



Mbewu ducks AIDS deaths

To the Editor: As public health specialists we read with dismay a recent Medical Research Council (MRC) media release,¹ later reprinted in the press,² written by Mbewu in both his personal and official capacities as the interim president of the MRC. Entitled 'Deaths, causes of deaths and rumours of deaths', the piece appeared to be an intervention in a debate on whether the burden of AIDS deaths can be inferred from explicit death certification alone. It asserts, *inter alia*, that 'cause of death information from death certificates are the most reliable and validated measures of mortality and changes in mortality'.

We conclude from the timing of the release that it was produced in anticipation of a report on death certifications by Stats SA requested by President Mbeki and that it was directed, *inter alia*, at a publication by MRC and University of Cape Town researchers of an empirical analysis of death certifications designed to arrive at a complete picture of HIV-related deaths.³

There are many reasons why HIV might not appear on the death certificate of a person who has died an HIV-related death, and a substantial discrepancy between the raw data and the empirical estimate was expected. There is nothing sinister about this discrepancy, nor does there appear to be any conflict of opinion between government statisticians and epidemiologists about the need to apply empirical analysis and demographic modelling to death certificate data to estimate the burden of AIDS deaths needed for public policy making.⁴

Unfortunately, instead of clarifying matters for the public, the media release expends considerable space in defending death certification as a 'gold standard' for public policy making and suggests that it is mainly in developing countries with inadequate death registration coverage that epidemiological analysis is needed. In putting forward this argument the release appears to confuse certification of the fact of death with certification of the medical cause of death, and fails to make the distinction between immediate and underlying cause of death.

Ignorance as to the deceased's HIV infection status and various pressures to maintain confidentiality where such status is known are obvious reasons why a medical practitioner may not certify HIV infection as the underlying cause of death on the death certificate. Further, contrary to what is asserted in the press release, medical practitioners are generally poor at accurate cause-of-death certification to the degree required for epidemiological analysis and public policy.⁵ They have little if any training in such certification. There is a large international literature showing this in relation to many conditions, let alone one attended by as high a degree of fear and stigma as AIDS. To take a local example, a recent study of death certification at a provincial teaching hospital found that 78.9% of 304 deaths in

1 year were certified as due to 'cardiorespiratory failure', an uninformative category.⁶

It is to the credit of the government to have improved death registration coverage and to be able to provide the data to which scientific reasoning and techniques can be applied to get the best estimate of the toll of AIDS and other causes of death. To try to diminish in the eyes of the public the essential role of science in this combined effort is a strange and unfortunate role for the interim president of a science council to play. The effect is to undermine the value of scientific reasoning and an evidence-based approach to public policy that we would expect to be championed by the MRC.

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Criteria for chronic dialysis

To the Editor: Chronic kidney disease and kidney failure are serious health problems in any society. The fact that these disorders are highly prevalent in our developing country and substantially increase the risk of hypertension and death from cardiovascular disease has made chronic kidney disease an important public health problem for all South Africans. Furthermore, it is recognised that economic disparities and competing public health problems in South Africa have made it far more difficult to formulate a series of standards that could be applicable to all individuals with chronic kidney failure. With the shortage of transplantable organs, dialysis is often the only form of adequate renal replacement therapy. When these patients develop end-stage kidney failure the aim of selection



for dialysis (haemodialysis or peritoneal dialysis) should be to use scarce resources to provide maximum benefit while affording such patients a good quality of life. Race, colour, creed, political affiliation and chronic disease (such as diabetes) should not influence selection and age should not be a criterion either.¹ Moreover, patients suffering from hepatitis B and C or HIV should not be excluded from dialysis therapy especially when receiving concomitant antiretroviral therapy, as their outcomes are similar to those of non-infected patients.²

To this end selection should be the responsibility of the treating nephrologist together with the nephrology team (social workers, psychologists, nursing staff) who are best qualified to judge prognosis and benefit from therapy. Patients with a poor overall prognosis, as assessed by the nephrologist and team, should receive optimal conservative therapy.

Response to therapy, patient outcomes and cost-effectiveness of treatment should be monitored, both by the treating dialysis units and by a peer-reviewed national nephrology forum or registry. Such close monitoring will not only improve the patient's lot but will also ensure adequate and economic dialysis in the private and public sectors.

Gone are the days when the state should be allowed to make draconian decisions on patient management, and I believe it is essential that all parties involved in dialysis therapy be consulted before any national criteria for dialysis are adopted.

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Caesarean section — claims and concerns

To the Editor: The article on caesarean section (CS) in a recent issue of the *Journal*¹ raises many interesting points. Unfortunately your senior news journalist does not reveal his sources so we have no way of verifying the claim that in

privately funded health facilities 65% of women deliver their babies by CS compared with 10 - 20% in public health facilities, or that 65% is 'almost double the percentages in the UK and USA'.

Nevertheless, assuming that these claims are correct and while costs of medical care are always a concern, surely our primary interest must be health outcomes? In this regard it would be interesting to see comment on the respective morbidity and mortality rates for babies born by CS compared with those delivered pelvically. To eliminate compounding variables, that study would presumably best be done in our public institutions. Anecdotally, the virtual absence in our practice of hypoxic ischaemic encephalopathy following elective CS suggests that CS may be of protective benefit to the child.

Of equal concern are the effects on women of ill-advised vaginal delivery. While the focus of these articles is usually on rates of CS and the direct cost of that mode of delivery, I have not seen commentators reflect on the substantial longer-term cost of repairs to the damaged pelvic floor and perineum in women who have delivered their babies vaginally. The psychological and physical morbidity related to urinary stress incontinence, cystoceles, rectoceles, prolapse, anal incontinence, dyspareunia, etc. is substantial. Any sensible economic appraisal of costs of caesarean versus pelvic 'normal delivery' ought to compute the costs of repair of the pelvic floor, vagina and perineum later in women's lives.

I am a paediatrician in private practice with part-time public hospital appointments. I am in favour of the mode of delivery that in each case brings the best health outcome to mother and baby. I believe that patients enjoy certain rights under our constitution, one of which is to make informed decisions about procedures and interventions that may affect their health and the health of their babies. I am also, therefore, pro choice.

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