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HOMOSEXUALITY IN SOCIETY

The report of the Departmental Committee on Homosexual Offences and Prostitution, medical features of which are summarized at p. 639, contains much of interest to the medical profession. Prostitution was recently discussed at length in these columns,¹ so that comment will now be restricted to those parts of the report concerned with homosexuality. This variety of deviant behaviour has, like others, been affected by the present general tendency by which "the concept of illness expands continually at the expense of the concept of moral failure."²

The Wolfenden Committee, doubtless guided by its medical members, kept clear of any too narrow and old-fashioned a concept of disease, and adopted the dictionary definition of homosexuality—"a sexual propensity for members of one's own sex." This leaves open the questions whether such a propensity results in overt behaviour that alone makes it of legal importance, and whether the propensity is to be detected in some people only, or, as the psycho-analyst asserts, in everybody. The committee agreed with the idea of a rating scale for sexuality as proposed by Kinsey, which ranges from complete heterosexuality to complete homosexuality. According to Kinsey about 4% of American men are exclusively homosexual; Desmond Curran and D. Parr³ found 5% homosexuals (most of whom had had overt experience) in a consecutive series of private patients, and certain other figures are close to these. The propensity is known to occur in association with a wide variety of psychiatric conditions as well as in people who are apparently normal, being stable, free of symptoms, and socially adjusted. This point is brought out particularly in a note by the medical members of the committee—Drs. D. Curran and J. Whitby—which agrees with the data of F. H. Taylor,⁴ T. C. N. Gibbens,⁵ and Curran and Parr.³ These psychological complexities are of special relevance to the difficult problem of the disposal and medical treatment of offenders.

The most far-reaching of the committee's recommendations (with one dissentient) is that homosexual

acts between consenting adults in private be no longer a criminal offence. This opinion derives from the committee's proposition that "it is not, in our view, the function of the law to intervene in the private lives of citizens, or to seek to enforce any particular pattern of behaviour, further than is necessary to carry out its purposes," which are "to preserve public order and decency, to protect the citizen from what is offensive or injurious, and to provide sufficient safeguards against exploitation and corruption of others." Most doctors will probably agree with the opinion expressed by the B.M.A. Committee in its evidence that, if the legal prohibition on homosexual acts between consenting adults is removed, then the age of consent should be not less than 21, and the consent must amount to complete concurrence of view. The undesirability and immorality of such acts are not in question. What is questionable is whether the present law is the best way of diminishing them, or whether more success would come from better education and the strengthening of individual responsibility. Medical opinion is probably divided on the issue, but psychiatrists have usually lent support to the majority view recorded by the Wolfenden Committee.

The medical treatment of offenders suffers from the familiar difficulties common to the treatment of all mental disorders—not enough doctors, not enough knowledge of the aetiology and treatment, unsatisfactory conditions under which doctor and offender must work, and factors in the patients' personalities that make treatment unrewarding. Psychiatrists usually consider that a prison sentence may do more harm than good, by providing opportunities for homosexuality inside and new partners to meet outside. An interesting corrective to this view comes from a survey, referred to in the report, by the Cambridge University Department of Criminal Science, which found that the same proportion—nearly one-third—of men relapse after being placed on probation as after a prison sentence. In a further note Drs. Curran and Whitby considered the committee had unduly stressed the difficulties rather than the constructive opportunities. But it must be admitted that the most likely and valuable effects of treatment will be helping the young man whose homosexuality is transient but who requires psychotherapy to help him past it. For the patient who is adjusted to being homosexual much less is possible; no doctor could produce for the committee a "cured" case of complete homosexuality. The committee stresses the need for planned research into all aspects of this problem, a view that every doctor will endorse.

The report of this committee, following hard on the report of the Royal Commission on Capital Punishment, prompts the question whether these complex subjects of medical, legal, and social interest

¹ *British Medical Journal*, 1957, 2, 399.

² Wootton, B., "Sickness or Sin," *Twentieth Century*, May, 1956.

³ Curran, D., and Parr, D., *British Medical Journal*, 1957, 1, 797.

⁴ Taylor, F. H., *ibid.*, 1947, 2, 525.

⁵ Gibbens, T. C. N., *J. ment. Sci.*, 1957, 103, 527.

⁶ *Homosexuality and Prostitution*, 1955, British Medical Association (2s. 6d.).

are best dealt with by committees of that kind. A changed attitude to suicide has taken place without the need for a committee to explore its legal and medical aspects. A somewhat similar problem now coming to the fore is the causes and effects of accidents, for in these days of comprehensive insurance and the welfare State hardly anything is an "accident" whose effects cannot be blamed on someone else, nor be spread over persons besides the victim. It is debatable whether the appointment of Government committees to consider such questions—usually not until much heat has developed round them—is the best way to ensure that the law, public opinion, and scientific knowledge remain in harmony with each other, particularly since the effectiveness of the committees' recommendations may be, and often is, defeated by the inactivity of a Government.

HAZARDS OF DIAGNOSTIC RADIOLOGY

Early in 1955 the Medical Research Council at the request of the Prime Minister appointed a committee under the chairmanship of Sir Harold Himsworth to report on the medical aspects of nuclear radiation, including the genetic effects. In a comprehensive report,¹ published in June, 1956, the committee estimated the levels of exposure to radiation from all sources, including diagnostic and therapeutic *x* rays, occupational exposure, and exposure due to nuclear explosions, and sought to assess the hazards resulting from these sources. An unexpected finding was that in the population as a whole the gonadal exposure from diagnostic *x* rays probably amounted to no less than 22% of the total normal background radiation and might well be considerably above this figure. It was estimated that the gonadal exposure attributable to fall-out from the testing of nuclear weapons was less than 1% of the background. Hard upon the publication of the M.R.C. report came the communication by Dr. Alice Stewart and her colleagues² which suggested the possibility that leukaemia in childhood might result from intrauterine exposure to *x*-radiation for diagnostic purposes in pregnancy, and this added to the disquiet already occasioned by the finding of the M.R.C. report. It seems likely that the developing foetus is more sensitive to radiation damage than the mature organism, and this may be true too of the early years of infancy.³

Little is known about the true magnitude of the genetic and leukaemogenic (and possibly carcinogenic) risks from diagnostic exposure, and in view of the urgent need of further information on these matters the Minister of Health and the Secretary of State for Scotland have with commendable promptitude set up a committee under the chairmanship of Lord Adrian to review the present practice in diagnostic radiology and the radiotherapy of non-malignant conditions with the object of determining its hazards. Meanwhile it is necessary to retain a sense of proportion when considering the magnitude of these hazards. Professor L. J. Witts,⁴ in a recent article in this *Journal*, wrote: "The possible 50 cases of leukaemia a year from *x*-radiation *in utero* must be set against 439 deaths of mothers in childbirth, 15,829 stillbirths, and 9,750 deaths in the first week of life in 1955. Obstetricians and radiologists believe that the mortality of mother and child may be significantly reduced by appropriate *x*-ray examination in pregnancy, and that they can save more lives than are likely to be lost from leukaemia, appreciating as they now do the hazards of *x*-radiation."

The leukaemogenic and carcinogenic risks affect only the individuals exposed to the radiations. Of another order is the genetic or racial hazard due to the increase of gene mutations in the population. It is believed that new mutation induced by radiation is probably directly proportional to the additional radiation.¹⁻⁵ Most geneticists agree that the radiation dose which would double the natural mutation rate might have serious ultimate effects on the race. Even if it were assumed for the purpose of argument that all the present mutation rate is due to natural radiation (which is not the case), then the increase due to the cumulative effect of diagnostic radiology would be of the order of 22% of the present rate. In fact, however, only a proportion of the natural mutation rate is due to radiation (estimated at from 2–20% in the M.R.C. report). Accordingly, even at the worst, the maintenance of the use of diagnostic *x* rays at current level would not increase the present burden of mutational disease and disability by more than a fraction, although, of course, because of the great increase in man-made radiation for all purposes, it is obviously desirable that exposure to radiation should be kept to a minimum. Attempts have been made to calculate the cumulated dose which would be required over the average reproductive lifetime (say 30 years) to double the mutation rate. The reports of both the Medical Research Council and of the American National Academy of Sciences⁵ agree that this dose may lie between 30 and 80 r—that is to say, an average dose of perhaps 1–3 r per year during the reproductive period. If the contribution of diagnostic radiology in Britain is taken to be 22% of the normal background of approximately 0.1 r per annum, it will be

¹ *The Hazards to Man of Nuclear and Allied Radiations*, 1956, H.M.S.O., London. See *British Medical Journal*, 1956, 1, 1472.

² Stewart, A., Webb, J., Giles, D., and Hewitt, D., *Lancet*, 1956, 2, 447.

³ Simpson, C. L., Hempelmann, L. H., and Fuller, L. M., *Radiology*, 1955, 64, 840.

⁴ Witts, L. J., *British Medical Journal*, 1957, 1, 1197.

⁵ *The Biological Effects of Atomic Radiation—Summary Reports*, 1956, National Academy of Sciences, National Research Council, Washington.

⁶ *Brit. J. Radiol.*, 1957, 30, 281.

⁷ Bewley, D. K., Laws, J. W., and Myddleton, C. J., *ibid.*, 1957, 30, 286.

⁸ Clayton, C. G., Farmer, F. T., and Warrick, C. K., *ibid.*, 1957, 30, 291.

⁹ Ardran, G. M., and Crooks, H. E., *ibid.*, 1957, 30, 295.

¹⁰ *ibid.*, 1957, 30, 436.

¹¹ Clarke, W. G., *Lancet*, 1957, 2, 316.

¹² *Effect of Radiation on Human Heredity*, 1957, World Health Organization, Geneva.