While screening for medical fitness to drive may seem an attractive idea, it is unrealistic. Not only is there a lack of effective screening tests but recent data suggest that this sort of strategy may be not only ineffective but also harmful. Some European countries have attempted to screen for illness relevant to driving by demanding a doctor's certificate at regular intervals after the age of 70. A comparison of accident rates between Sweden (where there is no medical control) and Finland (where regular medical recertification is required after age 70) showed no reduction in fatalities in motor crashes and an increase in pedestrian and cycle fatalities in Finland. This may be a result of stopping older people driving unnecessarily and forcing them into the much higher risk group of pedestrians and cyclists.[5]

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Assessments should be independent

EDITOR,—We agree with Jo Alexander that some elderly drivers are a hazard to themselves and other road users.[1] The author is provocative, however, in suggesting that general practitioners may have a vested interest in keeping their patients on the road. Although the ability to drive to the surgery may reduce the need for home visits and prevent social isolation, we are sure that general practitioners would not knowingly put people's lives at risk.

We believe that general practitioners are not the appropriate people to assess whether their patients are fit to drive, for several reasons: good general health does not imply good control behind the wheel; the relationship between a doctor and patient, which has been built up over many years, may be ruined if the general practitioner has to stop the patient driving; and there is no standard assessment system, and general practitioners' decisions would be subjective. We believe that an independent assessment, which should include a medical examination and a practical driving test, should be arranged by the Driving and Vehicle Licensing Agency.

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Rigid rules for hypomanic patients are unfair

EDITOR,—Jo Alexander is concerned about elderly people who continue to drive.[1] I wish to highlight the stigmatisation and unnecessary hardship suffered by some hypomanic patients because of the inflexible application of the Driving and Vehicle Licensing Agency's regulations, with limited rights of appeal. Current regulations require a person admitted to hospital with hypomania to inform the agency.[2] After a time, while medical reports are sought, the person loses his or her licence for six to 12 months. Appeal (within 21 days) is through the courts (and hence is public). Most appeals are lost, with the applicants having to bear their own costs and those of the agency. The case may be reconsidered after six months, and if the medical reports are supportive the licence may be restored.

Admission to hospital is a poor indicator of the severity of illness, depending more on social factors and perceived level of support.[3] Apart from in a few dramatic cases of speeding, mania and hypomania are not associated with increased accident rates.[4] No one whose road safety is impaired by illness or drug treatment should drive. Hypomania, however, is usually brief and recovery from it complete. Once well, people are keen to return to their usual lifestyle, and driving is essential for most. Losing the right to drive for six to 12 months can mean losing employment and access to social activities and can cause great hardship, especially in rural areas with limited public transport.

I believe that the rigid application of the Driving and Vehicle Licensing Agency's guidelines is often cruel and unnecessary, with no basis in accident data. The agency's medical advisers tell me that the regulations are likely to become more rigid when European Union directives are implemented. I suggest instead that each case should be examined individually, with reference to the medical reports already being requested. People with severe illness, frequent relapses, or poor compliance and those who are prone to reckless driving could then be dealt with independently of the majority, who are no more likely to be hazardous on the road than anybody else.

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DVLA senior medical adviser's reply

EDITOR,—The problem that Jo Alexander describes —of an aunt who continued to drive into her 90th year—is one of general concern.[1] We will always make medical inquiries if a health condition is declared, but some elderly people refuse to accept that they may be unfit and omit to declare a medical condition even when specifically asked to do so on renewal of their driving licence. Advice about to be published by the General Medical Council on when it is appropriate to release information to the Driver and Vehicle Licensing Agency should make doctors' role clearer.

In response to Eleanor Halloran's letter, I acknowledge that the loss of driving privileges inevitably causes hardship. Although we endeavour not to be unreasonable, our prime concern must be for road safety. The secretary of state must satisfy himself that any person who has a medical condition is fit to drive,[2] and the driving public expects this duty to be exercised properly.

The decision to revoke a driving licence held by a patient with hypomania is made not just on a history of admission to hospital but on the details of the admission and the previous history. A medical condition must be stable and seen to be controlled before driving is allowed: six months for a patient with severe hypomania does not seem unreasonable. This period may be reduced if it seems safe to do so, or increased for up to one year if not. The driving licence cannot be revoked until the medical evidence has been examined, and when it has been the patient is given a full letter of explanation and advice. The time allowed for an appeal to be made is defined in law: 21 days in Scotland and six months in England and Wales. In our letter to the patient, however, we suggest that a formal appeal, which can be costly, may not be necessary and that an informal approach by the patient's general practitioner or consultant to one of the medical advisers may be more useful.

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Sexual behaviour of men

Review mis-stated prevalence of anal intercourse

EDITOR,—Project SIGMA (Essex) provided the data on gay men's sexual behaviour that were cited in the *Public Eye* programme "Sex in the Dark," which Richard Momeyer reviews.[1] The data are drawn from sexual diaries (calibrated with data from interviews with the men) and were reported at a conference on behavioural interventions and HIV at the Royal Society of Medicine. The data cited by Momeyer, however, are incorrect. It is not true that 70% of gay men who engage in anal intercourse do not use condoms, as Momeyer reports. It is true, however, that 70% of acts of anal intercourse are unprotected and that 40% of acts of anal intercourse by HIV positive men are unprotected (the unit being the sexual act).

The statistics are undoubtedly high in either event, but our analysis suggests that acts of anal intercourse are fairly concentrated (half of all acts of anal intercourse are performed by a tenth of individuals). It is heartening that "risk rich" individuals are far more likely than occasional practitioners to carry condoms and use them.

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Survey shows unprotected sex is a common behaviour in bisexual men

EDITOR,—The proportion of men who have sex with both men and women and the pattern of their sexual behaviour have long been recognised as being potentially important in the future pattern of spread of HIV infection and other sexually transmitted diseases.[1] Until now, most information has been based on studies of gay men[2] or small studies of (mainly) self identified bisexuals.[3] The British national study of sexual attitudes and lifestyles estimated that 0.8% of the male population had sex with both males and females in the five years before interview; it acknowledged that several factors made this a lower bound estimate.[4] The members of this group who do not identify themselves as gay or bisexual have never been included in any numbers by a major European study of sexual behaviour.

In a recent national study commissioned by the Health Education Authority in Britain we interviewed 745 men who reported having had sexual contact with both men and women in the previous five years. Participants had responded to an invitation to take part in anonymous telephone

interviews, which had been placed in the "lonely hearts" or "contact" sections of local and national newspapers and magazines. The sample came from 107 of the 120 postal districts in Britain. The age range was 16-73 (mean 33·3 (SD 8·7) years), with only 148 coming from social and occupational classes 1 and 2.

Preliminary analysis shows that 644 reported having had sexual contact with men and women in the year before the interview (mean three male and three female partners). Six hundred and ninety nine reported vaginal intercourse with a female partner, of whom 502 had not used a condom. Four hundred and sixty one reported anal intercourse with male partners, of whom 135 had not used a condom. Five hundred and thirty one reported that they currently had a regular female partner, but only 233 currently had a regular male partner. One hundred and seventy four had both female and male regular partners. Almost all the respondents' regular male partners (203) knew of their sexual activity with women, but only a third (144) of their regular female partners knew of their homosexual activities.

Considerable potential exists for the spread of sexually transmitted diseases within and by this population, with its high numbers of partners and appreciable rate of unprotected anal and vaginal intercourse. The extent to which HIV will spread within this population depends crucially on the patterns of sexual contact with existing core groups (especially gay men).

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Protecting children in cars from tobacco smoke

EDITOR,—There is considerable evidence that exposure of children to environmental tobacco smoke is associated with an increase in morbidity in those with pre-existing asthma and an increase in the number of new cases of asthma.[1,2] In Australia, accreditation standards for child care now require that day care centres be smoke free,[3] and nearly one in four smokers report voluntarily smoking only outdoors at home.[4]

While the state regulates many aspects of the domestic environment (for example, electrical and building standards, smoke detectors), there are few precedents for the regulation of personal behaviours such as smoking in homes (although sexual and violent behaviour towards children is outlawed in many countries). When adults smoke in the enclosed, confined interiors of cars small children who are passengers are involuntarily exposed to often prolonged, concentrated volumes of environmental tobacco smoke. To our knowledge, public support for the regulation of smoking in cars has never been measured in any country.

To test community support for the banning of smoking in cars while children are passengers we conducted a random household survey, using standard methods for assessing the prevalence of smoking and attitudes.[5] The survey was conducted throughout New South Wales, Australia, in November 1994. Altogether 1461 people aged 18 and over were asked "Do you think it should be illegal to smoke in cars when travelling with children?" A total of 1048 (72%) respondents agreed, 396 (27%) disagreed, and 17 (1%) were undecided. There were no significant differences in responses by age, educational attainment, country of birth, city or rural residence, or employment status. A higher proportion of women (556/735 (75·6%)) than men (492/709 (69·4%)) agreed with the proposal ($\chi^2=6·78$, df=1, P=0.009). Two hundred and sixty two (63%) of 413 current smokers also agreed.

The compulsory fitting and use of car seat belts and infant restraints are obvious precedents in terms of the state interceding in the private conduct of parents in cars. Use of seat belts is enforced in Australia by opportunistic police checks and penalties, with the result that compliance with the law concerning seat belts is consistently higher than 95%. The strong community support shown in our survey for a ban on smoking in cars carrying children could give rise to similar compliance.

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Obtaining insurance should not depend on mechanism of diagnosis tests

EDITOR,—In his editorial on the parliamentary report *Human Genetics: the Science and its Consequences*, Peter Harper reports sharp criticism of insurance companies, but fails to clarify the grounds for complaint.[1] He seems to imply that insurance companies should not take into consideration the results of genetic tests that are known to the patient. It is difficult to discern the reasoning for differentiating between genetic and conventional predictive tests.

Take two examples, Huntington's disease and polycystic disease of the kidneys. These are both autosomal dominant conditions with a major impact on mortality in middle age. For Huntington's disease a highly accurate genetic test exists; for polycystic disease, ultrasound scanning can be almost as accurate, and in time, presumably, a genetic test will become available for this condition too. If access to results of genetic tests is forbidden, proposers with Huntington's disease and a positive result will obtain insurance while proposers with polycystic disease and positive findings on ultrasound scanning will not (until a genetic test is developed for the condition). This is inequitable. The ability to obtain insurance should not depend merely on the mechanism of a diagnostic test.

Without medical underwriting voluntary insurance schemes will not survive because of the adverse selection they will face. Therefore, one accepts compulsory schemes, such as national insurance, or allows the principle of underwriting, or both, as currently in Britain.

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Effects of helicopter service on survival after trauma

Service is part of a continuum of care

EDITOR,—In their study of the London helicopter emergency medical service J P Nicholls and colleagues failed to take account of a fundamental aspect concerning the potential added value of such a service.[1] In patients with trauma medical interventions before admission to hospital are generally most effective in reducing mortality and improving long term outcome if a continuum of medical care from resuscitation to definitive surgery and rehabilitation is in place.[2] The London helicopter emergency medical service together with related developments at the Royal London Hospital enables such care to be provided because of the integration of the various elements into a trauma system. Patients transported by other means or to other accident and emergency departments in London (even if by helicopter) are not necessarily assured of this continuum of care because of the following factors: long transfer times without adequate continuing resuscitation, inappropriate triage to hospitals that lack relevant medical specialties on site, and an inexperienced and inadequate medical response that fails to provide timely, definitive care when the patients arrive at those hospitals.[3,4]

Despite matching for severity of injury, the authors' study may have underestimated the effectiveness of the London helicopter emergency medical service by including, in the helicopter cohort, patients taken to other hospitals and by simultaneously reducing the proportion recruited from the Royal London Hospital. A more valid study would have compared patients taken by the London helicopter emergency medical service to the Royal London Hospital with a matched control group taken by land based paramedics to either the same or another major accident and emergency department.

Although the trial involving American helicopter services that the authors cite failed to show significantly improved outcomes in patients, this should be interpreted in the context of the superior land based ambulance services and hospital based trauma services in the United States compared with London.[5] In such settings it is not surprising that helicopter based services provide little added benefit.

Until the standard care provided for patients