerning the management of cardiac arrest in hospital.¹ We agree that it is vital to audit the cardiac arrest system and its performance in hospitals, and we are starting our own audit shortly. We found it interesting to note that Cook and Handel's preliminary results showed that the European Resuscitation Council's guidelines on resuscitation were not available in over a third of the arrests attended. In this hospital there is a copy of the advanced cardiac life support guidelines in each emergency drug box.² Thus when the box is opened at an arrest the sheet is removed and given to the leader of the arrest team, who then has the guidelines immediately to hand. We believe that this would be a simple solution to the problem and should be universally adopted. The last few editions of the *British National Formulary* also contain a miniature version of the European

Resuscitation Council's guidelines³; this source is readily available on most wards.

Posters are also displayed in all ward areas of this hospital. Training for both medical and nursing staff is enhanced by the work of three part time resuscitation training officers (nursing staff in the coronary care and high dependency areas). Obviously, advanced life support courses approved by the United Kingdom Resuscitation Council remain the gold standard in training terms for leaders and members of cardiac arrest teams, but local training can have a major impact on performance and should be encouraged.

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Problem solving treatment for major depression in primary care

Problem solving treatment is time consuming

EDITOR,—Controlled evaluations of psychological treatments in general practice are greatly needed. Two important issues, however, are not discussed by L M Mynors-Wallis and colleagues in their evaluation of problem solving treatment in primary care.¹

Firstly, their problem solving intervention is time consuming. Each patient in the problem solving group received an average of 214 minutes with either the general practitioner or a psychiatrist. This is relatively brief for mental health professionals, but such a commitment of time by general practitioners is impractical. Much more attenuated treatments will need to be developed before they will be taken up by general practitioners.

Secondly, the authors comment in their discussion that potentially suitable patients may not have been referred to the study because they were unwilling to take part in a trial with a randomised allocation to treatment. This is an extremely important point, about which no other detail is given. It is impossible from the authors' results to estimate how representative their patients were of all those with major depression attending the practices. We realise that it is difficult to make accurate estimates of patients not referred by general practitioners, but some estimation is crucial. One way around this difficulty is to use a patient preference controlled trial, in which only those patients who have no strong preference for one of the treatment arms are randomised; the remainder are given the treatment of their choice.² Thus all patients eligible to enter are retained in the trial, and the results in those randomised and those not randomised can be analysed separately.

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