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CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

A place to be born

SIR,—I was most disappointed by your leading article (10 January, p 55). The discussion on where delivery should take place has lasted too long already. Most doctors and midwives are likely to agree, for one reason or another, that our trend towards hospital confinement is the right one for us to pursue at present. When he was lecturing in this country a few years ago Professor A A Haspels pointed out the Dutch system which he advocated was, as he put it, "not for export." Efforts to demonstrate that falling maternal and perinatal mortality rates are directly related to the increasing proportion of hospital deliveries are full of pitfalls, as Professor A L Cochrane pointed out some years ago.[1] Neither does examination of our own regional figures give support to this view. It is surely time we rolled up these spurious arguments and devoted our attention to the things that really matter. The obstetric services in Holland may differ markedly from those in Sweden, but both countries can prove to us that our perinatal mortality has some way to fall.

It is time that doctors stopped focusing the whole of their attention on the clinical details of maternity and the place in which it occurs and instead looked far more carefully at the educational, social, and cultural background of parturient women. Our own regional variations in mortality indicate fairly clearly that it is these factors that have the most profound effects on the outcome of pregnancy. Regarding maternal mortality we still have no better example of the effects of education than that provided by Dr Alexander Topping, MOH of Rochdale between the wars. In 1930 Rochdale's mortality was over 9 per 1000 births. By 1932 it had fallen to under 2 per 1000. This was not achieved by a dramatic change in obstetric practice nor even by a sudden rise in living standards. He did it by telling women how they themselves can influence the outcome of pregnancy. He proved that education alone will produce huge effects. There is still plenty of room for improvement in the education of our own people and it is to this that doctors and nurses should direct their energies if we wish to enjoy the low mortality rates which others have achieved.

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[1] Cochrane, A L, *Effectiveness and Efficiency*, pp 63 and 65. London, Nuffield Provincial Hospitals Trust 1972.

SIR,—Discussion of this subject (leading article, 10 January, p 55) always seems to be dominated by hospital-based obstetricians and, as a result, the case for home confinement often seems to go by default. My own experience leads to the conclusion that the home *can* be a safe place for childbirth.

In 1968 I published a survey of domiciliary obstetrics in a group practice covering the period 1960-6.[1] There were 667 pregnancies initially booked for home confinement, and of these 83·1% were eventually delivered at home, 12·1% developed complications during the antenatal period requiring referral to hospital for delivery, and 4·8% were transferred to hospital in labour. Corresponding perinatal mortality rates were 5·4, 23·8, and 31·3 per 1000 live births. The overall perinatal mortality was 8·9 per 1000. Other findings of the survey were a high rate of transfer of primigravidae, both before and during labour, and a low incidence of serious complications in home deliveries. It was concluded that primigravidae should be excluded from home confinement but also that conscientious antenatal care and careful selection of cases provided a high degree of safety for mothers and their babies born at home.

Since 1966 advances in monitoring fetal health have made available to GP obstetricians new refinements of antenatal care. Furthermore, it is possible that delivery at home may actually be safer for some mothers. The security of husband, home, and familiar attendants can induce relaxation and normal labour, whereas the clinical and increasingly technological environment of hospital may promote obverse reactions. An analogy could be the cardiac monitoring units, where patient anxiety can result in the release of catecholamines promoting arrhythmias. There may be a better chance of survival from a cardiac arrest in hospital, but the patient may never have the arrest at all if nursed at home.

The aim should be to educate the GP obstetrician to recognise his limitations and to prevent booking unsuitable cases for home confinement. Failure to do this in the past has fuelled the argument against all domiciliary obstetrics. There is still a substantial case for some degree of home confinement, provided both mother and doctor desire it and that the latter is properly trained. Domiciliary childbirth may then be a most rewarding experience for all concerned, despite the fact that perfection is as difficult to achieve at home as in