Middle Articles

CONTEMPORARY THEMES

Relevance of American Experience of Narcotic Addiction to the British Scene

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The United States has had a large drug addiction problem for a long time. At present there are probably upwards of 60,000 narcotic addicts in the U.S.A. (O'Donnell and Ball, 1966), with New York alone perhaps accounting for half the total. In comparison the problem in Britain seems small, but the concern here must be not so much with the problem's present absolute size as with its rate of growth—from 57 heroin addicts in 1954, 521 in 1965 (Home Office figures), with by now perhaps 2,000 to 3,000, and extrapolation to 10 years hence suggesting a quite frightening figure. In planning our own response to this problem it is natural to turn for guidance to America's much greater experience.

But is American experience relevant to our own country's problem? The gross disparity, diminishing though that gap may be, between the two prevalence rates immediately suggests that different processes may be at work. One obvious explanation for this disparity in addiction rates is the contrasting general level of social disturbance in the two countries, as shown by the data in the Table.

Some Indices of Social Problems in U.S.A. and England and Wales, 1964

	U.S.A.	England & Wales
Infant mortality (deaths under 1 year of age per thousand live births) . . .	44.0	19.9
Illegitimate live births per thousand live births . . .	121	72
Divorces granted during year per thousand population . . .	2.3 (provisional figure)	0.7
Suicide per thousand deaths . . .	12.0	10.4
*Murder per million population . . .	48	6
*Robbery per million population . . .	582	83.5 (incl. blackmail)

Data gathered from *Vital Statistics—Statistical Abstracts of U.S.A. and Annual Abstract of Statistics*, Central Statistical Office, H.M.S.O., London.

* For difficulties of comparison between criminal statistics of different countries, see *Cultural Factors in Delinquency*, edited by T. C. N. Gibbens and R. H. Ahrensfeldt, p. 87. Tavistock Publications, London, 1966.

Thus undoubtedly a large part of America's drug addiction represents one more manifestation of the problems stemming from poverty, city disorganization, and the failure of the United States to integrate into its larger society the Negro, the Puerto Rican, and the Mexican. Narcotic addiction is to a considerable extent overrepresented in ethnic subgroups (Vaillant, 1966). Work by Chein *et al.* (1964) has shown the close relation in New York between addiction rates and the "delinquent sub-culture" of areas of poverty. Moreover, drug-addiction rates in the Chinese inhabitants of New York are falling, the presumed explanation being that they are gradually becoming assimilated and are advancing their social status (Ball and Lau, 1966).

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The differences between the U.S. and British scenes should certainly not be minimized. America, for instance, has an entrenched black market and greatly different legal provisions, while the addict is submitted to pressures towards treatment. Moreover, the absence of a national health service may bear on the ability of society to respond to a problem such as addiction. Nevertheless, to conclude that the explanation of American addiction is simply a matter for the sociologist would be wrong, for even in the very worst areas only a small proportion of those at risk become addicts. The general impression of American workers seems to be that although some fortuitous circumstance, some juxtaposition, may result in "the ordinary kid" becoming an addict, it is necessary to look at personality as well as the surroundings. Not all American narcotic addicts come from the grossly underprivileged sectors of society: America also has its white addicts of relatively privileged background, and Ball (1965) and Bates (1966) have shown how incorrect any description of the American addict would be which generalizes him into one stereotype. The tendency now is toward the delineation in America of several different types of narcotic addiction.

The history of narcotic addiction in the U.S.A. shows the rapidity and unpredictability with which drug-abuse patterns can change; and here surely is something which comes very close to home. O'Donnell and Ball (1966) have shown that in the earlier part of this century the American addict was thought of usually either as a Chinese "dope-fiend" or quite often as a respectable middle-class citizen from a rural area, while in some parts of the country free prescribing of opiates for gynaecological disorders meant that female were higher than male addiction rates. The Chinese problem has faded out, addiction has become dominantly urban, the Negro and now the Puerto Rican have become heavily involved, and recently there has been growing alarm about the increased use of amphetamine, barbiturates, and tranquillizers, and the cult of using psychedelic drugs among college students and the emancipated. The vital lesson is that patterns of drug usage are not static. Even if some aspects of the American drug problem seem remote from our likely experience today, we must heed the warning that America's problems today may be ours of tomorrow.

Legal Provisions, Punishment, and Compulsory Treatment

In fulfilment of the U.S. Government's obligations as a signatory to the 1912 Hague Opium Convention, which required member countries to introduce legislation to control domestic production, sale, and distribution of opiates and cocaine, Congress in 1914 passed the Harrison Act. Schur

(1963) has argued that the original intention of this Act was not to remove the management of the addict from the doctor. He contends that it was the Narcotics Bureau's misinterpretation of the Act's provisions that led to the bringing into existence of a large "criminal class." In 1951 Federal legislation (the Boggs Act) introduced severe mandatory minimum prison sentences, and with the Boggs-Daniel Act of 1956 penalties were made even heavier—5 to 20 years for a first offence, and 10 to 40 years for a second or subsequent offence of unlawful sale, possession, or importing of narcotic drugs, and the possibility of the death penalty for selling heroin to anyone under 18. Marihuana is for legal purposes generally classed in the U.S.A. as a narcotic.

"Civil Commitment"

An important new trend in legislative policy has recently developed with the introduction, first at State and now at Federal level, of "Civil Commitments." California's Civil Commitment Programme was set up in 1961 after a court ruling that previous provisions which sought to make *criminal* the mere fact of being an addict, as opposed to possession or sale of drugs, was unconstitutional. California has something between 10,000 and 20,000 addicts, and the intention of this legislation was to enable the State to institute an effective policy for the first time.

Previously an obvious addict picked up on some petty offence such as stealing would have been back on the street after a short sentence, for the court could take no cognizance of his addiction. But under the new Act a person found guilty of a misdemeanour or non-violent felony, and identified as an addict, can be committed for up to seven years to the California Rehabilitation Centre programme, which is administered by the Department of Correction. Of this seven-year term, rather more than the first year is on average spent in a closed institution, where the emphasis is on counselling, work rehabilitation, and exploitation of a therapeutic milieu. The addict is then placed on parole with strict supervision and chemical testing. Any breach of parole—a positive urine test or naline test (Way *et al.*, 1963, 1966)—will result in his immediate return to custody. By mid-1968 it is expected that there will in California be an institutional population of just under, and an outpatient load of just over, 2,000 cases (Wood, 1967).

Civil commitment is now also being introduced under the 1966 Federal Narcotic Rehabilitation Act (U.S. Government, 1966), and on 1 April 1967 an ambitious State civil commitment scheme began to operate in New York (State of New York, 1966). But for much of this legislation time is required to determine how the law will work in practice, and to see what interpretations will be made by the courts.

The questions of whether the addict is to be regarded as a patient or as a criminal and of whether narcotics should be legalized or still harsher laws enacted, have produced in the U.S.A. a debate of quite dramatic acerbity, despite a remarkable dearth of evidence on which to base assertions. A publication of the Federal Narcotics Bureau (U.S. Treasury Department, 1966) urges that "much effort needs to be exerted to have both the heavy penalties and compulsory hospitalization extended to every part of the United States." Chein, on the other hand, has argued that the worst consequences of addiction result not from the drug but from public policy towards the user, and it has been pointed out that the addict, risking his life every time he takes heroin, is not in the nature of logic particularly likely to be deterred by harsh penalties (Narcotics Conference Report, 1963).

Though this American debate on compulsion is highly relevant to the British scene, the central issues require clarification. Two separate questions are involved: firstly, whether harsh legal measures can prevent addiction, and, secondly, whether compulsion can be of help in the treatment of the individual.

Effects of Strict Legislation

National figures on the drug addiction rate are not sufficiently accurate or sensitive to reflect time trends or the influence of specific legislative measures. Strict laws in Ohio cut down narcotic convictions by 80%, but, to quote the Narcotics Bureau (U.S. Treasury Department, 1966): "Of course, some of the racketeers moved their dirty trade into more easy-going States." Champions of the punitive approach can argue that the problem in America would have been even worse if the law had been more lenient, but this is no more than speculation. Moreover, legislation there, aimed specifically at "the pedlar" rather than at the addict, seems to have proved relatively unsuccessful, partly because the two are often one and the same person and partly because the really high-level criminal is seldom convicted.

Thus, on reviewing the American experience, vindictive legislation is apparently not a successful method of preventive medicine. The important lesson for Britain is that, despite more than 40 years of punishing the addict, America still has a large drug-addiction rate, a well-established black market, and an addict population which is forced into varieties of criminality.

Compulsion in Treatment

Considering the role of compulsion in assisting in the treatment of the individual patient, one finds that the evidence is perhaps rather disturbing in its bearing on current British policy. Vaillant and Raisor (1966) reported a 12-year follow-up on 100 addicts discharged from the Federal hospital at Lexington. Because many of these patients had over the years undergone, in more or less random sequence, voluntary hospitalization, short- or long-term imprisonment, or imprisonment and parole, the authors were able to identify groups of patients who had as it were acted as their own controls. Patients were usually seen at three-monthly intervals by social workers whose prime aim was to obtain follow-up information, but who also offered social-work help. One-year abstinence rates following the different "treatments" were as follows: hospitalization 4%; short-term imprisonment (less than nine months) 4%; long-term imprisonment (more than nine months) 13%; imprisonment plus subsequent parole supervision 67%. The efficacy of probation is supported by the most recent report on the California Programme (Wood, 1967), which states that 34% of men on probation have not taken drugs for a year.

Does probation backed by effective threat of reimprisonment therefore offer excellent hope while other methods give desirous results? The interpretation of Vaillant and Raisor's important study should be more guarded than this, and it must be emphasized that they were comparing very vigorous probation supervision with community care which must often have been far from intensive.

Nevertheless, there seems to be a strong feeling among experienced workers in the U.S.A. that an element of coercion is necessary (Maurer and Vogel, 1967; Lieberman and Brill, 1967). Here, then, is a dilemma—repressive legislation appears to be an ineffectual and dangerous public health measure, and yet the threat of imprisonment seems to increase the chances that the probated addict will respond to treatment. How is Britain to solve this dilemma?

A Solution in Britain?

The only way of determining whether in Britain treatment can be successful without compulsion is to try intensive-treatment programmes in the setting of present law, and carefully to assess the results which are obtained. For a proper judgement such treatment must be skilled and energetic, and

one can predict at the outset that voluntary treatment will appear to be ineffective if the treatment under consideration is lackadaisical, carried out by medical staff with too many other commitments, and unsupported by adequate social work and rehabilitative services—in other words, treatment which focuses on detoxification rather than on the needs of a troubled person. In summary, therefore, rather than focusing energies and attention on reshaping the law, the whole lesson of the American scene in this respect would seem to be that we should act now while the problem is still relatively a small one, and set up the very best possible treatment services so that voluntary methods will be given more than a handicapped chance to prove their worth.

Heroin Dispensing and Alternatives to Heroin

In 1919 following a Supreme Court decision which appeared to indicate that the private physician who prescribed maintenance drugs to his addict patient would be risking prosecution, a number of special narcotic dispensaries were set up to cope with the needs of addicts suddenly deprived of their supplies. By 1923, however, the last of these dispensaries was closing down, and the experiment was generally being pronounced a failure.

What really happened? Though the American Medical Association (1963) has attempted to answer this question, it seems that proper data on the experiment were never gathered. The clinics closed partly because of medical pressure and partly because of opposition from the Narcotics Bureau; most clinics made no attempt at treatment but simply handed to the addict his drugs. Diversion of narcotics to other than registered addicts occurred and there were complaints that criminal elements were being attracted to the areas of town where the dispensaries were situated.

If the role of the clinics envisaged in the British legislation (House of Commons, Dangerous Drugs Bill, 1967) should degenerate into a mere handout centre, it is likely that the American experience would be repeated. Thus it is vitally important that the staff of the clinics which are being set up under the 1967 Act should be concerned with and involved in the total treatment programme, should have as their aim to woo the addict off drugs, and must have immediately available facilities for detoxification and later rehabilitation, so that, when the addict shows interest in treatment, treatment can be provided. The doctors staffing these clinics cannot be part-time clinical assistants unsupported by psychiatric training.

Even if the new British clinics are adequate for the purpose the policy of heroin prescribing will still face very considerable difficulties, inherent in the properties of the drug itself. The American evidence seems to suggest that its pharmacology weighs heavily against the possibility that most of our addicts will be safely maintained on a fixed dose of heroin, will return to social functioning, and be prevented from diverting their supplies to the black market (Wikler, 1952; Fraser *et al.*, 1963).

Maintenance Dosage

American studies also throw some light on what is one of the essential assumptions underlying the new British policy—namely, that an individual, satisfactory, fixed maintenance dose can be determined for any particular addict so that he will receive enough not to be tempted to patronize the black market, while at the same time he has no excess to sell or proselytize. Work by Martin and Fraser (1961) has shown that the patient may be in pharmacological balance—receiving the “correct dose” so far as the doctor is concerned—but may still, in the patient's judgement, be requiring more of the drug. Moreover, under a policy which seeks to stop the addict from turning to the black market, if doctor and addict disagree on “need,” then the addict must be the arbiter. One way of preventing over-

prescribing might be to rely on chemical assay methods. Urine levels will, however, largely reflect only the time at which the last injection was given, and a person with a considerable drug dependency might some time after the last injection show a near zero blood level. No doubt some technique could be worked out, but it is difficult to believe that such methods could easily be applied to the routine work of a drug maintenance clinic.

Hence research in America suggests that maintenance drugs will have to be given under the strictest supervision. Because heroin is a short-acting drug this will entail injections three or four times a day, and the demands on the staff at the clinic and on the patient in terms of travelling time are going to be considerable. Thus in reality either the drug will have to be given daily into the patient's own hands, or a supply of prescriptions will have to be deposited with a chemist for daily dispensing. In either case the possibility of black-market diversion is opened up again, while the fact that the patient is continuing to give his own probably unsterile injections carries the likelihood of more than occasional tragedy.

Whatever the theoretical arguments, only close observation of the actual running of the new clinics will give the answers—whether patients can be maintained successfully on a fixed dosage schedule, whether for most addicts less than optimal supplies of safely and legally obtained heroin are an acceptable alternative to escalation and seeking drugs on the black market, whether diversion of supplies to illicit distribution continues, whether training in sterile injection techniques can decrease the incidence of infections. But American evidence is not encouraging—heroin for maintenance is a bad choice of drug.

Other Drugs for Maintenance

Could any other drug be used? Dole and Nyswander (1965, 1966, 1967) have shown that methadone (Physeptone) is sometimes an acceptable alternative to heroin. The obvious advantages of methadone are that it is a long-acting drug and therefore given only once a day, that it can be taken orally, and that in daily doses of 80–120 mg. it blocks the euphoric effect of any other narcotic which is coincidentally taken, but does not in itself produce psychological or motor effects which impair social functioning. This interesting work has been criticized on several grounds, some of which are ill-founded, and there is an obvious need for continuing, careful assessment of the results of treatment.

The development of a series of N-substituted benzo-morphan derivatives may be of particular importance—for example, cyclazocine, which experimentally has been shown to be able to block the effects of morphine in daily doses up to 240 mg. (Martin *et al.*, 1966) and which in clinical practice is also of some value (Jaffe and Brill, 1966). The hope is that drugs can be developed which, unlike methadone, do not subject the addict's system to the continuing experience of narcotic intoxication but which relieve drug hunger and drug-seeking activity—cyclazocine itself, though given orally, is perhaps too short-acting to provide the ideal answer. Patients may find that by taking cyclazocine during the week and stopping it at week-ends they have a way of “chipping” without becoming “hooked.”

Two important differences should be noted between the American and British scenes so far as drug substitution is concerned. Firstly, in Britain addicts take a much higher heroin dosage than in America and the efficacy of substituting or blocking drugs is not so certain. Secondly, in America the choice facing the addict is between easily available methadone and expensively, criminally, and dangerously obtained weak heroin, whereas in Britain the choice is between free methadone and free, good quality, safely and legally obtained heroin. Only experience will show how many addicts genuinely want to give up heroin but, despite their intentions, find the task of remaining abstinent too difficult. Any change in the law

that sought to make methadone a drug which the doctor could prescribe without the addict's choice being consulted would have sound pharmacological argument on its side, but at present would probably result in a considerable number of addicts turning to the black market.

Hospitals and Alternatives to Hospitals

In the U.S.A. generally there is a mood of disillusionment regarding the role of conventional psychiatric inpatient ward care in the treatment of drug addiction. If there is no compulsion the patient discharges himself, and if there is compulsion then the patient and staff work against each other, or, worse still, the patients learn to "give the right answers." And yet there is the feeling that if the addict is to have any hope of successfully breaking with his habit and with the life pattern of the addict-criminal subculture he requires a period in a controlled environment right away from the street. This argument is supported by evidence that in the rat physiological changes persist for at least six months after heroin withdrawal (Martin *et al.*, 1963) and by Wikler's (1965) theory, which emphasizes the importance of conditioning factors in opiate addiction and relapse.

The way out of this particular dilemma seems to be to provide the initial period of "control and removal" in some sort of therapeutic community, either within the hospital or prison, or in some quite other facility unrelated to conventional institutions. In this both Synanon and Daytop have clearly played a major part in making people think again.

Synanon was started in 1958 (Casriel *et al.*, 1963) and today is a community of 700 former addicts who live without drugs and without locked doors. The community owns a fleet of cars and trucks, threatens to buy an aeroplane, runs businesses, has its own dance band, and bids fair to becoming one of the great American success stories. The brashness and aggressiveness of some of Synanon's claims have drawn criticism, and the critic can rightly point out that records which would allow proper assessment of results are not available, that because no urine testing is allowed validation of all claims is uncertain, and that Synanon may be similar to the methadone programme in that it takes an atypical addict. A visit to Synanon and time spent casually talking to its residents strongly suggests, however, that whatever the ultimate statistics this organization is achieving very remarkable successes. The importance of Synanon is not only in terms of the count of addicts helped, but also lies in what psychiatry has to learn from the methods of treatment which the community has evolved (Holzinger, 1965). Daytop village in New York (Shelly and Bassin, 1965), based on the Synanon model, seems to be achieving similar success; but in Daytop, unlike Synanon, many of the residents are under the coercion of a probation order.

The most interesting departures which Synanon and Daytop have made from the usual psychiatric approach to drug addiction include their emphasis on the addict not being ill but his being "stupid" and "a baby." Emphasis is on feeling rather than on cognition. The communities make no pretence at democracy, and the confusion regarding role and authority structure which can so easily occur in psychiatrically run models of the therapeutic community has in Synanon and Daytop been avoided. Interreaction in group discussions is often verbally violent and brutally frank, but there is also an emphasis on mutual concern—"you really have to love people, not just want to help them like a social worker."

Could a Synanon or Daytop function in Britain? There would seem to be no inherent reason why such an experiment should not succeed here, and the influence of the experiment on the whole scene might be important, forcing rethinking and imagination. The idealism, energy, and sheer fun of such communities may be more able to win the interest and loyalty of the young addict than can the "square" world of the mental hospital.

Community Centred Programmes

In the organization of psychiatric care the general American trend is toward provision of community-based services (Glasscote *et al.*, 1964; Ozarin and Brown, 1965), and thinking on the services for the narcotic addict follows this direction. Those authorities who advocate the initial period of "control" within a closed institution or Synanon type facility would probably all agree that there is no value in this period of removal from society unless on return to society continued help is given. Nevertheless, Vaillant and Raisor (1966) showed, with the particular group of addicts studied and with the community services of rather heterogeneous and uncertain intensity, that only small success could be expected from community care without coercion.

Though caution is necessary in applying experience to Britain, several U.S. experiments in community treatment of addicts are worth mentioning, particularly that of Dr. Efron Ramirez, in Puerto Rico (Ramirez, 1966). This rather startlingly reverses the usual phases of treatment: community care starts the treatment and only later is inpatient therapy offered. The induction phase—"a training process for future treatment"—lasts two to three months and comprises the street encounter, a sort of day hospital programme, and then detoxification. Ramirez believes that the best person to win the addict into treatment is the recovered addict, and it is the recovered patient who goes out on to the street to look for new clients, and the "training for treatment" then continues "in a store front office in a neighbourhood of high drug incidence." The period of residential treatment which follows is expected to last 10 to 12 months, and this is followed by a year in a "re-entry house," in which control is looser and there is gradual resumption of everyday life in the community. Ramirez has now moved to New York, where he is Co-ordinator of Addiction Programmes.

Several other influential but more orthodox community orientated projects have been based on and linked with hospital outpatient departments: the New York Demonstration Centre (Brill, 1965); the programme run by the Metropolitan Hospital Centre (Brotman *et al.*, 1965); the Washington Heights Rehabilitation Centre (Brill, 1966). The Greenwich Village Counselling Centre (Osnos and Laskowitz, 1966) and the Special Problems Centre in San Francisco have shown the feasibility of treating narcotic addicts and non-addict clients in the same premises.

Conclusions

The growing rate of drug addiction in Britain (Bewley, 1966) has forced revision of the law, but the underlying philosophy which guides the British approach remains unaltered: the thesis was and is that the interests of treatment and prevention are best served by regarding the addict as a patient, by giving him heroin if he so demands, by wooing him rather than coercing him into treatment, and by keeping addiction above ground rather than by driving it into the criminal underworld. The next few years will show whether this philosophy can be the basis of a viable policy. There is nothing in the American experience which guarantees failure, but much to suggest that we are playing against long odds—heroin is a bad and unpleasant drug for maintenance, and to hope that without any form of coercion the addict can be persuaded to abandon freely available narcotics is ambitious indeed. The whole of American experience would suggest that if our new programme is to be other than foredoomed to failure and a prelude to debacle, it must be conducted with vigour and energy, must be a matter of reaching out rather than of sitting back in hospitals, must focus on human needs and rehabilitation rather than on drug maintenance or detoxification. Saving of money at this stage may prove a costly economy.

As for research, the important focus in Britain as in any other country must be on finding why people become addicts and on discovering how they can be aided to recovery: the most profitable focus is likely to be on the society and the person rather than on the drug. Addiction research is nothing special: it is part medical and psychiatric research, and if the experts become isolated work will suffer. The study of schizophrenia, of the alcoholic, of the recidivist, exploration of the effective elements within psychotherapy, the wide and general field of psychopharmacology—all this is germane.

If there is one final lesson to be learnt from all of those who have been grappling with the problem of drug addiction in America for years, it is that discussion in these highly charged and disturbing matters should remain open—that rationality should prevail.

This paper is based on the experience of an eight-week trip to the U.S.A. and on discussions held with many people who with the greatest generosity and courtesy gave their time. To all of them I would like to express my warm and personal gratitude. My particular thanks are due to Dr. Stanley Yolles, Director of the National Institute of Mental Health, Washington, and to Dr. Sherman Kieffer and Dr. Tom Cassidy. The sponsorship of the National Institute of Mental Health made this trip possible. I would like to thank my secretary, Mrs. Julia Polglaze, and Miss Elsie Hoffmeister.

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MEDICAL ETHICS

Supervision of the Ethics of Clinical Investigations in Institutions

Report of the Committee Appointed by the Royal College of Physicians of London*

Following the receipt of a letter on 5 September 1966 on this subject from certain Fellows, the College appointed a committee to consider how far supervision of clinical investigation was required, and, if it was required, how best it might be effected.

The term "clinical investigation" is regarded by the Committee as covering all forms of experiment on man. There are broadly two kinds of clinical investigation or research. The first is that which has direct diagnostic or therapeutic relevance to the individual patient and which therefore seldom poses serious ethical problems. Indeed the doctor could sometimes be said to have failed in his duty to his patient if he did not perform such an experiment.

The second kind of investigation or research is that which is carried out to advance knowledge, and from which the subject, be he a patient or a normal person, cannot expect direct personal benefit. This kind of clinical investigation benefits the community, but may present difficult ethical problems in relation to the individual.

The design and conduct of clinical investigation should be guided by a code of ethical practice, and the Code of Ethics

of the World Medical Association (Declaration of Helsinki) is accepted throughout the civilized world. The Medical Research Council has also issued a statement on "Responsibility in Investigations on Human Subjects" (M.R.C. Annual Report, 1962-3. Cmnd. 2382, H.M.S.O.). This has been reprinted, together with the Declaration of Helsinki, in the *British Medical Journal* (1964, 2, 177, 178).

The Committee accepts that these statements define the ethical situation and considers that all clinical investigators should be familiar with their recommendations. However, because of the wide varieties of research, formal codes can provide only general guidance, and their application to specific problems must often remain a matter of opinion.

The Committee considers that it is of great importance that clinical investigation should be free to proceed without unnecessary interference and delay. Imposition of rigid or central bureaucratic controls would be likely to deter doctors from undertaking investigations, and if this were to happen the rate of growth of medical knowledge would inevitably diminish, with resultant delay in advances in medical care.

The Committee is satisfied that in the great majority of cases a very high ethical standard has been maintained in clinical investigations in this country.

The number of doctors involved in clinical investigation at the present time is large and is likely to increase, and the types

* Members of the Committee: Sir Max Rosenheim (chairman), Dr. F. Avery Jones, Dr. G. M. Bull, Professor D. V. Hubble, Professor A. C. Dornhorst, Dr. J. D. N. Nabarro, Professor D. R. Laurence, Dr. J. P. P. Stock, Dr. K. Robson, and Dr. P. A. Emerson.