

method to become confounded with the non-specific effects of therapeutic enthusiasm.

Adequate controlled studies of this new style of treatment are very few.<sup>1</sup> One recent study<sup>2</sup> of the treatment of erectile impotence is noteworthy, despite some defects in its design and execution, because of its profoundly negative findings. Impotent men did as well in a "no treatment" control group as they did with anxiolytic chemotherapy or with a modified version of Masters and Johnson's treatment method.<sup>3</sup> Those with an insidious onset did badly with any regimen. What conclusions can we draw from this study? Is treatment of erectile impotence a waste of time; will such problems either improve spontaneously or be resistant to any form of help?

Masters and Johnson,<sup>3</sup> the pioneers of modern sex therapy, have so far reported the most impressive results. Their study was uncontrolled, however, and no doubt relied on a highly selected sample of patient couples. Even so, their least satisfactory results were with erectile impotence. Many sex therapists would agree that some of their most difficult as well as some of their easiest cases come into this category. From the point of view of treatment outcome, therefore, men with erectile impotence form a heterogeneous group.

Sexual dysfunction of all kinds is a manifestation of psychosomatic relationships, and a wide variety of somatic processes (both pathological and physiological) may affect sexual performance adversely. In men this is particularly so in erectile impotence in comparison with other common dysfunctions such as premature or delayed ejaculation.<sup>4</sup>

There is an additional factor which characterises the impotence group—the effects of ageing. Kinsey and his colleagues<sup>5</sup> reported a dramatic increase in the incidence of erectile impotence with advancing age, and this is borne out in treatment clinics, where men with erectile impotence tend to be older than other patients (men or women) with sexual dysfunction.<sup>6</sup> This is not accounted for by longer duration of the problem. In the 1940s and '50s the "male climacteric" as a cause of late onset sexual dysfunction was a transiently fashionable concept.<sup>7</sup> Recently the effects of ageing on the male testis have been more soundly established,<sup>8-10</sup> though the relation between the variable but common testicular failure of the sixth and seventh decade and impairment of sexual dysfunction is still not clear. The usefulness of androgens in treating erectile impotence is also awaiting proper evaluation but may well have its principal place in this older age group. The physiological counterpart of erection in women, vaginal lubrication, is also affected by ageing, particularly after the menopause, but adverse psychological reactions are probably less definite and the problem is more susceptible to symptomatic treatment.<sup>11</sup>

Erectile impotence is therefore a physiological manifestation or symptom of a heterogeneous group of problems which vary enormously in the type and complexity of help required. Any proper appraisal of treatment methods must take this factor into consideration. Treatment may vary from simple hormone replacement, to basic sex education and the reduction of performance anxiety, to tackling complex inter- or intra-personal problems, of which the erectile failure is one manifestation. The research into treatment that is certainly needed requires a careful definition and control of these variables. We need a method for categorising problems which can be added to the traditional one of erectile or ejaculatory dysfunction and which would be more relevant to treatment and to prognosis. In the meantime Ansari's study serves as a reminder of this need, but it should not discourage those providing help for what is almost always a distressing and not infrequently a helpable problem.

<sup>1</sup> Mathews, A, *et al*, *Behaviour Research and Therapy*, in press.

<sup>2</sup> Ansari, J M A, *British Journal of Psychiatry*, 1976, **128**, 194.

<sup>3</sup> Masters, W H, and Johnson, V E, *Human Sexual Inadequacy*. London, Churchill, 1970.

<sup>4</sup> Bancroft, J H J, *Medicine*, 1974, **30**, 1790.

<sup>5</sup> Kinsey, A C, Pomeroy, W B, and Martin, C E, *Sexual Behaviour in the Human Male*. Philadelphia, Saunders, 1948.

<sup>6</sup> Milne, H, *The Role of the Psychiatrist in Psychosexual Problems*, eds H Milne and S J Hardy. London, Crosby, Lockwood, Staples, 1975.

<sup>7</sup> Heller, C G, and Myers, G B, *Journal of the American Medical Association*, 1944, **126**, 472.

<sup>8</sup> *British Medical Journal*, 1975, **3**, 2.

<sup>9</sup> Vermeulen, A, Rubens, R, and Verdonck, L, *Journal of Clinical Endocrinology and Metabolism*, 1972, **34**, 730.

<sup>10</sup> Stearns, E L, *et al*, *American Journal of Medicine*, 1974, **57**, 761.

<sup>11</sup> Masters, W H, and Johnson, V E, *Human Sexual Response*. London, Churchill, 1966.

## New thoughts from casualty

Medical and surgical emergencies—injuries, obstructions, and patients threatened with circulatory and respiratory failure—find their way to casualty departments, where they are forming an increasing proportion of the admissions into general hospitals.<sup>1</sup> Old habits of mind have let these very ill patients be seen first by relatively junior doctors, while circumstances within the NHS have determined that many casualty officers will come from alien cultural backgrounds. In the past backup by seniors has often been little more than nominal. All of this has meant that casualty officers have had to take decisions and carry out treatments at levels for which often they were inadequately prepared. Furthermore, casualty work has mistakenly been seen as a minor surgical exercise, which it is not. Challenging medical problems are met with daily which require experience even to recognise, let alone to treat. Casualty departments are often poky, depressing, and ill equipped to meet the challenge of the seriously ill. Long waiting times seem almost inseparable from this kind of work, generating their own anger as well as increasing the risk of delayed treatment for those who urgently need surgical or medical first aid.

Yet all is not as hopeless as may appear. Constructive proposals have been made from medical schools and from the royal colleges, where this state of affairs has long been recognised, and much is being done to improve emergency services. In undergraduate teaching<sup>2</sup> more emphasis is being placed on acute medicine with clinical attachments of students to casualty departments established at some centres. More attention is being given to a career structure in acute and emergency medicine, with training posts and the appointment of consultants on a wider scale than formerly. Emergency, short-stay beds attached to casualty should save pressure on expensive inpatient accommodation and increase job satisfaction. Casualty consultants have banded themselves together in North America<sup>3</sup> and Britain in associations designed to improve both the service and the present image of the specialty.

Casualty's new face is not confined to organisational change: there are new thoughts too. The concept of triage—a French word meaning sorting of patients on a basis of immediacy—has been borrowed from the military to be used brilliantly at Moorgate.<sup>4</sup> Selection for urgent treatment has been always practised, but the formulation of the principle of triage helps all concerned with high-risk patients to know what to do as well as to apply their knowledge more rapidly. Medical effectiveness declines exponentially<sup>5</sup> in cardiac arrest or

respiratory failure. Triage may be a helpful concept to the relatively inexperienced, alerting them to what to do first when there are a number of demands being made simultaneously. Triage can be taught to casualty officers, but it can also be taught to the front-line staff—the ambulance men<sup>6</sup> and nurses. Already ambulance men are taking proficiency certificates in resuscitation and intubation. Contrary to what many doctors may believe, it may be on these men and women that the responsibility lies for action—before the patient reaches casualty at all.

The concept of triage in civilian practice should mean that no considerations whatever—of administration, of hierarchy, or even of the doctors' personal feelings—may be allowed to stand in the way of prompt recognition and immediate treatment of the patient at high risk.

<sup>1</sup> Björck, G, *Journal of the Royal College of Physicians of London*, 1974, 8, 101.

<sup>2</sup> Monaghan, E D, and Johnson, G, *Journal of Medical Education*, 1973, 48, 1124.

<sup>3</sup> Haeck, W T, *Journal of the South Carolina Medical Association*, 1973, 69, 20.

<sup>4</sup> Members of the Medical Staff of Three London Hospitals, *British Medical Journal*, 1975, 3, 727.

<sup>5</sup> Freeman, J W, *Medical Journal of Australia*, 1976, 1, 114.

<sup>6</sup> *Journal of the Tennessee Medical Association*, 1972, 65, 816.

## Psychiatry and homicide

Is the abnormal murderer less common in Scotland than in England and Wales? A recent paper in the *British Journal of Psychiatry* by Hunter Gillies<sup>1</sup> has suggested so. He reviewed 400 psychiatric examinations of accused persons he carried out for the prosecution between 1953 and 1974 and found that he had classified 82% of them as having normal mental states, whereas in an earlier paper Driver, West, and Faulk<sup>2</sup> had diagnosed 41% of 66 persons found guilty of murder or manslaughter in an English series as suffering from schizophrenia, psychopathic personality, or personality disorder. The latest review of the Homicide Statistics for England and Wales from the Home Office<sup>3</sup> showed that on average 32% of English murderers are deemed abnormal by the law courts. Gillies strengthened his case for a low abnormality index in Scotland by pointing out that there were 43 cases of murder in Scotland with no suicides among the suspects,<sup>4</sup> whereas in England<sup>3</sup> on average 9% of homicidal incidents end up with suicide.

The differences between the countries may be more apparent than real. Reliability in psychiatric diagnosis is notoriously difficult to obtain,<sup>5</sup> especially when questions of "personality disorder" are concerned.<sup>6</sup> Gillies diagnosed 12 (3%) of his cases as schizophrenic; Driver *et al* also labelled 3% (2 out of 66) of their cases this way. The difference between the studies was that the English authors called 25 (38%) of their cases "personality disordered" as against only 7% (26) so labelled by Gillies. In the absence of clearly defined criteria and reliability data it is extremely difficult to interpret these figures. Nevertheless, one interesting finding from the Scottish study was that, as might be expected, most offenders were young men, many coming from social groups IV and V; many were defined as chronically unemployable; and 58% of the men were drunk at the time of the offence.

This last statistic does not mean that drink is a "cause" of murder,<sup>7</sup> but there are good pharmacological reasons for thinking that it plays its part in terms of disinhibition. Gillies's

figures could be interpreted as showing that psychiatry plays only a small part in preventing homicide. This is clearly a sensible and modest view of the psychiatrist's task. Doctors could, perhaps, take a more active role in the battle against excessive alcohol consumption (not just alcoholism), which is becoming one of the major public health issues of our time. Homicide prevention in a more specific sense could well turn on the issue of how much the psychiatric services should respond to the threatened homicide. There are no figures available to indicate what proportion of murderers consult a doctor before carrying out their act. An American study by MacDonald<sup>8</sup> suggested that it may be a sizable minority. Gunn<sup>9</sup> has recently suggested that the doctor has a crisis intervention role in preventing violent crime in general. Because of the laws of probability, predicting individual acts of violence will always remain a clinical judgment, taking into account previous history, the environment a person is living in, and his mental state—but one major aid to prediction, the homicidal threat, should not be ignored. A patient who is under stress and broadly hints that he may kill someone is rarely fooling—he is warning. Intervention by extra support, new medication, manipulation of the environment, or admission to hospital may save a life.

<sup>1</sup> Gillies, H, *British Journal of Psychiatry*, 1976, 128, 105

<sup>2</sup> Driver, M V, West, L R, and Faulk, M, *British Journal of Psychiatry*, 1964, 125, 583.

<sup>3</sup> Home Office, *Homicide in England and Wales 1967-71*. London, HMSO, 1975.

<sup>4</sup> Scottish Home and Health Department, *Criminal Statistics (Scotland) 1973*. Edinburgh, HMSO, 1974.

<sup>5</sup> Cooper, J E, *et al*, *Psychiatric Diagnosis in New York and London*. London, OUP, 1972.

<sup>6</sup> Walton, H J, and Presly, A S, *British Journal of Psychiatry*, 1973, 122, 259.

<sup>7</sup> Wolfgang, M E, and Ferracuti, F, *The Subculture of Violence*. London, Tavistock Publications, 1967.

<sup>8</sup> MacDonald, J M, *Homicidal Threats*. Springfield, Thomas, 1968.

<sup>9</sup> Gunn, J, *British Medical Journal*, 1974, 3, 611.

## Ectopic secretion by tumours

We now know that malignant tumours may secrete hormones which in the normal state are not secreted by tissue from which the tumour originates. This process is known as ectopic secretion, and in 1962 Liddle *et al*<sup>1</sup> described a syndrome due to ectopic production of corticotrophin (ACTH) by malignant tumours of non-pituitary origin; two years later research groups in the United States<sup>2</sup> and in Britain<sup>3</sup> isolated anti-diuretic hormone (ADH)-like material in the tumour and an excess in the urine and plasma of patients with bronchial carcinoma. Subsequently the British group extended its work and tried to establish that this activity was due to arginine vasopressin.<sup>4</sup> During the next ten years virtually every known polypeptide hormone was recognised as an ectopic secretion of malignant tissue, including corticotrophin-releasing substances<sup>5</sup> and growth hormone-releasing substances.<sup>6</sup>

A tumour may secrete more than one hormone—ACTH and ADH, for example—in which case the typical clinical syndrome of inappropriate secretion of ADH may not be present, since the excess cortisol may obscure the clinical picture of excess ADH.<sup>7</sup> Thus in none of the tumours from 25 cases of oat cell carcinoma without the syndrome of inappropriate secretion of ADH was any ADH-like material detected.<sup>8</sup> Nevertheless, there have also been reports of the syndrome's being present without any apparent rise in the bioactive concentrations of ADH in the plasma<sup>9</sup> or in the urine.<sup>10</sup> Thus the syndrome is not invariably due to excess production of ADH alone. Similar