

permission for postmortem examinations when an unanticipated and seemingly inexplicable death of a patient occurs? Regrettably, national statistics would seem to indicate that this is exactly what is happening.

Cyril Wecht, MD, JD
Pittsburgh, Pa

1. Goldstein AD. Coming home. *JAMA*. 1991;265:1099.

In Reply.—The purpose of my essay was to expose the personal shortcomings in the way our society chooses to handle medical malpractice lawsuits. Such shortcomings manifest themselves for physicians in at least two ways. First, most clinicians, regardless of their specialty or the health care setting, at least think about potential malpractice lawsuits subconsciously and consciously, and probably on at least a weekly if not daily basis, regardless of whether they have personally ever been sued. An aura of silence usually surrounds such thoughts despite the enormous implications for patient care. Second, as clinicians, we somehow often feel immune to the same diseases attacking the immune systems of our patients: stress, anger, hostility, rejection, burnout, disappointment, and more. Medical malpractice lawsuits, regardless of their origin, pathophysiology, or prognosis, negatively affect our personal and our family's health. Our own self-healing process can begin by openly acknowledging and discussing such effects, rather than acquiescing to silence, shame, or guilt.

In his letter, Wecht bemoans the fact that "the percentage of hospital and other private autopsies continues to decline," attempting to link such declines to the high rates of medical malpractice lawsuits. I do not know of any research that establishes such a relationship. Wecht is correct to reinforce the importance of autopsies as an important part of medical education, research, and clinical care, but his assumptions that I was sued after a patient under my care died unexpectedly before planned discharge from the hospital and that I did not seek an autopsy in the case, implying that such autopsy was actually purposefully avoided, are both false. The patient's family explicitly refused multiple requests for an autopsy. My interest in the autopsy was to learn from the cause of death so that I could take better care of patients in the future.

Physicians should not be asked to order autopsies to defend their own interests. While autopsies certainly may be used to justify a physician's actions in a medical malpractice lawsuit, it is a fact that the outcomes of such autopsies are also used to initiate these lawsuits.¹ The true purpose for autopsies would appear to lie in the advancement of scien-

tific knowledge and assistance in criminal investigations. Avoiding medical malpractice lawsuits is more easily accomplished by long-term, trusting physician-patient relationships. Such relationships are difficult to establish post mortem.

Adam O. Goldstein, MD
Chapel Hill, NC

1. Weir SS, Curtis P, McNutt RA. Expert testimony on decision analysis: a malpractice case report. *J Gen Intern Med*. 1990;5:406-409.

HIV in Prison: A Counseling Opportunity

To the Editor.—Vlahov et al¹ recently found higher human immunodeficiency virus type 1 (HIV-1) seroprevalence among female than male inmates in nine of 10 US correctional facilities surveyed. Seroprevalence among younger women (<26 years) was higher than among younger men but similar to that in both older women and older men. In their blinded study, Vlahov et al were unable to evaluate the extent to which female inmates were more likely to be intravenous drug users and to have acquired HIV-1 infection through parenteral transmission.

We reviewed the results of an anonymous 1987 survey of 3037 inmates in the Cook County (Illinois) Department of Corrections in order to determine if female inmates were more likely than male inmates to have a history of injectable drug use. In stratified analyses adjusted for differences in race-ethnicity and age, female inmates were almost twice as likely as male inmates to report injectable drug use (adjusted odds ratio [OR]=1.92; 95% confidence interval, 1.50 to 2.46). Moreover, the greater likelihood of female inmates to report a lifetime history of injectable drug use was significantly and inversely associated with age; ORs ranged from 2.13 among inmates younger than 26 years to 1.22 among inmates older than 45 years (Mantel extension for the test of trend: $\chi^2 = 25.27$, 1 df; $P < .001$).

These results and those of Vlahov et al may reflect gender- and age-related differences in the reason for incarceration. Both studies support the view that incarcerated younger women are likely to be HIV-1 seropositive due to intravenous drug use.

We believe it is important to underscore the potential of correctional facilities for reaching younger intravenous drug users, both male and female. In our survey, 17% of those who reported prior drug use with a needle were younger than 25 years. These recent initiates to intravenous drug use are at a high risk for HIV-1 infection^{2,3} but are unlikely to seek drug abuse treatment for sev-

eral years.⁴ Correctional facilities provide a setting for HIV-1 surveillance activities and the provision of acquired immunodeficiency syndrome-risk reduction counseling to younger intravenous drug users.

Thomas M. Lampinen
University of Illinois at Chicago
School of Public Health

Arthur M. Brewer, MD
John M. Raba, MD
Cermak Health Services
Cook County Department of Corrections
Chicago, Ill

1. Vlahov D, Brewer F, Castro KG, et al. Prevalence of antibody to HIV-1 among entrants to US correctional facilities. *JAMA*. 1991;265:1129-1132.

2. Vlahov D, Muñoz A, Anthony JC, Cohn S, Celentano DD, Nelson KE. Association of drug injection patterns with antibody to human immunodeficiency virus type 1 among intravenous drug users in Baltimore, Maryland. *Am J Epidemiology*. 1990;132:847-856.

3. Nicolosi A, Musico M, Saracco A, Molinari S, Ziliani N, Lazzarin A. Incidence and risk factors of HIV infection: a prospective study of seronegative drug users from Milan and northern Italy, 1987-1989. *Epidemiology*. 1990;1:453-459.

4. Lampinen T, Wiebel W, Hershov R, et al. Age bias in treatment-based HIV serosurveys: implications for monitoring the epidemic among younger IVDUs. Presented at the 117th annual meeting of the American Public Health Association: "Latebreakers" Epidemiologic Exchange; October 25, 1989; Chicago, Ill.

This letter was shown to the authors, who declined to reply.—ED.

Seasonality in Sudden Infant Death Syndrome

To the Editor.—A major objective of the Centers for Disease Control (CDC) *Mortality and Morbidity Weekly Report* is to document disease trends accurately. The effort to achieve this goal in the CDC study on sudden infant death and seasonality¹ was weakened by a failure to exclude cases certified as sudden infant death syndrome (SIDS) in which a death-scene investigation was not performed. Contrary to common belief, a high autopsy rate in a SIDS study confirmed by death certificate data does not strengthen the validity of this study when information is lacking concerning death-scene investigation of the presumed SIDS cases.^{2,3}

The observation by the author of the CDC report that the risk of SIDS was greatest for those white male infants whose mothers resided in the western United States must be cautiously interpreted since nonwhite Hispanic infants may be classified as white on death certificates. Because the incidence of SIDS is higher in Hispanic, black, and Native American populations, and because the largest and fastest growing Hispanic population is in the West, the emerging SIDS trend in white male infants, as suggested by the CDC, may represent SIDS cases from Hispanic minority groups that were misclassified according to race or ethnicity in the early and middle 1980s. During the last few years, governmental agencies responsible for vital statistics have encouraged more