

## Health care in Iraq

Sir—Many people probably do not know the horrible health situation in Iraq under the United Nations sanctions. The health service has come to a halt. During operations, many surgeons find that items are missing, especially the appropriate sutures and instruments. On many occasions, I have sutured the abdominal wall with catgut or silk instead of nylon.

Would anyone believe that sometimes we reuse the nasogastric tubes and surgical blades. Actually we no longer use a scrubbing brush before surgery and use only cheap soap and water.

On the wards the situation is worse where no painkillers are available most of the time. The choice of vital medications and antibiotics is so limited that sometimes only porcine penicillin is available for intramuscular injection and nothing is available for patients who are allergic to penicillin. Unfortunately, the situation has not changed much after the Memorandum of Understanding and doctors and patients continue to suffer. The world should realise the depth of this disaster and do something to rescue the patients of Iraq.

Q F Baker

Department of Surgery, Baghdad Teaching Hospital, Baghdad, Iraq

## Health-care camps for the poor provide mass sterilisation quota

Sir—The World-Bank-financed India Population Project VIII referred by Sanjay Kumar in his April 10 news item (p 1251)<sup>1</sup> operates in the urban slums of four cities in India (Delhi, Calcutta, Bangalore, and Hyderabad) to provide a full range of reproductive and child health services to the urban poor. The project has been exemplary in its partnerships with non-governmental organizations, particularly in Hyderabad. The Bank is concerned about the allegations of forced sterilisations and the use of incentives. We have received assurance from the state government that it has not reinstated the practice of targets and incentives for sterilisation and that it would take appropriate action if, indeed, the allegations have substance. When sterilisation is the method of choice, the World Bank reiterates its commitment to ensure such procedures are safe and done on a voluntary basis.

As Kumar rightly states, the World Bank is committed to the target-free

approach to family planning. The bank has endorsed and is a strong advocate of the International Conference on Population and Development (ICPD) Programme of Action. By linking population to poverty reduction the social development and by integrating family planning, maternal health, and the prevention of sexually-transmitted infections. The ICPD has shifted the focus from demographic targets and controls to a people-centred, rights-based approach.

India was one of the first countries to adopt the target-free reproductive health approach advocated at the ICPD. The World Bank has supported the national and state governments' shift from a system of numerical, method-specific targets and monetary incentives for providers, to a broader system of performance goals and measures that focus on a range of reproductive child health services. We are also aware that the Government of Andhra Pradesh's stated population policy and Vision 2020 aims to reduce population growth from 1.6% to 0.8% by 2020 through strategies of increasing the women's literacy and a total commitment to reproductive and child health approach, which emphasises client-based services that allow the community to decide its needs.

Tom Merrick

Human Development Network, World Bank, Washington DC 20433, USA

- 1 Kumar S. Health-care camps for the poor provide mass sterilisation quota. *Lancet* 1999; 353: 1251.

## Use of laboratory animals

Sir—J Hagelin and colleagues (April 3, p 1191)<sup>1</sup> report a decrease in the number of laboratory animals used per published paper since 1989. They claim that this is the result of "increased efficacy", but fail to define this term rigorously. Unfortunately, decreasing sample size inevitably increases the confidence interval for any given result. What Hagelin and colleagues in fact show is that researchers are willing to accept less certainty in their results, presumably due to the increased direct and indirect cost of animals. This situation is hardly a desirable outcome.

Mark Hauswald

Department of Emergency Medicine, School of Medicine, The University of New Mexico, Health Sciences Center, Ambulatory Care Center, Albuquerque, NM 87131-5426, USA

- 1 Hagelin J, Carlsson H-E, Hau J. Increased efficiency in use of laboratory animals. *Lancet* 1999; 353: 1191-92.

## Episiotomy: a form of genital mutilation

Sir—In his 'Sketches from *The Lancet*' (April 24, p 1453)<sup>1</sup> Peter Kandela describes how over 130 years ago *The Lancet* played a part in turning support away from one form of female genital mutilation in the UK—clitoridectomy. Hopefully, you can play a part in turning support away from another form of female genital mutilation which is widespread in the UK today—episiotomy.

After their review of scientific evidence, Thacker and Banta<sup>2</sup> concluded that an episiotomy rate over 20% cannot be justified. On the basis of this and other evidence, WHO published the recommendation: "The systematic use of episiotomy is not justified. The protection of the perineum through alternative methods should be evaluated and adopted".<sup>3</sup> More recent research presents further evidence against frequent use of episiotomy.<sup>4</sup>

All this evidence shows that, compared with a natural tear, episiotomy results in more bleeding, more pain, more permanent vaginal deformity, more temporary, and long-lasting difficulty with sexual intercourse. Further, the main benefits claimed by proponents of episiotomy—prevention of third-degree tears, prevention of long-term damage to the pelvic floor, and protection of the baby from the adverse consequences of an extended second stage of labour—are not supported by the evidence.

Despite the evidence, widespread use of episiotomy continues. In US hospitals "rates for primiparous women in excess of 80% are commonplace".<sup>4</sup> Episiotomy rates for all births in Eastern Europe are essentially 100%.<sup>5</sup> On the other hand, the national episiotomy rate for the Netherlands is 8%, and the rate for planned out-of-hospital births (home or birth centre) managed by midwives in the USA is between 4% and 20%.<sup>5</sup>

Closing the gap between the evidence for and against episiotomy and the practice of episiotomy is as difficult and painful as closing the episiotomy wound. Can *The Lancet* once more help turn support away from female genital mutilation, in this case its modern form—episiotomy?

Marsden Wagner

2950 Van Ness St NW, 911 Washington, DC 20028, USA

- 1 Kandela P. Sketches from *The Lancet*: clitoridectomy. *Lancet* 1999; 353: 1453.  
2 Thacker S, Banta D. Benefits and risks of episiotomy: an interpretive review of the

English language, 1860–1980. *Obstet Gynecol Surv* 1983; **38**: 322–38.

- 3 WHO. Appropriate technology for birth. *Lancet* 1985; **ii**: 436–37.
- 4 Klein M, Gauthier R, Jorgensen S, et al. Does episiotomy prevent perineal trauma and pelvic floor relaxation? *Curr Clin Trials* 1992; **i**: document 10.
- 5 Wagner M. Pursuing the birth machine: the search for appropriate birth technology. Sydney: ACE Graphics, 1994.

## COX-2 inhibitors

Sir—Alicia Ault, in a news item (May 1, p 1503)<sup>1</sup> refers to the recent US Food and Drug Administration Advisory Committee meeting on Vioxx (rofecoxib, Merck Sharp & Dohme), and makes two errors. She says that the “FDA also advised against chronic use of rofecoxib because of safety concerns”. This is not an accurate summary of the committee’s unanimous recommendation to approve rofecoxib 12.5 mg and 25 mg once daily for the treatment of the signs and symptoms of osteoarthritis. The committee’s recommendation was based on data submitted by the sponsor (Merck & Co, Inc), which included clinical studies of 1 year and longer. These studies showed that rofecoxib 12.5 mg and 25 mg is well tolerated and clinically effective in the treatment of osteoarthritis. In addition, the committee recommended approval of rofecoxib 50 mg once daily for the management of acute pain. It was in this context that a discussion ensued about the safety and efficacy of the 50 mg dose of rofecoxib since the studies supporting the acute analgesia indication were only from 1 to 5 days.

Results were reported from a predefined, combined analysis of two endoscopy studies evaluating the gastroduodenal ulcer rate at 12 weeks. These studies compared rofecoxib at doses of 25 mg and 50 mg once daily with ibuprofen 2400 mg (800 mg three times a day) and placebo. Ault fails to mention the gastroduodenal ulcer rate with placebo. In this predefined, combined analysis the cumulative rate of endoscopically detected gastroduodenal ulcers at 12 weeks was 7.3% placebo, 4.7% rofecoxib 25 mg, 8.1% rofecoxib 50 mg, and 28.5% ibuprofen. Rofecoxib was not significantly different from placebo, and rofecoxib and placebo were significantly lower than ibuprofen ( $p < 0.001$ ).

Beth C Seidenberg

Merck Research Laboratories, Rahway, NJ 07065, USA

- 1 Ault A. COX-2 inhibitors take one step forward—and one back. *Lancet* 1999; **352**: 1503.

## A much misunderstood caduceus and the case for an aesculapion

Sir—The caduceus has been widely accepted as the symbol of medicine, but in reality the connection is tenuous, the result of the confusion between two separate images with striking visual similarities but different origins.<sup>1</sup> The caduceus is derived from the Greek word for a herald’s staff, more specifically the magic wand of Hermes (or Mercury), the messenger of the gods and the patron of trade, and is represented by a straight staff with two wings at the end and two intertwined snakes. In Greek sculpture, medicine was represented by Asclepius or Aesculapius, son of Apollo, the god of medicine, holding a knotted staff around which is coiled a single snake.

Confusion of the two symbols has led to some interesting anomalies. A physician entering the Bank of England could be excused for thinking that he had entered a medical building, because the caduceus is prominently displayed, correctly symbolising Hermes as the patron of trade (figure). But several medical bodies, including the Royal Air Force and a number in the USA, use a symbol that resembles the caduceus. Even when the Italian Medical Association changed its symbol from the caduceus to the staff and single snake of Aesculapius, a published announcement of the event failed to make the distinction clear, in referring to the latter as “the more primitive caduceus”!<sup>2</sup>

Complainants in print about this conflation of two emblems have generally failed to notice the principle route by which the caduceus entered medical symbolism—through the prominent position Hermes held in alchemy, from which were later derived chemistry and pharmacy, which led to the appearance of the caduceus on the title pages of pharmacopoeias in the seventeenth and eighteenth centuries.<sup>3</sup>

In 1556 John Caius introduced a caduceus as part of the ceremonial procedures of the College of Physicians, and unwittingly added to the confusion.<sup>4</sup> His silver rod, “to indicate that the President should act with gentleness and clemency, unlike those of older times who ruled with a rod of iron”, has four small snakes at one end. As it is now carried on official occasions by the President of the Royal College of Physicians (preceded by the Beadle or Bedell bearing the mace), it is commonly assumed that it was intended as a medical symbol. But originally, it was carried by the Bedell



The caduceus on the front door of the Bank of England

With permission of the Bank of England.

walking in front of the President, as his herald—in the College’s early statutes the alternative name given to the Bedell was Caduceator—and this arrangement continued until the College was given its mace in 1694.<sup>5</sup> Confusion also then arose as a result of the use of the caduceus by a special publisher Churchill on its title pages, which must have reinforced the readers’ perception of it as medical symbol.

For those with little or no knowledge of its classical origins, the single word caduceus is clearly more memorable. By contrast, there is no specific name for the staff and snake of Aesculapius and Nature abhors a vacuum. This must be an important factor in perpetuating the use of the term caduceus for both symbols. We, therefore, suggest that a specific name should be given to the god Aesculapius with his staff and single entwined snake in the hope that those will help to bring an end to the confusion. An appropriate name for the correct symbol of medicine is perhaps the Aesculapion.

\*Ronald Finn, David A Orlans, Geoffrey Davenport

\*Department of Immunology, Medical School, Duncan Building, University of Liverpool, Liverpool L69 3GA, UK; 70 Childwall Valley Road, Liverpool; and Library, Royal College of Physicians, London

- 1 Bremer JL. The Caduceus again. *N Engl J Med* 1958; **258**: 334–36.
- 2 Simini B. Symbolic changes afoot in Italy. *Lancet* 1997; **350**: 1085.
- 3 Schouten J. The rod and serpent of Aesculapius: symbol of medicine. Amsterdam: Elsevier, 1967: 118–19.
- 4 Royal College of Physicians of London. *Annals* 1556 vol 1, folio 15b.
- 5 Statuta Collegii Medicorum Londinii, 1555 (Bodleian MS Ashmole 1826) printed in: Clarke GN. A history of the Royal College of Physicians of London, vol 1. Oxford: Clarendon Press, 1964: 381.

## DEPARTMENT OF ERROR

*Thromboprophylaxis for atrial fibrillation*—In this Commentary by Gregory Lip (Jan 2, 1999, p 4), the sentence starting on line 8 in par 5 should have read: “For example, patients with an INR of 1.7 had twice the risk of stroke of those with an INR of 2.0”.