litigation and escalating damages. It need not be so, for most of us are merely seeking the truth and the comfort that lessons have been learnt from such tragedies. That will require a changed GMC both in constitution and in remit.

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Profile of the GMC

SIR,—One of my tasks as postgraduate dean was to try to help doctors referred from the General Medical Council because of difficulties in fulfilling requirements for registration. On a few occasions I felt impelled to appeal to the president on their behalf. His replies were courteous and compassionate, but he pointed out that he was constrained by the regulations imposed on the GMC. It is sad, therefore, that the angry letter from Mr David Bolt and his distinguished colleagues[1] misses the point of Richard Smith's excellent and balanced series of articles. As I see it, he is trying to analyse critically and responsibly a system which many people feel is imperfect; at no time has he questioned the integrity of the people who have to work it or said that the medical profession should not regulate itself.

Those who have read Dougal Swinscow's recently published memoirs[2] may already have diagnosed an incipient case of the gold headed cane syndrome, when Hugh Clegg, then editor of the *BMJ*, was castigated by the medical establishment for writing a strongly worded leader under that title in which he criticised the Royal College of Physicians. He was ultimately vindicated by the representative body in the cause of editorial freedom; let us hope that this is not necessary in the present instance.

Many a rank and file doctor is as confused and suspicious about the workings of the GMC as are members of the public. Surely a calm and constructive debate is more likely to reassure the critics than the intemperance of injured pride. All of us as patients are entitled to expect clear and if possible unambiguous guidance from the council if things go wrong. Protection of the profession is of minor importance compared with public trust and confidence.

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Dose information needed to assess effect of exposure to radiation in utero

SIR,—After the explosion at Chernobyl nuclear power station several estimates were made of the expected number of fatal cancers and mutagenic effects caused by exposure to radiation. Much less attention was given to the effects of exposure in utero, although concern about this immediately after the accident led to an increase in induced abortions in some places.[1]

Recent studies by congenital anomaly surveillance systems[2,3] have been limited by the lack of readily interpretable information on dose to the fetus. There are some important distinctions to be made between the study of adult or postnatal exposures and fetal exposures.

Firstly, except for childhood cancer and possibly mental retardation, the possibility that the effects of fetal exposure (such as congenital anomalies) are non-stochastic, with a threshold level and dose related severity, must be considered.[4,5] It is therefore important to have information about the range of exposures in the population, not just the average dose.

Secondly, since specific teratogenic effects may have a relatively short sensitive period (after which exposure is no longer teratogenic) the dose rate (per day or month) in successive periods may be more important than the integration of the dose over one or more years.

Thirdly, exposure pathways differ between fetus and adult. The maternal body provides some shielding to external radiation. For radionuclides ingested by the mother caesium-137 is probably distributed fairly evenly throughout the fetal and maternal bodies, but iodine-131, which collects in the thyroid, may not cause serious exposure until roughly 11 weeks after conception, when the fetal thyroid begins to develop.[6] At this stage the sensitive period during organogenesis for many major congenital anomalies (though not microcephaly or mental retardation) has already passed.

To look for increases in the frequency of congenital anomalies due to exposure to low doses of radiation, we need to be able to formulate specific hypotheses about where and when those increases are likely to occur. Neither the average individual effective dose during the first year after Chernobyl[7] nor external dose rates[2] are sufficient measures on which to base risk estimates. For fetal exposures the range of individual exposures, the dose rate, and the type of radionuclide as well as the route of exposure are all important variables. When planning the type of information to be made available in the event of a future nuclear accident these comments might be taken into account.

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Sexual behaviour of men

SIR,—In their report on the sexual behaviour of men in England and Wales[1] Dr David Forman and Ms Clair Chilvers suggest that their study is population based. It was population based for their original study on testicular cancer but clearly was not population based for the sexual behaviour study.

The men they studied were the controls of the men with testicular cancer. The men with testicular cancer are clearly a highly selected subset of the general population and the controls, for whom tight criteria were set, will be a biased subset. Thus their results will not be generalisable and caution must be used in interpreting the data. Curiously they chose to look only at white men. They also excluded from their analysis 25 men who had moved out of the study area but did not include men who had moved in, so they excluded a more mobile section of the population. Their group was identified only from general practitioners' lists, so again men who are more mobile would not have been included in their sample.

They then interviewed these men using a woman interviewer, the reason for the choice not being given. It is probably reasonable to assume that the sex of the interviewer may affect the response to questions about sexual behaviour. I suspect that responses about heterosexual sex may be more accurate, but the responses about homosexual sex may well be less accurate and this opinion is confirmed by other colleagues. This would lead to underreporting of homosexual activity.

They also asked only about "homosexual intercourse," which they define in their conclusions as anal intercourse but did not so define it to their interviewees. If their aim is to look for risk factors for transmission of sexually transmitted diseases then more precise questioning is essential. It is our experience that gay men are much more imaginative in their sexual behaviour than heterosexuals and many do not engage in anal intercourse. The Sigma study suggests that as many as 50% of men who have sex with other men do not have anal intercourse. As often happens, these researchers are confusing sexual activity (which they can conceptualise in only heterosexual terms) with being homosexual. It is quite possible to experience homosexual attraction and remain celibate or even chaste.

Thus the findings of this study—which was reported in the national media as indicating that less than 2% of the population were homosexual—may be neither valid nor accurate.

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1 Forman F, Chilvers C. Sexual behaviour of young and middle aged men in England and Wales. *Br Med J* 1989;**298**:1137-42. (29 April.)

A tale of two sisters

SIR,—The reason why Dr A had to wait so long for her cataract operation[1] is because most eye operations in Britain are carried out under general anaesthesia despite the fact that many cataract patients are old and frail. The technique for local anaesthesia is simple and safe, and patients appreciate the advantages, especially their early mobilisation. Local anaesthesia also has the great advantage of reducing the operating time by half so that it is possible to carry out six cataract operations with implants per session, compared with the standard three under general anaesthesia.

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1 Anonymous. A tale of two sisters. *Br Med J* 1989;**298**:1107. (22 April.)

Discharge to nursing homes

SIR,—Dr Angela M Hilton described how the hospital authorities tried to suggest early discharge of her sick elderly father to private nursing care.[1] Clearly, the hospital was at fault. Two circulars about hospital discharge (HC89/5 and LAC(89)7) recently issued by the Department of Health describe the correct procedure, and both make clear that all parties should be consulted before discharge.

Dr Hilton's father was obviously in no fit condition to be discharged to the care of his elderly spouse, and if it was not the family's choice discharge to a private nursing home should be made only under a contractual arrangement. The 1948 act which placed responsibility for the chronic sick on the hospital service has not been repealed. Therefore when a hospital chooses to