sampling strategies may under-represent minorities with multiple partners (for example, prostitutes); and sexual partnerships occur outside the sampled population through migration and travel. Women have male partners who are, on average, older than themselves; thus the age distribution of men is not necessarily representative of the age distribution of the male partners of the women in the sample (and vice versa). "Lifetime" partners do not refer to a finite time period but to partners since first sexual intercourse "so far"; this may be the most inaccurate measure because of difficulties of recall, whereas discrepancies over shorter time intervals are much smaller. Although men and women are remarkably consistent about the frequency and type of sexual practices reported,⁴ strong cultural forces may nevertheless influence men and women in different ways with respect to accurate reporting of the number of sexual partners. We intend to examine this apparent anomaly more fully in future work.

Francome suggests that the only way to obtain reliable data about heterosexual behaviour is to ask men about their previous experiences and the ages of their partners and from the responses construct the data for women. For those men with many partners this would require a superhuman feat of memory. More importantly, it is unacceptable to construct data that are available by direct inquiry.

John Bancroft has highlighted an important observation that recently there seems to be a greater willingness to disclose socially censured sexual behaviour.⁵ Improved survey design (such as careful definition of a sexual partner) may result in more accurate information, but there is ample scope for further research into gender differences in reporting by detailed inquiry into the way people recollect their sexual behaviour. Increased acceptance of studies of sexual behaviour could indicate a change in the social acceptability of different lifestyles, which would lead to greater similarity between men and women in the interpretation of past behaviour.

J WADSWORTH
K WELLINGS

Academic Department of Public Health,
St Mary's Hospital Medical School,
London W2 1PG

A M JOHNSON

Academic Department of Genitourinary Medicine,
University College Medical School,
London W1N 8AA

J FIELD

Social and Community Planning Research,
London EC1V 0AX

- 1 Francome C. Sexual behaviour. *BMJ* 1993;306:212. (16 January.)
- 2 Gurman SF. Six of one. . . . *Nature* 1989;342:12.
- 3 Johnson AM, Wadsworth J, Field J, Wellings K, Anderson RM. Surveying sexual attitudes. *Nature* 1990;343:109.
- 4 Wellings K, Wadsworth J, Johnson AM, Field J, Anderson RM, Bradshaw SA. Sexual lifestyles under scrutiny. *Nature* 1990;348:276-8.
- 5 Bancroft J. Sexual behaviour in Britain and France. *BMJ* 1992;305:1447-8. (12 December.)

EDITOR,—In his editorial on studies of sexual behaviour in France¹ and Britain² John Bancroft raises two particularly important issues—namely, the training of interviewers and the importance of understanding rather than counting.³

In our study¹ special attention was paid to the selection, training, and psychological support of the interviewers. All had volunteered for the study and received two full days' training before its start. This training was to elucidate the objectives of the study, to familiarise interviewers with the questionnaire, and to prepare them for conducting interviews on intimate and possibly sensitive questions. There were 110 interviewers (48 men and 62 women) working in two private survey institutes. Only six resigned from the study on the grounds of stress related to the subject.

While the data were being collected (from 16

September 1991 to 15 February 1992) at least one of the researchers was present in each telephone room, in addition to the usual supervisory staff of the institute. At all times it was possible to listen in on interviews and to monitor the interviewer's work on a control screen. This enabled us not only to check the quality of the work but also to help if problems arose and to show the importance we attached to the role of the interviewers. At the midpoint of the study all interviewers were seen in small groups for a psychological debriefing. Key variables were monitored statistically, and a weekly meeting was held with senior institute staff. Acceptance rates were computed and surveyed every week.

With regard to Bancroft's second point, our research was designed not only to quantify sexual practices but also to understand why people put themselves at risk of contracting sexually transmitted diseases, especially AIDS. More than half of the questionnaire was devoted to questions aimed at understanding the psychological and sociological mechanisms in risk taking. These include social norms, the familial environment, verbal communication with new partners, attitudes towards body fluids, social networks, and an exploration of the "locus of control."

ALFRED SPIRA
On behalf of the consortium
Analyse des Comportements Sexuels
en France

Santé Publique-Epidémiologie-Reproduction
Humaine U 292,
Hôpital de Bicêtre,
94275 Le Kremlin-Bicêtre Cedex,
France

- 1 ACSF Investigators. AIDS and sexual behaviour in France. *Nature* 1992;360:407-9.
- 2 Johnson AM, Wadsworth J, Wellings K, Bradshaw S, Field J. Sexual lifestyles and HIV risk. *Nature* 1992;360:410-2.
- 3 Bancroft J. Sexual behaviour in Britain and France. *BMJ* 1992;305:1447-8. (12 December.)

Academic medicine

EDITOR,—Richard Smith has drawn attention to the concern expressed by academic physicians over the process of accreditation.¹ The royal colleges and the Joint Committee on Higher Medical Training (JCHMT) are often accused of inflexibility in their interpretation of requirements for accreditation in the case of academics, whereas in fact such applications are treated sympathetically.

So far as training for consultant practice in the NHS is concerned, all specialties accept one year of research towards higher medical training. One year in four seems to be a reasonable compromise between the acquisition of research experience and the need to acquire clinical skills. Academics may also find it more practical to obtain accreditation in a single specialty rather than dual accreditation including general medicine, because the experience in emergency admissions and continuing care may be difficult to obtain in some academic units. Others may obtain approval in advance for training in unusual specialties where no formal JCHMT programme exists.

Academic trainees should receive proper counselling before starting a research post in order that future career options are fully understood. The type of research, including its clinical component, may well influence future career choice and opportunity. Above all, trainees and their supervisors should discuss matters concerning accreditation with the JCHMT early in the training period.

Accreditation is of little relevance to those who compete for senior academic posts, which are decided on the basis of academic achievement. Problems may arise when trainees decide to switch from an academic to a NHS career. Accreditation is then perceived as a safety net, but here again consultant appointment depends less on accreditation than on possession of the required skills and

training. The colleges have always taken the view that accreditation was not a prerequisite for appointment; a recent survey revealed that approximately one third of physicians were not accredited at the time of their appointment.

A different form of accreditation for academics would not help. For those who wish to make the transition back to the NHS, the possession of a certificate testifying to their clinical adequacy only when part of a team of physicians is likely to be a stigma rather than of benefit.

The JCHMT continually revises its training programmes and awards accreditation to those who satisfactorily complete the prescribed period in training. The colleges have, however, always held the view that accreditation was less important for appointment to consultant status than that the skills and training of the individual should match the requirements of the post.

BRIAN L PENTECOST

Joint Committee on Higher Medical Training,
Royal College of Physicians,
London NW1 4LE

- 1 Smith R. Academic medicine: plenty of room at the top. *BMJ* 1993;306:6. (2 January.)

Poor growth in children

EDITOR,—Gary Butler¹ and N A Bridges and colleagues² have missed the fundamental point of our paper on poor growth in school entrants as an index of organic disease.³ We do not deny the value of long term repeated measurements of height for all children and have advocated that these should start at the earliest possible age.⁴ We had previously reported, however, that the imprecision of measurement of height is such that it is not possible, in the short term, to label a child a "good" or "poor" grower.⁵ The widespread practice, therefore, of delaying investigations in those children with very short stature for six or 12 months in order to estimate velocity is of no value. Once height at school entry has been measured nothing further is to be gained from such a delay. We have shown that a single measurement of height is of greater value in identifying disease in short children than a single measurement of velocity over 12 months.

L D VOSS
P R BETTS

Wessex Growth Study,
Southampton General Hospital,
Southampton SO9 4XY

- 1 Butler G. Poor growth in children. *BMJ* 1993;306:270-1. (23 January.)
- 2 Bridges NA, Hindmarsh PC, Brook CGD. Poor growth in children. *BMJ* 1993;306:270-1. (23 January.)
- 3 Voss LD, Mulligan J, Wilkin TJ, Betts PR. Poor growth in school entrants as an index of organic disease: the Wessex growth study. *BMJ* 1992;305:1400-2. (5 December.)
- 4 Betts PR, Voss LD, Bailey BJR. Measuring the heights of very young children. *BMJ* 1992;304:1351-2.
- 5 Voss LD, Bailey BJR, Cumming K, Wilkin TJ, Betts PR. The reliability of height measurement (the Wessex growth study). *Arch Dis Child* 1990;65:1340-4.
- 6 Voss LD, Wilkin TJ, Bailey BJR, Betts PR. The reliability of height and height velocity in the assessment of growth (the Wessex growth study). *Arch Dis Child* 1991;66:833-7.

Circumcision

EDITOR,—Andrew Gordon and Jack Collin's editorial is centred on the correct indication for circumcision—that is, true phimosis—and notes that most, if not all, of these cases could be the result of balanitis xerotica obliterans. The histological characteristics described in detail in the editorial are more appropriately called lichen sclerosis, as indeed they were in the article by Clemmensen *et al* which the authors cite.² Balanitis xerotica obliterans is a descriptive term and not a

diagnosis, as it represents the end stage of several skin diseases, including, rarely, cicatricial pemphigoid and lichen planus as well as lichen sclerosis.

Similar confusion has arisen in females whereby lichen sclerosis has been described by various now obsolete terms such as leucoplakia and kraurosis vulvae. The recognition of lichen sclerosis as a clear entity is a prerequisite for good management and follow up. Unfortunately, these aspects are relatively neglected in males, particularly boys,³ as few surgeons seem to send the ablated foreskin for histological examination. Genital dermatoses are seen by specialists from disciplines other than dermatology, and the evolution of multidisciplinary teams running combined clinics for vulval diseases has led to improved diagnoses and management of patients with these problems. Perhaps similar clinics should be organised for penile problems.

C M RIDLEY
S M NEILL

St John's Dermatology Centre,
St Thomas's Hospital,
London SE1 7EH

- 1 Gordon A, Collin J. Save the normal foreskin. *BMJ* 1993;306:1-2. (2 January.)
- 2 Clemmensen OJ, Krogh J, Petri M. Histologic spectrum of prepuces from patients with phimosis. *Am J Dermatol* 1988;10:104-18.
- 3 Ridley CM. Genital lichen sclerosis (lichen sclerosis et atrophicus) in childhood and adolescence. *J R Soc Med* 1993;86:69-75.

Initiation of hypertension in utero

EDITOR.—C M Law and colleagues, in their interesting paper on the initiation of hypertension, suggest that the relation between birth weight and blood pressure is amplified through life.¹ Although this assertion may be correct, the evidence that they present requires cautious interpretation. The four study populations reported on differ in their dates of birth as well as in their ages, with the oldest study populations being born earliest. Separating the effect of age from the effect of time of birth on the strength of the relation between birth weight and blood pressure is thus difficult.

To show conclusively that the association between birth weight and blood pressure is amplified with age, longitudinal study of individuals is needed. Only one of the four groups studied by Law and colleagues, the Farnborough (Brompton study) children, was followed over time. However, the regression coefficients relating birth weight and systolic pressure in those children, once adjusted for variation in the standard deviation of systolic pressure at different ages, do not become consistently stronger with age (figure). Moreover, within the Brompton study data, it is

Regression coefficients relating birth weight and systolic pressure (mm Hg/kg) between 4 days and 10 years, divided by standard deviation of systolic pressure (mm Hg) at each age (the Brompton study)

particularly difficult to interpret the regression coefficients (which are adjusted for concurrent weight throughout) in the youngest age groups. The relation between birth weight and blood pressure in the youngest age groups are thus being adjusted for measurements of weight only days or months after birth. Is it plausible that birth weight and weight four days after birth can be used to distinguish the effects of fetal and postnatal growth on blood pressure? The limited value of such an analysis is illustrated by the large standard error in the birth weight-blood pressure regression coefficient at 4 days, which reflects the high correlation of the two weight measures.

We have recently produced direct evidence supporting the possibility of amplification of the birth weight-blood pressure relation in childhood. In a cohort of 540 children, the association between birth weight and blood pressure increased in strength almost twofold between 5-7 years and 9-11 years.² The absence of any relation between birth weight and change in blood pressure percentile rank between 5-7 and 9-11 years suggested that the relation between birth weight and blood pressure is established by 5-7 years and that the subsequent increase in the strength of the association is due to blood pressure tracking and to the increasing dispersion of the blood pressure distribution with age.²

P H WHINCUP
O PAPACOSTA

Department of Public Health and Primary Care,
Royal Free Hospital School of Medicine,
London NW3 2PF

D G COOK

Department of Public Health Sciences,
St George's Hospital School of Medicine,
London SW17 0RE

- 1 Law CM, de Swiet M, Osmond C, Fayers PM, Barker DJP, Cruddas AM, Fall CHD. Initiation of hypertension in utero and its amplification in adult life. *BMJ* 1993;306:24-7. (2 January.)
- 2 Whincup PH, Cook DG, Papacosta O, Walker M. The influence of birth weight upon blood pressure in childhood (abstract). *J Hypertension* 1992;10:1427-8.

Primary prevention of neural tube defects with folic acid

EDITOR.—At Christmas we all received the HMSO circular dated 17 December from Dr Calnan and his colleagues at the Department of Health. We are exhorted to get all women planning a pregnancy to consume a supplement of 400 µg folic acid or folate daily and to continue through the first trimester. Unless you are addicted to Brussels sprouts and fortified cereals, you will find taking this amount of folic acid unachievable solely through eating the right food.¹

Imagine our horror at the thought that we might now be held legally responsible for the tragic results of an inadequate diet. Add to this our initial difficulty in knowing what to recommend, when the very same paper said that there was no such folic acid supplement to give. What a relief when a second circular dated 18 December arrived, saying that 0.4 mg supplements are available singly or as B group tablets.

Keen to work proactively, we asked eight local pharmacists what they could provide for our patients. Three responded. We could prescribe approximately 0.4 mg folic acid by using one of several iron and folate combinations recommended for pregnancy anaemias. But they had no low dose folic acid supplements. One pharmacist belonging to a national firm contacted the head office, which said that a suitable product can be made by special order at £100 for 100. Another asked the National Pharmaceutical Association, which said that there is no medicinal product licensed for sale but referred to one small firm's product, a 400 µg folic acid tablet, licensed only as a food supplement.

It seems extraordinary that circulars should be

issued with no public health promotional material and no infrastructure available for the delivery of the recommended supplements.

The obstacles to appropriate preconceptual and conceptual care of women in deprived urban areas such as ours are great; a pregnancy may be a welcome but unplanned event and many social and economic factors are beyond individual control. How can we help poor women to avoid neural tube defects when the appropriate supplements, even when they become available, are not going to be prescribable on FP10s but will have to compete with the rest of the family's needs?

ANNA LIVINGSTONE

Gill Street Health Centre,
London E14 8HQ

- 1 Department of Health. *Folic acid and the prevention of neural tube defects*. London: DoH, 1992.

Lunchtime admissions

EDITOR.—Recently, as a trainee general practitioner, I went out on an urgent call at lunchtime on a weekday. It turned out that the patient had probably had an intracranial bleed. I contacted the local neurosurgical unit, and one of the team agreed to admission. When I asked where I should send the woman I was told to contact the neurosurgical bed manager, who would tell me which ward to send her to.

I eventually got back to the switchboard and asked for the neurosurgical bed manager. It was 1.45 pm by this time. I was told that the manager had gone to lunch, and when I asked for him to be bleeped I was told again that he had gone to lunch and that he had left his bleep at the switchboard—all in a tone that suggested that this was standard behaviour. I then asked to speak to his superior and was told that he didn't have one as he worked on his own and there was no way of contacting him. I spoke again to the neurosurgical surgeon and explained that I had no choice but to send the patient, who needed urgent admission, to casualty. He eventually suggested sending her to one of the wards and said that he would sort things out from there.

I find it indefensible that a bed manager—especially for neurosurgery, a specialty in which admissions are often urgent—is allowed to go to lunch without a bleep and that no one covers for him. I wonder whether eventually admissions will be possible only during working hours but not during lunch or coffee breaks.

J A BRAY

Gosforth Memorial Health Centre,
Gosforth,
Newcastle upon Tyne

Radiology guidelines

EDITOR.—The paper from the Royal College of Radiologists Working Party would have had more impact if details of results of radiographs had been included.¹ The introduction of the guidelines appears to have led to around 1615 patients not being x rayed (we are not told whether there were confounding variables such as fundholding). Were these patients disadvantaged in any way? If not, one presumes that radiography would have either shown no lesion or not contributed to management of disease. If that is the case, the percentage of abnormalities should have increased in the reduced number who were referred.

This report is valuable, but incomplete. The suggestion that generation of referral data should be specified in contracts is welcome, but should be extended to feedback (through the medical audit network rather than through management) of the results of radiography referral in terms of