

PRACTICE OBSERVED

Practice Research

Review of maternity patients suitable for home delivery

E A DIXON

The number of home deliveries of babies has been decreasing and now only 1.4% of deliveries take place at home. Opponents of home delivery believe that the safest place for the patient to be delivered is in hospital where expert facilities and attention are immediately available for the mother and her newborn baby.

Patients

With the assistance of the Community Midwifery Service a list was compiled of the categories of patients who would not be suitable for home delivery: —nullipara; —gravid-multipara (more than four live births); —history of threatened abortion in the present pregnancy;

Results

During the antenatal period 41 of the 278 patients (14.7%) had complications that made them unsuitable for home confinement (table 1). Before 36 weeks' gestation a patient was considered to be hypertensive if the diastolic blood pressure was above 90 mm Hg on at least two occasions more than four hours apart over 48 hours while resting in hospital. There were six patients in this category and three

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continuous monitoring of fetal heart rate. Although routine monitoring of the fetal heart rate has been criticised, Dewhurst¹ stated that it is better than no monitoring at all. While Donald² stressed that anomalies in the fetal heart rate may be missed without continuous monitoring. By continuously monitoring fetal heart rate the diagnosis of fetal distress would not be made only on the basis of meconium-stained liquor as is done when the patient is at home³ or in GP units.⁴ In some cases the birth of an asphyxiated baby can be predicted and appropriate steps taken to adequately resuscitate the baby at birth.

Of the complications in labour, 14 (42.7%) occurred in the third stage. Placental retention or postpartum haemorrhage, or both, may occur without any warning and, like asphyxiation of the baby, may carry serious consequences if not treated immediately. Those who favour home delivery have recognised that there are dangers accompanying childbirth and they are willing to take the risks, especially when there is a good flying squad service available. James⁵ has stated that transfer to hospital late in pregnancy or in labour is undesirable from the mother's point of view for psychological reasons, while Adamson and Gare⁶ report that the delay associated in the transfer may result in a poor outcome for the infant and that even a five-minute delay may be fatal. Hudson⁷ showed in his review that the perinatal mortality rate rose for patients who were transferred in labour and in his experience the delay was commonly more than one hour.

I agree with Adamson and Gare⁶ that the first priority must be a live and healthy mother, the second a live and healthy baby, and the third a psychologically rewarding experience for the parents and baby. This review showed that there are unexpected complications in labour in even a low-risk group of patients, confirming that pregnancy, labour, and puerperium can only be judged as normal after it has taken place.

Conclusions

From a total of 1015 patients, 278 (27.4%) were considered to be suitable for home delivery at booking. Of these, 41 (14.7%) had complications in the antenatal period which made them unsuitable candidates for home confinement. Of the remaining

237 patients, 33 (13.9%) had complications during labour or up to the fifth postpartum day, while 16 babies (6.8%) needed specialised paediatric care at a later date than birth. This review shows that 31.3% of low-risk patients who were considered to be suitable for home confinement at booking had complications that could make home delivery unsafe for the patient or her newborn infant, or both.

I would like to thank Mr S J Bay, Mr J K P Perera, and Mr P G Rae for their kind permission to review these patients who were under their care, and Mr Perera and the Community Midwifery Service for their assistance.

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MRC trials in general practice

Many general practitioners will know of the Medical Research Council's trial of treatment for mild hypertension. This trial is still in progress and most of the 176 group practices that have been brought together in this research are still participating. We hope to extend this valuable framework and carry out studies of other problems suitable for investigation in general practice. Firstly, there will be studies, such as the hypertension trials, that are particularly suitable for investigation in general practice, for both scientific and organisational reasons. We shall shortly be starting a study of the use and possible adverse consequences of hormone treatment given for the relief of menopausal symptoms; a large scale trial of treatment of hypertension in elderly people will, we hope, also be started later this year; and other studies of observational or clinical trials are being discussed. The second type of study envisaged will be concerned with the conduct and organisation of medical care in general practice. Any practice in the group is, of course, free to participate only on those studies that the partners feel are of interest.

Financial assistance is provided towards compiling age/sex registers, and for additional nursing or medical services required. Equipment, laboratory facilities, and postal arrangements are also provided, so that no practice is to be put at a disadvantage by its participation. We should be glad to hear from other group practices who might be interested in joining this research. Practices with total lists of at least 7500 patients (preferably 10 000 or over) are required, and should ideally have accommodation that would allow one room to be used for follow-up at regular times each week (inside or outside normal surgery hours) and for storage of records, drugs, and instruments. Many practices currently participating are willing to be contacted or visited by others wanting to know what participation in this research involves. Their names and addresses, and further information, may be obtained from the Coordinating Centre, MRC Epidemiology and Medical Care Unit, Northwick Park Hospital, Watford Road, Harrow (Middlesex), HA1 3UJ. We should also be contacted by GILMAN GREENBERG, BSC, MB, BCh, MSc, MD, FRCP, MRC Epidemiology and Medical Care Unit, Harrow.

had proteinuria. Antihypertensive treatment was started in all, and labour was induced at 38 weeks' gestation in five cases. The sixth patient had labour induced at 37 weeks' gestation because of increasing proteinuria. Six patients had a diastolic blood pressure above 90 mm Hg after the 38th week of pregnancy. Two had proteinuria. All were admitted and labour was induced after the blood pressure reading was verified.

TABLE 1—Complications in the antenatal period (n=41)

Table with 2 columns: Complication, No. (n=41). Rows include: Hypertension/proteinuria (12/29.3), Maternal death (1/2.4), Postpartum haemorrhage (5/12.1), Pre-eclampsia (3/7.3), Anaesthetist's error (4/9.8), Premature rupture of membranes (9/21.9), Other (9/21.9), Intrauterine growth retardation (1/2.4), Fetal death (1/2.4), Cord prolapse (1/2.4), Cervical incompetence (1/2.4), Temporal epidural (1/2.4), Drug overdose (1/2.4), Appendicitis (1/2.4).

The patients who were considered to be postpartum were at least 10 days past term. Term was considered to be 40 weeks' gestation as calculated by menstrual dates and checked by son scans or x-ray films. The three patients who were excluded during the antenatal period because of antenatal haemorrhage did not have placenta praevia, but they continued to bleed intermittently throughout the pregnancy and labour was induced before term. Spontaneous rupture of membranes occurred in two patients between the 32nd and 33rd weeks of pregnancy. In one patient spontaneous labour followed shortly afterwards, while the other was delivered 48 hours after the membranes had ruptured. Both deliveries were assisted by forceps and the babies were transferred to the special care baby unit.

Rhesus antibodies rose in a rhesus-negative patient who had no antibodies present when she booked. Labour was induced before term and the baby, who was not jaundiced at birth, was transferred to the special care baby unit. The patient who had a suspected subarachnoid haemorrhage during the second trimester had a forceps delivery, and the patient who developed deep vein thrombosis was treated with anticoagulant drugs before and after delivery. Temporal epidural was noted for the first time in one patient at 36 weeks' gestation. The cause of intracranial fetal death occurred at 32 weeks' gestation. The cause of death was not known.

Of the 237 patients who had no complications in the antenatal period, 33 (13.9%) had complications in labour or in the first five postpartum days (table 1). Ten patients were delivered by forceps,

TABLE 2—Complications in labour and early puerperium (n=33)

Table with 2 columns: Complication, No. (n=33). Rows include: Forceps delivery (10/29.7), Postpartum haemorrhage (5/15.1), Blood transfusion (5/15.1), Caesarean section (1/3.0), Hypertension/proteinuria (3/9.0), Premature labour (1/3.0), Pyrexia (1/3.0).

five because fetal distress was diagnosed. The diagnosis of fetal distress was made by noting type 1 (late) or variable decelerations of the fetal heart rate using either the external ultrasonic Doppler or fetal scalp electrode tracings. Two of the babies, which were born alive, needed intubation at birth and two others were born with nuchal entanglement of the umbilical cord.

The other five forceps deliveries were performed because the second stage of labour was considered to be prolonged and the maternal effort was poor. In all cases the second stage lasted longer than 50 minutes and in two cases it was more than 60 minutes. There was deep transverse arrest in one case.

Three patients had a caesarean section as an emergency procedure. One had prolapse of the umbilical cord after spontaneous rupture of membranes and the others had failed to progress after 12 hours in the first stage of labour. Two patients went into spontaneous labour before 38 weeks' gestation. The babies who were born to these patients developed respiratory distress syndrome and were transferred to the special care baby unit. Nine patients had retained placentas, which were removed manually under general anaesthesia.

Four patients had postpartum haemorrhage and all needed blood transfusion. A fifth patient received a transfusion on the second postpartum day because her haemoglobin concentration was 8.4 g/dl. Three patients were hypertensive, noted for the first time in two in labour. Both had diastolic blood pressures greater than 100 mm Hg, and one had proteinuria when a catheter specimen of urine was tested. The third patient became hypertensive immediately after delivery. There was no postnatal treatment. The patient who started and all three patients were normotensive on the third postpartum day. One patient developed peritonitis on the day after delivery and was treated conservatively.

Sixteen babies (6.8%) needed specialised paediatric care. Thirteen of them had to be intubated at or soon after birth. Intubation was performed if spontaneous respiration was not established after simple resuscitative measures were carried out or if the baby had difficulty in maintaining respiration. In all cases intubation was continued for longer than two minutes. Two of these babies were delivered by forceps because of fetal distress and one was delivered by caesarean section because of prolapse of the umbilical cord.

Two babies who were born at 38 weeks' gestation developed the respiratory distress syndrome and were transferred to the special care baby unit. One further baby was jaundiced because of blood group A/B incompatibility. Any practice in the group is, of course, free to participate only on those studies that the partners feel are of interest.

No perinatal deaths were recorded for the patients who were still suitable for home delivery after the antenatal period.

Discussion

Of the patients who were thought to be suitable at booking for home delivery, 31.3% had complications in the antenatal period, during labour, or in the first five days of the puerperium, or their baby needed specialised paediatric care during the first few hours of life. In the antenatal period 14.7% of the patients were found to be unsuitable for home delivery. Hudson⁷ rebooked 11.2% of multiparae women before labour, and Cox et al⁸ transferred 11.1% for hospital care. Lewis et al⁹ found an increasing number of patients who were being transferred from GP units to consultant units and said that this was due to a greater awareness among general practitioners of antenatal problems.

Of the patients who were suitable for home delivery after the antenatal period, 30 (12.7%) had complications in labour. Hudson⁷ and James⁵ reported that 4.1% and 7.3% of multiparae were transferred in labour from home and GP units respectively, while Mehl et al¹² have shown that at least 10% of women who expect to deliver at home will require transfer to hospital for an unexpected complication in labour.

The first stage of labour was prolonged in two cases—more than 12 hours—in my review. James⁵ stated that patients were transferred to hospital after being 46 hours in the first stage. Although there is no agreement on when labour becomes prolonged in the first stage, more than 18 hours in multiparae must be considered outside normal limits. In this series assistance was not given before 50 minutes in the second stage of labour; James⁵ however, transferred multiparae to a consultant unit after 45 minutes. Like prolonged labour in the first stage, there is no agreement about delay in the second stage. The median duration of the second stage is 20 minutes,¹¹ and the 95th percentile value is 1.1 hours.¹⁰ Donald² stated that after 20 minutes the patient should be reviewed so that an early decision may be made about giving assistance. Since there are so many opinions on when labour becomes prolonged, the condition of the patient or the fetus, or both, must therefore be the deciding factor about giving assistance in both the first and second stages of labour.

Forceps were used in five cases of fetal distress diagnosed by

A Family Practice

Six generations in Wiltshire

DICK MAURICE

It was in 1792 that my great-great-grandfather, Thelwall Maurice, MD, settled in Marlborough. A graduate of St Thomas's Hospital, he was 25 when he joined Dr Pinckney, who had himself been in practice in the town since 1769. Thirteen of Thelwall's descendants are still in practice as doctors in Marlborough—Marlborough—Wiltshire. We claim to be the oldest group practice in the country.

Centre of a widely scattered rural community, the distances that had to be covered on horseback or by carriage were far greater then—and indeed for ensuing generations—than they are today with the motor car. Reference to the practice day-books for 1794-5 and 1799-1800, which are preserved, illustrate this. Journeys might set out on the Kennet valley—a flag or article of clothing in the window of a cottage would be a signal for the doctor to call—then to Avebury, and on through the villages to Wroughton and Swindon. Half way on this journey fresh horses would be met, brought by the direct route over the downs.

Sundays do not seem to have been a rest day; what would a doctor today think of having to make up 12 repeat prescriptions as appears under Die Solis 2 Nov 1794? But as today, Monday seems to have been a bad day; opened at random there are 26 entries under Die Lunae 8 Decemb 1794, only 14 for Die Martis 9 Decemb.

Thelwall seems to have kept himself up to date. In 1824 Longmans published the fourth edition of *A Treatise on Dislocations and on Fractures of the Joints* by "Sir Astley Cooper, Bart, FRCS, Surgeon to the King etc etc." Many personal communications are included. Case XV appears on pages 54 and 55. Headed "Marlborough Feb 12—1823," it tells how George Davis, aged 35, fell and dislocated his hip. The reduction is vividly described: "30 ounces of blood having first been bled, (Sir Astley stresses the importance of this in his preface), pulleys were applied "according to your instructions," and "suddenly, with an audible snap, it slipped into its proper cavity." The account concludes "Yours respectfully, T Maurice."

Two of Thelwall's five sons adopted medicine, two the church, and one the law. The elder son, another Thelwall, went to Reading after qualifying at St Thomas's; perhaps there was no vacancy in Marlborough at the time and it was David, the third son, who had left St Thomas's with FRCS, who joined his father in the family practice. Thelwall died in 1830 and

Davis, aged 28, married the same year. He acquired a good property on the south side and toward the western end of the High Street; his father had practised from the other end of the street and on the north side of the street his house Lloran House the ancestral home Lloran Ucha in Denbighshire; this house was to remain in the family until 1955 and an extension to the house is the practice surgery to this day: initially the surgery was in a small lane adjoining his property.

The decade starting in 1840 was an important one for the practice. The railway from London to Bath and Bristol had just been completed and passed through Swindon, which was to grow as a railway town. Marlborough's famous Castle Inn, an important staging post for the old coaches, was acquired for the foundation of a "School for the sons of Clergy etc etc." David applied for the post of medical officer for the new school. His printed application, dated 9 March 1843, with 17 testimonials from prominent medical men (two were Fellows of the Royal Society and another, David's own brother-in-law, was to become one) together with four from local persons of importance, is still preserved; so also are the original letters from which the printed application was made. He got the job and held it for three years until the increasing size of the school made a full-time medical officer essential. It was not until 1971 that the care of the school returned to the practice on the retirement of its fourth and last full-time medical officer.

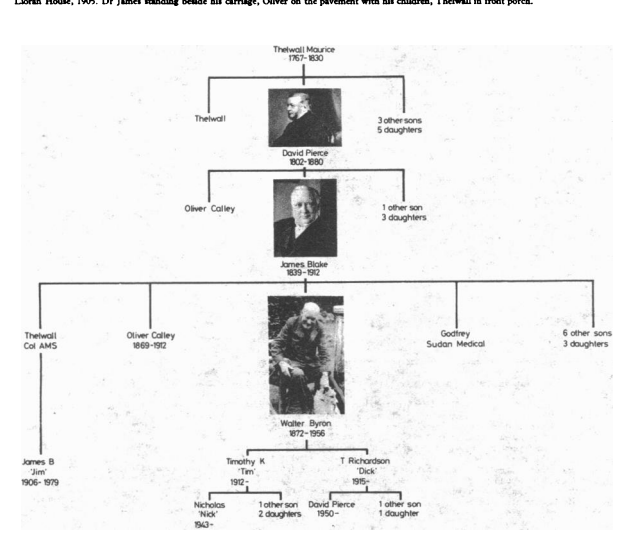
Davis's work load must have been prodigious. The day-book for 1845 reveals that Mrs Letitia Codrington of Wroughton House (close to Swindon—a ride there and back by the most direct route, the track over the downs, of at least 16 miles), was visited every day including Sundays from 27 September to 7 November. During this time she received 35 medicines, tablets (less usual), or lozenges. She had a further 12 visits during the following three weeks. The nature of her illness is not recorded, but Mrs Codrington's coachman was also being attended, though less frequently, over the same period. During all this time journeys of equal length were being made in the opposite direction. It is satisfactory to record that Mrs Codrington lived on until 1878.

The railway and the foundation of St Mary's hospital, so close to Paddington station, made it convenient for David's two doctor sons to do their training at the new hospital—a tradition that has continued ever since. The elder son moved to Reading like his uncle and became a Surgeon to the Royal Berkshire. James, the younger son, armed with FRCS like his father, joined the practice in the early 1860s. James took over the family house, which was considerably extended, and incorporated a surgery while his father built a large house, Mantong Grange, just to the west of the town beyond the college. No doubt young Jimmy had to do those tiresome night calls! The surgery had a waiting room, dispensary, and a large examination room. The surgery could be carried out here but was more often done in the patient's own home. More important patients would be seen in a consulting room in the house proper. The surgery backed on to a courtyard and coach houses and stables, to which there was and is access through an arch.

Marlborough, Wiltshire. DICK MAURICE, retired general practitioner



Lorn House, 1905. Dr James standing beside his carriage, Oliver on the pavement with his children, Thelwall in front porch.



Awareness of alcohol problems

One difficulty of dealing with alcohol problems is recognising the problem. To help increase one's awareness of patients with alcohol problems it is useful to have a check-list or a register of patients at risk (table I). The physical complaints of heavy

TABLE I—Alcohol problem check-list

Table with columns for symptoms/signs and occupational/psychological factors. Symptoms include morning shakes, tremor, weight loss, etc. Occupational factors include catering, bartending, etc. Psychological factors include anxiety, depression, etc.

drinkers are often vague: loss of appetite, tummy upset, morning shakes, backache, memory lapses, and accidents. Symptoms of psychological difficulties include unhappiness, erratic moods, sexual failure, family conflicts, and confusion.

Records are the GP's paper instruments for detecting patients with a drinking problem, and accurate records are important, especially in a group practice where the patient may consult with a different partner. Any suspicion should be recorded in the notes, and the alcohol problem entered on a chronic morbidity register.

Safe level of drinking

It is surprising how many people will adjust their drinking habits when it is pointed out to them the difficulties that drinking is causing. This is particularly so of those who have developed a medical problem that is instantly made worse by drinking and so reminds them constantly of the need to change their drinking habits. It is necessary to tell people what is a safe level of drinking. The Royal College of Psychiatrists recommended that the equivalent of four pints of beer for men and three pints for women was the uppermost acceptable daily intake.

GP's advice

Individuals must be made aware of the health hazards of drinking since heavy drinkers are less aware of the health consequences of drinking than light drinkers (table II). One should also point out that alcohol is an addictive drug and that anyone could, in a given combination of circumstances, become alcohol-dependent (table III). Attention needs to be paid to the

TABLE II—Medical conditions related to alcohol

Table listing medical conditions related to alcohol, such as Accidents, Brain damage, Cancer, Cardiovascular system, Gastrointestinal, Liver disease, and Nutrients.

TABLE III—Symptoms of alcohol dependence: typical order of occurrence

Table listing symptoms of alcohol dependence, such as Completely unable to keep to a drink limit, Needing more drink than companions, Irritability when getting drunk, etc.

benefits of reducing drinking rather than to the harm of continuing excessive consumption. One obvious benefit is financial. Others include better judgment and performance, safer driving, and weight loss for obese patients.

Although many people succeed in cutting down their drinking without any help, others need help and the doctor should be willing to help. The advice should be offered not only when requested but also when the opportunity presents in any consultation, especially if it can be related to the presenting medical problem.

Goal of treatment

The patient has acquired a drinking habit that is damaging his personality, his family, social life, and health. Habits are hard

1866 was an important year for the practice. On 17 January a public meeting was held in the Town Hall and Severnake Hospital was founded. D P Maurice and J B Maurice were both appointed to the staff, together with two other medical men. The hospital now comprises some 70 or more beds and has been continuously staffed by the family ever since.

brother had joined the partnership in 1938. I joined the family team in 1947 to succeed my father, Walter, and when the only non-Maurice member of the four-man partnership retired in 1949 he was succeeded by his son, a surgeon like his father. The family had been addressed by their Christian names (it is hoped with the prefix doctor) since David's time, now they were all so addressed.

Practising Prevention

Alcohol

PETER ANDERSON

Size of the problem

During the past 20 years alcohol consumption in Britain has roughly doubled. In 1980 the British population spent £10 200m—7.5% of consumer outlay—on alcohol, drinking the equivalent of nine pints of beer a week for each individual over the age of 16.

Role of the general practitioner

GPs have special opportunities for helping patients with alcohol problems because they are ideally placed to recognise the problem early and intervene. In terms of prevention we should

concentrate on the heavy drinkers rather than the alcohol dependents. Most people who are dependent on alcohol only present for help around their mid-forties, after 10 to 20 years of heavy drinking during which time help might have prevented the onset of serious difficulties.

Effectiveness of treatment

GPs are frequently pessimistic about the outcome of efforts to help people who are alcohol-dependent and problem drinkers. Much of the available data about treatment, however, relates only to samples of severely dependent individuals. Results might be more encouraging in the earlier stages of the cycle, since heavy drinkers are more likely to be able to cut down their drinking than those who are alcohol-dependent.

to change and the patient may be ambivalent about changing his drinking pattern. This ambivalence may be met by asking the patient to draw up a balance sheet of the good and bad consequences of his continued drinking, as discussed.

Changing lifestyle

For many heavy drinkers, drinking has become their predominant interest, and to achieve their desired goal they may have to make major changes in their way of life. The patient will need help to look at implications to change and alternatives to drinking.

Family

The family will need help in supporting the problem drinker. The family may feel confused, bitter, and devalued and will welcome the chance of being understood and participating in the process of recovery.

Review

Whatever the agreed goals it is essential to review the patient's progress and to offer continuing help and support and advice on managing difficulties. A diary in which the patient makes a note of any drinks consumed, the time, the quantity, and the occasion is useful for self-audit.

Relapse

Most patients will drink again whatever the original goal of treatment, but this should not be regarded as a loss of all that has been achieved. It should be viewed as an opportunity for the patient to learn more about himself and the problem. Once the relapse has been openly discussed the patient can recognise strategies for preventing a further recurrence.

Drugs

Drugs have very little place in the long-term management of patients with alcohol problems. Drugs may be needed to help withdrawal symptoms for someone who is physically dependent on alcohol.

disulfiram or citrated calcium carbimide, have little use, though some patients find them helpful.

Referral

Most heavy drinkers and patients with alcohol problems can be helped by their GP, but there are some whose care the GP may wish to share. Alcoholics Anonymous provides a very supportive self-help group. Referral to an alcoholic treatment unit may be needed as much for support of the GP as for the patient.

Summary

- The role of the GP in relation to drinking is to:
—be aware of problems related to drinking;
—offer advice when requested;
—seek an opportunity to offer advice in any consultation;
—advise on how to cut down or stop drinking;
—supplement advice with appropriate literature;
—follow-up attempts to reduce drinking.

The advice offered should include:

- reference to the presenting problem when possible;
—information about the safe level of drinking;
—information about the health and personal hazards of excessive drinking;
—information about the nature and meaning of dependence;
—emphasis on the benefit of reducing drinking;
—plan for a short-term goal;
—ways to cope with the difficulties after reducing drinking;
—warning of the dangers of relapse;
—explanation of the need for follow-up.

Further reading for patients and doctors

ABC of alcohol. *BMJ* November 1981; February 1982. A straightforward guide to helping patients with alcohol problems.
Alcohol—reducing the harm. London: Office of Health Economics, 1981. An excellent booklet covering the problems of alcohol in Britain.
Alcohol and alcoholism. *BMJ* September 1981; January 1982. An excellent series by Richard Smith covering the problems of alcohol in Britain.
Alcohol and alcoholism. London: Royal College of Psychiatrists, 1979. A comprehensive account of alcohol problems.
Alcohol and disease. *British Medical Journal* 1982; 284:1. A detailed account of many of the medical and social problems of alcohol.
Alcoholism. Max Glan. Teach Yourself Books: Care and Welfare Series, 1982. A very comprehensive review of alcohol problems and their treatment.
Alcoholism. Neil Kessel and Henry Walton. Penguin Books, 1969. An easily read account of alcohol problems and their treatment.
Drinking sensibly. London: HMSO, 1981. A discussion document on the prevention and health effects.
Drugs and alcohol. Camberwell Council on Alcoholism, 1980. A comprehensive coverage of the problems of alcohol as experienced by women.

ONE HUNDRED YEARS AGO In a recently published report by the Board of Trade on the overcrowding of emigrants in lodging-houses, Dr Brodie states that he has been personally informed that, when the beds in the lodging-houses are full, an itinerant musician is introduced to attract the attention of the sleepers, who are encouraged to rise and join the dance in which those who have been unable to obtain sleeping accommodation are engaged. When this ruse has succeeded in getting them to bed to vacate their places, the beds are then occupied by those who first commenced the dancing, so that the same bed or floor-space may be occupied by different persons during the night. It is not difficult to see, Dr Brodie adds, to comprehend the fearful state of overcrowding that must necessarily exist, and the consequent poisonous state of the air. (*British Medical Journal*, 1882.)

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