TABLE VI—*Outpatient attendances during 1975-8*

	1975	1976	1977	1978
New patient referrals	23	67	116	81
Total outpatient attendances ..	28	95	754	542
Ratio of new referrals to total attendances	1:1·2	1:1·4	1:6·5	1:6·1

Many patients attend for a full day so that comprehensive assessment can be carried out by the unit's staff and consequently the need for inpatient care can often be avoided. Outpatient rehabilitation programmes are arranged to provide a continuing support service to the disabled at home.

Discussion

The pattern of care adopted by a newly commissioned younger disabled unit has shown that even the most severely disabled individuals may be cared for at home. Substantial benefit can accrue from the close support of a caring family or community. This almost inevitably leads to an increased demand for community support services, but this represents a considerable saving on the cost of hospital-based residential care.

It has been possible to promote this pattern of care largely by taking advantage of the more positive approach to rehabilitation currently practised by the remedial professions. The physiotherapist has increasingly concentrated on restoring or maintaining motor power and locomotor function rather than providing passive or placebo treatments, and the occupational therapist has become skilled in the problems of personal care and environmental adaptations rather than in the supervision of diversional activities. Therapists have also been increasingly collaborating with each other and with their colleagues in the community services. It has therefore been possible to develop a more sensible provision of aids, appliances, and equipment, and to arrange appropriate training in their use.

The increase in co-operation between different groups of health care workers and their increased involvement with local authority social services and housing departments has been to the advantage of the disabled. Only a very small percentage of the young physically disabled population should now be expected to need such a degree of supportive care that they must be provided with long-term residential care on a hospital site.

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Personal Paper

Breast or bottle

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"Of course, breast-feeding is best, but if you can't, this is how to mix a bottle-feed." The rest of that antenatal class was spent on the mechanics of artificial feeding. No doubt the midwives were strongly in favour of breast-feeding, but the practical advice was mainly about the bottles, partly because it is easy to demonstrate, and partly because our teachers had not had the benefit of personal experience of breast-feeding. I no longer find it surprising that only half of a nationally representative survey of mothers[1] wanted to breast-feed, and in those who succeeded only 4% were still fully breast-feeding as soon as six weeks after birth, and under 1% at four months. I was lucky: as a medical student I had been convinced by an enthusiastic paediatric registrar that breast-feeding is the only way to feed a baby properly, so I was determined to succeed—which is more than halfway to doing so. Yet during pregnancy and after the baby was born the social pressures mounted to discourage this belief.

I had looked forward with interest to hearing more about breast-feeding during my pregnancy, since like most doctors I had little idea about the practicalities. I was surprised to find no interest shown in the method of feeding that I might adopt when I visited GP and hospital clinics. Was this because, knowing me to be a doctor, everybody assumed that I must know it all, or was it because each person assumed that it was somebody else's responsibility? In some areas this important subject may not even be covered in antenatal classes—a DHSS survey[1] found that 25% of mothers heard no mention of it. I wonder how uncommitted mothers decide what to do. In the absence of firm advice and encouragement a mother is likely to do what her own mother did or what her peer group does—so that in social classes IV and V especially, where breast-feeding is less common, bottle-feeding will tend to remain the norm.

Finding out

Apart from the short discussion at one antenatal class my own instruction came entirely from one book, *Breast is Best* by Penny and Andrew Stanway, which I found invaluable and more useful postnatally than the conflicting advice of midwives and health visitor. I picked up the free literature in the clinics and thought it disappointing. Though the medical profession is learning to accept the sound physiological sense of demand feeding, there still seems a great reluctance to abandon the clock. Also forgotten is the fact that increased suckling produces

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an increase in milk supply; the mother of a hungry baby is often advised to start complementary bottle-feeds.

Inevitably the free booklets are peppered with advertisements for artificial foods; and, though some of these point out that breast-milk is better, this reminds me of the Government health warnings on cigarette advertisements. Similarly, while there may be a single photograph of a mother breast-feeding her baby there will be numerous ones of bottles and bottle-feeding; this, together with the prominence of bottles and the other equipment related to artificial feeding in the shops and the absence of mothers seen breast-feeding in public, will tend to reinforce the impression that breast-feeding is unusual.

Early days

In the early days after a hospital delivery a mother needs help and encouragement as she learns about her baby. In those early days when one feels tired, ignorant, and insecure most mothers appear to be bottle-feeding by the clock—with peaceful nights while the nursing staff give the 2 am feed and leisurely days with bottles of ready-mixed milk brought to the bedside. This may be enough to push the mother hesitant about breast-feeding to switch to those bottles already placed at the end of her bed by a thoughtless nurse. The hospital routine may not help either with the lack of privacy and almost constant interruption by drug trolley (not more iron pills . . .), drinks, domestics (didn't they once respect closed curtains and doors?), and meals that just get cold and more unappetising while the baby finishes his. It can be difficult to establish a faultless let-down reflex under these conditions despite the advantage of being free from one's own domestic responsibilities.

Fatigue was the one factor in the early weeks that might have made me give up breast-feeding if I had not been determined to continue. Demand feeding can be very demanding in the first two or three months. We doctors think that we are working hard on a one in two rota, but the breast-feeding mother cannot have a night off, her responsibility cannot be delegated. She may be disturbed two, three, or more times each night for several weeks, and by day there is little time for anything else but feeding and changing nappies. In the days of the extended family sharing of housekeeping duties was taken for granted, but with the current trend for nuclear families that ideal is not so easily attained; a stranger who constantly needs instructions may provide more work for the mother than doing the chores herself.

The calorie-consuming nature of breast-feeding is another aspect inadequately publicised. Once the baby is born and is being breast-fed the physiological fat stores laid down for this purpose in pregnancy are mobilised, with easier return to pre-pregnant weight and figure. If no extra fat has been laid down the lucky mum can eat for two. I believe that too little attention is paid to maternal diet throughout. It is not much use getting dietary advice at antenatal classes in the third trimester when it is needed from the first.

So we pay lip service to the benefits of breast-feeding as we do to many things, but we fall over backwards to reassure mothers who want to bottle-feed, or who have had to give up breast-feeding, that artificial milks are as good. Even if they are, the incidence of errors in making up the feeds[2] lends more support to the view that Nature's way is best. We are frightened of causing these mothers to feel inadequate, but this ambivalent attitude does little to promote breast-feeding.

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Letter from . . . Oregon

Friends of Medicine*

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Fortunately, the humanity of doctors is more often recognised in their strengths than in their weaknesses. The doctor is looked to for leadership, forbearance, intelligence, and wisdom, but, unhappily, the expectation is not always fulfilled. The doctor who displays appetites where he is expected to abstain, ignorance when he should know, or weakness when he should be strong, is a persistent problem. The experience of Oregon's doctors in meeting this problem by forming the Friends of Medicine may be valuable to other medical communities in dealing with the disabled doctor.

*Based on a presentation at the VI World Congress of Psychiatry, Honolulu.

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Beginnings

The Friends of Medicine began in 1968 with a letter from a local doctor to our county medical society. He wrote of his deep concern for a colleague of many years who appeared to be steadily deteriorating. He gave examples of his colleague's poor medical judgment, incompetence, and loss of friends and staff privileges. He wondered if a committee existed within the government of medicine to help this man before he took his final plunge into professional oblivion. The letter stirred deep feelings in the doctors and administrative staff of the medical society. Ths miserable and sometimes terrifying experience of standing by and watching a colleague fray his life to shreds is too common; but what can be done? How can we protect him and his patients from his destructive behaviour? The letter's clear plea to help the doctor and protect his patients was the beginning of the Friends of Medicine.

The initial group formed, the Committee of Concern, was led by a doctor who knew well the desperate problems that illness and poor judgment had brought down on the heads of fellow doctors. He had spent years as a member of the state board of medical examiners, that window on personal and professional tragedy, and was aware that one in ten doctors in Oregon will appear before the board during their