a more enlightened relationship of mutual participation.

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Medicine in the armed services

SIR,—How the mists of time play tricks with the memory. I certainly remember Major Ricky Villar as a vigorous, enthusiastic, and optimistic surgical registrar when I first joined the army, but I do not recall that he wore rose tinted spectacles as he seemed to be when writing the article in the anniversary issue of the *BMJ*.[1] These must have been obtained when dekitting.

I, too, remember my army days with great affection, but his vision of medicine in the armed services is as realistic as a recruiting sergeant's view of life in the ranks. I fear that he has omitted to tell prospective cadets of the hours of mindless boredom spent in converted warehouses in the border country of Northern Ireland waiting for nothing to happen; of the "generous training programmes" that include being posted abroad at short notice, days before taking a high professional examination, as recently happened to an acquaintance of mine; of the first weeks in practice in the army counting morphine syrettes and performing "fit for typing course" medical examinations; of the almost universal one in two rotas with no locum cover; of the fact that "different parts of the world" means Germany and the United Kingdom for most and Cyprus or Hong Kong for only the lucky few. Was there any mention of the feeling among many army doctors that no one "up there" has much interest in their welfare or training and that those who command in the medical services pay scant attention to the principles of "man management" that are held so highly in the "big army"? Until these questions are considered, preferably by administrators from outside the medical corps, it will be easy to understand why retention rates are so low and recruitment so difficult.

I make these points not because of sour grapes: on the contrary, my memories of the army are sweet, and I would encourage any young doctor to join, but only if he or she knows the other half of the story. Don't forget that once you are in there is no going back, and if you can't take a joke you should not join.

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Atenolol in essential hypertension during pregnancy

SIR,—Ms Lucy Butters and colleagues concluded that treatment with atenolol started in the first trimester of pregnancy was associated with intrauterine growth retardation.[1] Given the study's small size, however, before accepting that it shows a cause and effect it is important to know about additional possible confounding variables such as maternal age, weight, parity, and fetal sex ratio, details of which were not included in the report. Nevertheless, other uncontrolled studies have suggested that β blockers, and in particular propranolol, are associated with intrauterine growth retardation.[2,3]

The effect of atenolol on growth retardation may be related to the duration of treatment or at least its use from an early gestation (mean 15·9 weeks). In the more recent prospective studies, however, in which β blockers have had no effect on fetal growth, the treatment was initiated in the third trimester. In addition, the study populations were largely patients with hypertension induced by pregnancy rather than essential hypertension, which, of course, has a different aetiology and pathogenesis.

We analysed data from a randomised controlled study of 114 women comparing labetalol with no antihypertensive treatment for hypertension in pregnancy. All the women had singleton pregnancies and non-proteinuric hypertension and were recruited between 24 and 39 weeks' gestation. Intrauterine growth retardation was more common in both primigravid (6/31) and multigravid (4/20) women treated with labetalol when compared with primigravid (7/45) and multigravid (22/18) controls. These trends were not significant but add support to the findings of Sibai *et al*, who also found an effect with labetalol.[4] Labetalol acts as a competitive inhibitor of α and β adrenoceptors and lowers blood pressure primarily by reducing peripheral resistance.[5] Although the acute and chronic haemodynamic effects of labetalol are different from those of β blocking drugs such as atenolol, which reduce cardiac output without affecting peripheral resistance, it seems that both drugs have a similar effect on fetal growth. A randomised comparative study between labetalol and atenolol would be required to see if there is any quantitative difference in the effect on fetal growth.

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Obstetrics and the general practitioner

SIR,—Dr Irvine Loudon is incorrect to cite our publication "Where to be born?"[1] in support of his allegation that "... there is an increasing demand from a small but vocal group of mostly middle class women for a greater degree of personal care and even for a return to home deliveries."[2]

Although we acknowleged the need for more user friendly services in our review, it was devoted almost exclusively to a discussion of evidence about the safety of delivery in different settings and the ways in which policies have developed without reference either to the evidence that existed or to the need for more rigorous evaluation. We concluded that there is no evidence to support the claim that the safest policy is for all women to give birth in hospital or the policy of closing small obstetric units on the grounds of safety.[1]

Although early campaigns for better maternity services were pioneered by the Women's Co-operative Guild, a largely working class organisation, more recent campaigns, particularly those for home birth, have tended to be dominated by middle class women. This is not surprising as middle class women are more likely to have the necessary time and political skills. The same probably applies to campaigns for contraception, legal abortion, and, not so very long ago, hospital births. Yet these services have undoubtedly been used by the rest of the population.

Estimated distribution of home births and all births within marriage in England and Wales in 1979 according to fathers' social class[4,5]

Social class of father	Planned home births (%)*	All births (%)*
Professional and managerial (I and II)	36·6	27·6
Skilled (III)	47·1	48·2
Partly skilled and unskilled (IV and V)	14·8	21·1
Other	1·5	3·3

*Because of rounding columns do not add up to 100.

Furthermore, a survey of childbearing in 1975 showed that, compared with working class women, a higher proportion of middle class women thought that they had been given a choice about whether their labour was induced. When it came to wanting a choice, however, there were no social class differences, and over three quarters of all women questioned wanted to have a choice about induction of labour.[3]

There is no recent information about the social class of women having planned home births. It should be possible to derive this information in the future when the maternity hospital episode system is fully implemented and links can be made with birth registration data. Meanwhile, the table gives data for 1979 from our home births survey. It shows that in 1979 women with husbands in social classes I and II formed a higher proportion of those having home births than they did of all those giving birth. This is hardly surprising as these women are likely to have fewer obstetric problems and better homes. On the other hand, they accounted for only 37% of planned home births in England and Wales in 1979.[4]

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Major accidents

SIR,—The picture accompanying Mr Stephen Miles's article shows a medical team in protective clothing wearing their legging inside the wellingtons.[1] Although this may be fashionable, it is not functional and should be discouraged. Wet weather may mean only wet feet, but contamination trapped inside wellingtons could have serious consequences.

This illustrates that training is needed for even the simplest type of protective equipment as often the intelligent fail to recognise the obvious.

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