and will ensure that the quality of the hospital services will deteriorate long before any alternative adequate provisions can be created. The recent investigations into conditions at Ely and Farleigh Hospitals show how dangerous poor staff morale can be to the wellbeing of patients.

There is yet another danger which has been adumbrated by the Batchelor report on the staffing of mental deficiency hospitals in Scotland,² and that is that the care of the mentally handicapped will become divided between a number of specialists such as paediatricians and general and child psychiatrists, to whom the care of the mentally handicapped will present a fringe interest. Those who remember the dismally poor quality of the care for the aged before geriatrics was recognized to be an independent discipline will realize what a backward step such a fragmentation promises to be.—I am, etc.,

ALEXANDER SHAPIRO

Harperbury Hospital,
Nr. St. Albans, Herts

¹ Department of Health and Social Security, *Better Services for the Mentally Handicapped*, London, H.M.S.O., 1971.

² Scottish Home and Health Department, *The Staffing of Mental Deficiency Hospitals*, Edinburgh, H.M.S.O., 1970.

SIR,—Miss Ann Shearer (4 December, p. 623) suggests that workers in the present hospitals are seeking to defend the existing pattern of residential care for the mentally handicapped in Britain by drawing false conclusions from Scandinavian practices. Without the co-operation and goodwill of the staff who care for the mentally handicapped the task of establishing new services will be harder, but the reasons for their scepticism are understandable.

This group of workers have suddenly found themselves spotlighted and made to feel scapegoats for years of parsimony and indifference towards the problems of the mentally handicapped by the community at large. It seems to them that the service which they have been giving for years has overnight become misplaced, misguided, misinformed, and has apparently been in the wrong hands. In these circumstances it is not surprising that the morale of staff in many hospitals for the mentally handicapped is poor.

Scandinavian provision has been advanced as a model, but there the equivalent of £60 per week per resident is spent on accommodation. This is three to four times as much as is spent on mentally handicapped patients in the hospitals in Britain, which constantly denied staff and resources, have had little chance to improve their effectiveness. In sparsely populated Sweden there are residential institutions which appear to be as remote and isolated as any in Britain, even though material conditions in them are undoubtedly better. Despite the emphasis on community care and small units Sweden (population 8,000,000) has nearly 2,000 places in so-called special hospitals which were excluded from the itinerary of a recent study tour,¹ but which, it was reported, housed the most severe and disturbed cases and where conditions, on the Swedes' admission, were not ideal. Hence the Swedish methods have not entirely eliminated hospitals, 7% of patients still being accommodated there.

It is these facts which prompt the suspicion that the protagonists of the Scandi-

navian system of provision are being disingenuous. The Swedes conceded that there is little voluntary service in their establishments for the mentally handicapped. Recent adverse reports about hospitals in Britain emphasized the need for a drastic overhaul of this provision for the mentally handicapped. Unfortunately this has trapped many well-intended people into supposing that some entirely different system copied perhaps from another country can be applied to all cases. In practice the apparent solution of one problem always raises others. The care of the mentally handicapped can be improved best by the application of a multi-disciplinary and eclectic approach. The relevant contributions of particular modes of provision—hospital, hostel, home, or community care—for the mentally handicapped can be determined only on a basis of evolution and experience in relation to the ethos and resources of each nation.—I am, etc.,

D. A. SPENCER

Meanwood Park Hospital,
Leeds

¹ National Society for Mentally Handicapped Children. *Professional Study Tour 1971. Services for the Retarded in Sweden*. London, N.S.M.H.C. 1971.

Hospital-based Social Workers

SIR,—I was very interested in the letters from Drs. G. L. Davies and A. G. Chisholm and Dr. C. F. J. Cropper (1 January, p. 50). In adult psychiatry there is needed a hospital-based psychiatric visitor. These are a valuable if not essential part of a mental health team, and, indeed, their value is comparable in my view to that of a ward sister, charge nurse, or even a registrar.

Such workers have existed as part of the hospital staff, but in many areas they have also existed as part of the local authority staff by courtesy of the medical officer of health—I refer to the mental welfare officers. I consider their removal to the social services department to have been a retrograde step, taken in the teeth of expert opposition and advice. I think it arose through a semantic confusion through the words "welfare" and "social work" in the title.

What we really need is a psychiatric health visitor, and I think these should be recruited through a registered mental nurse training with a subsequent training in the methods and scope of the various other social services, and I think they should be employed by the area health boards to come. The new circular from the Department of Health and Social Security, "Hospital Services for the Mentally Ill," talks of teams, including a social worker. I think this post should be retitled psychiatric health visitor and the latter should be part of the team and not seconded from somebody else's team—that is, not from the director of social services.—I am, etc.,

E. A. BURKITT

Department of Psychiatry,
Darlington Memorial Hospital,
Darlington

Hypoxic Newborn Infants

SIR,—Dr. J. S. Wigglesworth (1 January, p. 53) states that the burden of our paper (27 November 1971, p. 516) was to demon-

strate an association between asphyxia at birth and blood coagulation changes in the full-term newborn infant. He is quite right. Drs. Chessels and Wigglesworth's paper,¹ which appeared after our paper was accepted for publication, also gives evidence suggestive of such a relationship in babies of various gestational groups who were severely asphyxiated and required ventilation, though their series did not include results for matched control infants.

The results of our observations strongly suggested that the hypoxic babies had disseminated intravascular coagulation. Evidence for this includes lowered platelet counts, raised levels of fibrin degradation products, and prolonged thrombin clotting times. Hence we believe that babies who have sufficient asphyxia to cause a severe consumption coagulopathy are at serious risk of spontaneous haemorrhage, as the process of intravascular coagulation is accompanied by a reduction in certain coagulation factors.

An association between disseminated intravascular coagulation in the newborn and certain complications during pregnancy has been reported.^{2,3} It is therefore relevant that in our series antenatal complications (either pre-eclamptic toxæmia or antepartum haemorrhage) had occurred with 46% of the anoxic infants but with only 17% of the control babies. Two infants in our series who had severe asphyxia died. Both had Apgar scores of 0 at birth and required ventilation. One of these showed intracranial haemorrhage at postmortem. The parents of the other baby refused permission for necropsy, but as it had a falling haematocrit and a full fontanelle at death the diagnosis of intracranial haemorrhage seems likely.

We are grateful to Dr. Wigglesworth for drawing attention to the errors in Table I of our paper. The gestation in both groups was 39 and not 35 weeks as shown. The data for rectal temperatures in the two groups were inadvertently transposed: the percentage of babies who had had a rectal temperature of less than 35°C was 25% in the hypoxic group and 4% in the control group.—We are, etc.,

M. A. CHADD

P. C. ELWOOD

O. P. GRAY

S. M. MUXWORTHY

Department of Child Health,
Welsh National School of Medicine,
Cardiff Royal Infirmary,
Cardiff

¹ Chessels, J. M., and Wigglesworth, J. S., *Archives of Disease in Childhood*, 1971, 46, 253.

² Leissring, J. C., and Vorlicky, L. N., *American Journal of Diseases of Children*, 1968, 115, 100.

³ Edson, J. R., Blaise, R. M., White, J. G., and Krivit, W., *Journal of Paediatrics*, 1968, 72, 342.

Clotting Factor Concentrates

SIR,—Your leading article (8 January, p. 66) on the need for concentrates of the prothrombin complex, particularly for treatment of liver disease, prompts us to report our experience in this field.

We are just completing a pilot study on the feasibility of preparing such a concentrate at a regional blood transfusion centre. We chose the method of Bruning and Loeliger,¹ with slight modifications, for the following reasons: (1) supernatant ACD