the prey of their forceps? Does not having epidural analgesia or pethidine make for a successful birth, as she implies? Moreover, do epidural analgesia and pethidine equate with failure?

Doctors become involved in childbirth when they are needed for its successful outcome. The ultimate success is the delivery of a live and healthy infant and a live and healthy mother at the end of the procedure. Medical intervention is not synonymous with loss of dignity—indeed, obstetric epidural analgesia often restores dignity. Doctors do not work without compassion.

The above sentiments are well expressed in a book review in the same edition of the *BMJ*: "Medical history used to be the narrative of how humanity moved from primeval ignorance to brilliant enlightenment, thanks to the efforts of heroic pioneers. Now that the sociologist has got hold of it, however, medical history is very nearly the reverse: it is the tale of how the medical profession has betrayed humanity down the ages. Doctor knows best has become sociologist knows best."

KATHRYN M GRADY
Consultant anaesthetist

South Manchester University Hospitals' Trust,
Manchester M23 9LT

- 1 Oakley A. Becoming a grandmother—has childbirth really changed? *BMJ* 1996;312:1426-7. (1 June.)
- 2 Daniels A. The health of prisoners [book review]. *BMJ* 1996;312:1429. (1 June.)

Author confused natural birth with normal birth

EDITOR,—Ann Oakley rightly wants quality of care and consumer satisfaction in childbirth to increase; an increase in these two variables should be our aim in all aspects of medicine. Whether Oakley is well placed to judge them in childbirth is another matter.

In her description of her daughter in law's labour the health of the baby and mother takes second place to her acerbic comments about obstetricians. It is unclear why she believes that obstetricians, whom she derisively refers to as "hovering outside the door" and making threats about using forceps, should not have the patient's best interests at heart or should want to intervene unnecessarily. Despite the reductions in junior doctors' hours, many registrars in hard pressed specialties such as obstetrics and paediatrics still work long hours and are unlikely to go looking for work. They will often be blamed, however, when the result of a pregnancy and labour is not a perfect baby: in such cases the parents often believe that there should have been more intervention, not less. In 1990, allegations of meconium staining and inadequate fetal monitoring were cited in 32% and 58% of obstetric complaints, respectively.² Allegations that labour was unnecessarily prolonged were made in 40% of complaints.

Oakley's criteria for a successful birth—little analgesia, a relatively short second stage, "and we kept the doctors away"—show that she is confusing a natural birth with a normal one. Would Oakley have described the labour as not being a success if her daughter in law had requested epidural analgesia? If the baby had been delivered by caesarean section because either the mother's or the baby's health was in jeopardy would her daughter in law have been a lesser woman because of the intervention?

A result of this exaggerated focus on the 24 hours around the birth, rather than on the nine months before and the many years after, is that many women feel guilty about events that are under physiological rather than voluntary control. As a neurodevelopmental paediatrician, I frequently review with the parents of disabled

children the details of the labour. The resentment of parents and families who believe that there was unnecessary interference in the birth of their well baby pales beside the guilt and grief of parents of a disabled child.

I am concerned that a professor of social sciences should have these prejudices about several thousand obstetricians, or doctors in general. I question the validity of her research as a sociologist in this area.

CHARLES ESSEX
Consultant community paediatrician

Child Development Unit,
Gulson Hospital,
Coventry CV1 2HR

- 1 Oakley A. Becoming a grandmother—has childbirth really changed? *BMJ* 1996;312:1426-7. (1 June.)
- 2 Crimlisk S. 1990 obstetric claims boom. *BMJ* 1990;301:947.

Long term backache after childbirth

Potential confounding by obstetric malposition was not considered

EDITOR,—Epidural analgesia forms an important part of the clinical management of labour. Robin Russell and colleagues' study showing a lack of association between epidural analgesia during labour and the development of new backache after childbirth should prove reassuring to clinicians and prospective parents alike.¹

The authors do not, however, seem to have considered the potential confounding effect of obstetric malposition, in particular the occipitoposterior position, in both pregnancy and labour. It has been estimated that at least a fifth of women start labour with the fetal head in the occipitoposterior position.² This malposition can cause severe back pain both in labour and in the later stages of pregnancy. The occipitoposterior position is recognised as a common cause of prolonged and dysfunctional labour. Certain pelvic shapes seem to predispose to a recurrence of this malposition in subsequent pregnancies.

Pregnant women whose fetus remains in the occipitoposterior position, and those who enter labour with the fetus in this position, are more likely to experience back pain and to have a longer labour. They are therefore more likely to request epidural analgesia in labour. Indeed, many obstetricians regard an epidural block as an integral part of the management of dysfunctional labour when the fetal head is in the occipitoposterior position. The association between these two relatively common obstetric phenomena may therefore contribute to an apparent relation between obstetric analgesia and back pain.

More information is needed on the proportion of pregnancies and labours complicated by the fetal head being in the occipitoposterior position so that the contribution of this malposition to both acute and chronic back pain after childbirth can be assessed.

IMOGEN F D STEPHENS
Registrar in public health medicine

Argyll and Clyde Health Board,
Paisley PA2 7BN

- 1 Russell R, Dundas R, Reynolds F. Long term backache after childbirth: prospective search for causative factors. *BMJ* 1996;312:1384-8. (1 June.)
- 2 Ritchie JWK. Malpositions of the occiput and malpresentations. In: Whitfield CR, ed. *Dewhurst's textbook of obstetrics and gynaecology for undergraduates*. London: Blackwell, 1986.

Study should have been randomised

EDITOR,—We wish to make several comments about Robin Russell and colleagues' study looking at possible factors in long term backache

after childbirth.¹ Firstly, the study was not randomised with respect to controls, and the authors justify this by stating that randomisation would have been unethical. We would argue that a randomised controlled trial is the only way to validate the use of epidural analgesia in comparison with any other technique. At present, we are conducting a randomised controlled trial of pethidine versus epidural analgesia for pain relief in primiparas in labour; this trial was approved by Harrow Research Ethical Committee.

We collected data at six months post partum and found that 185 (36%) of 515 mothers had back pain. Among those who had had epidural analgesia the incidence of back pain was 36% (99/273). This supports Russell and colleagues' finding that epidural analgesia is unrelated to the subsequent development of back pain. Since late 1994, however, all patients in the trial who complain of back pain have been seen by an experienced spinal physician who is blind to the method of analgesia. Of the first 78 seen, 36 (46%) stated that the back pain had started before the pregnancy; this contrasts with Russell and colleagues' finding that of 150 women with postpartum backache lasting three months, only 117 (78%) had had backache before or during pregnancy. Our figure excludes backache in pregnancy because pregnancy is a confounding factor.

The authors' study, unlike ours, was not restricted to primiparas, and therefore any association with increasing parity becomes a confounding variable. Failure to standardise the management of labour will introduce further problems in assessment. Although both studies support Mason's finding that many women with back pain believe that it was caused by pregnancy or childbirth, or both,² studies should pay more attention to randomisation, the effect of parity, and standardisation of obstetric practice.

BERNADETTE A LOUGHNAN
Consultant anaesthetist
HARRY GORDON
Consultant obstetrician and gynaecologist
ANDREW O FRANK
Consultant physician in rehabilitation and rheumatology

Northwick Park Hospital,
Harrow,
Middlesex HA1 3UJ

- 1 Russell R, Dundas R, Reynolds F. Long term backache after childbirth: prospective search for causative factors. *BMJ* 1996;312:1384-8. (1 June.)
- 2 Mason V. The prevalence of back pain in Great Britain. A report on OPCS omnibus survey data produced on behalf of the Department of Health. London: HMSO, 1994.

Authors' reply

EDITOR,—Imogen F D Stephens points out that, though we did not show an association between epidural analgesia and long term backache, we overlooked a mechanism by which a relation might exist. Although occipitoposterior presentation may produce back pain in labour, no association with long term postpartum backache has been reported. Moreover, were malposition a cause of such backache and also, as Stephens points out, an indication for epidural analgesia, one would expect in a non-randomised study such as ours to see more backache in the population who had epidural analgesia. This was not the case.

We will be interested to learn the results of Bernadette A Loughnan and colleagues' randomised trial of epidural versus systemic analgesia and hope that the authors avoid the high drop out rates that have occurred previously.¹ We defend the validity of our findings, however, since in a non-randomised study the risk of post-natal backache would be expected to be greater in the population who have epidural analgesia, given their more complex labours. The appar-