all infants with clinical signs of neonatal encephalopathy and then applied criteria indicating possible intrapartum asphyxia.

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Epidural anaesthesia and low back pain after delivery

EDITOR,—The final key message in the paper by Alison Macarthur and colleagues is that everyone “can assure women that any increased risk of low back pain is small and transient.” The two key questions are then “How big is the risk?” and “How long does it last?”

Despite differences in the definition of the outcome backache, when the data from the paper¹ were combined with those from previous studies²⁻⁴ a significant odds ratio resulted (fixed effects model), with a number needed to treat of 12 (table 1). The “small” risk mentioned in the key message is therefore 1 in 12.

The earlier paper by Macarthur and colleagues stated that 69% of the 1634 women with backache had had it for over a year.² Assuming transience in the key message of the recent paper may not be fair because there was no report beyond six weeks.

The authors say that a randomised trial of epidural versus non-epidural pain relief in labour was considered to be unethical, though this ignores the fact that at least two such trials are under way and recruiting successfully. This judgment is based on the assumption of the superior effectiveness of epidural anaesthesia, but of nine randomised studies of epidural anaesthesia in childbirth, only one had pain as an outcome measure.⁵

Surely factors other than just effectiveness—for example, safety—come into the debate. A marvellously effective intervention that caused one nose in 12 to fall off would surely have to be compared with a less marvellous intervention that did not cause any noses to drop off (or be discarded altogether). The argument that a randomised trial of epidural anaesthesia is unethical in labour

trivialises the backache. The professional argument is that more difficult labours attract epidural anaesthesia, and more difficult labours would be more likely to result in backache. The surveys do not support this. Given the homogeneity of the survey data, should women be told of the 1 in 12 risk, or do we wait for the randomised trials to rebut or confirm it?

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Use of drama in education

My Friend Willy has been well received in schools

EDITOR,—Harry Snook, the 13 year old reviewer of the play *My Friend Willy*, concludes, “I don’t think it would be possible to create an effective play providing sex education for teenagers.” The play was commissioned by Norfolk Health as part of our HIV/AIDS education programme for young people. I would like to explain why it was commissioned and why it is proving so popular and effective with local schools.

Firstly, *My Friend Willy* is not intended to give facts. It is intended to address emotions, attitudes, beliefs, and behaviours commonly experienced by young men as they struggle for sexual maturity.

Secondly, the strength and skill of drama is to relate educational fact to real life situations.

Thirdly, sex education is not just about imparting information. We know that information alone will not bring about desired behaviour.

Fourthly, teachers are expert in giving information.

Fifthly, educational drama is intended to encourage work in the classroom. That is why a comprehensive pack has been produced to help teachers use *My Friend Willy* long after the actors have gone.

Sixthly, young people tell us that they need and want a sex education that is open, honest, and related to life as they know it. They ask that sex education be taught in the context of human relationships. *My Friend Willy* is about human relationships. More importantly, it addresses many of the issues that boys face as they grow up in the 1990s. While I respect Snook’s view of the play, it is not one that I have encountered elsewhere. *My Friend Willy* has been well received by its many audiences of teachers, youth workers,

and young people and has been widely praised as effective and appropriate in contributing to a comprehensive sex education.

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1 Snook H. Back to the drawing board? *BMJ* 1995;311:1376. (18 November.)

Is popular and becoming increasingly common

EDITOR,—I was disappointed and somewhat surprised to read Harry Snook’s review of Tiebreak Touring Theatre’s latest production, *My Friend Willy*.¹ All Tiebreak’s productions are carefully targeted at a specific age range, and, at 13, Snook was outside the intended age range for this particular play. Snook saw the play alongside older students at Sudbury Upper School and not only is disparaging about it but also describes the students’ reaction as bored and uninterested. On the contrary, feedback from Sudbury’s staff and students, as from all the schools visited on the tour, was very positive. Comments ranged from “Brilliant,” “Excellent,” “Cool,” “Well done, very good” to “A good issue to tackle,” “You were so open about sex,” and “The best play I have ever seen”—hardly the views of a bored audience.

Studies have shown that drama is widely considered to be one of the most effective ways of communicating with young people and raising awareness of important and sometimes sensitive issues. As health authorities all over Britain increasingly turn to theatre companies for plays dealing with health education issues, drama seems firmly to have their vote of confidence.

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1 Snook H. Back to the drawing board? *BMJ* 1995;311:1376. (18 November.)

Developed countries should stop spending on the arms trade too

EDITOR,—It is instructive to juxtapose the article on the international arms trade and its impact on health¹ with those on “cardiac surgery in the Dunkirk spirit”² and the “OxDONS” syndrome.³ The developing countries’ squandering of national resources on expensive military technology at the expense of many basic necessities for health for the populace has its parallel in the developed world. Thus the governments of Britain and France, with outdated notions of great nationhood, are greatly contributing to the crumbling national health care systems by pouring money into the bottomless pit of military spending and research.

I have no doubt which is the more deserving when the choice is between a Trident submarine and untold numbers of patients waiting for cardiac surgery, hip replacements, cataract operations, or whatever.

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Table 1—Odds ratio of backache after epidural anaesthesia during childbirth in four studies

Trial	Study design	No with backache		Odds ratio (95% confidence interval)	No needed to treat (95% confidence interval)
		After epidural	No epidural		
Macarthur <i>et al</i> , 1990 ²	Retrospective survey	903/4766	731/6935	2.0 (1.1 to 2.2)	11.9 (10.3 to 14.1)
Russell <i>et al</i> , 1993 ³	Retrospective survey	109/612	47/403	1.6 (1.1 to 2.3)	16.3 (9.5 to 55.9)
Breen <i>et al</i> , 1994 ⁴	Prospective exploratory	44/100	45/100	0.96 (0.6 to 1.7)	∞
Macarthur <i>et al</i> , 1995 ¹	Prospective cohort	23/164	12/165	2.0 (1.0 to 4.1)	14.8 (7.5 to 816)
Four trials combined		1079/5642	835/7603	1.93 (1.8 to 2.1)	12.3 (10.7 to 14.5)

$\chi^2=7.75$, $df=3$, $P=0.05$.