CORRESPONDENCE

Correspondents are asked to be brief

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Smoking in Hospitals

SIR,—It has been estimated that about 8,500 in Britain are occupied as a result of cigarette smoking.¹ The Department of Health and Social Security states that the expenditure on hospital beds due to smoking is currently £25m. a year.² Since there are 190,000 hospital beds in this country, this shows that every 800-bed general hospital is spending at least £100,000 each year on the results of this habit. Yet despite this evidence little is done to discourage smoking in many hospital wards, which is needed both in order to help patients who need to stop and for the benefit of nonsmokers who prefer fresh air.

For the past 20 years at this hospital we have insisted that the chest and heart wards should be no-smoking areas. Many patients appreciate the opportunity given them to stop, and complaints have been very few. Over half our patients discharged after a coronary attack who had been cigarette smokers have stopped a year later. This simple preventive measure should be enforced in all acute medical and surgical wards. Those heavily addicted or with incurable disease, where depriving them of

cigarettes would be inhumane, should be segregated from other patients.

Many hospitals still sell cigarettes in their shops and even sell them on trolleys visiting wards where there are patients with cigarette-induced diseases. At this hospital, on the advice of the medical committee, the League of Friends agreed to stop selling cigarettes two years ago in their shop. Despite initial fears by some people, the profits made have not been affected by this move.

As a profession, it is time we took a much more aggressive attitude against this cause of so much disease. As a start all hospitals should agree to stop selling cigarettes in their shops and to be much more active in discouraging smoking in their wards.—I am, etc.,

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¹ Ball, K. P., *Lancet*, 1970, 2, 48.

² Department of Health and Social Security, *Smoking and Health: A study of the Effects of a Reduction in Cigarette Smoking in Mortality and Morbidity Rates, on Health Care and Social Security Expenditure and on Productive Potential*, July 1972.

Active Management of Labour

SIR,—Few engaged in the clinical care of the obstetric patient will not support the advocacy by Professor Kiernon O'Driscoll and his colleagues (21 July, p. 135) of the active management of labour. The era when a long and dreary labour was accepted as a normal variant, interference with which was categorized as meddling obstetrics, should be long past. One doubts, of course, that your contributor's arbitrary definition of 12 hours as being the acceptable period for primigravida labour is necessarily correct, but it need not be cavilled with at the moment.

I fail completely, however, to understand the authors' claim that the institution of a policy of active management "places the problem of pain in a new setting." I believe that your contributors are guilty of confusing the condition of pain with that of exhaustion. A painful labour tends, without the aid of

stimulation, to become a long and exhausting labour (though mothers have been observed to be exhausted after an unrelieved labour of only 3-4 hours). In my view, however, patients (specifically primigravidae) are little concerned about the duration of labour, but are concerned about the pain involved. This latter attitude is hardly a new phenomenon induced, as suggested by Professor O'Driscoll, by the propaganda of anaesthetists and other "do-gooders." It has been known through untold ages by womankind that, for the majority, labour is a painful process—or do your contributors contend that it is "all in the mind," and advocate a universal return to the messianic exhortations of Grantly Dick Read? I am utterly at a loss to understand why adequate pain relief should not be provided during the course of an actively managed labour. I am prepared at any time

and in any place to substantiate my claim that in the majority of cases such labours are painful.

Adequacy of relief may be provided by pethidine, intermittent inhalational analgesia, or an epidural block. I advocated a "loading dose" of 150 mg pethidine¹ because I believed that such a regimen offered the better prospect of gaining the patient's confidence in the efficacy of the drug, but I accept that a small proportion of patients find the response unpleasant. (The reference to "hard drugs" puzzles me—I doubt that many of our obstetric patients in the U.K. have previously had more than one dose of a narcotic). My own preference is outstandingly for the application of an epidural block. The analgesia is, both quantitatively (in respect of the incidence of successful pain relief) and qualitatively (in respect of the "total success" rate and the absence of disconcerting clouding of the sensorium), superior by far to the other available techniques. In addition, an epidural block carries the bonus of being beneficial to the fetus.² It has been conclusively demonstrated³ that the fetus of the mother who does not have an epidural block (and does or does not have some other form of analgesia) becomes progressively more acidotic throughout the established first stage of labour, whereas the acid-base status of the fetus whose mother has had an epidural block does not deteriorate. Furthermore, the end-result—the delivered infant—of the "epidural case" is in a better condition both biochemically and clinically than is the infant of the "non-epidural" mother.³ The differences are admittedly of little moment in respect of patients without obstetric pathology, but they are worthy of serious consideration in cases in which the fetus is at risk (pre-eclamptic toxæmia, maternal diabetes, small-for-dates fetus, Rh incompatibility, and the like). It is true that Professor O'Driscoll and his colleagues claim to have considered epidural block for patients who "were distressed soon after admission," "were not close to full dilatation after six hours," or "suffered from special diseases such as toxæmia or heart disease." However, as only 53 patients came into one or other of these categories (5.3% of a consecutive series of