



Valuing human life above that of aquatic invertebrates

DDT was first synthesised in 1873, but it was not until 1939 that Paul Muller of Geigy Pharmaceuticals discovered its effectiveness as an insecticide, for which he was awarded the Nobel Prize in physiology in 1948. DDT was used to great effect in combating mosquitoes and lice during World War II, virtually eradicating malaria and typhus in the affected areas. After the war it was used extensively in countries with malaria with similarly dramatic results, saving over 25 million lives according to the WHO.

Then in 1962 American activist Rachel Carson, regarded as the mother of the environmental movement, published an emotional book called *Silent Spring*, in which she painted a picture of a future world without birds, insects or fish, and of humans dying from cancer and other diseases as a result of the widespread use of DDT. The book caused a huge public outcry in the US, and eventually led to a DDT ban across the world. But her claims were never validated. A 2004 study in the *Journal of American Physicians and Surgeons* concludes: 'Public pressure was generated by one popular book and sustained by faulty or fraudulent research. Widely believed claims of carcinogenicity, toxicity to birds, anti-androgenic properties, and prolonged environmental persistence are false or grossly exaggerated.'

While DDT is thought to be toxic to certain species of aquatic invertebrates, it is quite innocuous in humans. But the ban on DDT has cost millions of lives around the world, not least in South Africa, as is dramatically demonstrated in the report by Maharaj, Mthembu and Sharp (p. 871).

Would you do *in vitro* fertilisation for an HIV-infected woman?

In their editorial 'Supporting the sexual and reproductive rights of HIV-infected individuals', Myer and Morrone (p. 852) argue the case for sexual and reproductive rights for HIV-infected individuals, noting that 'in some settings, health care providers may have a negative attitude towards sexual activity and child-bearing by HIV-infected women'. They believe that in counselling patients on antiretroviral treatment, too much emphasis is placed on the provision of contraception, and not enough on 'broader issues of reproductive choice'.

They assert that 'autonomy in decisions whether and when to have children is a widely recognised component of human rights', and that 'there are few situations in which individual choices around sexual activity or childbearing are overruled by

health care providers or policies'. They go on to point to the stigmatisation that comes with childlessness in much of South Africa, and aver that denying HIV-infected women the right to have children 'may compound pre-existing psychosocial concerns for many women'.

No one can quarrel with this line of thinking in principle, but it does raise at least two vexed questions, both having to do with boundaries. May a health care provider counsel *against* a patient's choices on account of health risks? It is generally accepted, for example, that one can and should counsel teenagers against getting pregnant, for social and health reasons. Pregnancy is not without risk for the HIV-infected woman (HIV infection has become a major contributor to maternal mortality) and her baby. Would it be wrong to counsel *against* it in individual cases?

The authors plead that 'health policies must support the availability and accessibility of relevant [reproductive] services including contraception, pregnancy planning ...' etc. Are there boundaries to what the health service might be expected to support with regard to a desire for pregnancy? Might such services include facilities for infertility workup and, to use a caricature, even *in vitro* fertilisation?

What causes cot death? Take your pick

Prone sleeping position; excess bedding and clothing; maternal smoking or alcohol use; long QT syndrome; *Helicobacter pylori*; bed-sharing with a parent; inhalation of toxic gases released from the linen; brainstem abnormalities ... the list goes on, according to this enthralling account by Kibel, Molteno and De Decker (p. 853). There is no real definition of cot death, either. The syndrome is merely described as unexpected sudden death during sleep in a child under one year of age, for which no cause is found after exhaustive investigation.

The suggestion that infants should sleep in a supine position with minimal bedding accords with common sense. But contradictions abound in cot death research. Whether you should sleep with the baby in your bed depends on where you are in the world. If you are in Australia, the baby will be exposed to a higher risk of SIDS; if in Japan (or in Africa and you are black), to a lower risk.

Among the many fascinating theories is the hypothesis that cot death is caused by noxious gases secreted in the cot by fungi that thrive on arsenical biocides used in PVC sheeting. Older bedding is more likely to be infested, which may be the reason why second- and third-born siblings sleeping in used cots are more likely to die from SIDS.

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