cal shock, neonatal ventilation and perinatal deaths shows a significant difference (1.16% vs. 0.18%, the Fisher exact 1-tailed p value = 0.03) between home and hospital deliveries. I recognize that this analysis selects outcomes post factum; nonetheless, these are important outcomes.

Hospital deliveries and births are safer, and this is why there is a selection process for assigning patients to home birth. The issue is how small the risk is to women delivering at home. Relevant risks of home birth and the risks of being transferred in labour (16.5%) need to be discussed and understood. Extensive information is available that shows lower rates of analgesia, monitoring and cesarean section at home, but this is to be expected of home deliveries.

Janssen and colleagues showed that the risks of home birth are quite low but possibly significant. An analogy may be that keeping patients in hospital for the full 9 months of pregnancy would be the safest thing to do. However, neither patients nor caregivers would consider the risks worthy of such a drastic measure. The still unanswered question is if home delivery carries a similar low risk in selected patients.

Dan Farine
Professor of Obstetrics and Gynecology
University of Toronto
Toronto, Ont.

Reference

1. Janssen PA, Lee SK, Ryan EM, Etches DJ, Farquharson DF, Peacock D, et al. Outcomes of planned home births versus planned hospital births after regulation of midwifery in British Columbia. *CMAJ* 2002;166(3):315-23

[One of the authors responds:]

We want to thank those who have responded to our manuscript. We would like to address the misconception that we were trying to create comparison groups in our study that were equal in obstetrical risk status. Although we tried to ensure that comparison groups met eligibility criteria for home birth, women who choose home birth differ from those who select hospital birth in both measurable and unmeasurable ways. This selection bias is unavoidable. The purpose of our study was not to determine which method of care was better, home vs. hospital, but rather to assess whether, at the 2-year interval, home birth was safe enough to continue to be offered as a choice for women in the context of ongoing evaluation.

Although we have expressed concern about the rates of some outcomes ("babies exposed to thick meconium who are not vigorous at birth may be disadvantaged in the home birth group"), the small numbers of mothers or babies who experienced adverse outcomes cannot justify a recommendation to avoid home birth at this time. We believe that the final statement "these comparisons are based on small numbers and warrant ongoing evaluation" reflect the possibility of a type II error, that is, lack of power to detect differences in some of the rare outcomes in our study.

With regard to Dan Farine's analysis, two of the subjects with obstetrical shock also received blood transfusions so should not be counted twice. Among the babies requiring ventilation > 24 hours, one was the baby that died during the neonatal period, who similarly should not be counted twice. With respect to perinatal mortality, note that the one perinatal death in the comparison groups occurred not in the group of hospital-intended births attended by midwives, as Farine's table indicates, but in the physician comparison group. No evidence suggests that any of the perinatal deaths in the home birth group were related to labour management at home. Composite outcome scores are normally presented separately for mothers and babies, as outcomes in the two groups are not always independent of each other. In addition, the denominators for the maternal and newborn analyses are different because only outcomes among newborns born without major anomalies were assessed. Although composite outcome scores have greater power than analyses of individual outcomes, we did not specify a composite outcome *a priori* because of the lack of validated tools relevant to babies born at term.

With respect to tracheal suctioning, we observed that only 45% of babies in the home birth group who were exposed to thick meconium and were not vigorous at birth (Apgar score less than 7 at 1 minute) received tracheal suctioning, compared with 75% in each comparison group. As a result of our observations, the Home Birth Demonstration Project Evaluation recommended to the Ministry of Health that this issue be referred to the Newborn Resuscitation Committee at BC's Children's Hospital. This committee will examine issues related to the expectation and maintenance of competency in tracheal intubation. However, maintenance of competency is a problem common to all health care providers who do not routinely practise intubation. A comprehensive approach to the acquisition and maintenance of intubation skills is needed throughout the province.

As we discussed in our interpretation section, our intrapartum transfer rate of 16.5% was well within published rates.

The small number of adverse outcomes among an essentially healthy population of women limits the power of a single study to make valid conclusions. We look forward to seeing either larger studies of home birth in Canada or pooled results from smaller studies.

Patricia Janssen
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Politics at the CMA

The CMA has proposed a "Canadian Health Charter" to the Romanow commission — yet another political stance and an example of the weak leadership so often demonstrated by our organization. The proposal restates the ideals in the Canada Health Act, but conspicuously fails to address the obvious underlying problem: a severe money shortage.

As long as the healthcare system is based on the Canada Health Act, healthcare funds can be generated only through taxation, or by diverting them from other priorities, such as education and housing. Rather than address this obvious and ultimately fatal flaw in our present system, the CMA sees fit to propose a charter that bypasses the real issue and only entrenches the attitude that the Canada Health Act is sacred and inviolate.

Should this proposed charter achieve anything approaching legal status, it is the legal profession who will be rejoicing as the various parties fight for their unaffordable "rights."

This proposal is nothing but a political declaration and does not deserve the support of the membership.

Roger Leekam
Diagnostic Radiologist
West End Diagnostic Imaging
Toronto, Ont.

Hippocrates reflect

Thank you for pointing your readers back to some ancient principles of medicine in your "Hippocrates redux" editorial.[1] I do agree that a new vision is necessary to pull modern medicine up from its current valley of disillusionment and greed. But I doubt that the new Charter of Medical Professionalism[2] will be able to chart the course up to the mountaintop once again.

A fundamental Hippocratic principle is missing in the Charter you summarized. Patient welfare, patient autonomy and social justice are empty phrases without regard for the sanctity of life. Whose welfare, autonomy and justice are we seeking? Increasingly, medicine is treading upon sacred ground, whether that is in the womb or at a dying widow's bedside. Injustice reigns when one individual is deemed worthy of life while another is snuffed out. In contrast, Hippocrates would plead that we serve to our utmost even the least of these.

Karen Stel
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Kingston, Ont.

References

1. Hippocrates redux [editorial]. *CMAJ* 2002; 166(7):877.
2. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med* 2002;136(3): 243-6. Available: www.annals.org/issues/v136n3/full/200202050-00012.html (accessed 29 Apr 2002).

Your "Hippocrates redux" editorial[1] was remarkable, not because it quite rightly concluded that a new vision is needed but because of the hyperbolic and questionable assumptions on which this conclusion was based.

While some *members* of the profession are doubtless "demoralized," it is far from clear that the *profession* is. Yes, the profession is challenged, questioning, stressed and certainly overworked, but I dispute the generalization of demoralization.

Your allegation of "debilitating cuts in health care budgets" is inconsistent with the multi billion-dollar increases in my province's spending. Restructuring issues, structural inefficiencies and inadequate resources exist, but "debilitating cuts" is inaccurate.

It is true that more than a decade ago some experts posited that physicians were cost centres and thus their numerical reduction would save money. Since then I have not seen literature that seriously considers physicians in this light. Instead, they are viewed as scarce expert resources whose skills and knowledge require careful and functional deployment.

No evidence is presented that medical schools graduate their students with a "not-so-shiny degree." While I dispute this in general, Queen's medical school continues enthusiastically to expend considerable intellectual resources on ensuring access of the best qualified and most appropriate candidates to an enriched and effective MD program. Our students are engaged in a curriculum that prepares these future physicians for a lifetime of critical inquiry, self-directed learning and confident practice. Our application numbers and offer/accept ratio [1.5:1] would suggest a functional program.

Few students graduate with "a debt of $100 000." We are profoundly concerned about the effect of debt on our students — on access, diversion, fiscal viability and stress, and on debt's effects on career choice. We assess, track and address these influences, while we prioritize maximizing offsetting supports, grants and bursaries to those in need. Support for our students has tripled in the last 3 years to a 2001 total of $1.5 million. In the 2001/02 academic year, with tuition fees of $11 500, 10% of our students received grant/bursary support above $10 000, 25% received support between $8000 and $10 000, and another 36% received substantial support below $8000. Students are also eligible for student loans.

A journal that espouses the centrality of evidence in decision-making might consider the effect on an otherwise sensible conclusion of such mythical, unsubstantiated and incorrect assumptions.

David M.C. Walker
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Reference

1. Hippocrates redux [editorial]. *CMAJ* 2002;166 (7):877.

Correction

In a recent article by Jacqueline Lewis and colleagues,[1] on the second line of page 1146, Fred Sarkis' affiliation is incorrectly given as "Spacelabs Medical." His correct affiliation is Distributor, Vita-Stat blood pressure machine.

Reference

1. Lewis JE, Boyle E, Magharious L, Myers MG. Evaluation of a community-based automated blood pressure measuring device. *CMAJ* 2002; 166(9):1145-8.