may not prove to be cause and effect. The fetal abnormalities caused by thalidomide and the oculomucocutaneous syndrome caused by practolol were brought to doctors' attention by letters to the *Lancet*[1] and the *BMJ*[4] respectively, and in each case the association was quickly confirmed by further reports.

In contrast, associations may prove false alarms which cast an unwarranted blight on a useful drug. One such was the report associating skeletal malformations with Debendox,[5] which has not been confirmed by later large-scale studies[6] but played a part in the loss of public and medical confidence in the use of the drug by pregnant women.

The *BMJ*'s current policy aims at steering a path between the extremes of crying wolf too often and insisting on near-certain evidence. In general, we are likely to accept a report of a drug side effect if it describes more than one case and if the evidence points clearly to a single drug. Something more than simple coincidence in time is usually required—rechallenge (with the patient's informed consent) or immunological investigations may tip the balance of probabilities. Two other vital sources of information should be checked by authors before submitting a report: Has the manufacturer been told of any similar episodes? And have any reports been made to the Committee on Safety of Medicines?

[1] McBride WG. Thalidomide and congenital abnormalities. *Lancet* 1961; ii:1358.
[2] The Sundy Times Insight Team. *Suffer the children: the story of thalidomide.* London: Andre Deutsch, 1979.
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[5] Donnai D, Harris R. Unusual fetal malformations after antiemetics in early pregnancy. *Br Med J* 1978;i:691-2.
[6] Harron DWG, Griffiths K, Shanks RG. Debendox and congenital malformations in Northern Ireland. *Br Med J* 1980;**281**:1379-81.

Episiotomy

Childbirth in Britain has never been safer than it is today, though we are not yet among the European leaders in the league table of lowest maternal and perinatal death rates. Understandably, pregnant women, their husbands, and doctors are all paying more attention to subtler aspects of care, especially those concerned with making the experience of pregnancy and childbirth more comfortable and pleasurable. With increasing insistence individual women, and sometimes well-organised groups, are asking whether some procedure is manifestly to the advantage of mother and baby or amounts to unnecessary interference by doctors. Among the targets have been the steadily rising incidence of induction of labour (the subject of considerable debate a few years ago[1–5]), forceps delivery, and caesarean section; and the whole matter of intervention in obstetric practice was recently the subject of special study at a scientific meeting organised by the Royal College of Obstetricians and Gynaecologists.[6]

The spotlight of public concern has now moved on to episiotomy. The National Childbirth Trust has recently published a collection of essays[7] on the physical and emotional aspects of episiotomy with contributions from obstetricians and midwives, concluding with Sheila Kitzinger's assessment of its effects on postnatal sexual adjustment. On page 243 Reading *et al* report their account of patients' attitudes towards the pain and discomfort that may occur after episiotomy. All these studies show how many questions remain unanswered.

Here is a surgical procedure widely used by doctors and midwives, yet we have few objective data to support claims that perineal incision performed correctly at the appropriate moment eases delivery, protects the head of a small baby from trauma, is more easily repaired than a ragged tear and will heal more quickly and effectively, is less liable to infection than a bruised and torn perineum, and reduces the risk of later complications such as dyspareunia and prolapse. Reading *et al* were largely concerned with the discomfort associated with episiotomy, and the findings are disturbing: many women had severe pain at the time and afterwards, and nine out of 10 who subsequently experienced dyspareunia attributed this directly to the episiotomy scar.

In some aspects, the study of Reading *et al* confirms work[8] that the *BMJ* discussed in 1973,[9] and the questions remain the same. Unfortunately we still do not know whether the pain associated with episiotomy is greater or less than that associated with a perineum that has been allowed to become bruised and torn. On first principles most—though not all[10]—obstetricians would argue that a clean surgical incision in the perineum, correctly timed and repaired, is more likely than a ragged, bruised tear to heal by first intention and cause less trouble at the time and later. But it would be helpful to have firm evidence to support or refute this belief. And as women themselves become better informed and more articulate they are sure to have strong views on this important subject. It would, however, be a pity if clinical practice were changed on insufficient evidence because of a patient-led protest. The answers should come from clinical research.

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[1] Anonymous. A time to be born. *Lancet* 1974;ii:1183-4.
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Children's accidents

1980 was designated Year of the Child and 1981 International Year of Disabled People, and all too often the two concepts overlap. Increasingly, accidents have become a main cause of mortality and morbidity in children of all ages. Reduction in mortality from infectious disease and improvements in chemotherapy and surgery have reduced infant and childhood mortality from other causes, with a consequent increase in the proportion attributable to accidents.

Concern about children's accidents has been given a focus with the formation of the Child Accident Prevention Committee, which is supported by Government and voluntary funding. In conjunction with the BBC, the Health Education