mentally dull or socially isolated individual. Exploratory behaviour motivated by curiosity or a craving for physical contact may appear in dull or emotionally immature people and, if encouraged may pass on to mutual masturbation or other activities. Such behaviour should of course be firmly discouraged, but even in very young boys a sharp distinction should be made between those who are coercive, aggressive, or rough in their approach to another child and those lacking in aggression. Any tendency to aggressive behaviour calls for urgent, specialized intervention and close supervision, for the risk of physical harm to the victim is great. In the treatment of the non-aggressive offender explanation, education, adequate supervision, and the provision of appropriate opportunities for social contact may be sufficient. If doubt exists, the patient should be referred to an appropriate clinic.

Indefinite Borderlines

The variations of sexual deviance and perversity are enormous, and the borderlines between normal and abnormal, between acceptable and unacceptable, are difficult to define. Many sexual deviations cause guilt, distress, and remorse to the individual, his family, and, where others are involved, to his victim. Whether the deviance is best explained in behavioural or psychopathological terms, it is extremely difficult for the individual to overcome it alone, yet he is reluctant or ambivalent in seeking help and accepting treatment. Once he presents his problem, usually in response to some specific stress, he should be encouraged to involve his family or sexual partner in helping him overcome his difficulties. When an offence has been committed a probation order can be added to family pressure to keep the individual in treatment. Ventilation of the problem, understanding of its nature and its seriousness by the doctor, and sympathetic but firm advice will often enable the individual to overcome his deviant impulses.

It is imperative, however, that sufficient time and regular opportunity for discussion, encouragement, and follow-up are allowed, for if the initiative is left to the patient he is likely to drop out. The doctor should beware of the patient who uses the consultation to elaborate and titillate his phantasies and has no intention of abandoning his deviant outlets. If simple measures are ineffective, expert advice should be sought from a psychiatrist or other colleague with a special interest in these problems.

Some groups in society are critical of the role of the physician in treating deviants, accusing him on the one hand of pandering to bizarre sexual appetites and on the other of acting as a punitive agent compelling the individual to conform to the arbitrary norms of society. In my view the management of these cases calls for the exercise of the full range of the skills of the physician. They provide him with an opportunity to alleviate real suffering

Letter from . . . Chicago

Confrontations

GEORGE DUNEA

British Medical Journal, 1975, 3, 151-153

The passing by Congress of the largest tax cut in American history, much larger than originally requested by the President, has touched off speculations about an early national health insurance bill; but the Administration's resolve to keep the budget deficit within acceptable bounds may thwart further action this year, and even the proposed medical assistance for the unemployed has not yet materialized. Work on a comprehensive health insurance programme, however, is expected to begin shortly, because any plan approved would take at least a year to implement. Meanwhile, government control over medicine steadily increases with regulations on planning, utilization review, and use of drugs. Indeed, apart from benefits for some groups presently uncovered, the main pieces of a national health scheme may already be in place.

The growing malpractice crisis may provide further opportunity for federal intervention, a prospect opposed by "organized medicine" in favour of local legislation such as has already been passed in several states. This is just as well, because centralized federal programmes tend to become unwieldy and wasteful—a consequence, at least in part, of what many think is the all-too-frequent inclination to solve social problems by relying on money rather than intelligence, imagination, and common sense. An estimate, for instance, of the cost of the new utilization review procedure is that it could easily reach $500 million a year, and already some of the newly established professional service review organizations are reportedly unable to continue their function because of the recent shortage of federal funds.

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Pie in the Eye

By contrast, the evidence increases that only federal legislation to ban the sale, manufacture, and possession of handguns will ever stop the unprecedented carnage in our streets. Last year more than 100 gun laws were introduced in Congress, but none were passed. This year the chances are brighter, and congressional hearings are now being held on the subject. And, since crime has come to dominate so much of our lives, it is probably worth reporting that a new form of violence has gripped the nation: pie violence. The trouble originated in Washington, where a trail of rhubarb and meringues leads to the headquarters of the now infamous Pie Face International. The facts are simple: for $60 the association will arrange to throw a pie in the face of any chosen victim, whether the motive be overt fury, suppressed rage, or a marital love-hate relationship.

In Chicago two episodes have occurred in the full glare of the television cameras. In one a well-known columnist settled an old score with a television weatherman; in another a reporter, sent

to cover the pie crisis, had his chief editor splattered with a pie in the very inner sanctum of the newsroom and then conveniently wrote up the story without having to get up from his desk. Later pie throwing spread to Indiana, where students first hit the governor of the state with a lemon meringue pie and then splashed the attorney of the "Chicago Seven" with a chocolate cream pie only seconds after he had commented that American students had lost their revolutionary spirit. Similar episodes have also occurred in other parts of the country.

There have been complaints, however, about the high price of pies and the urgent need for low-cost pie throwers; warnings about the need to take the pie out of the metal pan before throwing it; and admonitions about avoiding fruit pies because the juices could ruin a good suit. Suggestions for stronger pie-control laws are being opposed by the powerful pie lobby in Washington. Pie proponents argue that banning pies would be ineffective because it is people not pies that hit people. Nevertheless, some action will be required, and perhaps a compromise measure to register or license throwable pies might appease the public outcry for law and order.

Abortion Law

But compromise as one may over pies there is certainly no compromising over abortions. Almost 40 years after the famous trial in Britain of the recently deceased Aleck Bourne a fierce fight is raging all over the U.S.A. and a new abortion trial has shaken the nation. Until 1973 termination of pregnancy was a serious crime in most states unless it was to preserve the mother's life. Modern advances in medicine made it increasingly difficult to show that any abortion was literally to save life. Nevertheless, about 10 000 "legal" abortions were done every year, while an estimated one million illegal abortions resulted in roughly 8000 maternal deaths a year. In 1973 the legal standpoint changed dramatically with the U.S. Supreme Court ruling that decision on an abortion must be left to the woman and her doctor and that states might prohibit abortions only after the fetus became capable of life outside the womb, usually at 28 weeks.

Since that ruling abortion has become the most prevalent surgical procedure in the country. Almost one million were performed in 1974. Yet abortion is still not freely available. In some states over half of the hospitals refuse to terminate a pregnancy unless the mother's life is in danger, often on the ground that no willing doctors or nurses are available to perform the procedure. Abortions are often difficult to obtain in rural areas and also in some of the public hospitals, with the burden falling on the poor, the young, and the ignorant.

In some states the attorneys general and medical societies have persisted in contesting the federal decision, thus making it difficult to have a legal abortion. Within the last year the courts have intervened in several states to repeal local restrictive laws or regulations, including requirements of parental consent for women under the age of 18, and in Chicago this year a high court overruled a judge's decision to forbid termination of pregnancy in a 12-year-old girl.

A continuous hassle is also taking place over which government agency should foot the bill. Meanwhile the anti-abortionists are campaigning vigorously with leaflets, films, and marches and in the courts and the legislatures. Several constitutional amendments in Congress are currently seeking to negate the Supreme Court decision and to provide due process and equal protection to the "unborn children at any stage of their biological development." In Massachusetts a bill was introduced in the legislature prohibiting abortion by saline injection because of "pain and suffering to the fetus." Hostility to abortion has also affected medical research. In Boston clinical trials with a new fiberoptic fetoscope were recently stopped, and four doctors studying intrauterine infections were charged under an 1814 grave-robbing statute with "illegal and unauthorized conveyance of human bodies or remains for the purpose of dissection."

Fiasco of a Trial

But the most widely publicized episode occurred in February this year in Boston, where a black physician, Dr. Kenneth C. Edelin, was tried and convicted of manslaughter and later received a suspended sentence of one year's probation. One of the 12 members of the predominantly Catholic jury subsequently claimed she had voted wrongly, and wished that she had stuck to her initial vote of not guilty. The jury foreman said he was "tickled pink" when he heard of the light sentence, and another member of the jury said he would have given only five minutes' probation. Dr. Edelin had performed a hysterotomy on a 17-year-old black girl. The fetus was believed to be 18 to 24 weeks old. The prosecution contended that the fetus would have lived outside the womb if given proper care and that Dr. Edelin was guilty not to provide that care and not to try to keep the fetus alive. The jury agreed. There will be an appeal to the higher court.

The doctor, clearly a sacrificial victim in the continuing strife on abortion, was immediately invited to return to work at the Boston City Hospital, and its executive medical committee expressed outrage at the conviction. The American College of Obstetricians and Gynecologists issued a strong statement supporting Dr. Edelin, asserting that "the adversary system of the courts is not the place to define abortion." In the *New England Journal of Medicine* Dr. F. J. Ingelfinger[1] questioned the prerogative of the lay jury to decide on the viability of a second trimester fetus, called the trial a fiasco and a reprehensible attempt to undermine the 1973 Supreme Court decision by guerrilla tactics, and regretted that the verdict had hardened the positions and inflamed the rhetoric between opposing groups.

Clearly the Boston trial raises many questions and calls for a clarification of the situation and for more specific legal guidelines. Doctors will undoubtedly become more cautious about performing abortions. Already the Right to Life Committee has announced plans to examine other pregnancies terminated in the sixth and seventh month so as to further take legal action against physicians. For Dr. Edelin the whole affair has been a gruelling experience, not to mention legal costs of over $75 000, and though he has received widespread support he remains convinced he was indicted and convicted because he was black. Yet he believes that at least the trial has solidified forces and made the pro-abortion majority more willing to be outspoken. Feelings, however, continue to run high, and a Chicago physician recently decided to emigrate with his family to Ireland rather than pay property taxes that support a city hospital which offers abortions to the indigent.

First Doctors' Strike

But while the final resolution of the Boston trial remains to be decided a more decisive confrontation took place in New York: the first major doctors' strike in this country. Ostensibly a strike over contracts and working conditions, the roots of the trouble lie in the all too easily forgotten initiation ordeal our profession has traditionally imposed on the newly accepted members of the guild. The situation is worst in some of the nation's municipal hospitals, with long hours, no sleep, endless throngs of indigent patients, slow elevators, no messenger system—and precious little co-operation from clerks, nurses, and administrators. Interns draw their own blood samples and take them to the laboratories (there is no one else to do it for them), only to be told two hours later that no specimen was received. Radiographs get lost, patients get lost, medical records get lost, doctors push the patients to the elevator themselves because there is no other help, and vital pieces of equipment are lacking when required for emergencies. These conditions not surprisingly breed, or perhaps attract, activists; it is these conditions that culminate in strikes.

And so in New York 1600 interns and residents stopped work

in 21 of the city's 91 voluntary and municipal hospitals after the failure of many months' negotiations over hours and working conditions. The house staff organization had demanded a reduction of the working schedules to no more than 80 hours a week instead of over 100, which included in some instances more than 50 consecutive hours on duty. The strike lasted four days. Patient care is said not to have suffered greatly because non-striking doctors worked harder to take up the slack. An agreement was eventually reached to set up committees at each hospital to formulate guidelines for work schedules, with a general understanding that no doctor should be on duty more than one night in three. There were also increases in annual salaries ranging from $1000 to $4000.

The strike marks the climax of years of house staff activism and demands for better working conditions, contracts, and recognition as bargaining units and of an increasing tendency towards unionization. In many cases demands for better working conditions went hand in hand with the struggle for better patient care, especially in New York, where overcrowding, understaffing, poor housekeeping, and lack of equipment have been a constant feature of the hospitals operated by the virtually insolvent Health and Hospitals Corporation.

Though the strike in New York has been settled the trouble may spread to other cities, because "house staff physicians across the country are now determined to end exploitation by hospital administrators." Indeed, in many hospitals house staff and administrators are now bogged down over procedural disputes, recognition of house staff organizations as unions, the right to hold elections or strike, and whether residents should be regarded as trainees or workers.

In general, public opinion has been sympathetic to the house officers, and even the A.M.A. supported the strike as being a strike for better patient care. Yet, as the *Chicago Tribune* pointed out, it sets up a worrisome precedent and emphasizes the need for early arbitration to avert confrontation, because, as the editorial concluded, "the bottom line remains the same: doctors should not strike." The question also arises whether the house officers are not about to gain a Pyrrhic victory by pricing themselves off the market at a time of increasing pressures to reduce the number of training programmes and positions and force more doctors into primary care. Granted trainees render most of the care in many of the nation's hospitals, but that has not always been so nor is it desirable—nor does it follow that this situation will continue unchecked forever. Already many institutions are exploring alternative options.

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Any Questions?

We publish below a selection of questions and answers of general interest

Clomiphene Hazards

How successful is clomiphene in inducing pregnancy in women with low fertility? What are the risks of using this drug and what sort of control is necessary during administration?

The success rate of clomiphene citrate or any other anti-oestrogen depends on the causes of the infertility. An increasingly common cause is amenorrhoea after stopping the contraceptive pill.[1] Fortunately there is a high spontaneous remission rate and the condition frequently responds to induction of ovulation with clomiphene. In a mixed population of infertile women the success rate of clomiphene is more varied. Enthusiasts have claimed ovulation rates as high as 80% of treatment cycles, though the much lower figure of 47% in a large series seems nearer the mark. If patients fail to respond ovulation can occasionally be induced with other triphenylethylenes, such as cisclomiphene or tamoxyfen.[2] Naturally the pregnancy rate is lower than the ovulation rate. In one series a pregnancy rate of 18% was recorded.[3] The risks of the treatment have been surveyed in a British review:[4] they are minimal. A very few patients present with pelvic discomfort caused by a rapidly formed ovarian cyst. Such cysts subside over a few weeks although patients may need observation in hospital for a few days during the acute phase. The incidence of multiple pregnancy is so small that it requires a fairly large group of patients to demonstrate it. Because complications are few, standards of control have declined. The drug should not be prescribed without instituting close follow-up and it is desirable to ascertain whether ovulation took place. A basal temperature record is often adequate, though infertility clinics usually undertake to measure urinary pregnanediol or plasma progesterone three weeks after the start of treatment when the woman will be in the luteal phase if she has ovulated. It is wise to see patients weekly during therapy and to examine them for evidence of ovarian enlargement if pelvic discomfort is reported. When clomiphene fails to induce ovulation a pregnancy can often be achieved by the use of gonadotrophins. The risks of this treatment are much higher and it should not be undertaken except under expert surveillance and with sophisticated laboratory services available.

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[2] Klopper, A., and Hall, M., *British Medical Journal*, 1971, **1**, 152.
[3] Rivo, E., and Rock, J., *Pacific Medicine and Surgery*, 1965, **73**, 413.
[4] MacGillivray and Klopper, A., *Practitioner*, 1968, **200**, 1.

Neurological Sequelae Rare after Polio Vaccination

Is there any risk of neurological complications after poliomyelitis immunization with oral live virus?

The results of poliomyelitis surveillance in England and Wales,[2] the United States,[3 4] and Japan[5] show that administration of live poliovirus vaccine carries a remote risk of neurological complications in recipients and close household contacts. The incidence of vaccine-associated paralytic poliomyelitis in vaccinated persons is about one per four million doses and in close contacts possibly no more than one per 10 million. Whereas vaccine-associated paralysis usually affects infants and is apparently due to Sabin type 3 poliovirus, the affected contact is usually an adult male from whom Sabin type 2 poliovirus may be isolated. Immune-deficient children are prone to paralytic poliomyelitis after vaccination with oral poliovirus vaccine.[6 7]

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[3] Henderson, D. A., *et al.*, *Journal of the American Medical Association*, 1964, **190**, 41.
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[5] Takatsu, T., Tagaya, I., and Hirayama, M., *Bulletin of the World Health Organisation*, 1973, **49**, 129.
[6] Feigin, R. D., *et al.*, *Journal of Pediatrics*, 1971, **79**, 642.
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