

be used in 1968." The answer is already published^{2,3} (with references): the vaccine is "once again highly effective, as it was in the 1950s against the then-prevalent strains." The decline of the 1950s followed the initial introduction of vaccine,⁴ acceptance of which neared its peak by 1957. Eradication seemed imminent. Then serotype 1,3 emerged in the 1960s: his own graphs¹ show how the decline decreased—until the vaccine was modified.

Thus, far from despising notifications or being in conflict with Colindale, I support Dr N D Noah's view (17 January, p 128) that "notifications . . . reflect trends in the incidence of *Bordetella pertussis* infection." But they are unreliable for evaluating vaccine, as it is difficult to diagnose mild cases clinically. The data of Dr Christine L Miller and Mr W B Fletcher (17 January, p 117) suggest that the new vaccine is very effective against illness that can be diagnosed more accurately—either severe cases or hospital admissions. In these groups only 10% of their children aged 1-2 years had been vaccinated, although there would be about three times as many vaccinated as non-vaccinated at risk. This implies that current vaccine is more than 95% effective, a figure which agrees with my recent (unpublished) data. Also, Professor Stewart pays only lip-service to the "desirability of bacteriological confirmation." His claim¹ that "antigen 3 . . . did not . . . protect against . . . the prevailing serotype 1,3 in 1974" is substantiated by only four cases of type 1,3 infection—and no indication whether even these had received the new vaccine.

He accuses me of asking people to "accept the new vaccine as being non-toxic." On the contrary, I said² that "its safety is rightly being examined." However, I have never seen a vaccine-damaged child, though many severely ill with whooping cough and cultures from some of them post mortem. But those who have recorded possible vaccine-damage^{5,6} admit that they cannot compare the risks of natural infection and vaccination; and even *World Medicine*⁷ now talks of an "occasional—and possibly receding—hazard" with vaccine that "appears to be both good and safe." Mrs Rosemary Fox (21 February, p 458) still picks on pertussis vaccine as the culprit, though only 65% of her cases followed the use of triple vaccine. Moreover, she tells us nothing of the incidence of similar conditions in children who have not received any vaccine. Perhaps we should allow the Subcommittee on the Complications of Vaccination to study the problem as they think best.

Perhaps Professor Stewart may now follow his own advice and await parturition of my data.

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¹ Bassili, W R, and Stewart, G T, *Lancet*, 1976, 1, 471.
² Preston, N W, *Lancet*, 1974, 2, 1138.
³ Preston, N W, and Stanbridge, T N, *Lancet*, 1975, 1, 1089.
⁴ Griffith, A H, *Symposia Series in Immunobiological Standardization*, 1973, 22, 13.
⁵ Kulenkampff, M, Schwartzman, J S, and Wilson, J, *Archives of Disease in Childhood*, 1974, 49, 46.
⁶ Aicardi, J, and Chevie, J J, *Lancet*, 1974, 2, 894.
⁷ *World Medicine*, 1976, 11, No 8, 5.

A place to be born

SIR,—Dr R Dingwall (14 February, p 396) has done well to remind your readers that the social aspects of childbirth can be the subject of systematic research, albeit in a mode somewhat different from that employed in clinical research. Too often statements relating

to the social and psychological aspects are dismissed as "merely subjective," "just emotion," or matters of (pigheaded) opinion. As a sociologist, I believe that there may be more hazards in the way we handle childbirth than can be measured by perinatal and maternal mortality rates and that we should take account of these.

At a recent seminar at Warwick University funded by the Nuffield Foundation, where obstetricians and social scientists met together to discuss mutual problems, Dr Iain Chalmers produced evidence, using conventional obstetric outcome measures, which suggested that the active management of labour did not result in the benefits claimed for it. If this is so there can be no doubt that social and psychological variables should be taken into account, as should the views of the women themselves. The predominant impression with which most of us emerged from that day of talking at Warwick was that there was a long way to go before mutual understanding was achieved. The correspondence in your columns confirms this impression. For example, it is suggested that hospitals should be made more home-like, that women there should be given more choice and be more involved in the birth—all proposals which I personally would applaud. But there seems no recognition of just how difficult such goals are to achieve. A hospital is a totally different sort of social organisation from a home; it is not possible for a woman to be treated there as she is at home. Social scientists can help by analysing and explaining these differences so that the problems may be better understood.

I am glad to learn that in various parts of the country social scientists are getting together with obstetricians to try to establish a dialogue so that the latter may come to some understanding of the sociological and psychological hazards of childbirth, while the social scientists learn more of what are seen by obstetricians as medical imperatives. Let us not go blindly forward, perhaps doing unintentional damage, which is no less real because it is not immediately visible or readily measurable.

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SIR,—In your leading article "A place to be born" (10 January, p 55) you make comparisons between the results of the British and the Dutch systems of obstetric organisation. As you brought our country in and we share your interest in promoting all aspects of maternal and child care as much as possible, we feel compelled to make some remarks.

(1) You quote De Haas-Posthuma as follows: "De Hass-Porhuma [*sic*] has shown that those parts of Holland with the highest incidence of hospital confinement have the lowest perinatal mortality rates." According to the list of references this statement is to be found on p 220 of the *Proceedings of the Organisation for Health Research, Series A, No 11*. On that page we cannot find the quoted sentence. On p 211, however, we read: "Although home confinement still strongly predominates an increasing tendency towards institutional confinements is to be found in the Netherlands also: 27½% in 1960 as against 22% in 1952 or a relative rise in hospital confinements of 25% in 8 years. During the same period perinatal mortality fell from 31 per 1000 in 1952 to 25 per 1000 in 1960. Even if a causal relationship were to exist between hospitalisation and falling perinatal mortality—a point that has not been proved—this would not yet mean that the tendency towards hospitalisation should be encouraged indiscrimi-

nately. An excessive degree of hospitalisation should be guarded against."

(2) The decline in the percentage of home confinements in the Netherlands has continued since then. In 1973 this percentage was 51. Perinatal mortality in 1973 went down to 16.3 per 1000. In that same year 84% of the home confinements took place in co-operation with the so-called Organisatie inzake Kraamhulp (Maternity Home Help). Perinatal mortality in that group was 4.5 per 1000. Hospitalisation of the newborn during the first 10 days post partum took place in 2½% of all cases. In 1960 perinatal mortality of the same group of home confinements was 14 per 1000. This means that from 1960 to 1973 hospitalisation went up from 27.5% to 49% (a relative rise of 78% in 13 years); perinatal mortality fell from 25 to 16.3 per thousand (a relative decline of 34%). Perinatal mortality in home confinements with maternity home help fell from 14 to 4.5 per thousand in that same period (a relative decline of 68%).

(3) From the facts now available we can conclude that any correlation between the percentage of hospital confinements and perinatal mortality by region or municipality is very poor or even non-existent. It seems that other factors must be responsible for the differences in perinatal mortality in the various parts of the Netherlands.

(4) In a recent study stimulated by the obstetrical department of the University of Amsterdam one of us (D van A) followed accurately a group of 916 women who were pregnant with their second child and who were selected for normality and home confinement in accordance with the Dutch list of "medical indications for hospital confinements." From this group 24 women (2.6%) were transferred during labour to the hospital. In this group of transferred women there was one artificial delivery (vacuum extraction) and one case of perinatal mortality. Of the whole group of 916 women 892 were delivered at home or in a simple home-like maternity unit at Wormerveer, where only midwives or family doctors were present and where no hospital facilities and no possibilities for artificial delivery or blood transfusion existed. These 892 women gave birth to 893 children (one unrecognised twin pregnancy). Among the 893 children perinatal mortality was zero.

We do not make propaganda for home confinements but we protest against the simplification that total hospitalisation should be the aim of an ideal obstetrical organisation. In the Netherlands for example we can show that improvement of the care in our hospitals will be of considerably more importance than compelling every pregnant woman to have her baby in hospital. Before we are entitled to demand total hospitalisation it is our duty to make every hospital a place for "the best way to be born."

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Dangerous labelling

SIR,—The varicose vein sclerosing fluid called "S.T.D." (a proprietary preparation containing 3% sodium tetradecyl sulphate) is labelled "for intravenous use" on the bottle and the carton, with no indication of the sclerosant nature of the contents. The fluid is available in many operating theatres.

Although this method of labelling has apparently been passed by the Dunlop Committee, I consider it to be extremely dangerous as the fluid could be drawn up into a syringe and handed to an anaesthetist or surgeon in an emergency and injected into an arm vein, in which case it might not only