morbidity, but this "inconvenient" statistic is explained away by many arguments, such as the size of the women, the geographical nature of the terrain, and the demographic characteristics of the country rather than the obvious contention that with appropriate clinical care and selection of cases home confinements can be as safe as or even safer than hospital deliveries. In this context it is important to correct the oft-quoted, inaccurate statement that as hospital delivery rates rise the mortality and morbidity figures improve. It has been shown that this is not the case.¹

It is worthy of note that almost all correspondents have expressed a deep dissatisfaction with the present state of hospital obstetric care in regard to its response to the human and psychological needs of those for whom the service is provided, and we fully agree that a most important focus for the attention of us all is to improve this situation. However, it must be recognised that although many stress the need for a change in approach, few have achieved the steps enumerated by Dr M Rosen and his colleagues (21 February, p 458). Also hospital, however modified, can only approximate to but never achieve a sense of "home".

Dr R Dingwall (14 February, p 396), urging the need for a thorough review of the social aspects of maternity care, underlines the fact that there has been insufficient research into childbirth as a social experience. The critical question that we posed previously and here repeat is how and on what grounds are the decisions concerning the overall management of our childbirth services to be made? We believe they are ones for which an interdisciplinary approach, free as far as possible from the prejudice and dogma alluded to by Dr C N Barry (7 February, p 342) and sensitive to the needs of mothers and their families, is one which has much to commend it.

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¹ Ashford, J R, *British Journal of Preventive and Social Medicine*, 1972, 26, 1.

Support for varicose veins

SIR,—Professor P H Fentem and his colleagues (31 January, p 254) should be congratulated on their study of the static compression produced by various types of elastic stocking. A previous problem in this field has been the inaccurate methods of measurement of the compressive force. Their method of using a low-volume water-filled flat bladder is better than most but has been improved upon by a "no-volume" electrobladder designed by the Kendall Company. This consists of a small flat bladder into the walls of which are built two small electrodes; these are in contact and connected to a pressure recording circuit. Air is infused into the bladder at an increasing pressure until the contacts "break." The pressure recorded when the circuit breaks is that which exactly counters the compression produced by the stocking. The volume of the bladder is essentially zero at the moment of contact separation, though the separation force has been distributed over the whole area of the bladder and not just the electrodes themselves.

There is no disturbance of the contour of the stocking, which, as explained by Professor Fentem and his colleagues, is important for accurate measurement.

In their investigation the compressive devices studied produced a gradually reducing or "graduated" compression, being high at the ankle, less at the knee, and least over the thigh. In many previous studies of the effect of static compression the compressive device has been a cylindrical tube of elastic material, such as Tubigrip. This produces areas of high compression over the calf, and especially the thigh, and may be likened to a tourniquet. This is the inevitable effect of applying a cylindrical compression to a conically shaped structure, the leg, and is undesirable for whatever reason static compression is being applied. If static compression is to be effective as therapy the compressive device must be sensibly designed and correctly fitted. The design should be based upon physiological experiment. This is certainly not true of most previous studies on the effects or usefulness of static compression. When these criteria have been satisfied it will be necessary to make a reappraisal of static compression as therapy.

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C P HOLFORD

Liquor licensing and public health

SIR,—Your leading article on the above subject (14 February, p 359) requires comment. You return to the charge that recommendations to relax the licensing law are "proposing a gamble with the nation's health." This statement falls short of that objectivity which you usually provide concerning important problems of the day.

I do not propose to comment on individual recommendations of the Erroll Committee's report, nor on the proposals of the Departmental Committee on Scottish licensing law,¹ with which I was associated. Suffice it to say that, although the two committees differed in 14 practical recommendations, largely arising from the special problems in Scotland, they were united in the view that the licensing law in Great Britain must be quickly relaxed. We were not "proposing a gamble with the nation's health."

Your conclusion that for the present there should be a moratorium on all measures that would make drink more readily available is not valid unless you favour limitation of incomes. We, the British public, live for the time being at least in a democracy. We are free to spend the disposable portion of our increasing incomes how we like. It is a melancholy fact that, whereas in 1964 we spent £1394m on alcoholic drink, in 1974 we elected to spend £3927m in this way, with the unhappy consequences we all know. The indications are that this trend will continue.

If the British public perseveres in this practice within present licensing restrictions the pressure to drink must quite inevitably continue to increase, and with it the evils we all seek to avoid will be aggravated. But if the consumption of alcohol can take place within more relaxed licensing conditions the pressure to drink will be lessened, the quality of leisure will improve, and the misuse of alcohol will diminish. In this way reformed licensing law will at last support the educative and social

controls that are so vitally important to the proper use of alcohol.

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¹ Departmental Committee on Scottish Licensing Law, Report, Cmnd 5354. Edinburgh, HMSO, 1973.

Failure to confirm anticonvulsant hypomagnesaemia

SIR,—In their letter on this subject Dr S H Katz and others (7 February, p 341) report that they found no significant difference in mean serum magnesium level between a population of epileptics receiving anticonvulsants and a carefully matched control population. They state that the significant decrease in serum magnesium concentration reported by Christiansen *et al*¹ may have been due to their use of an unmatched normal outpatient control population.

In our study of this subject² we compared a population of 80 epileptics (18 of whom were receiving primidone, alone or along with other anticonvulsants) with 75 controls consisting mainly of inpatients. The figures that we obtained reflect those of Dr Katz and his colleagues, the mean value for serum magnesium being 0.835 ± 0.086 mmol/l (2.03 ± 0.21 mg/100 ml) in the population receiving anticonvulsants and 0.814 ± 0.083 mmol/l (1.98 ± 0.20 mg/100 ml) in the control population. The coefficient of variation (between batches) of the method used was 4.1%.

It would therefore appear that the choice of control population may not be the cause of these conflicting results.

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¹ Christiansen, C, Nielsen, S P, and Rodbro, P, *British Medical Journal*, 1974, 1, 198.

² Blyth, A, and Stewart, M J, *Clinica Chimica Acta*, 1975, 62, 305.

Alleviation of IUD menorrhagia with ethamsylate

SIR,—Your leading article "IUDs and heavy periods" (7 February, p 304) rightly states that the mode of action of intrauterine contraceptive devices remains obscure. Although menorrhagia is the commonest side effect that may cause recommendation of device removal there may be times when it is in the best interests of the patient to advise continuance of the method despite such side effects rather than substitute a less effective or less acceptable contraceptive technique. It then becomes the gynaecologist's duty to prescribe a therapy that can minimise the menstrual disturbance.

Few effective preparations are available to this end. Therefore ethamsylate, which has been reported to be of use in primary menorrhagia,¹ is undergoing evaluation in the family planning clinic at this hospital. This drug appears to act in combating excessive menstrual flow by its haemostatic properties, increasing capillary resistance and reducing bleeding time. A preliminary study has recently been completed on 13 patients considered to have menorrhagia associated with IUDs of varying types that had been in situ for at least one year. Menstrual blood loss was estimated by atomic spectrophotometric determination of the iron content of used sanitary wear of five successive

menses in each patient, one before treatment, two while on ethamsylate (500 mg four times daily from five days before the anticipated onset of menstruation for 10 days) and two while on indistinguishable doses of placebo with double-blind random allocation of each of the tablets. The Wilcoxon signed rank test was used in statistical analysis of the results. Mean blood loss was 64.8 ml before treatment and 64.6 ml during placebo therapy ($P > 0.10$) but was significantly less (53.5 ml; $P < 0.05$) during administration of ethamsylate. The mean percentage reduction in blood loss was 18.6 ± 4.7 , giving a range at the 95% confidence level of 8.4-28.8.

Such results, if confirmed by a longer series, would suggest that a patient with an IUD in situ who complained of menorrhagia should be offered ethamsylate as primary treatment. This could prove sufficiently effective in controlling the cycle to make further manipulation unnecessary.

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¹ Jaffe, G, and Wickham, A, *Journal of International Medical Research*, 1973, 2, 127.

Computers and privacy

SIR,—In your leading article on this subject (24 January, p 178) you seem to regard the Swedish data protection law as an almost ideal model. Some further information is needed. The Swedish Government Data Inspectorate and the data protection law mainly deal with securing the data banks against undue commercial infringement and also with checking the accuracy of the information stored. Very little has been done to avoid undue governmental infringement of the registers—that is, to prevent one agency from using data stored by another agency for a different purpose.

The Swedish National Health Security Board has by now constructed gigantic data banks of all Swedish inhabitants, easily identified by the unique 10-figure person identification number. Even extremely sensitive facts about individuals are now accessible to other public agencies, such as police and taxation officials, not primarily concerned about health and sick care. In many ways the foundation of the Government Data Inspectorate has increased the threat to privacy as it has made it easier to make different computerised registers compatible.

In Sweden nowadays 1984 does not seem so far away as eight years.

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Encouragement of breast-feeding

SIR,—In discussing this subject Dr E Eastham and others (7 February, p 305) conclude by suggesting "appropriate literature" and "a nurse with special training." They rightly stress an "educational approach" and "husband's advice" as well. I doubt if anyone would disagree. However complex the problem may be, I believe we can reverse the decline if we simply take a positive approach.

For over 18 months I have been involved in an active programme aimed at promoting breast-feeding. This may be summarised as

follows. I talk to expectant parents in groups of 20 to 30 couples, well before the expectant dates. I try to explain the facts and figures about breast-feeding and artificial feeding and answer their queries. It is sometimes amazing to learn about the myths that surround infant feeding. The midwifery nursing staff maintains a positively charged environment in the maternity wards. They encourage the mothers and help them to breast-feed their infants.

On preliminary survey it appears that over 80% of the mothers who attended the talk breast-fed their babies during their stay in the maternity unit. In contrast, only 20% of those mothers who did not come to the talk breast-fed their infants. But on discharge from the hospital the incidence of breast-feeding dropped drastically in both groups over the next three to four weeks. We hope to reverse this decline with the forthcoming understanding and the co-operation of the district midwives and health visitors, who would try to maintain the positively charged environment in the homes and welfare clinics.

There is yet another group of parents in whom there is a family history of atopy. They are seen separately in smaller groups of 8-10. I talk to them on infant feeding in general and also stress the possible role of human milk in prevention of atopic diseases. The mothers are seen in groups two to three times before delivery and at intervals of two to four weeks after delivery. This is, in fact, a part of another prospective study. In this group, however, about 90% of the mothers start with breast-feeding and about 80% do it successfully for at least three months.

A longer period of study is evidently required before we can arrive at a legitimate conclusion. The preliminary result however, does suggest the following: (1) If a positive approach is taken by all concerned with infant wellbeing the decline of breast-feeding can be reversed. (2) There is a constant publicity on artificial feeding. This has to be matched with a similar publicity on breast-feeding. The family physicians, the welfare clinic doctors, and the health visitors can play the most important roles.

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SIR,—Drs C J Bacon and J M Wylie (7 February, p 308) confirmed the usual factors found to be associated with successful breast-feeding, and their figures are comparable to my own unselected series of 302 cases from general practice.¹ They note the increase in breast-feeding compared with the other Newcastle series of Dr E Eastham and his colleagues (p 305) studied some 18 months before, but they do not consider the probable part played by the DHSS report, *Present-day Practice in Infant Feeding*,² which received very wide publicity in the period between. They imply that their patients were questioned in mid-1975 and the report came out in October 1974, at an important time for most babies born in 1975.

Mothers in my own practice have always been encouraged but not persuaded to breast-feed by doctor, health visitor, and midwife from early on in pregnancy. This encouragement was not intensified during 1974-5, yet there was a striking increase in breast-feeding which presumably followed the publicity given to the report.

	1969	1970	1971	1972	1973	1974	1975
Decided to breast-feed (%)	49	52	46	48	57	48	59
Fully breast-feeding at six weeks (%)	24	27	22	23	28	27	42

Recent further publicity against high-solute milks can be expected further to encourage breast-feeding.

MALCOLM AYLETT

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¹ Aylett, M J, *Update*, 1975, 10, 1133.

² Department of Health and Social Security, *Present-day Practice in Infant Feeding*. Reports on Health and Social Subjects No 9. London, HMSO, 1974.

Mobile resuscitation units

SIR,—Your leading article on "First aid in acute myocardial infarction" (14 February, p 356) will, we hope, encourage further interest in the use of mobile resuscitation units in Britain. In the field of myocardial infarction the facts, as you say, speak for themselves. We should, however, like to reiterate our view that measures for resuscitation and immediate care are similar irrespective of the nature of the emergency.

The creation of a mobile resuscitation unit (MRU) requires enthusiasm, energy, time, and money together with an ability to push their merits through many committees. Our MRU was created in 1971 and combined with an active in-hospital training programme for ambulancemen. The report, shortly to be published,¹ indicates the wide measure of acceptance once the unit was functioning. By creating an MRU to cover all suitable emergencies a better return for the financial investment is obtained and, more important, a better service is rendered to the public. Our MRU responds to 10-12 call-outs a week, of which 30% are for presumed myocardial infarction, 34% for accident victims, and 36% for other medical and surgical emergencies. Both the specially equipped ambulance and its staff (which includes the intensive treatment unit anaesthetist) have proved more than equal to the task of coping with the immediate care of all of these groups of patients.

We wholly support the proposal for more mobile units for myocardial infarction but suggest that there is no need to restrict the type of emergency to which such a unit may be called.

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¹ Baskett, P J F, et al, *British Journal of Anaesthesia*. In press.

SIR,—The prospects for improving the outlook of those stricken with heart attacks, as depicted by Dr J R Hampton (24 January, p 201), are indeed bleak. Our view is more optimistic and is endorsed by the recent Royal College of Physicians/British Cardiac Society working party report which stated that mobile coronary care units should be further developed.¹

Dr Hampton demonstrated that patients brought to hospital using a special alerting system had a different overall mortality (that