midwives who form an integral part of the primary health care teams. Thirdly, the unit is situated in the district obstetric hospital and, although autonomous, is subject to the same professional disciplines and patient management policies as generally prevail there. Fourthly, selection of patients for GP booking, while not entirely inflexible, is maintained within well-defined guidelines. Fifthly, GP contact and consultation with specialist staff is promoted and ongoing participation of the GP in cases transferred to consultant care is encouraged. A regular series of lunchtime meetings is held to update practitioners with advances in obstetrics and thus maintain high standards of antenatal and intranatal care. Finally, the unit is subjected to regular and penetrating audit when statistics are examined and problem cases discussed in depth by GPs, consultants, and midwives.

In conclusion, while universal induction of labour, fetal monitoring, and epidural analgesia may in some eyes be the counsel of perfection for intranatal care, three questions must be asked: (1) Is such a policy economically feasible on a nationwide basis? (2) Are the results so greatly superior to more traditional systems of care? (3) In any case, is this what the patient wants and expects? Until these questions can all be answered in the affirmative there may yet be a place for the GP obstetrician and community midwife backed by proper training, support, and facilities.

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¹ Lloyd, G, *British Medical Journal*, 1975, 1, 79.

² Wilkes, E, *et al*, *British Medical Journal*, 1975, 4, 687.

³ Curzen, P, and Mountrose, U M, *British Medical Journal*, 1976, 2, 1433.

Alcohol and cirrhosis

SIR,—Minerva's discovery (25 February, p 516) that there has been a ninefold increase in cirrhosis of the liver in Finland between 1964 and 1974, due supposedly to a trebling in alcohol consumption, is impossible to reconcile with statistics from the World Health Organisation.^{1,2} She also fails to mention the fact that mortality from the disease in Finland, as in other northern countries, is remarkably low compared with the death rate of the more southern Europeans, who are predominantly wine drinkers. The accompanying table gives the death rates per million of population from cirrhosis of the liver in 1967 and 1972 for Finland and other representatives of the two groups.

The 38% increase in cirrhosis mortality in Finland between 1967 and 1972 is inconsistent with the alleged 800% increase between 1964 and 1974, and it still leaves spirit-drinking Finland with only 13% of the cirrhosis death rate of wine-drinking France in 1972. If

drinking is really the main cause of cirrhosis of the liver then it must be due to some constituent of wine other than alcohol which is not carried over by distillation into spirit. Only a comprehensive survey of the relationship between all types of alcoholic drink and drink mortality will permit an unprejudiced judgment of the effects of alcohol. I strongly suspect that the negative correlation between alcohol consumption and deaths from ischaemic heart disease would far outweigh any positive connection with cirrhosis and that a regimen of moderate drinking of well-diluted spirits before and during meals would come out statistically as the ideal for long life.

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¹ *World Health Statistics Annual*, 1967, vol 1, Vital Statistics and Causes of Death. Geneva, World Health Organisation, 1970.

² *World Health Statistics Annual*, 1972, vol 1, Vital Statistics and Causes of Death. Geneva, World Health Organisation, 1975.

Traumatic tenosynovitis of the wrist

SIR,—With reference to your leading article (4 March, p 528), until 1947 I used to treat cases of tenosynovitis in plaster-of-Paris for three weeks. When it was removed they were usually symptom-free but frequently relapsed in a few days. In 1947 a gardener came to see me with a bad tenosynovitis crepitans. I told him I would have to put him in plaster-of-Paris for three weeks and he would have to stop work. He said he could not do this as he had a cow of his own which he had to milk every day. I told him that if he carried on like that he was unlikely to get better. I applied an Elastoplast bandage and hoped for the best. He came to see me a week later having milked his cow every day and remained at work and he was symptom free. I removed the Elastoplast and he did not relapse.

Since then I have encouraged all patients with tenosynovitis to remain at work. I apply an Elastoplast bandage and ask them to apply deep friction to the tender area through the Elastoplast and show them how to do it. I cannot remember any that did not get better in a week, nor do I remember any relapsing.

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Factors affecting length of hospital stay

SIR,—The paper by Dr L Carol Fernow and others (4 March, p 556), compiled from a great deal of clerical work, confirms the well-known fact that "length of stay . . . is complex, and that these complexities should be taken into consideration before establishing norms." Quite so.

Even if "the study shows that much new information could be [made] available routinely" what good would this do? Suppose that after allowing for patient and process variation some differences in length of stay were found among the surgeons in an area health authority. It would be argued that some of the difference was due to unavoidable factors such as day-of-week of operation leading in some firms to the optimal discharge day falling at the weekend (no ambulances and shops shut). Eventually, after consideration of every variable in the hospital it might

be shown that one or two surgeons kept their patients in a day or two longer than their colleagues did. These surgeons would certainly argue that this policy was better for their patients (fewer return cases, complications, GP consultations, etc). A very expensive investigation might disprove this claim to the satisfaction of some non-clinicians but not of the doctors concerned, who are unlikely to alter their policies.

The collection of the routinely recorded information that this study uses can only add to administrative costs at a time when everyone is trying to reduce these costs. Qui bono?

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Inactivation of agent of Creutzfeldt-Jakob disease

SIR,—In the interests of neurosurgeons, pathologists, virologists, and others who may have to deal with material from cases of Creutzfeldt-Jakob disease it is important to clarify the puzzling and possibly inaccurate description given in your leading article "Creutzfeldt-Jakob under control" (25 February, p 463) of the conditions leading to the inactivation by wet heat of the related agent of scrapie.

The combination described, of a temperature of 121°C and a pressure of 20 psi (1.4 kg/cm²), is in theory obtainable in an autoclave if only two-thirds of the air has been removed. The above figures occur in Gajdusek's article referred to¹ and also in an earlier one of his² so may be a correct description of the results of his procedures, but it is a very unusual way of using an autoclave and the conditions operating in the vessel under these circumstances are probably not uniform.

If, however, his autoclave was used in the normal way with all the air evacuated or discharged either the temperature or the pressure is incorrect, as 121°C then corresponds to 15 psi (1.05 kg/cm²) and 20 psi to 126°C.

In order to be sure that autoclaving will inactivate the agent of Creutzfeldt-Jakob disease, about which rather less is known and which will often be embedded in tissue debris, it would seem extremely important to set out clearly, accurately, and in full how the autoclave should be operated to achieve inactivation.

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¹ Gajdusek, D C, *et al*, *New England Journal of Medicine*, 1977, 297, 1253.

² Gibb, C J, *jun*, and Gajdusek, D C, *Abstracts of 3rd International Congress for Virology*, Madrid, September 1975, p 47.

Aids to drug compliance

SIR,—We were very interested to read Dr M R Klaber's letter (4 February, p 302), in which he made some valuable suggestions regarding aids to drug compliance.

The concept of a "calendar pack" has been considered by our group working on aspects of drug compliance but was rejected on the grounds of expense and the significant increase in storage space that would be required in

Regional mortality from cirrhosis of the liver^{1,2}

Country	Deaths per million		Percentage change
	1967	1972	
<i>Northern Europe</i>			
Finland	32	44	+38
England and Wales	28	34	+21
Sweden	74	102	+38
Norway	38	46	+21
<i>Southern Europe</i>			
France	357	342	-4
Spain	203	221	+9
Italy	248	318	+28