needs of prisoners and at avoiding giving spurious labels to large numbers of "normal" criminals. Criminality and substance misuse were recorded independently and the diagnosis of personality disorder reserved for those with other evidence of disordered functioning.

We did not find the subcategories in the ICD (ninth revision) useful in describing inmates with personality disorder as most of the inmates (over 80%) showed pronounced features of two or more subcategories. Axis II of DSM-III-R suffers from a similar problem, assigning several labels to one patient. This phenomenon has been called comorbidity but can best be regarded as reflecting the unsatisfactory state of existing classifications of personality disorder.

Despair over the diagnosis of personality disorder has led some professionals to reject the diagnosis[2] and others to reject patients who have been given the diagnosis.[3] We adopted Lewis's view that the diagnosis is problematic but indispensable in referring to a group of patients who show profound psychiatric disturbance but do not fit readily into other categories of mental illness.[4] The inmates we identified stood out from their peers by virtue of their mental state or behaviour. Usually the interviewee, other inmates, prison officers, and doctors shared our view that their personality problems were of a nature and severity that warranted psychiatric attention. More time or information may have yielded more cases, but we would claim a degree of face validity. A comprehensive psychiatric service for prisoners would have to take these inmates into account.

Deciding which diagnosis is primary depends on the purpose for which the question is asked. Our criterion in compiling table II was the provision of services: which problem would dictate the immediate management of the patient? It represents an oversimplification of the reality of psychiatric practice.

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HIV and discrimination

SIR,—Although there is much emphasis on the discrimination carried out by the United States with the travel restrictions on foreigners with HIV infection,[1] very little is officially known on the discrimination carried out by health workers against people with HIV infection either in or outside of the United States. In Italy we conducted a prospective study to evaluate this phenomenon.

A coded questionnaire was distributed to all outpatients and inpatients of the AIDS unit of our institution. Informed consent had been obtained and questionnaires were anonymous. Between 30 May and 7 August 1991, 86 subjects filled in the questionnaire. Sixty three used intravenous drugs (48 men and 15 women), 11 were heterosexuals (five men and six women), nine were homosexual men, and three were men without known risk factors for HIV infection. Among these persons, 84 were HIV positive; the two others were HIV negative but at high risk of HIV infection. Of the 34 reporting episodes of discrimination by health workers in public or private Italian institutions, eight reported more than one episode. Twenty three of the 42 episodes involved dentists; seven involved surgeons; six involved internists; four involved other specialists; and one involved a general practitioner. It must be emphasised, however, that some persons reported the opposite—for example, that general practitioners took care of them in a more heedful way than previously. Different kinds of episodes of discrimination were reported, but particularly common was the refusal to give the requested health service (37 episodes). If these findings are confirmed in other prospective studies the health authorities should consider intervening with practitioners who are not following the ethical rules of their profession.

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General practitioners' access to *x* ray services

SIR,—Dr N E Early states, "It might be pertinent to ask radiologists how many referrals they reject (as a proportion of the total) from junior hospital staff, consultant hospital staff, non-fundholding general practitioners, and fundholding general practitioners."[1]

I do not have any figures for the number of referrals rejected but can assure him that general practitioners are not the only group of doctors being asked to reduce the number of requests for examinations. We have achieved a considerable reduction in the numbers of preoperative chest radiographic examinations and of contrast examinations of the urinary tract that we perform. Hospital doctors as well as general practitioners are being asked to reduce their requests for *x* ray examinations.

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Complications of pregnancy and delivery and psychosis in adult life

SIR,—Do obstetric complications constitute a risk factor for later schizophrenia? From the results of their national follow up study Dr D John Done and colleagues conclude that they do not.[1] Their study is impressive, with large numbers and elegant statistical analyses. But is their conclusion justified?

Two aspects of the study give cause for concern: the statistical power and the clinical factors used to define risk. With an overall sample size of some 16 000 the issue of statistical power might seem irrelevent. Yet, as the authors themselves hint, the final number of under 50 cases of schizophrenia may well be too small to test adequately the hypothesis in question. Obstetric complications in general probably confer in the order of a twofold increased risk of later schizophrenia.[2] This is not a large effect in comparison with that of familial risk factors, for example. The analyses of the subgroup of patients with high risk showed that all the groups with psychosis, including schizophrenia, but not those with neurosis had an odds ratio of stillbirth or neonatal death of between 1·4 and 2·4. The wide confidence intervals on these figures testify to the small sample sizes and may well explain the inability to show a significant effect.

The second problem is the choice of clinical variables used to define obstetric risk. A model that includes only one variable, the prescription of drugs, as indicating the condition of the baby must be interpreted with the greatest caution. Understanding of neonatal physiology at that time was poor, and drug treatments were empirical—for instance, the main indication for treatment with nikethamide (Coramine) was impending death from any cause, and most babies dying in hospital would have received this as a last resort. It thus makes little sense to include this as an independent predictor of neonatal death.

Increased rates of obstetric complications in the histories of patients with affective psychosis, as well as schizophrenia, compared with neurotic patients have been shown before.[3] One way in which the authors might examine further the issue of obstetric risk and later schizophrenia is to look for an inverse correlation between calculated risk and age at onset of the illness. Several previous studies have reported that obstetric complications predict an earlier onset, and if this can be shown not to be the case in the reported sample it will strengthen the authors' conclusions that no link between obstetric risk and later schizophrenia has been shown.

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Child sexual abuse

SIR,—Dr Brendan McCormack's editorial on sexual abuse and learning disabilities drew attention to an important problem affecting the lives of children and adults who are unable to speak for themselves because of severe communication or cognitive impairments, or both.[1] The inadequate protection provided by current law is particularly worrying.

There is one aspect of the author's discussion of diagnosis, however, that needs clarification. Dr McCormack emphasised the difficulty of recognising that sexual abuse is occurring and mentioned the presence of "sexualised behaviour, temper tantrums, and challenging behaviour" as pointers. Unfortunately, the latter two features are very common in conditions in the spectrum of autistic disorders; they arise from the characteristic severe impairments of understanding of social interaction and the rules governing social behaviour. "Sexualised behaviour" in the form of masturbation in public is also frequently seen. If the author's recommendation that "such behaviour should always give rise to suspicion of abuse in an adult with learning disabilities" is adopted uncritically then this would involve a large proportion of people with autistic conditions. If it is assumed that the parents or other carers are at fault, this would add immeasurably to the stress of looking after those with communication problems and socially inappropriate behaviour. I have recent experience of three such cases in which parents were unjustly accused solely because of the behaviour of their autistic children—classic examples of the difficulty of proving a negative.

Autistic children and adults are, of course, potentially vulnerable to all kinds of abuse. The