urine and the serum urea rose to 450 mg./100 ml. Haemodialysis was then carried out and the serum urea fell to 180 mg. However, her general condition continued to deteriorate and next day she died.

Post-mortem Examination

The appearance of the heart was normal and there was patchy consolidation in both lungs. The whole length of the colon above the colostomy showed the macroscopic and histological changes of severe ulcerative colitis. The rectum and the small length of colon below the colostomy consisted of a fibrosed tube without any lumen. The pancreas, adrenals, and bladder appeared normal. The liver, spleen, and kidneys felt very firm, but were normal in size. Histological examination of the kidneys and spleen showed widespread amyloid infiltration in both these organs and the renal amyloidosis involved the glomeruli, tubules, and arterioles. Sections of the liver were not taken.

Comment

Although amyloidosis has rarely been observed in ulcerative colitis, it should always be considered in those patients with signs of renal disease. Renal amyloidosis was present in all the 12 cases that have been reported in detail, and was responsible for death in 10 of these. The nephrotic syndrome was present in eight patients, six of whom were also uraemic. The two patients described here were the only ones with uraemia who did not have signs of nephrosis.

Factors which appear to lead to the development of amyloidosis are a long history of ulcerative colitis, perirectal suppuration, and delay in performing a colectomy when medical treatment has failed. Eight of the 12 patients had

perirectal abscesses or fistulae, and in 10 patients the diagnosis of ulcerative colitis was made more than four years before that of amyloid disease. Either perirectal suppuration or a long history of ulcerative colitis was present in all the patients.

Colectomy had not been carried out in 11 patients, and the other patient had had a subtotal colectomy two years before her death. The prevention of amyloidosis is therefore a further indication for early colectomy in patients with persistent active colitis; for, once renal amyloidosis has developed, subsequent successful treatment of the ulcerative colitis may not prevent the development of renal failure.

Summary

Two cases of chronic ulcerative colitis are described in which death was caused by renal amyloidosis. Both patients were uraemic and neither had signs of nephrosis. A review of these two cases, together with the 10 others described previously, suggests that important aetiological factors are perirectal suppuration, a long history of ulcerative colitis, and delay in performing a colectomy when medical treatment has failed.

We wish to thank Mr. Eric Edwards and Dr. E. Mavis McConnell for permission to publish the clinical and pathological details respectively of Case 2.

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Duration of Stay in Hospital for Normal Maternity Care

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Brit. med. J., 1964, **2**, 95-99

In Britain one of the main issues in hospital planning today concerns the number of maternity beds that should be provided. This number depends upon three factors: (1) the number of births per year; (2) the proportion of deliveries taking place in hospital; (3) the mean length of stay. In 1961, 66% of British births occurred in hospital; in the future, according to the recommendations of the Cranbrook Committee, this proportion should be stabilized at 70%. However, it seems at least as likely that it will continue to rise towards the very high figure which is current in the United States, Australia, and Sweden. If this is so, and the prevailing birth-rate is maintained, the extent to which new building is required will depend directly upon the duration of stay in hospital.

In a recent article Sir George Godber (1963) has called for further information concerning factors which determine duration of stay in maternity beds and for follow-up information to determine the effects of longer or shorter stays in hospital on the health of mother and baby. In the present paper, which is the first of a series planned to study this topic, an analysis will be made of the variation in the duration of stay for normal

maternity care, and, in particular, the extent to which this variation is due to differences in the behaviour of the doctors in charge rather than to differences in the medical or social needs of their patients.

Material

The studies reported here are based on data routinely collected by the Oxford Record Linkage Study (ORLS); (Acheson, 1964; Acheson and Evans, 1964). This project involves the collection and integration in a single central file of information concerning every delivery (whether at home or in hospital), discharge from hospital, and death in the population of Oxford County Borough, Oxfordshire (except Henley), and part of Berkshire.

Of 4,435 hospital deliveries in the ORLS area in 1962, there were 2,142 normal deliveries (I.S.C. 660.0), in which no complication of pregnancy, delivery, or the puerperium had been recorded, and which resulted in the birth and subsequent discharge of a living baby, accompanied by its mother.¹ Deliveries

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¹ The reduction from 4,433 to 2,142 was as follows: 2,163 deliveries were omitted because of complications of pregnancy, delivery, or puerperium; 101 were omitted because mother and baby were not discharged home together; 27 of the remaining deliveries were omitted because they resulted in multiple births.

after which the baby was transferred to a special care unit, or mother and baby were transferred for further treatment at another hospital, were also excluded. The figures include private patients delivered in N.H.S. hospitals, and are complete for the population at risk with the exception of a small number of cases where delivery occurred to residents of the area at a distance, e.g. in London, and in non-N.H.S. obstetric beds in the area.

The deliveries were performed in nine hospitals; six of these had almost all of the cases, only 13 deliveries occurring in the other three hospitals (Table I). Two of the hospitals (Nos. 1 and 2) are maternity departments of urban teaching hospitals. Two others are cottage hospitals—one (No. 4) also taking general medical cases and one (No. 6) specializing in maternity, and both are served only by general practitioners. One of the remaining hospitals (No. 5) is a maternity cottage hospital run by several practitioners and having a special relation with a consultant obstetrician from the teaching hospital who supervises antenatal and postnatal care and admits abnormal cases to his beds; the other (No. 3) is the newly built maternity department of a district hospital and is served by both G.P.s and consultants. Our attention is limited to these six hospitals. Five consultants were in charge of 1,212 deliveries; local general practitioners with hospital appointments cared for an additional 856. Of the remaining 74, 56 were under the care of three consultants. Our attention is limited to the deliveries which occurred under the care of the five main consultants (Table I. A to E), and the two groups of G.P.s; the G.P.s having a special relation with a teaching hospital consultant are considered separately (Group Y) from the remainder (Group X).

TABLE I.—Number of Mothers Delivered by Hospital and Doctor in Charge

Hospital	Doctor	A	B	C	D	E	X	Y	Others	Total
1	..	126	177	145	79	—	—	—	—	527
2	..	1	—	276	220	—	—	—	—	497
3	..	—	2	—	2	176	131	—	66	377
4	..	—	—	—	—	1	201	—	6	208
5	..	—	—	—	—	—	4	309	—	313
6	..	—	—	—	—	—	205	—	2	207
Others	..	—	—	2	4	1	6	—	—	13
Total	..	127	179	423	305	178	547	309	74	2,142

X and Y represent the two groups of G.P.s.

Results

1. Variation in Total Length of Stay

The five consultants and two groups of general practitioners to be discussed in this paper cared for 2,065 normal deliveries. The mean stay for these 2,065 cases was 8.24 days and the standard deviation was 2.98 days. Table II indicates the number of cases by day of discharge, the percentage of all cases discharged each day, and the cumulative percentage discharged by that day.

TABLE II.—Distribution of Duration of Stay in Hospital in 2,065 Normal Mothers

Day of Discharge	Number of Cases	Percentage of Cases	Cumulative Percentage
0-1	16	0.77	0.77
2	55	2.66	3.43
3	68	3.29	6.72
4	80	3.87	10.59
5	84	4.07	14.66
6	105	5.08	19.74
7	292	14.14	33.88
8	473	22.91	56.79
9	337	16.32	73.11
10	264	12.78	85.89
11	104	5.04	90.93
12	73	3.54	94.47
13	35	1.69	96.16
14	15	0.73	96.89
15	25	1.21	98.10
16-20	27	1.31	99.41
21+	12	0.58	99.99

2. Variation Between Doctors

Table III shows for each doctor the mean duration of stay, its standard deviation (σ) and the number of cases (N). The last column indicates the probability that the doctor's mean stay is equal to the mean stay of the preceding doctor. In four out of the six comparisons the doctor's mean stay is significantly different from the closest mean stay at the 1% level.

TABLE III.—Mean Duration of Stay, etc., by Doctors in Charge

Doctor	Mean Stay	Standard Deviation (σ)	Cases (N)	Probability P <
A	7.03	2.53	127	—
B	7.04	2.92	179	0.99
C	7.13	2.20	423	0.72
D	7.60	3.26	305	0.01
E	8.96	2.62	177	0.01
X	9.92	2.40	546	0.01
Y	8.18	2.14	308	0.01

The distribution of duration of stay achieved by the various doctors was also compared in other ways. Table IV shows, in addition to the mean duration of stay, the modal (most common) duration, the percentage of cases discharged at the end of the first week, and the coefficient of variation. It can be seen that although the most common (modal) length of stay for five doctors (that is, the length of stay of about 25% of their cases) is the same, the treatment of their other cases differs in a way that results in some doctors achieving shorter mean stays than others.

TABLE IV.—Modal Duration of Stay, etc., by Doctor in Charge

Doctor	Mean Stay	Modal Stay	Coefficient of Variation	Percentage Discharged in First Week	Cases
A	7.03	8	36.00	57.49	127
B	7.04	7	41.44	60.90	179
C	7.13	8	30.79	48.45	423
D	7.60	8	42.95	44.28	305
E	8.96	8	29.24	20.32	177
X	9.92	10	24.16	9.24	546
Y	8.18	8	26.15	29.86	308

This can also be seen from the fact (Table IV) that those doctors with the lowest mean stays usually have high coefficients of variation in stay, and vice versa ($r = -0.72$; $P < 0.02$). In general it seems that two doctors differ not because one gives fewer days to every case than the other but because the doctor with the shortest average stay selects some cases for earlier discharge, thus "skewing" the distribution (see Chart).

Perhaps the most striking display of the differences between the doctors is given by the proportions of patients discharged in the first week (Table IV). Thus while about 60% of the patients of doctors A and B have been discharged from hospital, only 10% of those under the care of the general practitioners have been discharged.

Table V indicates the extent to which a doctor's mean duration of stay is influenced by the hospital in which he is working. Doctors C and D work at three and two hospitals respectively.

TABLE V.—Variation Between Doctors at Different Hospitals

Doctor	Hospital	Mean* Stay	Standard Deviation (σ)	Cases	Doctor's Mean at Other Hospitals	Hospital Mean of Other Doctors
C	1	6.28	3.59	145	7.90	7.09
	2	7.58	2.83	276	7.57	7.66
D	1	7.35	3.93	79	7.68	6.78
	2	7.64	3.00	220	7.50	7.60
X	6	9.15	1.60	204	†	†
	3	9.79	2.95	131	9.96	9.12
Y	4	10.78	2.41	201	†	†
	5	8.18	2.14	308	†	†

* Mean duration of stay for the doctor-hospital combination.

† No valid comparison, as almost all deliveries are done by one doctor.

The performance of general practitioners (Groups X and Y) can be compared at four hospitals.

Two questions arise from Table V: (1) Do doctors' mean durations of stay differ significantly among hospitals? ; (2) Is a doctor influenced more by the policy of the individual hospital than by his own performance elsewhere? Both questions can be answered in the affirmative. The difference between doctor C's performance at the two hospitals is significant at the 1% level. For doctor D the difference is not significant ($P=0.56$). The performance of general practitioners as a group also differs significantly between hospitals 6, 3, and 4. It is

Percentage distribution of total days in hospital for delivery of 2,065 normal mothers resident in the ORLS area in 1962 by consultant or doctor in charge of case. A-E represents consultants, X and Y groups of general practitioners.

interesting that the group of practitioners with much the shortest duration of stay (Y) is the one with a special relationship with a consultant obstetrician. Turning to the second question, we can compare the mean stay for each particular doctor-hospital combination with the mean stay of the doctor's cases in other hospitals and with the mean stay of the other cases in the same hospital; in four of the five possible comparisons in Table V we see that the doctor-hospital combination mean stay departs from the mean of the doctor's other cases in the direction of the hospital mean. The hospital thus usually influences the doctor to alter his pattern of duration of stay more in line with that in the rest of the hospital.

In Table VI the data are analysed from the opposite point of view, to determine what differences exist between the behaviour of different doctors practising at the same hospital. Some doctors closely resemble others within the same hospital (for example, doctors A and B in hospital 1, or doctors C and D in hospital 3); there are other doctors for whom the similarity is much weaker, and others still who differ very much within the same hospital (for example, doctor C and the others in hospital 1, or doctor E and general-practitioner group X in

hospital 3). We can conclude, therefore, that, although the hospitals influence the doctor's behaviour, he still plays an important part in determining the duration of stay of his own patients.

TABLE VI.—The Variation Between Doctors at the Same Hospital

Hospital	Doctor	Mean Stay	Standard Deviation (σ)	Cases	P ₁	P ₂	P ₃
1	C	6.28	3.59	145	0.06	0.05	0.01
	A	6.99	2.50	126	0.90	0.47	—
	B	7.03	2.93	177	0.52	—	—
	D	7.35	3.93	79	—	—	—
2	C	7.58	2.82	276	0.65	—	—
	D	7.64	3.00	220	—	—	—
3	E	8.93	2.62	175	0.01	—	—
	X	9.79	2.95	131	0.97	—	—

P₁ is the probability that the doctor-hospital combination has a mean duration of stay equal to that of the succeeding doctor-hospital combination.

P₂ is the probability of equality with that of the next-but-one combination.

P₃ is the probability of equality with the next-but-two. All probability values shown are upper limits.

3. Medical and Social Factors Influencing Differences in Duration of Stay Between Doctors

The doctor in charge of the case and the hospital in which he is working are only two of the factors that influence the length of stay allotted to a particular mother and child. Medical and social characteristics are also likely to be important; for example, elderly mothers or those having their first child may need longer stays than average. Obviously the distribution of patients with characteristics justifying longer or shorter stays may not fall equally on every doctor. Therefore it was important to make certain to what extent the differences demonstrated between doctors and hospitals were due to such a non-random distribution of patients.

Ten factors were considered: age, civil state, social class, source of admission, parity, past obstetric history, baby's health—that is, any diagnosis reached in respect of the baby during this spell in hospital—month of delivery, baby's weight, and proximity of mother's home to hospital. For each factor we examined whether the distribution of subclasses of that factor among the doctors was random, using a chi-square test with a 10% significance level, and in the same way whether each doctor's distribution of cases by subclass differed from that of all other doctors.

The mean duration of stay for seven of these classes of patients is shown in Table VII. It must be emphasized that these averages cannot be taken as indicating the effect of each factor separately. The average duration of stay in each subclass also reflects the other characteristics of the mothers in that subclass; for example, younger mothers receive longer-than-average stays, but this in part reflects the fact that a higher-than-average proportion of them are also having their first baby and are unmarried. Nevertheless, these averages are informative as a guide to the care being afforded to different kinds of patients.

Our findings, which will be dealt with in more detail elsewhere, may be summarized as follows: Although the distribution of medical and social characteristics was not random among the doctors, these factors not only did not explain the differences in mean stay between doctors, but suggested that if doctors had all treated an identical set of patients the differences between them would have been even greater. Thus the doctors with the shortest stays (A and B) had the highest percentage of those subclasses which received longer-than-average stays—for example, young mothers, social class I, primiparae, babies reported to have various types of illness, and cases coming from a distance—and the doctors with the longest stays had the smallest percentage of long-stay subclasses.

In Table VII each mean stay should be considered in comparison to the overall mean stay of 8.28 days (standard

deviation=3.01, N=2,138). Each factor is divided into a number of subclasses and the mean stay for each is given, along with its standard deviation, and the number of cases. The analysis covers all normal deliveries except for the four cases for which no information regarding duration of stay was available; for some factors a few cases that could not be assigned to a particular subclass have been omitted. It is interesting

TABLE VII.—Mean Duration of Stay, etc., in 2,138 Normal Mothers by Various Factors

Factor	Subclass	Mean Stay	Standard Deviation	Cases
Age	15-19	8.56	2.75	222
	20-24	8.41	2.80	741
	25-29	8.06	2.91	599
	30-39	8.15	3.31	534
	40+	9.24	3.80	42
Civil state	Married	8.28	3.00	2,024
	Others	8.48	2.72	112
Social class	I	8.64	3.02	145
	II	8.49	3.05	228
	III	8.23	2.97	880
	IV	7.94	2.41	341
	V	8.27	3.18	212
	A.F.*	8.46	3.21	190
	Students	7.71	2.15	34
Source of admission	Miscellaneous	8.71	2.50	100
	Booked	8.33	2.90	2,036
	Emergency	7.26	4.54	78
	Transfer	7.40	3.88	5
	Others	7.78	3.36	18
Parity†	0	8.98	2.80	762
	1	7.97	2.82	640
	2	8.08	3.01	389
	3	7.44	3.42	162
	4	7.40	2.99	77
Past obstetric history	5+	7.80	3.44	103
	None	8.29	2.91	1,821
	Stillbirth	8.34	3.66	43
	Miscarriage	8.25	3.34	252
Baby's birth weight	1-3.9 lb. (450-1,814 kg.)	9.05	3.62	38
	4-5.9 " (1,815-2,722 ")	8.20	2.96	1,091
	6-7.9 " (2,723-3,629 ")	8.38	3.00	861
	8+ " (2,630+ ")	8.03	2.83	144

* Armed Forces. † First birth is parity = 0.

that, in spite of their presumably more favourable home circumstances, mothers in Social Classes I and II are allotted substantially longer periods in hospital than are mothers in Classes III, IV, and V. The shorter average duration of stay in emergency cases probably reflects their shorter period in hospital prior to delivery.

Three factors are omitted from Table VII—month of delivery, distance of patient's home from hospital, and baby's illness. No seasonal effect on duration of stay was demonstrated. In some hospitals patients coming from a distance received longer-than-average durations of stay, but this was not consistent. The effect of different types of baby's illness on duration of stay will be dealt with in a subsequent paper.

Discussion

Our material shows that considerable variation exists in the duration of stay in hospital of normal mothers under the care of different doctors. As some of the distributions are skewed, the variation in the mean (7 to 10 days) understates the differences observed. The proportion of patients discharged by the end of the first week varied from about 10% for one of the groups of general practitioners to approximately 60% for two of the teaching-hospital consultants. A significant inverse correlation between the mean duration of stay and the relative variation about the means was found so that in those with the longest stay there is least variation, and vice versa. One explanation for this is that in the more leisurely atmosphere of the practitioner beds it may still be possible to support the notion of a rigid "dose" of in-patient care for all normal mothers; while in the consultant beds, with their heavier load of complicated cases, individual mothers are selected for earlier dismissal on their merits.

When the performances of doctors working at more than one hospital were compared significant differences were found which showed that the doctors' practice is in part influenced by the policy or climate of the hospital in which he works. It was also possible to demonstrate significant differences in the performance of doctors within the same hospital.

An analysis of ten social and biological factors relating to the mother showed that the differences in performance between doctor and hospital could not be explained by differences in social or demographic characteristics of the patients. Indeed, in most instances the doctors with the *shortest* mean durations of stay were dealing with *more* than their share of mothers who might expect a longer-than-average stay in hospital for sound medical reasons. A random allocation of cases would have exaggerated the differences observed.

The significance of these factors comes into perspective when the whole picture of obstetrics in the Oxford Record Linkage Area is considered. Although the proportion of the 5,991 deliveries within the area in residents in 1962 which took place at home (27.1%) is close to the national average, a high degree of organization and antenatal care in both the hospital and domiciliary services has helped to achieve an overall stillbirth and perinatal mortality rate well below the national average (14 and 26 per 1,000 births respectively). Nevertheless, even if attention is limited to the groups with very high risks for which the Cranbrook report (Ministry of Health, 1959) recommended 100% hospital care—that is, all mothers of 35 years of age or more, all primiparae aged 30 or more, women who have had four or more children or who have had a stillbirth—we find that in our area 23% were delivered at home. This takes no account of any additional mothers with a past history of a complicated pregnancy or delivery who may also have been confined at home, nor of other primiparae.

Our material cannot answer the question of what is the optimal duration of stay in hospital for a normal mother and baby after delivery. Provided it were on a sufficiently large scale, the system of linked records could be used to study this by analysing the morbidity and mortality of mother and child in the years following delivery according to their duration of stay in the maternity hospital at delivery. Nevertheless, this analysis has uncovered an important degree of variation in the use of a resource in limited supply for which no obvious medical or social reason can be found.

Summary

A study is described of the duration of stay in hospital of the 2,142 mothers resident in the Oxford Record Linkage Study area in 1962 who experienced no complication of pregnancy, delivery, or the puerperium. There was a substantial degree of variation in length of stay, and significant differences were demonstrated among the mean stays of mothers under the care of the five consultant obstetricians and the two groups of general practitioners concerned. Where more than one consultant practised at a hospital it was possible to show that the hospital influenced the doctors' behaviour; nevertheless, the doctor also played an important part in determining the duration of stay of his patients.

Ten medical and social attributes of the patients were studied and it was found that the distribution of patients with these characteristics was not random among the doctors. However, these factors not only did not explain the differences in the mean stays but suggested that if the doctors had all had a similar set of patients these differences would have been greater. A preliminary analysis of duration of stay by seven characteristics of the patients is presented.

This study would not have been possible without the co-operation of all the obstetricians in the area. We also wish to acknowledge the help of Mr. A. Barr and other members of the Records Department.

ment staff of the Oxford Region Hospital Board and of Miss Dorothy Milne for assistance with the calculations. The research was assisted by grants from the Ministry of Health, the United States Public Health Service, and the Health Information Foundation. The Oxford Record Linkage Study is financed by a generous grant from the Nuffield Foundation.

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Early Discharge of Maternity Patients

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Brit. med. J., 1964, **2**, 99–100

For many years the consultant obstetric staff of St. Mary's Hospital had sought to arrange for a selected number of their patients to be discharged early in the puerperium. The reasons for this were twofold. Firstly, the belief that there are some patients who should be delivered in hospital for medical reasons who yet neither merit nor, in many cases, wish for full hospital stay. Secondly, such a scheme would make more efficient use of the limited number of obstetric beds then available.

Efforts to initiate such a scheme had failed because of the natural reluctance of district midwives to accept more than the occasional hospital patient for puerperal care at home. However, in 1960 a temporary reduction occurred in the number of maternity beds during the rebuilding of our maternity department. This was at a time when, in the London area, there was a serious increase in the number of unbooked obstetric cases, admission for which could be obtained only through the Emergency Bed Service.

This combination of factors provided the opportunity to ask for and obtain the co-operation of the London County Council authorities to operate an early discharge scheme from St. Mary's Hospital for an experimental period. This was initially for one year, but the results were encouraging enough to all concerned for the scheme to be continued. The results of the first three years form the basis of this paper (see Table I).

TABLE I

	1st Yr.	2nd Yr.	3rd Yr.	Total
No. of cases initially booked for early discharge ..	137	118	122	377
No. cancelled before delivery ..	40 (29%)	25 (20%)	11 (9%)	76
No. sent home after 48 hours ..	80	80	99	259

Selection of Cases.—Our cases were selected geographically from the area of the domiciliary midwifery practice of St. Mary's Hospital. Suitable patients from this area were chosen by the hospital staff at the first antenatal visit and booked subject to a satisfactory report by the domiciliary midwife on their home and social conditions. In the early months of this scheme these patients were mainly those who attended too late to be allocated a bed and who would otherwise have had to be "booked" with the Emergency Bed Service. As the scheme became known both patients and general practitioners began to request it themselves early in pregnancy. Table II shows the reasons for cancellation of a certain number of patients between booking and delivery. It appears that a certain wastage is inevitable. The selected patients were mainly multigravidae whose previous obstetric history merited hospital delivery but for whom full hospital stay did not appear to be

essential. As opportune, a certain number of primigravidae were included, as were a few multigravidae who would not normally have been allocated a hospital booking but expressed concern about a home confinement.

TABLE II.—Reasons for Cancellation Before Delivery

	1st Yr.	2nd Yr.	3rd Yr.
Home conditions considered unsuitable	8	9	7
Change of address to area outside that covered by this scheme	9	3	1
Full stay offered elsewhere, or alternative arrangements made by patient	13	4	—
Transferred for full stay	5	4	3
Miscarriages	3	4	—
District confinements	2	1	—
	40	25	11

Antenatal Care.—Once a patient was accepted the general practitioner was notified and invited to co-operate in the arrangements by taking over the intermediate antenatal care of the patient and her care in the puerperium. If the practitioner agreed to this the patient attended the antenatal clinic only at 30 and 36 weeks, otherwise her entire supervision was undertaken by the hospital staff. The majority of practitioners in the area preferred this latter arrangement.

Labour.—Of the 259 (Table I) patients sent home after 48 hours, 242 had uneventful labours. Among the remaining 17 there were five forceps deliveries, three retained placentae, and nine postpartum haemorrhages. All these patients were fit to be discharged at the end of 48 hours.

Puerperium.—Table III gives the reasons for prolonging the hospital stay of certain patients who were initially booked for early discharge. As stated above, we did not consider that forceps delivery or third-stage complications in themselves merited full stay in hospital. Patients sent home after 48 hours were provided with a small pack of suitable dressings. At the time of discharge the practitioner and domiciliary midwives

TABLE III.—Reasons for Full Stay

	1st Yr.	2nd Yr.	3rd Yr.
Investigation of albuminuria ..	1	—	—
Severe concealed accidental haemorrhage ..	2	1	—
Investigation of persistent puerperal pyrexia ..	1	1	—
Extensive second-degree laceration ..	1	—	—
Lower-segment caesarean section ..	4	4	2
Change of address discovered after delivery ..	3	1	—
Third-degree prolapse in puerperium ..	1	—	—
Hypertension ..	2	2	1
Diseases of infant and prematurity ..	2	3	5
Social reasons ..	—	1	1
Puerperal psychosis ..	—	—	1
Maternal chest infection ..	—	—	1
Severe thrombophlebitis ..	—	—	1
	17	13	12

Indications for caesarean section: placenta praevia 2, foetal distress 2, breech presentation 2, prolapsed cord 2, severe toxæmia 1, malpresentation 1.

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