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 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. 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 unchanged. But the high mortality and morbidity of addicts to heroin in particular 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 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 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 specialities 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 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-
Maternal Deaths

The latest report on Confidential Enquiries into Maternal Deaths in England and Wales has, like its predecessors, a fairly long gestation period whose outcome all obstetricians anxiously await. Though it can be a source of maternal congratulation, it has some lessons on how maternal care may be improved.

In the years 1964 to 1966 there were 2,600,367 births in this country, more than in each of the previous four triennia. There were 579 deaths directly due to pregnancy and childbirth and 176 deaths due to associated causes, both numbers being less than any previously recorded. This may be gratifying, but when the report's figures are compared with those of the Registrar General it is seen that there were a further 135 maternal deaths and 41 deaths due to associated causes on which confidential reports were not obtained. The first message of the report is, therefore, that an increased effort is needed to see that all maternal deaths are fully recorded. Despite this deficiency the information obtained is of more than academic interest, for it gives a picture of the circumstances of childbirth and defines those in which special care must be taken of individual patients. It is only by unremitting care and attention to detail that results can be improved.

The number of deliveries in hospital has steadily risen to an overall percentage of 72, and it is still rising, while the domiciliary service declines. With present trends the domiciliary service will soon be no more. This needs planning for, but it is worth noting that results are improving with the present pattern.

The main causes of maternal death (with numbers of cases in parentheses) were abortion (133), pulmonary embolism (91), haemorrhage (68), toxaemia (67), cardiac disease (50), complications of anaesthesia (50), rupture of the uterus (30), and amniotic fluid embolism (30). An additional category of deaths included in this report and now subject to special comment is that of ectopic pregnancy, of which there were 42 cases. Abortion is therefore the outstanding problem requiring attack, but it is interesting that, if the actual cause of death from abortion is reclassified as due to bleeding or sepsis or embolism, the order of the causes of death changes to haemorrhage (152), sepsis (123), embolism (95), and toxaemia (67). This new order draws attention to the special roles of haemorrhage and sepsis in causing death. Provided the patient reaches hospital, these two causes of death ought to be better controlled than they are. There are remedies for them which are not being applied as they should be.

Deaths from abortion have scarcely fallen in total numbers over the series of five reports. Perhaps the law legalizing certain types of therapeutic abortion might make an impression here, but there were ten deaths due to therapeutic abortion in the years 1964 to 1966, five of them associated with abdominal hysterectomy, two with injections of paste into the uterus, and two with injections of hypertonic saline into the amniotic cavity. There were no deaths due to vaginal termination of pregnancy in the early weeks of pregnancy. The factors in these cases considered in these reports to be "avoidable" were nearly all social ones. These facts speak for themselves and indicate how deaths might be prevented.

Deaths from pulmonary embolism have been reduced from 129 in 1961–3 to 91 in 1964–6, despite the fact that there were more births in the later years. Yet the number of caesarean sections performed over the whole country has increased and so has forces delivery. More must be learned about the causes of this disease before rational prevention can be instituted. It is worthy of note that 24 of the deaths from embolism occurred during pregnancy.

Deaths from toxaemia are down, but there was still considered to be an "avoidable" factor in 56%. This was usually inadequate antenatal care, and faults were attributable to consultants, hospital medical staff, general practitioners, midwives, and the patients themselves. Six deaths classified under toxaemia were found at necropsy to have been caused by pheochromocytoma, and it would seem that this diagnosis must be seriously considered in all cases of severe pre-eclampsia.

The message of the report, as of the previous ones, is still the same. Deaths can be prevented by vigilance and care. Enough is known to prevent deaths provided the knowledge is put into action at the right time. The report emphasizes that danger lurks for the patient as her age increases (and the risk begins at 25) and as she has her fifth or subsequent pregnancy, and that the ogres of obstetric practice are still not overcome. But they can be overcome if those who care for childbearing women will learn the lessons ably and well presented here and then act appropriately. The flags of danger should be seen flying over all abortions, the conditions that might predispose to pulmonary embolism, all haemorrhage and sepsis, pre-eclampsia and eclampsia, women with heart disease, and those undergoing operations, especially with general anaesthesia. None of these patients is yet as fully safe as she should be.