In conclusion I would hate to think that any of my hard-pressed hospital colleagues were irritated by this suggestion, as it would leave them free to do what they are really best at doing—highly skilled and technical modern medicine for the seriously sick.—I am, etc.,

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Drugs in Infertility

SIR,—Your article on drugs in infertility (21 October, p. 167) was in many ways admirable but certain comments seem justified. For example, the postcoital test was omitted from the preliminary investigations, but mentioned only later on, and analysis of a seminal specimen from the husband would be more appropriate at an early stage rather than "finally." Absence of ovulation—in the presence of menstruation—is more likely to be supported by the persistence of "good"—that is, oestrogen-stimulated—cervical mucus than by the presence of poor mucus which, other than at the time of ovulation, has no diagnostic significance.

From reading the article one might gain the impression that hyperstimulation with clomiphene is not uncommon, but I would suggest it is indeed a rare event when the generally practised five-day course at a daily dose of 50-200 mg is used. I am also surprised that no mention was made of the probable time of ovulation after a course of clomiphene (mostly 8-12 days after the end of the five-day course) and of the importance of explaining to patients the need to have intercourse at this time though not for perhaps a week before.

The use of short courses of clomiphene (for example, 50 mg daily for three days from the third day of the cycle) in women with ovulatory but irregular cycles in order to reduce cycle variance, which it commonly does, and so make more predictable the probable time of ovulation, was also not mentioned. Nor was the use after clomiphene of human chorionic gonadotrophin (HCG) for the induction of ovulation in patients whose ovaries, though responding to clomiphene with follicular growth, fail to ovulate—presumably because of failure of the positive feedback effect of oestrogen to cause luteinizing hormone release. (We give HCG 5,000 IU intramuscularly on day 15—counting the first day of the five-day clomiphene course as day one—and again on day 23.) Of 19 pregnancies this year resulting from treatment with clomiphene in my clinic at University College Hospital 11 were due to the combined treatment after clomiphene alone had failed to cause ovulation. I agree with the disappointing results of treatment of defective spermatogenesis with clomiphene. Using a dose of 50-100 mg daily the sperm count showed no improvement in nine cases, was worse in two, and increased in one case, while in no case did sperm activity improve.

I do not share the optimism for mesterolone. Of 17 men with defective spermatogenesis treated with a daily dose of 50-200 mg five showed improved sperm counts (with one conception), 11 showed no improvement (again with one conception) or actual decrease in sperm count, and only one showed improved sperm activity. Of five eunuchoids treated with daily doses of 200 mg three

showed no androgenic response at all and two responded in the expected fashion. For these latter the equivalent daily maintenance doses of fluoroxymesterone were 10 and 20 mg respectively. These findings suggest that mesterolone is a weak androgen with no very obvious special qualities since at maintenance dose levels suppression of endogenous testosterone production does occur.—I am, etc.,

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Confinement of Subnormal Offenders

SIR,—Dr. D. C. Jones (28 October, p. 231) is correct in stating that we are often asked to admit to hospital mentally subnormal persons because they have committed an offence and are not fully legally responsible for their actions. I would regard an I.Q. of 75 or below as justifying this. He is also correct in stating that we can seldom cure them and we find that on going into their history there is usually an established pattern of antisocial behaviour.

The therapeutic community of a mental subnormality hospital, which removes temptations and limits opportunities for misbehaviour, can often provide an acceptable mode of living for these people. Each large subnormality hospital should have within its grounds a purpose-built unit to which such people can be admitted. Once they have settled in many of them are able to move on to the more open facilities of the rest of the hospital and a good deal of freedom within the hospital grounds can then be given. I am not in favour of isolated establishments to deal solely with this problem.—I am, etc.,

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Consultants in Mental Handicap

SIR,—At present there are 125 consultants specializing in mental handicap in England and Wales.¹ They are responsible for some 59,000 inpatients in hospitals for the mentally handicapped and have many other commitments in the community services, administration, teaching, and research.

If the Command Paper *Better Services for the Mentally Handicapped*² is fully implemented there will remain 27,000 hospital places for mentally handicapped adults and 6,400 for children, with 4,900 adult day patients and 2,900 child day patients. Consultants in mental handicap today may be responsible for from 200 to 500 or more inpatients, and to achieve in the future a more ideal ratio of one consultant to 200-250 inpatients and to meet the needs of extended community provision more consultants will be needed.

There is difficulty in filling consultant posts in this specialty as doctors with the appropriate attitudes, interests, and expertise appear to be few and far between and the 14 senior registrar posts in mental handicap attract insufficient applicants of the right calibre. The widespread misinterpretation of the Command Paper that all hospitals for the mentally handicapped are to disappear does not encourage the young doctor to choose the specialty. Without mention of the consultant in mental handicap the report of

the British Paediatric Association Working Party on Mental Handicap³ expresses a sympathetic concern for the care of the mentally handicapped child, but there is no obvious eagerness on the part of paediatricians in practice to take ongoing responsibility for these children, even though the circular H.M.(65)104⁴ recommended that children with physical disabilities and mental handicap may often be more suitably placed in paediatric units than in hospitals for the subnormal.

The medical profession is failing to reach the standard it should do in the care of mentally handicapped patients. If the consultant in mental handicap is to become an extinct animal his work will still have to be done and be accepted increasingly by paediatricians, and general and children's psychiatrists.—I am, etc.,

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- 1 Department of Health and Social Security. *Health Trends*, 1972, 4, 47.
- 2 Department of Health and Social Security. *Better Services for the Mentally Handicapped*. Cmnd. 4683, London, H.M.S.O., 1971.
- 3 British Paediatric Association. *Report of Working Party on Mental Handicap*. London, B.P.A., 1971.
- 4 Ministry of Health. *Improving the Effectiveness of the Hospital Service for the Mentally Subnormal*, H.M.(65)104. London, Ministry of Health, 1965.

Active Management of Labour

SIR,—Your leading article under the above heading (21 October, p. 126) is very welcome, though I must take issue with it on two important points.

Firstly, the statement that the success of this policy clearly shows that inertia is nearly always secondary to some other cause—most commonly minor disproportion. It shows nothing of the sort. Active management of primigravid labour resulted in such a dramatic reduction in the incidence of disproportion in this hospital that it could be only concluded that in years past difficult labour was mistakenly attributed to disproportion instead of properly to inefficient uterine action. This point is of crucial significance, because so long as the spectre of disproportion continues to dominate obstetrics so long will the dismal record of watchful expectancy in labour continue.^{1,2}

Secondly, the inference that practical problems arising from supervising numerous transfusions represents a serious barrier to active management. This is very difficult to understand. The first reference³ given showed that only in this hospital, which is currently the largest in Britain or Ireland, every patient has a personal nurse—simply because she is in labour for a shorter time. Not surprisingly it also showed that there are 2½ times as many babies born for each nurse employed in this delivery unit as in similar hospitals in five other centres.³

In conclusion, I agree that oxytocin, like other drugs should not be used indiscriminately.—I am, etc.,

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- 1 O'Driscoll, K., Jackson, R. J. A., and Gallagher, J. T., *British Medical Journal*, 1969, 2, 477.
- 2 O'Driscoll, K., Jackson, R. J. A., and Gallagher, J. T. *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1970, 77, 385.
- 3 O'Driscoll, K., *Proceedings of the Royal Society of Medicine*, 1972, 65, 697.