Table 1—All cause mortality ratios* (95% confidence intervals) adjusted for socioeconomic status among second generation Irish people in England and Wales at working ages† during extended period of follow up (1971-92)

	Women		Men	
	Standardised mortality ratio	No of deaths	Standardised mortality ratio	No of deaths
Mortality adjusted for:				
Age	126 (103 to 152)‡	104	124 (110 to 140)‡	267
Age and social class I-IV§	134 (103 to 170)‡	67	129 (111 to 149)‡	184
Age, housing tenure, and access to car	126 (102 to 152)‡	102	122 (107 to 138)‡	247

*Relative to all men or all women (standardised mortality ratio = 100).

†Ages 15-64 for men, 15-59 for women.

‡Standardised mortality ratio significantly different from 100 at 5% level.

§First five years of follow up were excluded to allow for health selection.²

one or both parents born in the Republic of Ireland represents not only a possible genetic contribution but, importantly, the effect of lifestyle and cultural factors ("ethnic features") that could persist across generations. We consider variation in lifestyle factors to be an integral part of ethnic analysis and likely to be a major contributor in this case.

While we agree with Fielder and colleagues that health problems of second generation Irish people are not comparable with those of population groups for whom language and culture may cause difficulties in access to health care, this does not rule out the fact that Irish people may have problems different from those of the majority population. This would apply not only to second generation but also to first generation Irish people.¹ How can it be wrong to direct time and effort to this group when an opportunity to achieve considerable health gains exists?

We disagree with Fielder and colleagues that if concerted efforts were made to address health problems connected with socioeconomic deprivation in the whole population then the issue of the health of Irish people would be addressed. Though socioeconomic status is important, it cannot explain the excess mortality shown in table 1.

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Going home after a heart attack

Patients should visit their general practitioner, not vice versa

EDITOR,—Doubtless H J N Bethell is correct in stating that there is much that can be done in primary care for patients recently discharged after having a myocardial infarction.¹ Nevertheless, in the context of current efforts to delegate some of the average general practitioner's ever increasing workload and to encourage patients to attend the surgery rather than expect a visit, Bethell's assertion that general practitioners should visit these patients soon after discharge is disappointing.

There is no reason why a suitably trained nurse practitioner could not undertake all the

tasks that Bethell outlines. Nor is there any reason why, in most cases, the patient could not attend the general practitioner's surgery. Ironically, expecting the general practitioner to visit runs counter to the rehabilitation process. Surely a patient who is fit enough for sex within a week or two of arriving home ("unless it is with an unfamiliar partner")¹ is fit enough to consult at the surgery (unless, perhaps, it is with an unfamiliar doctor).

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Depression is also a risk factor

EDITOR,—H J N Bethell's editorial on care after myocardial infarction omits to mention depression, particularly in the list of factors that increase risk.¹ This is surprising, as depression is known to be an "independent risk factor for mortality at six months. Its impact is at least equivalent to that of left ventricular dysfunction ... and history of previous myocardial infarction,"² its effects being at least partly mediated through further myocardial ischaemia.³

Depression after myocardial infarction is often chronic⁴ and associated with non-compliance with treatment and with refusal of rehabilitation programmes. It is diagnosed and treated much less frequently than would be the case if the patients were free of physical illness.⁵ This is probably because doctors perceive a lack of effective treatments. It is likely, however, that rehabilitation is effective, at least partly through an effect on psychological symptoms, and psychological treatments should be used if available. Few trials of antidepressant drugs have been carried out in these patients, but the risks of using such drugs have probably been exaggerated.⁵ High quality trials of these treatments are urgently needed.

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Women with urinary incontinence should be referred to a specialist

EDITOR,—Arnfinn Seim and colleagues give some useful reminders about improvements that can be achieved by treating urinary incontinence in women in general practice.¹ At the end of their study, however, 80% of the women were still incontinent to some extent. It is interesting that only 16% of the patients were referred for specialist opinion. In the long term it may be better for patients to be referred for expert diagnosis and treatment, to avoid some of the long term financial and social burdens of prolonged incontinence.² When the prospect is many years of incontinence (the youngest patient was only 20 years old) a referral to a specialist—who can perform urodynamic tests, make an accurate diagnosis, and devise a management plan—is preferable to making an unsupported diagnosis and providing treatment that may be inappropriate. Obtaining a good clinical history of bladder disorders is known to be difficult, so if treatment is to be based on the history alone then treatments that are effective in both common forms of incontinence (genuine stress incontinence and detrusor instability) are probably more appropriate—for example, pelvic floor exercises.³

The trial was undoubtedly performed by a team interested in this subject and method of treatment, and I suspect that the results would not be as good if the trial was repeated by a less enthusiastic set of practitioners. Although, as a hospital urogynaecologist, I would not like to see my urodynamic clinics overrun, I would like more than 20% of patients to become fully continent.

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1 Seim A, Sivertsen B, Eriksen BC, Hunskaar S. Treatment of urinary incontinence in women in general practice: observational study. *BMJ* 1996;312:1459-62. (8 June.)

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Interventions in childbirth

Medical intervention is not synonymous with loss of dignity

EDITOR,—In her effort to empathise and share the experience of childbirth with her daughter in law, Ann Oakley (a professor of social science) offers a one sided view of care in labour.¹ I can assume only that her personal involvement has caused her to be unable to appraise the event with objectivity or professionalism.

Although, as a sociologist, Oakley has witnessed many labours, she repeatedly misinterprets the best of professional intentions. Obstetric practice may well have had—and probably still has—shortcomings. But in describing former practices that were attempts to minimise the incidence of puerperal sepsis as "dehumanising" Oakley does not sufficiently consider the reasons for the practices and implies intent to take away the dignity of the labouring mother. The idea of doctors "hovering with their forceps outside the door" having to be overcome by midwives brings images of bizarre behaviour to mind. Does Oakley really believe that obstetricians would choose to lose sleep rather than lose

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."

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- 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.

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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.

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- 1 Russell R, Dundas R, Reynolds F. Long term backache after childbirth: prospective search for causative factors. *BMJ* 1996;312:1384-8. (1 June.)
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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.

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- 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 postnatal backache would be expected to be greater in the population who have epidural analgesia, given their more complex labours. The appar-