

Safety and risk in practice

Midwives: A hopeful trend

The fact that birth is a physiological process, which in the great majority of instances does not call for the services of a doctor at all, has often enough been touched upon in this *Journal*, but in parts of the developed world, and particularly in North America, the medical obstetrician is still prone to regard birthing as his (or her) prerogative and midwifery as little more than an archaic institution providing second-rate care. Despite the excellent standard of midwifery training in almost every country (and evidence, discussed elsewhere in this issue, that doctors may be too prone to have recourse to caesarian section), that attitude has been slow to change. Canada's Alberta province took a small step in the right direction in December 1999 with legislation allowing "non-physician practitioners such as midwives to admit patients to hospital and to use diagnostic services such as X-rays and ultrasound". Since then, five of the province's 17 regional health authorities have been busy drawing up plans for incorporating midwives into their hospitals. Permitting midwives to practise in hospitals had been a contentious issue because obstetricians and other specialists whom they consulted did not receive a consultation fee; such fees were paid only when a family physician asked for the consultation. Thanks to money set aside by Alberta Health's Innovation Fund, however, these physicians will now receive their full consultation fee. As one might have suspected, money was at least in part at the root of the problem. And Alberta's mothers-to-be will still have to pay for midwifery services in hospital out of their own pockets. . .

Reference

- [1] M. Vlessides, Alberta allows midwives to practice in hospitals if patients pay, *CMAJ* **163** (2000), 74.

Fraud most foul

Fraud in medical research is reprehensible at the best of times; when exposed it is largely treated as a matter of breached medical ethics, and the sanctions are as a rule only disciplinary. What is often left out of consideration is the risk to the patient whose treatment has been based on fraudulent claims. That issue cannot be overlooked when the fraud concerns high-risk treatment of serious illness. Dr Werner Bezwoda has now been dismissed from South Africa's Witwatersrand University Medical School after falsifying cancer research data. In 1999 he reported in a paper for the American Society of Clinical Oncology on successful use of a controversial treatment for breast cancer, involving both high dose chemotherapy and subsequent bone-marrow transplantation. In his study of 154 women with "high risk" breast cancer he had claimed to detect an increased survival rate and lower relapse rate with this treatment than with a more orthodox low-dose approach. The findings were in flat contradiction to those of other researchers. Only later did it emerge that his control group was not receiving conventional therapy but was the subject

of another experimental form of treatment. Since the fraud was discovered – and admitted to be deliberate in an attempt to flatter the findings – the largest health insurer in the USA has announced that it will no longer finance the controversial treatment.

Reference

- [1] *South African Medical Journal* **90** (2000), 333–334.

Cervical cancer: Post-surgical irradiation or not?

One of the most common errors in medicine is over-treatment; and when the over-treatment becomes a habit and the habit becomes a dogma a great deal of harm can be done. There is no reasonable doubt that many women who have undergone surgery for cervical carcinoma in stages 2 or 3 will benefit from subsequent irradiation; there is little doubt that for many other women, whose cancers have not proceeded beyond stage 1, it will be no more than an additional and toxic burden which does not enhance their prospects for survival, even though the chance of local recurrence may be reduced. For all that, follow-up irradiation has become customary. One of the few investigators who has challenged the conventional wisdom is Carien Creutzberg, a Rotterdam oncologist whose work (published in *The Lancet* early in 2000) provides remarkable evidence that, provided the tumour has not developed beyond the cervix at the time of operation, there is no point in irradiation. Her study of 715 women with an average age of 66 showed that the risk local recurrence was reduced by irradiation from 14 to 6%, but that survival rates and times were entirely unaffected. Analogous work in Britain is still underway, but the Rotterdam study has led Holland's gynaecologists and radiotherapists to agree that post-surgical irradiation of stage 1 patients should be abandoned.

Reference

- [1] Anon: Bestraling van baarmoederkanetr vaak onnodig, *Algemeen Dagblad (Rotterdam)* (May 12, 2000).

Endophthalmitis as an iatrogenic complication

Endophthalmitis is a rare but very serious complication, not only of penetrating injury to the eye but also of ophthalmic surgery; all too often, despite such radical steps as vitrectomy, it leaves to virtual loss of sight. Eyvind Rødahl of Norway's Haukeland Hospital at Bergen, has examined 34 cases of endophthalmitis seen at the hospital over a period of a decade. Fourteen of the cases followed ophthalmic operations, generally on the lens, and most of them arose within 1–11 days after surgery, though occasional cases developed much later. Compared with the total of some 10,000 ophthalmic operations carried out during that period the risk is a small one, but disastrous for the individual victim. There is clearly a place for a well-chosen antibiotic umbrella when such surgery is undertaken.

Reference

- [1] E. Rødahl, Endoftalmit, *Tidsskr Nor Laegeforen* **120** (2000), 669–674.

Thiazides – cheapest and safest?

In most areas of therapy one can identify one or two advances, achieved at some time in the mid-twentieth century, which have been so significant that they still retain their place despite all efforts to supercede them. The treatment of hypertension is most certainly a case in point. Around 1950, high blood pressure was very commonly being treated with the unpleasant rauwolfia derivatives and the positively dangerous alpha-blockers. By 1955 the first of the thiazides had arrived, providing a simple and safe means of bringing blood pressure down to normal in the great majority of patients requiring any treatment at all. Chlorthiazide was soon followed by hydrochlorthiazide which remains as of the twenty-first century a drug of choice for very many cases. It was soon appreciated that in some instances one might need to supplement it with a little potassium (or a potassium-saving diuretic), and a decade later the role of thiazide treatment was enhanced by the arrival of the first effective beta-blocker. Have these drugs ever been supplanted by anything safer and better? In our distinguished contemporary the *Canadian Medical Association Journal*, James Wright of Vancouver concludes in the light of a thorough review that in hypertension “low-dose thiazide regimens are equivalent to or better than other classes of drugs for each of the specific goals of therapy. Therefore, the best first-line therapy for the management of most patients with hypertension is a low-dose thiazide regimen.” Significant is that he still regards hydrochlorthiazide itself as the staple, and that the one-time fear of potassium depletion has receded significantly with the use of doses as low as 12.5 mg, which is common enough; nor have the fears once voiced that lipid changes might be problematical with the diuretics proved to be a significant problem. The World Health Organization’s “Essential Drugs” approach still relies heavily on the old thiazides in treating high blood pressure, despite the fact that in richer countries newer drugs which cost a great deal more (and bring with them much more in the way of adverse effects) have as a result of massive publicity edged their way into the forefront of the market. It is good to see that, here at least, the simplest and cheapest way of doing things still seems to be safest.

Reference

- [1] J.W. Wright, Choosing a first-line drug in the management of elevated blood pressure: What is the evidence? Part 1: Thiazide diuretics, *CMAJ* **163** (2000), 57–60.