these components of the infection are visible in a radiograph, the differentiation from chicken-pox should be easy. The difficulty lies in attributing to one or the other disease scattered nodules of calcification when they are the only abnormality. In the past such appearances were often regarded as due to healed miliary tuberculosis, but the almost uniformly fatal course of the untreated disease makes this rather unlikely. Since the introduction of antituberculosis drugs instances of eventual calcification after miliary tuberculosis have been observed. The differential diagnosis also includes histoplasmosis, which is very rare in Britain and can be confirmed by skin testing. Sometimes the inhalation of industrial substances having a high silica content will induce nodular calcification. The radiographic densities which occur in idiopathic pulmonary haemosiderosis and in chronic left heart failure need to be distinguished, though they are rarely as dense as the nodules of chicken-pox, and the associated clinical features serve to differentiate them. G. Simon considers that nonspecific scattering in the lungs may sometimes calcify.

Among the sizable list of causes of scattered calcified nodules in the lungs chicken-pox is one of the commonest. A history of a severe attack of the disease in adult life goes a long way towards making a firm diagnosis.

Compulsive Gambler

The "compulsive" gambler has made news. A young man, apparently incorrigible and resistant to the crime-and-punishment formula of the courts, has been handed over to doctors for treatment by a lobotomy operation. Psychiatry, it seems, has become one arm of the law.

Clearly he must have been considered a psychiatric casualty. But is there not danger in the old saw that unless one sees psychiatry everywhere one will see it nowhere? Where does social misdemeanour end and mental illness begin? Gambling above one's means and doing lots of it, even with other people's money, does not warrant being called "compulsive" unless this term is used in a loose, non-specialist way.

A compulsion in its strict psychiatric definition is a repetitive act performed by a patient against his will which he is unable to suppress. An obsession is a recurrent thought or idea which similarly obtrudes imperatively in a patient's mind. Obsessive-compulsive symptoms may occur in isolation, as the forerunner of serious mental incapacity, or in the wake of brain disease such as encephalitis. They are always felt as something foreign and stronger than self, as intrusions which are distressful. Far from bringing social gain they may severely restrict a patient's life. He may not even be able to leave his home because he has to check and recheck doors and windows, or because he cannot satisfy himself that his hands do not require washing once more.

So to say that somebody gambles compulsively is not the same as making a medical diagnosis of a compulsive state manifesting as gambling. The gambler enjoys every bit of his "compulsion," the tension it creates, the element of risk it involves, the rewards it holds out. The act elates him, and depression, if it comes at all, does so in the aftermath and is then more properly called remorse. He may say, "I cannot stop," but what he means is that he does not want to stop—the attractions are too great.

More correctly he should be called an excessive gambler, though he himself does not consider it excessive—society does. True, his gambling is uncontrolled, but the rituals of the compulsive are uncontrollable because they arise outside consciousness. The gambler's behaviour is a source of pleasure in which he indulges irrespective of cost; the compulsive's is a burden which makes him anxious and depressed.

If, then, he is more accurately called an excessive gambler his motivation is no different from that of the ordinary gambler or the man who likes betting. It provides excitement, the quest for which has become increasingly a motive and incentive for so many activities. The gambler does not hurt himself as the compulsive patient does. The risk is for those who have to shoulder his debts. He lacks a sense of responsibility or of duty to society, but again this does not make him a psychiatric casualty. Every man in the street can imagine himself in his place, which alone puts him outside the pale of psychiatry.

It is possible that the man's gambling may have been only one expression of a more widespread disorder. His behaviour may have been not only uncontrolled but uncontrollable because of brain damage or disease. But the form in which the case was reported calls for reflection. Should the boundaries of psychiatry be extended so far that they exceed its own strictly clinical terrain? There is a growing danger that society will use psychiatry to gloss over its own shortcomings and ills by making its victims "patients." Anti-social behaviour must not be confused with mental illness, and psychiatrists must beware of having forced on them the role of controlling misfits or regarding it as their function to normalize the abnormal and non-conforming. The doctor's primary duty is to diagnose and treat his patients, not to enforce society's rules.

Kidney Disease and Pregnancy

With the prospect of the new Abortion Act coming into operation on 27 April a B.M.A. Committee recently reported on clinical indications for termination of pregnancy. The report did not set out to be more than a general guide and one that must be interpreted in the light of individual circumstances. Now in a particularly timely article Priscilla Kincaid-Smith and colleagues, in Australia, discuss the indications for therapeutic abortion when the mother has renal disease.

These authors note that though kidney disease and pregnancy are known not to combine well, surprisingly little information is available to enable us to give accurate advice to a patient who wishes to decide whether she should become pregnant in spite of her renal disease, or who wonders whether it is safe for her pregnancy to continue. The article goes on to point out that in spite of the relative lack of information opinions are sharply divided on the outlook for the mother and the indications for terminating the pregnancy. On the whole obstetricians have tended to be more gloomy than physicians. Thus F. J. Browne and J. C. McClure Browne state, "Pregnancy is always a very serious risk for the patient with chronic nephritis and should never be allowed to continue without the gravest consideration and without apprising the

1 The Times, 2 April 1968.