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 report[1] 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 particular[2] 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 Edwards[3] 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 accommodation 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 ? Edwards[3] 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.

[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.

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 addition[1] 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] *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.

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