facts, and to see if such facts are relevant clinically I am astonished to find no less than a leading article in the *BMJ* (10 January, p 55) seeming to ignore these cardinal rules of unbiased objectivity.

When you state that "so much has been achieved that reversal of the trend is unlikely" is this not dogma? In referring to the "persistent belief that selected groups of 'low risk' cases may safely be delivered at home" this is surely allowing bias to creep in. The reference to "a considerable risk to the baby when the mother had to be transferred to hospital late in pregnancy" is putting the cart before the horse. The baby is at risk as a result of the condition necessitating transfer, not because of the transfer itself.

The statement that "deaths from neonatal pneumonia were commoner among babies delivered at home" is a classic example of a quotation becoming misleading when taken out of context. What the National Perinatal Mortality Survey showed¹ was that the overall mortality ratio for hospital bookings was 103, while that for home bookings (irrespective of place of actual confinement) was 88. Also in babies weighing more than 2½ kg there was no significant difference between places of booking, and of pregnancies confined within 38-41 weeks the mortality ratios were similar for hospital and home deliveries (48 for hospital, 47 for home).

I would love to know if Aberdeen women are representative of all British women in height and have yet to see evidence linking minor variations in height with obstetric performance. As for the regional variation in Holland, in the 1972 Confidential Enquiry² maternal mortality was unrelated to the proportion of domiciliary confinements.

I contend that the figures available cannot show a significant difference in safety between hospital and home confinements because like is never compared with like. What is needed is a survey similar to that reported by Dr C A Cox and others (10 January, p 84) but comparing the outcome of a group selected (faults and all) for home booking with that of a matched series of controls booked for hospital confinement. The onus is on the supporters of either side to prove their case and this has yet to be done.

Brevity compels my arguments to be incomplete. I look forward to criticism.

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¹ Butler, N R, and Bonham, D G, *Perinatal Mortality, First Report of British Perinatal Mortality Survey*. London, Livingstone, 1963.

² Department of Health and Social Security, *Report on Confidential Enquiries into Maternal Deaths in England and Wales 1967-69*. London, HMSO, 1972.

SIR,—If the hospital experts are going to throw bricks we, as general practitioner obstetricians, would appreciate the opportunity to throw a few back.

The article on domiciliary obstetrics by Dr C A Cox and others (10 January, p 84) makes the assumption that all obstetricians and paediatricians consider that all babies should be born in hospital and later refers to the "back to nature" cult of home confinements. We doubt the first premise and consider the second remark highly pejorative.

They mention the clinical errors made by the GP obstetricians. By implication no errors

are made, they would aver, in hospitals. Sadly, we who have worked in both milieux know that this is not the case. Added to this, patients in hospital are inevitably and necessarily treated, and administered to, by junior medical and nursing staff, the results of which can be as or more dangerous than exposure to the domiciliary obstetric team.

Dr Cox and his colleagues mention several reasons why women prefer home confinements. Another is the high level of analgesia given in hospitals, necessitated by the system. We find these high levels generally unnecessary in home deliveries because of efficient psychoprophylaxis. This means that it is rare to have a home-delivered baby needing resuscitation.

Surely, Sir, if some British women wish to have their babies at home as Dr Cox and his colleagues reluctantly concede is the case, and this is certainly our experience, they should be allowed to do so. Those of us who participate in domiciliary obstetrics are convinced of their wisdom and shall continue to ensure that the process can be safely accomplished. We heartily agree with Dr Cox and his colleagues that this should be attempted only in properly selected cases.

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Effect of junior doctors' action on self-poisoning

SIR,—The increasing incidence of deliberate self-poisoning is now so extensively documented that any record of a decrease must be considered seriously. The "dramatic reduction" of admissions in the first 18 days of December at Kettering and District General Hospital (10 January, p 92) is the more interesting for it coincides with the junior doctors' industrial action. Unfortunately, in Dr G S Crockett's brief report only females were counted and the derivation of the expected number of cases is not clear. As it stands, the difference between the expected (12) and observed (1) cases is highly significant, though it could have been smaller if males as well as the total period of industrial action were to be considered.

Assuming that the admission policy or the definition of an "emergency" in that hospital remained as before the industrial action, and it is indeed stated that all departments were

"adequately covered for 24 hours," what is the likely explanation of this result?

Dr Crockett's view is that the press reports that junior doctors were working a 40-hour week must have created some uncertainty among potential self-poisoners. "One can only conclude," he states, that the knowledge that prompt treatment will be given "plays a large part in the decision of patients to carry out these 'suicidal' gestures, and when this prompt treatment is in some doubt these gestures are not made."

While a reduction in hospital admissions based on such a small sample need not be readily presumed to indicate that the behaviour itself is lessening, it would be of some interest to know whether other parts of the country showed a comparable reduction in acts of self-poisoning. We present below the hospital contacts for self-poisoning in Chichester and Southampton. Not unlike Northants, our population must have been aware of the reports in the mass media, though in none of the four casualty departments included in the survey had the medical cover been restricted during December. Because the junior doctors' dispute was not confined to December we recorded all patient contacts for self-poisoning between 1 September 1975 and 15 January 1976 and focused our attention on four periods of the dispute; and in addition we screened the same periods of time for the preceeding two years. The result (see table) shows conclusively that there was neither any reduction in hospital contacts in general nor a specific sex effect in particular related to the junior doctors' action or its reporting by the press.

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Chromosome damage produced by psoralen and ultraviolet light

SIR,—Psoralen has been known for a number of years to produce lethal and mutagenic effects in a number of widely differing biological systems ranging from bacterial viruses to mammalian cells.¹ These effects are associated with DNA-psoralen photoproducts and interstrand DNA cross-links.² Psoralens plus long-wave ultraviolet light (320-360 nm) are used successfully for the treatment of psoriasis.³⁻⁵ In the course of a series of

Hospital contacts for self-poisoning in Chichester and Southampton in three consecutive years. (Expected numbers based on yearly totals)

Year*	No of contacts	(A) 1 Sept-11 Oct (41 days)			(B) 12 Oct-26 Nov (46 days)			(C) 27 Nov-23 Dec (27 days)			(D) 24 Dec-15 Jan (23 days)		
		M	F	Total	M	F	Total	M	F	Total	M	F	Total
1973-4 (Sept-15 Jan) n = 182	Observed	24	26	50	19	33	52	12	26	38	16	26	42
	Expected	21	33	54	24	37	61	14	22	36	12	19	31
1974-5 (Sept-15 Jan) n = 212	Observed	16	42	58	27	45	72	13	19	32	16	34	50
	Expected	22	42	63	24	47	71	14	28	42	12	23	36
1975-6* (Sept-15 Jan) n = 255	Observed	32	39	71	27	50	77	23	36	59	17	31	48
	Expected	30	47	76	33	52	86	19	31	50	17	26	43

*No industrial action in 1973-74 and 1974-5. In 1975-6: A = free of industrial action; B = sporadic unofficial industrial action; C = official industrial action; D = suspended industrial action.