miscarriage, of whom 12 said that they would like to have been shown the products of conception even if no fetus could be identified. The desire to see he fetus or products was not related to the patients' age, parity, marital status, gestation, or planning of the pregnancy.

These results indicated that one third of patients would like to be offered the opportunity of seeing the fetus after a spontaneous miscarriage. Whether such a measure would help the patient to grieve remains to be determined. In the absence of scientific proof, however, there is a strong case for acceding to the wishes of the parents if they ask to see the fetus after a spontaneous miscarriage. Miscarriage is the commonest complication of pregnancy, but we still have much to learn about the best way to help couples to come to terms with their loss.

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1 Awoonor-Renner S. I desperately needed to see my son. *BMJ* 1991;**302**:356. (9 February.)
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Early pregnancy assessment

SIR,—The article by Drs M A Bigrigg and M D Read exemplifies how by reorganising their obstetric services they could offer a better care and cost effective service for their patients with problems in early pregnancy.[1] The result of their study may also be well taken by the hospital managements who with the new trust arrangements would be happy to look into the cost effectiveness of any service offered under their trust care system.

Drs Bigrigg and Read have omitted to mention who actually undertakes the ultrasonography on their patients—are their patients referred to the radiographers or is this service offered by the obstetricians? If it is done by the obstetricians it serves two purposes: diagnosis and further management counselling.

It is heartening to report that North Devon District Hospital has been offering such care and cost effective treatment to its patients referred with bleeding or pain in early pregnancy, within limited medical staffing resources, and without the need for reorganisation of its gynaecology and obstetric services. The key point in being able to offer such a service by this unit is the fact that ultrasonography is undertaken by the consultants or registrar with the Toshiba sonolayer LSAL-77A with curvilinear abdominal transducers, which is installed in the maternity unit and is available for use any time of the day or night.

This hospital serves a population of 150 700 and receives patients within a perimeter of about 72 km. The obstetric and gynaecological medical team consists of three consultants, one registrar, and three senior house officers. Women requiring assessment for bleeding or pain during early pregnancy, who are otherwise in satisfactory general condition, are accepted by the house officer on behalf of the consultant on call. Once the patient arrives at the hospital a brief history is taken, and a sample of venous blood is taken for full blood count and blood group analysis. Ultrasound scanning sessions are arranged between the morning and afternoon scheduled sessions, and the patients are scanned and counselled. Patients needing evacuation of the uterus are often dealt with as an additional case added on to the end of the afternoon gynaecological operating list, and rarely some cases spill beyond the routine operating list. Other patients not requiring further treatment are discharged with further follow up appointments if necessary.

This policy is also helpful in dealing with the extra load of work during the summer, when the district receives many holidaymakers and some of these women reach the hospital with early pregnancy complications. Although this practice of early assessment sometimes puts pressure on the consultant or registrar who undertakes the scanning procedure to decide further management, it is of greater benefit to the patient and to the hospital management.

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1 Bigrigg MA, Read MD. Management of women referred to early pregnancy assessment unit: care and cost effectiveness. *BMJ* 1991;**302**:577-9. (9 March.)

Epidural analgesia and maternal satisfaction

SIR,—Dr J D Murphy and colleagues state that by adding fentanyl to conventional bupivacaine for epidural analgesia in labour it is possible to improve maternal satisfaction and increase the chances of a normal vaginal delivery.[1] Although the former assumption may be correct, their overall results suggest that a normal vaginal delivery with epidural analgesia is the exception rather than the rule.

The results indicate an overall rate of normal vaginal deliveries of only 35% (30/85), a rate of caesarean sections of 20% (17/85), and a rate for a combined (simple plus rotational) forceps delivery of 40% (34/85). I suggest that this is not normal, particularly as the authors state in their methods that they were dealing solely with primiparous women at term with a singleton fetus and with a cephalic presentation.

This category of women is the basis of the active management of labour,[2] and the hospitals that adopt this policy in labour have remarkably constant figures for caesarean sections and forceps deliveries for their primigravid population. Indeed, the latest annual report from the maternity hospital in Dublin showed a rate of non-elective caesarean sections of 6% and of forceps deliveries of 11·9% in primigravidas.[3]

I realise that Dr Murphy and colleagues are anaesthetists and therefore are not responsible for the obstetric management of their delivery unit. None the less, I think that the reason for the overall low percentage of normal vaginal deliveries coupled with the high rates of caesarean section and forceps deliveries should have been stated in their paper. If these figures are par for the course in their delivery unit—and I would hope they are not—then better management of the mother's labour rather than her analgesia might give her greater satisfaction in the end.

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1 Murphy JD, Henderson K, Bowden MI, Lewis M, Cooper GM. Bupivacaine versus bupivacaine plus fentanyl for epidural analgesia: effect on maternal satisfaction. *BMJ* 1991;**302**: 564-7. (9 March.)
2 O'Driscoll K, Meagher D. *Active management of labour*. London: Baillière Tindall, 1986.
3 National Maternity Hospital. *Clinical report for the year 1989*. Dublin: National Maternity Hospital, 1989.

SIR,—It seems that the two main conclusions of Dr J D Murphy's study on epidural analgesia during labour are that there was greater maternal satisfaction and fewer operative deliveries in women receiving epidural bupivacaine and fentanyl versus bupivacaine alone.[1] Both are in question as the inherent difficulties in this type of study were not overcome.

The woman and the anaesthetist were aware of whether she was receiving one or two drugs. The use of an analgesic depends on the patient's and the anaesthetist's perception of the effectiveness of the drug. Thus, where the principal aim of a study is to assess a soft end point, such as maternal satisfaction, more rather than less effort must be made to blind the receiver and deliverer of the drug(s).

Furthermore, no statement was made to suggest that the anaesthetists (preferably few) were standardised. It can only be assumed that the anaesthetists concerned were whomever happened to be "on that night."

It is also very unlikely that the obstetricians who "were not told which treatment each mother had received" could not have spotted (and indeed needed to know) which drug was being given. The obstetrician's decision to proceed to operative delivery is based in part on maternal comfort. The important difference between the operative deliveries is that the two groups cannot therefore be attributed to the differences in analgesia, as was suggested.

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1 Murphy JD, Henderson K, Bowden MI, Lewis M, Cooper GM. Bupivacaine versus bupivacaine plus fentanyl for epidural analgesia: effect on maternal satisfaction. *BMJ* 1991;**302**: 564-7. (9 March.)

AUTHORS' REPLY,—We are aware that the likelihood of a normal vaginal delivery is disappointingly low for primigravid patients who choose epidural analgesia in our hospital but without altering obstetric practices, which have an obvious influence, we have shown that the anaesthetists' management of epidural analgesia can also affect the mode of delivery.

In answer to Dr Stein's letter, the mothers, obstetricians, and the anaesthetists who interviewed mothers after delivery were all unaware of the epidural treatment used. The epidurals were inserted and managed by the first three authors of our paper. Dr Stein's assertion that maternal comfort may have influenced the obstetricians' decisions about operative delivery is not supported as we showed similar analgesia in both groups of mothers.

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Organisation of antenatal care

SIR,—In his discussion of the various styles of antenatal care[1] Professor Geoffrey Chamberlain did not mention community antenatal care schemes. Although perhaps not numerically important, they have brought benefits to both mother[2] and baby[3] and have helped with administrative difficulties such as late booking[4] and high defaulter rates.[5] In Huntingdon, where all the consultants visit general practitioners in the area, the perinatal mortality rate in 1987-9 was 4·6, the lowest in the country.[6]

The Tower Hamlets community antenatal care scheme with which we are involved has not only helped make antenatal care more convenient and personal for women but also produced obstetric