Science meets politics at the National Forum

Kudos to Michael Kramer[1] for articulating a major problem in the relationship between health policy and research evidence. Several years ago I was invited to write a National Forum on Health position paper on the prevention of adverse pregnancy outcomes. In terms of incidence and economic and social impact, preterm birth is the main adverse pregnancy outcome in North America. After a critical appraisal of evidence regarding the effectiveness of programs to prevent preterm birth, I concluded that the Canada Prenatal Nutrition Program should be discontinued.

Although I knew that my conclusion would be unpopular, I had no idea that I would be caught in a maelstrom of invective, rhetoric, and personal attacks from National Forum reviewers. Their comments reflected the tension between health promoters and epidemiologists, to which Kramer referred. More disturbing than the personal attacks was the evidence that the reviewers had little skill in critical appraisal of research evidence. In an attempt to correct the latter problem, my next version of the position paper included a section on the main sources of bias in epidemiologic research designs and how these biases led to faulty conclusions about the effectiveness of the Women, Infants, and Children Program in the US, and about similar programs in Canada.

After many months of rebuttal and debate, and struggles to rewrite without compromising my professional integrity, I decided I had wasted enough time and refused to participate any further. Subsequently I was told that my conclusions could not be refuted but were too controversial and that someone would be assigned to rewrite the paper. This position paper went unpublished — in any form. Perhaps nonpublication conveys the same message my paper did: although we know little about how to prevent preterm birth or most other adverse pregnancy outcomes, we do know that our current health promotion programs are ineffective.

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Reference

1. Kramer MS. Maternal nutrition, pregnancy outcome and public health policy. *CMAJ* 1998;159(6):663-5.

Doctors within Borders?

I recently received a letter from Médecins sans Frontières (MSF) /Doctors without Borders. It asked for money, of course, and I was quite happy to donate $100, knowing full well that $100 spent in Africa will do far more good than $1000 spent here. I knew this because I spent the early part of my career there. Indeed, 2 of my children were born in a rural hospital on the Uganda/Kenya border. My experiences in Africa have proved important during my subsequent career as a rural GP in British Columbia.

The MSF letter was accompanied by a list of physicians currently working in Africa and other parts of the world, and it was interesting to learn that they all came from Canadian cities. Why are these physicians so willing to work overseas and so unwilling to work in rural areas in their own country, where they are so badly needed? Twenty-five years ago the town I live in had 7 Canadian graduates working full time; today it has one. Why? Are young Canadian graduates not suitably trained? Are they afraid of the lawyers and the colleges? Are they afraid of working too hard?

Thank God for South Africa. May it continue to supply MSF services in Canada, even as doctors from Toronto, Montreal and Vancouver provide them outside our borders.

R.G. Holmes, MB
Merritt, BC

Defining futility

The paper by Charles Weijer and colleagues on dealing with demands for inappropriate treatment[1] did a good job of clarifying this difficult area of clinical care, but the case example involving cardiopulmonary resuscitation (CPR) is out of touch with clinical reality. In fact, it missed what I think is the central cause of

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