reception services were available in most practices in their area during the whole working day. Fewer than half the committees responding answered the question about the extent of employment of ancillary staff by practices and only a tiny proportion of these said that practices took up their full allocation; the vast majority of practices took up between one and one and a half whole-time equivalents and the balance less than one. Nearly one-third of committees thought the information we were seeking should be available and that they would like to have it.

This survey revealed a lack of general information and considerable variations between practices, confirming Patients' Liaison Group members' local knowledge of practices with no reception staff situated in the same neighbourhood as those with full-time services.

This small survey has raised several questions about what patients might reasonably expect. Should information about reception times be available in the same way as surgery consulting hours? What is the present situation and are changes taking place? We would welcome the views of general practitioners, family practitioner committees and patients.

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Home births

Sir,

The First International Conference on Home Births, held at the Wembley Conference Centre on 24/25 October 1987, brought together representatives of over 20 countries, and today's most famous campaigners for natural childbirth and informed choice, including Michel Odent, Wendy Savage, Luke Zander, Sheila Kitzinger, Beverley Beech and Janet Balaskas.

The dramatic decline in home births is due to the alleged risks but even today 10 to 12% of women in Britain would choose a home birth if given the option. None of the statistics in Rona Campbell's recent publication, *The place to be born,* support the claim that hospital births are safer than home births and the figures suggest that for some women the iatrogenic risk associated with delivery in an institution may be greater than any possible benefit.

Melody Weig, an independent midwife, told the conference how she had treated five cases of retained placenta with less blood loss than cases dealt with in hospital where the sister insisted on waiting for a doctor. She then described a case of prolapsed cord where she had to keep her hand on the presenting part throughout the 50 mile journey to the hospital while the mother stayed in the 'knee-chest' position. On arrival at the forewarned hospital, Caesarean section delivered a healthy baby. The crucial factors in safety would seem to be the competence and autonomy of birth attendants.

Many women have difficulty relaxing in an unfamiliar, clinical room and studies with animals have shown that a change in environment during labour can dramatically increase the incidence of stillbirths. During labour, many women doubt their ability to cope with the labour and to give birth. Reassurance, encouragement and care by someone they know and trust are surely preferable to hazardous technology such as epidurals and forceps.

John Davis, Professor of Paediatrics at Cambridge, felt that babies should be given the best chance to grow into well-balanced citizens, unharmed directly or indirectly by their birth. A small proportion of babies struggle when anaesthetized for surgery and investigation revealed that these babies had required resuscitation at birth and obviously 'remembered' the experience. There is strong evidence that babies react sensitively to their mothers, and thus maternal depression (emotional or drug-induced) may be of lasting significance. Michel Odent has found that some babies born at home have a static weight for two or three days then start to gain weight; the initial loss observed in hospital may well be a sign of emotional or physical stress.

Patients need general practitioners' support, not only for home births but also for more humane and physiological obstetric care. Unless doctors listen and respond to the desires of the consumer, the relationships between doctor and patient, and the profession and society, are likely to become adversarial. Consumer groups and the facts are creating an opportunity for general practitioners to improve their patients' experiences in childbirth. As one speaker reported, some general practitioners attend their first ever home birth as a principal; it is never too late to start.

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Advantages of a fellowship

Sir,

I finished vocational training in the UK in 1979. Since 1982 I have been working in a primary care clinic in Israel and recently it became clear to me that there would be advantages in spending a couple of years in academic medicine, critically examining research and teaching techniques.

It appeared that only in the USA do the financial resources exist to fund any numbers of 'fellowships'. The *Fellowship directory* published by the Society of Teachers of Family Medicine in Kansas City lists over 40 programmes for fellowships in family medicine and at first the range of places and structures was confusing. The content of the programme, the location and the level of remuneration were the factors influencing my choice of scheme.

After visiting several centres I applied and was accepted to a two-year fellowship programme at St Margaret Memorial Hospital in Pittsburgh. One fellowship is available each year. The programme is based at a modern, well equipped, community hospital which has two family health centres where the 30 residents of its family practice residency programme see their 'practice' patients and are taught family practice. The programme includes training in teaching, actual teaching, clinical work, training in research as well as a research project and a master of public health degree course at the University of Pittsburgh.

Working as a fellow one is not overwhelmed by patient load while trying to learn and a suitably designed fellowship programme will provide all the necessary training and courses.

The Residency in Family Practice at St Margaret Memorial Hospital is, in British terms, a vocational training scheme for general practice that lasts three years and starts immediately after medical school, qualifying the trainees to take the examination of the American Board of Family Practice.

The hospital is a private, non-profit making, community based hospital where local doctors, generalists as well as specialists, admit their patients who need inpatient care, investigations or pro-

cedures such as surgery. The hospital has about 250 beds and is equipped with an intensive care unit, operating room and all diagnostic equipment short of magnetic resonance imaging. While in the hospital all the patients are cared for by a resident in family practice who may also admit his own patients from the family health centres. Patients admitted to the hospital are still under the care of their doctor whether general practitioner or specialist and the resident works in cooperation with these doctors.

The residents rotate to other hospitals for training in such subjects as paediatrics and obstetrics and senior residents in such subjects as surgery rotate to the hospital. The residents have formal teaching every day and the residency is run by directors who are engaged in family practice as well as teaching.

Thus, St Margaret Memorial Hospital has a large teaching system on which to base the fellowship. In fact, this is fairly typical of community hospital based residency programmes although most of the fellowships available are university based.

Since I arranged the fellowship much interest has been expressed in the idea which in both the UK and Israel is fairly rare. In view of this interest and the advantages to be gained by a fellowship I would recommend its more widespread acceptance outside the USA.

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Digoxin prescribing in general practice

Sir,

With reference to the study by Cupples and colleagues,[1] I wish to report the results of an audit of digoxin prescribing in a new town health centre in West Lothian with 9200 patients. The analysis of 23 patients (seven men and 16 women) on digoxin therapy was started prior to the publication of the larger study,[1] but our methods and analysis were modified slightly to allow direct comparison.

Only four of the 23 patients were under 60 years of age and the duration of therapy ranged from two to 36 years. Ten patients were clinically well, eight were in cardiac failure and five had signs suggesting digoxin toxicity. The serum digoxin level did not correlate well with clinical signs of toxicity in that it was below the therapeutic range (1.0–2.6 nm) in nine patients, of whom three had clinical signs of digoxin toxicity; within the therapeutic range in 11, of whom one had signs of toxicity; and above the therapeutic range in three, of whom only one had signs of toxicity.

Twenty one patients were taking digoxin for adequate reasons, one was started on treatment for sinus tachycardia alone and one had mitral stenosis and was given digoxin prophylactically in case she developed atrial fibrillation. Of the 15 patients with an atrial tachyarrhythmia, only four had ventricular rates below 90 beats min^{-1}. This suggests undertreatment and this view is supported by the finding that six of the 11 patients with atrial tachyarrhythmia and a ventricular rate above 90 beats min^{-1} had subthera-peutic levels of digoxin.

The audit revealed lack of consistency in the investigation and management of patients who were prescribed digoxin. Fifteen patients had an electrocardiogram recorded prior to digoxin therapy and 16 during treatment. Twelve patients had had a biochemical profile more than a year ago while 10 had had a profile in the last year. Only eight patients had had their serum digoxin level determined.

After the initial assessment a letter was sent to each patient's doctor with suggestions as to how the management of digoxin treatment might be improved. Four months later each patient's therapy was reviewed. Of the three patients with digoxin levels above the therapeutic range, two remained on the same dose without further serum analysis, while the dose in the third patient had been halved, bringing the serum level into the therapeutic range. Two patients had been taken off digoxin; both had been in sinus rhythm at 80 beats min^{-1} and had had subtherapeutic levels of the drug — one was the patient who had been started on digoxin therapy for sinus tachycardia alone. Five patients had their digoxin dosage increased — in four of these patients the serum level had previously been subtherapeutic. The serum digoxin level has since been rechecked in three patients and only one was within the therapeutic range.

The survey showed that in this health centre digoxin is not commonly prescribed, but that when it is, it is for adequate reasons in the majority of cases. Our findings are otherwise similar to those of the Belfast study.[1] Assessment before and during treatment is poor, and suggested changes in therapy are not always implemented.

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Reference

1. Cupples ME, Irwin WG, McDevitt DG. An epidemiological study of digoxin prescribing in general practice. *J R Coll Gen Pract* 1986; **36**: 454-457.

Nifedipine and prostatism

Sir,

One of my patients, a man aged 72 years with long-standing exertional breathlessness secondary to ischaemic heart disease, controlled purely by bumetanide and potassium (Burinex-K, Leo), was commenced on nifedipine (Adalat, Bayer) 5 mg twice daily as a trial to improve his dyspnoea after walking 150 yards. Within 24 hours he developed urgency, poor stream, nocturia (four times a night), daytime frequency and dribbling, but there was no evidence of actual retention. The nifedipine was discontinued on his own discretion and within 12 hours his urine flow had returned to normal.

A second trial of nifedipine was begun which produced exactly the same symptoms, therefore treatment was discontinued.

This problem has been reported previously[1] but I would like to alert readers unaware of this potential danger when prescribing a calcium antagonist.

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Reference

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Disabled living centres

Sir,

It is the general practitioner to whom the patient turns in time of need. It was not appreciated until 1971 that approximately 10% of the patients on a general practitioner's list have some sort of disability[1] and only recently has teaching about disability been a significant feature of undergraduate medical and general practice training. It is well documented[2,3] that general practitioners are not always aware of the problems disabled patients may have in carrying out daily activities and,