

choose it (and it has been the policy in the Netherlands for over one third of births). Most women will continue to be delivered in large specialist units. There is good reason for creating alongside or attached units for low-risk women. General practitioners could then become the medical support for midwives. This would be welcomed by patients and result in less intervention. It could also be a welcome help to beleaguered consultants who may find junior staff in short supply in the future. Women at high risk would then benefit from greater consultant input.

We need a flexible response to maternity care, paying more attention to evidence and to women's wishes while paying less attention to entrenched beliefs and professional rivalries. Attitudes must change at government level and through all professional groups if we are to provide safe effective care that women want. The recently formed House of Commons Health Committee, at present holding an inquiry into the maternity services, has a great opportunity to lead the way. It is to be hoped that the committee will use the opportunity to promote necessary change.

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Stroke and the carer

THE social and economic implications of stroke are great. Stroke is estimated to account for 6% of the total running costs of a hospital and is the major cause of chronic disability in the community.¹ Stroke is primarily a disease of the elderly,² the proportion of whom in the population is expected to rise by at least 15% in the UK over the next 20 years.³ Recent projections have suggested that because of their greater age and frailty fewer victims of stroke will survive for long periods in a disabled state.⁴ These demographic trends suggest that the burden of stroke is unlikely to alter in the future. For many years it has been accepted that physically disabled people should and could be cared for outside hospitals and only a minority of patients remain in institutional care as a result of their stroke.⁵ It is estimated that over 80% of stroke survivors are living in the community one year after their stroke, of whom at least 25% are wholly dependent upon their immediate carer and a further 30% require regular support.⁶ The future implementation of the government white paper *Caring for people*⁷ will further increase the number of disabled persons in the community with implications for beleaguered carers who are at risk of psychological and physical morbidity.

In most cases the stroke patient lives with the principal carer who is usually either the patient's spouse, offspring or daughter-

in-law.⁶ It is estimated that up to 14% of carers give up their employment to look after the stroke patient, with obvious financial implications.⁶

The problems faced by carers of stroke patients may be directly influenced by the type of neurological impairment or severity of disability in the patient. Intrinsic recovery following stroke occurs mainly in the first month.⁸ However, functional recovery is more prolonged and is possible up to one year after the acute event.⁹ It is not surprising that the continuing presence of aphasia can result in marital disharmony, including even cessation of sexual activity.^{10,11}

Depression in stroke patients occurs in both the acute and chronic phase with a prevalence of approximately 15% in stroke patients at home.¹² Increased social and functional disability may result from depression.^{13,14} Depression should be differentiated from emotionalism, which is characterized by an inappropriate tendency to tears or, less commonly, laughter which occurs suddenly. Symptoms of emotionalism are usually persistent and their management depends upon joint education of patient and family together with a consistent approach being taken by medical staff and carers to avoid inadvertent reinforcement of behaviour.¹⁵ Depression following stroke usually responds to appropriate drug therapy,^{16,17} however, phar-

macological measures in emotionalism are as yet unproven, although there is increasing evidence that the newer 5HT antagonists may be of value.¹⁸

Depression may also occur in 11–13% of carers of stroke patients and more specifically, in up to 40% of spouses.^{19,20} The risk to the carer of developing depression is directly related to the stroke patient's functional status. This is especially true where assistance is required for personal tasks of self care such as toileting. It is important to recognize that in the first year following stroke, despite the patient's improved level of functioning,^{19,20} the risk of depression in the carer may increase. After this period, the risk of depression remains since unrealistic expectations and negative attitudes often persist among stroke carers. In one study, Kinsella and Duffy found that at least 65% of spouses still expected the patient's full recovery even up to 16 months after the stroke.¹⁰

The adverse effects of caring for the stroke patient may extend beyond the immediate carer and can interfere with family functioning. The presence of a disabled person in the family may result in an overprotective environment,¹⁰ and may lead to the isolation and exclusion of the needs of the other family members.²¹

Stroke patients usually remain dependent upon others for help, and integral to any community care programme must be the provision of adequate and appropriate support for these patients and their carers. There is a positive association between available social support and a favourable outcome from stroke,²² but, unfortunately such support is increasingly from a close relative who is at risk of both physical and mental illness. However, it is unlikely that the provision of specific services for stroke patients will significantly reduce stress in the carers. In Edinburgh the introduction of a specialist stroke unit failed to produce a sustained long term advantage over conventional medical care for stroke patients, and a more recent community study demonstrated that the provision of a home care service for patients in the acute phase of their stroke did not reduce the stress on relatives.^{23,24}

What support can therefore be offered for the carer? Adequate information and counselling must be given. This should not be restricted to the period immediately after the acute event but needs to be reinforced throughout the patient's recovery. Expectations for recovery must not be raised inappropriately and should reflect the patient's previous functional and social level. Comprehensive support strategies for both patient and carer should be sought using both statutory and charitable resources. The Chest, Heart and Stroke Association have an effective local network of day centre care where interaction among stroke patients and trained counsellors can take place. Most geriatric services offer respite admission programmes for stroke patients and their carers. Ideally this should be on a regular basis, to offer support and prevent a crisis but may occasionally be limited to facilitate a much needed holiday for the carer. A recent review of respite care in our own unit demonstrated that levels of dependency and disability in respite patients were no different to those in patients in continuing care. The only reason the former group of patients were maintained in the community was the presence of a carer.²⁵

Physical and psychological illness in carers need not be an inevitable consequence of their commitment. While depression in the carer is not infrequent it is still commonly overlooked and treated inappropriately.²⁰ The general practitioner should be aware that a carer's frequent attendance at the practice may indicate that he/she is under intolerable stress at home looking after the patient, necessitating additional support and treatment of depression where indicated.

For those professionals responsible for stroke services the im-

mediate priority is all too often only the patient. It is important not to forget the carer and family; a happy family will result in better patient compliance with rehabilitation and a better functional outcome from stroke.^{23,26}

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