permissible but obligatory? This technique identified factors which *each independently* was associated with special benefit—namely, a pre-entry history of anterior infarction and below-average blood pressure at entry. In our paper we discussed collateral evidence, and adduced reasons, for believing that patients with anterior infarction are at special risk from late serious arrhythmias. We understand less well the apparent importance of β-blockade to patients with lower diastolic blood pressures, but it would not be justifiable to ignore statistically significant trial results.

Finally, we are puzzled by the authors' reluctance in their last paragraph to accept the arguments that the life-saving effects were due to β-adrenoceptor blockade rather than to any property peculiar to practolol. Indeed, in the first sentences of their second paragraph they claim that the results obtained using practolol confirm the results of their own small-scale trial with alprenolol.[1] With this we agree.

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[1] Wilhelmsson, C E, *et al*, *Lancet*, 1974, **2**, 1157.

A place to be born

SIR,—In their haste to do battle with the medical establishment in the form of those (still) anonymous leader writers (10 January, p 55) the members of the Study Group on Home Confinement of the National Childbirth Trust (31 January, p 279) ignore our article (10 January, p 84) and imply that the choice for mothers is either a "nasty" hospital birth or a "nice" if slightly risky home confinement. The acceptance by this well-meaning pressure group that there are only two possible alternatives does mothers a dangerous disservice.

Although we consider the physical safety of mother and baby to be of paramount importance, as paediatricians and mothers we know that the important social and emotional aspects of childbirth are frequently neglected, especially in hospitals. We would like to see a change in the relationship between hospitals and mothers and agree that the latter should be directly involved in decisions concerning childbirth. One essential component of this change is that mothers must have access to knowledge currently the prerogative of the professionals, among whom we number ourselves and the study group signatories. We must be wary of the ways in which such knowledge is interpreted, as evidence can be presented to make either option attractive. For example, the signatories point out that Sweden has the lowest perinatal mortality rate, closely followed by Holland, but omit to mention that Sweden also has the lowest maternal mortality, for which several other countries return better rates than Holland.[1 2] If decision-making is the critical question how much real control does a mother have at home where, as we have shown in our paper, she is clearly subject to the whims and current opinions of the individual practitioner?

Finally, the National Childbirth Trust should consider the prospect that they may in the not too distant future acquire some unlikely allies in their campaign. In the present economic climate bureaucrats whose first thought is "cost-effectiveness" may decide that neither physical safety nor emotional satisfaction is the overriding consideration.

Although we do not underestimate the difficulties we believe that the aim must be a maternity service which combines the safety of hospital with the personal qualities possible in home confinement.

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[1] United Nations Statistical Yearbook, 1973. New York, 1975.
[2] Wallace, H M, in *Health Care of Mothers and Children in National Health Services*, ed H M Wallace. Cambridge, Mass, Ballinger Publishing Co, 1975.

SIR,—Your leading article (10 January, p 55) produced a wave of controversial correspondence that has given only a passing reference to the important observations made by our colleagues Drs C A Cox and P M Zinkin and ourselves in the same issue (p 84). As the obstetricians concerned with this article we would like to comment on the emotive, negative, and statistical arguments raised by your correspondents both in favour of and against domiciliary delivery.

The emotive factors were well illustrated by Dr C K Hudson (24 January, p 216) and Professor J Ashford and others (31 January, p 279)—the security of husband, home, and familiar surroundings; the continuity of care and the 80% preference for home confinement by women who have had experience of both home and hospital. The negative factors were equally well represented and directed, predictably, against the large, impersonal maternity unit with its "increasingly technological environment." An attempt was made to restore the balance by Professor A G M Campbell (31 January, p 279) and the medical correspondent of *The Times* (9 January, p 16). The former noted that the wishes of the mother and her attendants may be given precedence over the safety of the child and the latter pointed out the shattering effect of a home confinement resulting in a complication leading to loss of life or damage to the future welfare of mother or child.

No one can ignore the abundant statistics in favour of hospital confinement that were ably summarised in your leading article, yet it would seem that disproportionate publicity is given to diminutive studies that use inadequate statistics to show that the home is as safe as, or even safer than, the hospital for confinement. Dr Hudson refers to just such a publication.[1] Examining the original article more closely, it is apparent that perinatal mortality rates were used as the main supportive argument. His series of 671 cases was broken down into three categories, the smallest of which included 32 cases, from which a perinatal mortality rate per 1000 live births was derived! Discounting this particular example, it is our opinion that the perinatal mortality rate is a very crude measure of the quality of obstetric care, as it records only the ultimate catastrophe of death in a group of human beings renowned for their ability to survive extremes of anoxia and clumsy obstetric manipulations. Applying these criteria to the series reported in our paper we should congratulate the doctors and midwives on a perinatal mortality rate of 0 per 1000. Nevertheless the study in depth revealed some 20% of babies who had been exposed to unreasonable hazards. The National Perinatal Mortality Survey emphasised the importance of social class and geographical location. In Dr Hudson's series no figures were produced for the former, and the influence of the latter could be deduced only from his address in Tadley, Hants. No grounds were given for the original selection of cases, but it was noted that 82 changed to a hospital booking before the onset of labour. This left a final highly selected group of 589.

We now quote his own observations on this group, not as a criticism of a person keen enough to publish his figures but only to illustrate the size of the gap that still exists between the factors that alarm the consultant as opposed to the general practitioner obstetrician. The series included one pair of undiagnosed twins, two forceps deliveries, and four retained placentas. In addition there were 32 cases "transferred in labour due to delay in the first or second stage or for fetal distress," and 24 patients who had a post-partum haemorrhage, though "only five of these gave rise to sufficient anxiety to call a flying squad." Unfortunately, no observations were made on the condition of the babies at birth and there was no reference to resuscitative measures. The actual number of these cases at risk was not recorded and some may well have had two problems. However, if we take a reduced figure of 60 cases this represents roughly a 10% risk to mother or child. It must surely be questionable whether this risk is balanced by the emotional advantages of the home environment.

In our paper, in criticising the selection of cases for home confinement, we emphasised the fact that strict application of accepted "risk" criteria would not have reduced the hazards to the baby. Professor Ashford and his 18 colleagues from the National Childbirth Trust suggest that demands for 100% hospital confinement remove the mother's freedom of choice. May we respectfully suggest that it is our professional inadequacy in the field of prediction rather than our dictatorial personalities that prompts us to recommend this course? Every advance in obstetric and neonatal management leads us further from the home. However, there is no reason why the benefits of the home should not be introduced into the hospital.

It is interesting to reflect on the reasons why an article attacking domiciliary deliveries should provoke such controversy when two months previously the same unit published an article[2] outlining a community obstetric project which answered almost all the criticisms made by your correspondents, yet, despite its free distribution to every member of the medical profession, it was received with almost universal disinterest. It outlined a hospital service which combines continuity of care, homely surroundings, and family participation with all the technology and expertise of the large maternity unit and without even interfering with the contract between general practitioner and patient.

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[1] Hudson, C K, *Practitioner*, 1968, **201**, 816.
[2] Matthews, A E B, Shearman, W H, and Steffens, E M, *Health Trends*, 1975, **7**, 69.

SIR,—I read with increasing annoyance the letter from the members of the Study Group on Home Confinement (31 January, p 279). I would take issue with them on two points.

Firstly, they misquoted references in your leading article (10 January, p 55), inferring that a 50% domiciliary confinement rate in Holland did not adversely contribute to their

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