its instability, its short duration of action, and its requirement for carefully monitored infusion techniques.

For the present, then, we must accept that prostacyclin is indeed powerful and useful in extracorporeal shunts. How ironic that, despite its early claims to be a natural balancing substance in the thrombotic equation, the usefulness of prostacyclin has been most clearly proved in entirely man made settings where blood meets an artificial surface. In the common spontaneous vascular diseases we must recognise that not only is prostacyclin not yet of proved value but that it is unlikely to be so. The real hope here lies in the exploitation of this novel compound to generate a stable, orally active prostacyclin analogue which will have selective affinity for the platelet receptors and will have minimal effects on the heart and blood vessels. Like the inventor who answered his critics by saying "But what is the use of a newborn baby?" we should be prepared to say of epoprostenol "Wait till it grows up and has children of its own—for what the world is waiting for is 'Son of Prostacyclin.' "

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Legislation and teenage sex

To paraphrase Jane Austen, it is a truth universally acknowledged that parliament should not make new laws when those most closely affected advise that the proposed legislation is unwise and unworkable. Earlier this month the BMA called a press conference to leave the press and public in no doubt that doctors do not want any change in the law governing the prescription of oral contraceptives for girls under the age of 16. No one doubts the good intentions of most of those who want to prohibit doctors from prescribing the pill in these circumstances without the consent of the girl's parents; but the campaigners have mostly been arguing from conviction rather than experience. The attitude of doctors would have been very different if the call for legislation had come from the families directly affected—namely, those in which 14 and 15 year olds have been prescribed the pill—or from doctors working with teenagers. In practice the pressure has mostly come from adults shocked by reports of promiscuous sexual behaviour among adolescents but with little or no direct experience of the realities.

Doctors in family planning clinics or in general practice who are asked for advice on contraception by teenage girls have to make a pragmatic assessment. Almost always these girls have already formed a sexual relationship, often stable and overt. Most have no wish to keep their mothers in the dark; of those few who do ask for confidentiality, one third can be persuaded at the first interview to tell their parents and another third agree later.[1] The remaining third of girls must believe they have very strong reasons for rejecting the doctor's advice—for doctors do always make an attempt to bring the parent into the picture.[2] Who will gain from a law insisting that in these circumstances the girl should be told that she may not be supplied with a contraceptive?

At the heart of the matter are the very different ways in which people think of teenage sexuality. Should pregnancy be seen as a punishment for illicit sex? Is fear of pregnancy really an important deterrent? If sexually active teenagers are denied access to medical contraception are they more likely to stop having sex or to use some unreliable contraceptive technique that requires no prescription?

The BMA press conference spelt out the medical hazards of early sexual experience and of pregnancy; doctors working with schoolchildren are only too aware of the physical and psychological problems that may sometimes be associated with sexual activity in the early teens. But like it or not, doctors have to work in the real world. Over the years we have worked out a whole range of compromise solutions that seem to minimise damage to our patients; intending legislators should be extraordinarily certain that they have found a better answer.

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