

to customers infringe the consumer protection regulations, and it is likely to involve the coal merchants in financial loss. It pays everyone to keep coal dust to a minimum.

Whether any depot is a nuisance in law must be decided on the local circumstances and evidence, but that the problem is not a simple one is clear from Irvine and Davies's paper. So long as raw coal is used for domestic and industrial purposes, so long will concentration of depots be an economic necessity. Reasonable siting, careful management, and screening so far as practicable from the gaze of the neighbours will minimize the annoyance they are apt to cause. "What the eye doesn't see the heart doesn't grieve over" is not a sound maxim in regard to noxious agents, but where subjective and psychological factors are involved "Out of sight, out of mind" is not an unwholesome tag to apply.

Transport of Specimens to the Laboratory

Ever since the inception of the Public Health Laboratory Service in 1939 public health laboratories, of which there are now 62 throughout England and Wales, have accepted specimens from general practitioners for microbiological investigation. More recently it has become the declared policy of the Department of Health and Social Security that general practitioners shall have open access to the facilities of all N.H.S. hospital diagnostic laboratories. So far so good. But there is still a serious problem. How can the doctor get the specimen to the laboratory? If the patient is well enough, he or she can take it. If not, a relative or even the doctor himself may provide the necessary transport. In some areas the medical officer of health has arranged that specimens left at local authority clinics or other suitable collecting centres will be transported to the appropriate hospital or public health laboratory. This would seem to be a sensible arrangement which might be developed with advantage throughout the country.

Even with the best of delivery services for specimens, delay of several hours is likely. For some specimens the delay may not significantly affect results, but for most microbiological specimens it may be disastrous. Though swabs can be sent in a suitable transport medium, usually obtainable from the laboratory, specimens of urine present a special problem. Since the work of E. H. Kass¹ it has become generally accepted that the presence of more than 100,000 organisms per ml. in a properly collected and freshly passed specimen of urine is indicative of urinary infection. Urine itself is a good culture medium in which bacteria may multiply rapidly during the time between the passing of the specimen by the patient and its arrival in the laboratory. The numbers of organisms present when the specimen reaches the laboratory may therefore greatly exceed the number present when the urine was passed by the patient. There is a serious risk that contaminating organisms of no significance may multiply and be present in apparently significant numbers by the time the specimen is examined in the laboratory. Refrigerating the specimen during transit is one way of overcoming this, but is clearly not ideal.

A paper by Drs. I. A. Porter and J. Brodie at page 353 of the *B.M.J.* this week describes the use of boric acid in a final concentration of 1.8% as a preservative for urine specimens. Compared with dip-inoculum transport medium and also an ice-box, boric acid in their hands gave as good results and provided a simpler and almost certainly cheaper means of transporting the urine. Apart from the effect of boric acid on maintaining bacteria in the samples in a state of virtually suspended animation, it was shown not to have any adverse effect on the content of albumin and sugar. Furthermore, the numbers of red and white blood cells and casts did not appreciably diminish. The authors point out that one possible hazard of the boric acid outfit is that the powder may be emptied out before the addition of urine, despite instructions to the contrary on the label. It should not be beyond the wit of man to devise a means of causing the boric acid to adhere to the inside of the container. Certainly the use of boric acid for the preservation of urine in the manner described should be tried by others. It might well provide a simple solution to an important problem.

Scotland Goes Forward

While doctors in England and Wales are still waiting for Mr. Crossman to produce his revised version of the Green Paper¹ on the administration of the N.H.S. their colleagues in Scotland have accepted the principle of unification. It seems likely that they will soon reach broad agreement with the Scottish Home and Health Department on the future pattern of their health services.

The special meeting of representatives held in Edinburgh on 24 April (see *Supplement*, p. 79) rejected any phased or partial unification of the N.H.S., and recommended that area health boards should provide the full range of services, including preventive medicine and the planning and development of health centres and hospitals. Nevertheless, both general practitioners and hospital staff are still apprehensive that an area board might be too remote for day-to-day management in comparison with the present executive councils and hospital boards of management. In England a second tier, as proposed by Mr. Crossman at Norwich,² may be the solution. In Scotland, on the other hand, a single tier system of more and smaller boards might prove satisfactory, with some specialized services organized on a national basis. This is one of the problems still to be discussed.

The Scottish Green Paper³ had already indicated that local authorities would be kept distinct from area health boards, so the meeting reserved judgement on the possible advantages or disadvantages of boards having the same boundaries as the future new local authorities. The Scottish G.M.S. Committee has approved the principles of integration and of area boards, though it has suggested that 17-21 boards would be a better number than the 10-15 proposed in the Green Paper. The meeting also agreed that if management of the Health Service is to be efficient, then arrangements for reimbursement of expenses should be generous enough to attract the "best

¹ *The Administrative Structure of the Medical and Related Services in England and Wales*. London, H.M.S.O., 1968.

² *British Medical Journal*, 1969, 1, 590.

³ *Administrative Reorganization of the Scottish Health Services*. Edinburgh, H.M.S.O., 1968.

¹ Kass, E. H., *Transactions of the Association of American Physicians*, 1956, 69, 56.

people." Board-members should be part-time, and the execution of policy should be left to area committees.

The Scottish Green Paper was not the twin of the English one. It was the result of prolonged, informal discussions between the Department and the professions. Good relations have existed between doctors and the Department for some years, and this contrasts with the more sceptical attitude that English doctors often adopt to proposals from the Elephant and Castle. But conditions are not the same on the two sides of the border, and indeed the two sets of proposals, discussions, and later legislation are justified only because different solutions are needed to the problems.

Scottish doctors have for years differed from their colleagues in the south in several respects—for example, by their ready acceptance of the value of health centres. So Scotland is likely to lead the way to a unified service. The rest of the profession should welcome the chance to observe the process, and so benefit from following behind.

Energetic Treatment of Addicts

The emphasis on the treatment as opposed to the "maintenance" of drug addicts in last week's report¹ from the Advisory Committee on Drug Dependence is welcome. The report was prepared by the Subcommittee on the Rehabilitation of Drug Addicts, and its recommendations include the suggestion that two kinds of hostel should be set up, one for homeless addicts attending outpatient clinics, the other for the rehabilitation of addicts who have completed treatment.

A year ago, when the regulations restricting the right of doctors to prescribe heroin to addicts came into operation, hospital outpatient clinics in the London area found within a few weeks that they were seeing nearly 800 such addicts.¹ In addition 150 heroin addicts were being seen as outpatients elsewhere in Britain, and 152 all told were receiving inpatient treatment. Many doctors were thus suddenly presented with a host of socio-medical problems as unfamiliar as they were complex. Not the least of these problems is the well-known ambivalence of the patient's attitude to treatment. He may claim to want it yet fail to co-operate, or he may co-operate to get the drug but not really want treatment. Nor is his attitude likely to remain unchanging. But the high mortality and morbidity of addicts to heroin in particular² and the readiness with which the condition is transmitted mean that both the medical profession and a number of social agencies have an inescapable responsibility to provide treatment for it.

If treatment of the individual and prevention of spread in the community are to be successful, they must be carried out, as Griffith Edwards³ has stressed, with vigour and energy. The present report agrees with this, and it rightly adds that success depends to a considerable extent on the development of effective services for rehabilitation. Hospital beds should be immediately available, it recommends, for any heroin addict ready and willing for admission. Two hostels at first, one for each sex, should be constructed for 12 patients each in the metropolitan area to provide short-term accommoda-

tion for homeless addicts attending outpatient clinics. These would be on an experimental basis and if found suitable could serve as models for hostels elsewhere. Then in addition four hostels (one for women) should be built in the metropolitan area, the report recommends, where addicts would live while undergoing rehabilitation. Clearly this last process needs to be devised with care if it is to have any hope of success with this exceptionally difficult group of patients. Even the siting of such hostels poses problems that the subcommittee has analysed in relation to the propensities of drug addicts. They should be built, it suggests, not in the country, with its lack of facilities for employment, not in the centre of cities, with their all too ready temptations, not in suburbs which have already acquired a reputation for drug peddling, but perhaps on "a site in the outer suburbs or as much as twenty to thirty miles from London where the addict would be able to face and overcome the temptation to make the not-too-difficult journey to the city centre." Unfortunately there must be difficulty in finding places even so far from the metropolitan centre which are free of drug addicts and the temptations they hold out.

All this together with substantial numbers of trained staff must be an expensive operation if it is to provide the resources needed for even some hope of success. But there is little doubt it must be tried. Drug addiction may continue to increase. If it is not tackled with the sort of vigour put into a campaign against an outbreak of smallpox it seems certain to do so. Will even that stop it? Edwards³ has raised this question in relation to American experience. Is the provision of facilities for energetic treatment and rehabilitation enough, or must some degree of coercion be introduced? To do this would pose many further problems, and it would seem best at present to continue in the British tradition of regarding the addict strictly as a patient while keeping watch on the consequences of this policy.

Clinical Pharmacology as a Specialty

Even if Britain's entry into the Common Market is still some years away, the country should find itself well prepared with a list of medical specialties when the time comes. In the last few years a series of reports from the Royal College of Physicians has listed which of the various branches of medicine should qualify for recognition as specialties, and how entrants to them should be trained. The latest addition¹ to the list is clinical pharmacology. The college suggests that two main types of specialist are needed—full-time clinical pharmacologists, who should be based on teaching hospitals or research institutes, and physicians with a special interest in clinical pharmacology, who would normally work in district hospitals and would be responsible for advising on therapeutic problems as well as teaching their colleagues and junior staff.

But if doctors are to be trained for posts in clinical pharmacology will there be any jobs for them? These are few enough now, and there is little sign that the drift of pharma-

¹ *The Rehabilitation of Drug Addicts*, Report of the Advisory Committee on Drug Dependence, Home Office, 1969. London, H.M.S.O. 4s. net.

² Bewley, T. H., Ben-Arie, O., and James, I. P., *British Medical Journal*, 1968, 1, 725.

³ Edwards, G., *British Medical Journal*, 1967, 3, 425.

¹ *Report of the Committee on Clinical Pharmacology*, 1969. London, Royal College of Physicians.

² *British Medical Journal*, 1967, 1, 125.

³ Hurwitz, N., and Wade, U. L., *British Medical Journal*, 1969, 1, 531.

⁴ Hurwitz, N., *British Medical Journal*, 1969, 1, 539.