teach at both undergraduate and postgraduate levels. Experience of the application of the different specialties can be identified and it is not unlikely that needs can be matched with means.

A prerequisite to a balanced curriculum of medical education is the recognition that no single specialty is at present adequately covered and in consequence no subject can be adequately taught.

THE HOPEWELL HYPOTHESIS

ON 9 OCTOBER 1761 the ship *Hopewell* arrived at Halifax with between two and three hundred immigrants destined to settle in Nova Scotia. Many of these were of Scottish extraction who had sought to escape oppression of the Presbyterians during the reign of James I by migrating to Ulster, and the group of immigrants became known as the 'Ulster Scots'. From a first settlement in Colchester County, Nova Scotia, descendants of this immigrant group have spread throughout North America.

During the last 20 years Bode and Crawford observed a number of families in which nephrogenic diabetes insipidus was prevalent among patients seen at the Massachusetts General Hospital, and noticed that many of these claimed descent from the original settlers of Nova Scotia. This observation led to a study of the genealogies of families known to have been aboard the *Hopewell* and into the folklore surrounding the 'water-drinkers'. Both folk-legend and genealogical evidence strongly suggest X-linked transmission of the trait.

Thus historical and medical research can meet and complement one another. In this instance the observation was made at a general hospital but the next might as easily be made in a general practice. It may well be that practitioners in the British Isles or in Canada can carry this story further, adding more to our knowledge not only of nephrogenic diabetes insipidus but perhaps also identifying other conditions which may be associated with it. This fascinating paper in the *New England Journal of Medicine* (**280**, 750–754) 3 April 1969 is a challenge to us.

MATERNAL DEATHS AND MATERNITY SERVICES

THE current triennial Report on Confidential Enquiries into Maternal Deaths in England and Wales[1] relating to the years 1964–1966 brings together interesting items of background information relating to the maternity services. The birth rate, which had been rising since 1955, reached a peak of 18.8 in 1964 and fell steadily to 18.0 in 1966, a fall which continued after the review period to 17.2 in 1967. This was so complete a reversal of trend that it fell in three years by more than it had risen in the previous five.

The number of first births, which had been rising for several years, continued to do so. On the other hand second births, rising until 1964, fell in 1965 and remained at the same level in 1966. Third and subsequent births each reached a peak in 1964

and fell steadily thereafter. The number of births to mothers under 25 years of age had been rising and continued to do so. The number to mothers in higher age groups fell from 1964 onwards.

Growth of population is a complex matter depending on many factors of which only one, the number of available mothers-to-be, can be predicted with reasonable certainty for 20 years ahead. The most important factor, and one of the most difficult to predict, is the future size of the average family; a factor which, with the use of oral and intra-uterine contraception, is coming under the control of the female as never before. Whatever the reason, there is apparently an increasing tendency to limit the number of children to two, a trend which, if it continues, will nullify the effect on the birth rate of women having their babies at earlier ages, a factor partly responsible for the rising rate up to 1964.

Predictions of ten years ago that the number of births might rise to 965,000 by 1970 are not now likely to be fulfilled. There was in fact a fall from 890,518 in 1964 to 863,066 in 1966. The load on maternity services will not be as great as was feared and the task of hospital services may be lightened by an increasing demand for 48-hour bookings. There should be no difficulty, other than geographical, in securing hospital delivery for all who require it and the stage is set for reduction of maternal mortality to the minimum.

During the review period, 1964–66, there were 671 maternal deaths directly due to pregnancy or childbearing, the equivalent of a maternal death per annum in the practice of one general practitioner in 88; or the maternal death of a patient in his lifetime for 1 in 3. The report showed that there was an avoidable factor in 45 per cent of deaths, a preventable death in his lifetime for 1 in 7. The person most likely to be able to prevent it was the patient and her most probable error was seeking illegal termination. But in over 60 per cent of preventable deaths there was an avoidable factor other than this.

Compared with the previous review period, mortality in 1964–66 was lower by 16 per cent at 0.26 per 1,000 births. The reduction was considerable in toxaemia, postpartum haemorrhage without a retained placenta, and pulmonary embolus. In most other cases it was slight and there was even an appreciable increase in deaths due to anaesthesia and to puerperal or postoperative sepsis. In cases of abortion, death is classified as due to abortion, not to the terminal cause such as sepsis or haemorrhage. If deaths due to septic abortion are added to those due to puerperal and postoperative sepsis, the second most common cause of maternal death is sepsis, a surprising finding in this antibiotic era.

Apart from abortion, which accounted for 105 avoidable deaths, the greatest room for improvement still lies in cases of toxaemia and haemorrhage with 38 and 30 cases of avoidable death respectively. As in previous reports, there are criticisms of unsuitable cases booked for home or general-practitioner unit delivery, some of which should not be taken too seriously. Patients who are over 30 years of age or of high parity are more likely to develop abnormalities than the average patient but it is not beyond the wit of doctors to detect serious abnormalities and transfer to specialist care those patients who need it rather than book for specialist hospital delivery large numbers destined to stay normal.

On the other hand there are grave and unwarrantable risks in booking for home or general-practitioner unit delivery patients with diabetes, heart lesions or chronic renal disease. Patients should not die of toxaemia without having had specialist attention, nor of postpartum haemorrhage without the flying squad having been called. Ruptured uterus after intramuscular pitocin injections should not occur and doctors who perform

only one or two caesarean sections a year should seriously consider whether someone else should take over.

Illegal abortion, however, followed by haemorrhage or sepsis, remains the most important cause of maternal death directly due to pregnancy or childbirth. Elimination of illegal abortion, a social problem, may have even more effect on the remaining maternal deaths than the efforts of members of the maternity services. It remains to be seen how much will be achieved by the Abortion Act of 1967.

REFERENCE

1. Reports on Public Health and Medical Subjects No. 119. Report on Confidential Enquiries into Maternal Deaths in England and Wales 1964–66. London. Her Majesty's Stationery Office.

DIPLOMATES IN FAMILY MEDICINE

The American medical profession has scored a significant victory in the battle to restore personal health care by establishing the new specialty of Family Medicine.

Commenting on the decision, which was recently ratified by the Council on Medical Education of the American Medical Association and the Advisory Board for Medical Specialties after two years of deliberations, American Academy of General Practice president, Dr Maynard I. Shapiro, said: "The decision marks a milestone in medical history".

Moreover, he said, it will end "the country's nonsystem of health care" by making available again a personal approach based on intimate and continuing knowledge of an entire family's medical history. Such knowledge, he said, would be augmented by special family physician training in psychology, sociology, and other behavioural sciences, as well as in economics so that the new breed of GP is equipped to act as a family counsellor in sickness and in health, and to handle "the emotional overlay" that increasingly accompanies disease.

However Dr Shapiro warned, the new specialty status will not be awarded automatically; practising physicians will have to undergo at least 300 hours of postgraduate education to earn certification.

The new status is expected to encourage more medical students to choose the specialty of family medicine. In 1967 less than two per cent of graduates opted for general practice, and of more than 300,000 MDs in the United States, only 72,000 are general practitioners.

Physicians who pass the new certification board exams will become Diplomates in Family Medicine—with the same rank and status as Diplomates in the other specialties. The exams—devised by the National Board of Medical Examiners—will be held for the first time by the end of 1969. Study and residency requirements will be similar to those required in other specialties, with three years of graduate work following four years of medical school.

From the *Canadian Family Physician*, March 1969. P. 61.