study was important because of other contemporary reports.^{2,3}

Gardner *et al.*'s results² were not published until after our interviews were completed. Thus they cannot have led to any recall bias related specifically to the prenatal period. Nevertheless, there was geographic overlap and the time period and methods of control selection were similar so that our results were not independent of theirs. We have now been able to cross check our entire study population against their data base (which includes more recent cases and controls added since the original report). We excluded all subjects who were present on their data base and analysed all remaining case-control sets that were discordant for paternal radiation exposure (in one of the three time periods) using exact methods of analysis with the statistical package EGRET.

The table provides exposure classifications for the subjects in this analysis. The overall numbers are reduced, as was anticipated; in particular, the numbers classified as certainly exposed to ionising radiation have become almost negligible (one case "exposed" before conception and one control exposed postnatally, both with extremely small lifetime doses).

Exposure of fathers to ionising and non-ionising radiation

Timing	Exposure*	No of cases	No of controls
Before conception only	Ionising radiation:		
	Certain	1†	0
	Possible	1	2
	Unlikely	1	2
	Non-ionising radiation	2	0
Preconception, periconception, and during gestation	Ionising radiation:		
	Certain	0	0
	Possible	3	0
	Unlikely	1	0
	Non-ionising radiation	2	0
Postnatal only	Ionising radiation:		
	Certain	0	1‡
	Possible	1	0
	Unlikely	0	2
	Non-ionising radiation	0	0
	Total	1	3

†Total lifetime dose=1.11 mSv. ‡Total lifetime dose=2.98 mSv.

Ionising: certain= registered radiation workers (National Register of Radiation Workers or British Nuclear Fuels Ltd); uncertain=others whose job description is consistent with exposure to ionising radiation (industrial radiographers and contract workers at nuclear sites); unlikely=unlikely to have been exposed to ionising radiation but exposure cannot be ruled out.

Several points noted in the first report persist. Firstly, our data provide no evidence of independent risk associated with paternal postnatal exposure (three controls, one case). Secondly, they do show significant associations of leukaemia risk for paternal exposure before conception (11 cases, four controls; odds ratio 5.08, 95% confidence interval 1.50 to 21.99); a stronger effect but based on smaller numbers remains evident for periconceptional exposure (six cases, no controls; 2.14 to ∞). These results include four cases and no controls exposed to non-ionising radiation and two cases unlikely to have been exposed. If all of these are excluded the strengths of the associations are reduced and they are no longer significant (preconception: odds ratio 4.59, 0.74 to 45.58; periconception, 0.83 to ∞). The evidence for increased risk is not confined to West Cumbria. All the case children included in this analysis of prenatal parental exposure had diagnoses of acute lymphoblastic leukaemia.

These results yield a modest independent contribution to the scientific debate concerning possible effects of paternal radiation exposure before the birth of children. We recommend extreme caution in their interpretation: the numbers are very small; almost none of the exposures have been validated; these fathers had had a variety of other occupational exposures; and

entirely different exposures³ may be relevant in these data.

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Classifying suicide

EDITOR,—Derrick J Pounder's argument regarding the official misclassification of suicide¹ is based on the assumption that all deaths by hanging are suicidal. However, accidental death by hanging is a recognised hazard of sexual practices in which partial asphyxia, by using nooses or other means, is deliberately induced as an adjunct to masturbation.^{2,3} Public awareness of this practice has increased in recent years and the increase in fatal hangings classified as "undetermined" may reflect this fact. The extent of misclassification occurring in official suicide statistics can be clarified only by research using data on individual cases.

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EDITOR,—I share Derrick J Pounder's view that a change in the burden of proof for suicide verdicts is overdue.¹

During the 25 years from 1965 to 1989 there were 250 deaths at the Beachy Head cliffs. The inquests returned 134 suicide verdicts, 100 open verdicts, and 16 other verdicts. All the suicide or accident verdicts were substantially correct. Of the deaths with an open verdict, 97 had a suicide profile with at least three factors.^{2,3} In total, the balance of probability is that 236 were suicides.

To give an example: a 1975 victim had been in a psychiatric hospital with depression. In the fortnight before his death he made four serious suicide attempts. At Beachy Head he ran to the edge, where he was held by a witness, whereupon the victim said, "For God's sake let go, I am a mad brute.... If you don't let me go you are coming with me." At the inquest the coroner stated there was no note and "at no time on the cliff edge did he say he was going to take his life." He returned an open verdict: by any standards an obtuse verdict.

Coroners aim at consistency and accept that it is their duty not to presume suicide, but certain interpretations of "clear intent" have confined suicide verdicts to those who left a note.

Verdicts have never represented the "true" suicide rate. A review of Sussex coroners' inquests for 1485 to 1558 states, "Because of the stigma

attached to suicide...suicides must have been cases about which there could be no doubt." In 1912 M R Cozens-Hardy, reviewing a verdict, said, "Suicide is never presumed...the Judge seems to have thought it was more likely that the man committed suicide than anything else. The Judge is not entitled to act on a surmise of that nature." Even after the Suicide Act of 1961, the Court of Appeal reiterated that suicide requires an intention to kill oneself which must be affirmatively proved.⁴

Dr C A H Watts wrote that "the coroner... bends over backwards to avoid the verdict of suicide, so that the statistics are an underestimate,"⁵ at which a coroner pointed out that "it is not a question of bending...but of giving a decision in accordance with the law of the land."⁶

Presumption of suicide will harmonise British criteria with those of the Scandinavian countries.^{9,10} If others followed, comparison of suicide rates would be less of a voyage of serendipity.

The feelings of the bereaved must be considered (less publicity would help and might reduce suicides at Beachy Head), but despite the 1961 act a suicide verdict is not acceptable for some relatives, who will appeal against the coroner's decision unless there is change.

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Monitoring ambulatory blood pressure in general practice

EDITOR,—We accept that the introduction of non-invasive ambulatory blood pressure monitoring in general practice should occur within the context of research and audit, as described by Chris Silagy and colleagues,¹ since this was a major thrust of our original letter.² We remain concerned, however, that this may then lead to wholesale introduction of the technique before the levels of systolic and diastolic blood pressure requiring drug treatment have been defined. These levels will depend on whether "day" or "night" (currently imprecisely defined) or 24 hour measures of ambulatory pressure are used. At present we rely on a consensus view³ based on meta-analysis of several population studies that a daytime average blood pressure of more than 135/85 mm Hg may indicate hypertension.

The correspondence generated by our original letter illustrates the lack of consensus in practice. Coats and Clark have recently suggested that treatment should be recommended for a daytime average pressure of more than 160/95 mm Hg,⁴ while Coope and Coope recommend using a 24 hour average (which is usually lower than the daytime average) diastolic pressure of 90 mm Hg.⁵ Even more confusing, Conway, a cosignatory with Clark and Coats in response¹ to our letter, has recently advocated widespread use of ambulatory monitoring of blood pressure in general practice without providing any guidelines as to what constitutes normal or raised blood pressures.⁶ It is not our intention to suggest that "general practitioners are incapable of interpreting current evidence,"⁷ but rather, as suggested elsewhere,⁷ that specialists in the field have yet to agree a basis on which