

urgency of need of people on waiting lists and encourage clinicians to use them. Finally, new measures of efficiency are needed which reflect and encourage more appropriate and effective health care. This may mean providing care in different settings and doing less in hospital, not more.

JENNIFER DIXON

Fellow in health policy analysis

SEAN BOYLE

Fellow in health policy analysis

ANTHONY HARRISON

Fellow in health policy analysis

King's Fund Policy Institute,
London W1M 0AN

- 1 Brindle D. *Guardian* 1996 May 7:1.
- 2 Brindle D. *Guardian* 1996 May 9:4.
- 3 Adams CBT. OxDONs syndrome [letter]. *BMJ* 1996;312:1297.
- 4 Bunker T. OxDONs syndrome [letter]. *BMJ* 1996;312:1297.
- 5 Court-Brown CM, McQueen MM, Christie J. OxDONs syndrome [letter]. *BMJ* 1996;312:1297.
- 6 Radical statistics. NHS "indicators of success": what do they tell us? *BMJ* 1995;310:1045-50.
- 7 *Analysing changes in emergency medical admissions*. London: NHS Trust Federation, King's Fund, 1995.
- 8 Dunnell K. Population review (2): Are we healthier? *Population Trends* 1995;82:12-8.
- 9 *Hospital doctors: training for the future. The report of the Working Group on Specialist Medical Training*. London: Department of Health, 1993.
- 10 Ham C, ed. *Health care variations: assessing the evidence*. London: Kings Fund, 1988.
- 11 Adams CBT. OxDONs syndrome: the inevitable disease of the NHS. *BMJ* 1995;311:1559-61.
- 12 Edwards N. Day for night. *Health Service Journal* 1996 2 May:24-6.

Caesarean section or vaginal birth for breech presentation at term

We need better evidence as to which is better

Sept 1996

About 3-4% of pregnant women reach term with a fetus in breech presentation, although an active policy of external cephalic version would be expected to lower this incidence somewhat. Over the past 20 years planned caesarean section has increasingly become the favoured approach for the delivery of these infants, despite the absence of good data to support this trend. Indeed, there have been only two randomised controlled trials that have compared the policy of planned caesarean section with that of planned vaginal birth.^{1,2} Although the trials were too small to have reasonable power to measure clinically important differences in serious neonatal morbidity or mortality, the studies did not find caesarean section to be a better option than planned vaginal delivery.

A meta-analysis of these two trials, undertaken as part of a Cochrane systematic review, found no significant differences between the two approaches in terms of perinatal mortality (excluding malformations) (typical odds ratio 0.22 (95% confidence interval 0.00 to 14.52)) and Apgar score <7 at 5 minutes (0.64 (0.18 to 2.34)).³ Not unexpectedly, a policy of planned caesarean section was associated with higher rates of maternal morbidity (1.63 (1.03 to 2.57)). These results, which are the best evidence that we have available, do not support a policy of planned caesarean section.

To explore further whether planned caesarean section might be better than planned vaginal birth for the delivery of the breech presentation at term, we undertook a systematic review of retrospective and prospective studies that compared these two policies.⁴ Although most of the studies included in the review were retrospective hospital audits, the results from our meta-analysis showed significantly lower rates of perinatal mortality and neonatal morbidity with planned caesarean section than with planned vaginal birth.

In contrast, the retrospective population based study reported by Danielian *et al* in this issue of the *BMJ*—in which 1387 infants, with breech presentation at term, were followed to school age—did not find planned caesarean section to be associated with better long term infant outcomes (p 1451).⁵ The handicap rate of almost 20% in this large study is disturbing, and the observation that it is just as high in the cohort who underwent elective caesarean section raises once again the question whether underlying fetal abnormality, from whatever cause, may be associated with an increased incidence of breech presentation at term.

Where lies the truth? Non-randomised studies are prone to selection bias, and thus differences in outcomes may just reflect differences in the women and the infants being studied in the two policy groups. In addition it is often not clear from these studies what the selection criteria or intrapartum management protocols for vaginal breech delivery were or whether they were appropriate. The published studies also give

very little information about the skill and experience of the practitioners at delivery. The question of which is better for the mother and her infant—planned caesarean section or planned vaginal birth—therefore remains unanswered.

If planned caesarean section should be better for the infant, information on the size of the benefit is also important if parents are to be expected to make an informed choice about which approach they would prefer, since increased maternal morbidity is an inevitable consequence of abdominal delivery. Care providers would also have to weigh other possible disadvantages of a policy of planned caesarean section. These include less training for vaginal breech delivery and thus fewer experienced practitioners available to deliver these infants. This could possibly increase the risk of adverse neonatal outcome for mothers presenting in advanced labour with a breech presentation, when caesarean section is not possible.

We believe that an appropriately large randomised controlled trial is needed to determine whether planned caesarean section is better for the infant than planned vaginal delivery and, if better, to determine the size of the benefit. Indeed, we consider that the need is urgent, as a survey of Canadian obstetricians indicated that 69% of obstetricians thought that resident physicians were not acquiring the necessary skills to manage safely a trial of labour and conduct a vaginal delivery for a mother with a frank breech presentation at term.⁶ The most frequently cited reasons were lack of clinical volume and staff obstetricians' inexperience or reluctance to undertake vaginal breech deliveries. If such a trial is not conducted soon the art of vaginal breech delivery may well be lost, and planned caesarean section may become standard practice by default. Not only would this limit the childbirth alternatives for women, but the costs associated with such a policy would be substantial.

In fact, plans for a large international randomised controlled trial, coordinated in Toronto, are in an advanced stage. So far, 130 centres in Canada, the United Kingdom, the United States, Australia, Israel, South Africa, and other countries have expressed interest in participating in the trial. Additional participating centres would be welcome. This will not be an easy trial to undertake, but we agree with Danielian *et al* that the question of which is the better management for women at term with a breech presentation will never be answered until such a trial is completed.

M HANNAH

Associate professor and director

W HANNAH

Professor emeritus

Maternal, Infant, and Reproductive Health Research Unit,
Centre for Research in Women's Health,
Toronto, Ontario,
Canada M5G 1N8

- 1 Collea JV, Chein C, Quilligan EJ. The randomised management of term frank breech presentation: A study of 208 cases. *Am J Obstet Gynecol* 1980;137:235-44.
- 2 Gimovsky ML, Wallace RL, Schifrin BS, Paul RH. Randomized management of the nonfrank breech presentation at term: a preliminary report. *Am J Obstet Gynecol* 1983;146:34-40.
- 3 Hofmeyr GJ. Planned elective cesarean section for term breech presentation [revised 10 July 1995]. In: Keirse MJNC, Renfrew MJ, Neilson JP, Crowther C, eds. *Pregnancy and childbirth module*. In: *The Cochrane database of systematic reviews* [database on disk and CDROM]. Issue 2, Oxford: Cochrane Collaboration, 1995.

- 4 Cheng M, Hannah ME. Breech delivery at term—a critical review of the literature. *Obstet Gynecol* 1993;82:605-18.
- 5 Danielian PJ, Wang J, Hall MH. Long-term outcome of term breech presentation by method of delivery. *BMJ* 1996;312:1451-3.
- 6 Penkin P, Cheng M, Hannah ME. Survey of Canadian obstetricians regarding the management of the term breech fetus. *Journal of Society of Obstetricians and Gynaecologists of Canada* 1996;18:233-43.

Jack Kevorkian: a medical hero

Rare heroism to make us all feel uncomfortable

The hero "is a man of action rather than thought and lives by a personal code of honour that admits of no qualification. His responses are usually instinctive, predictable, and inevitable. He accepts challenge and sometimes even courts disaster."

Oxford English Dictionary, 2nd edition

Last month, Dr Jack Kevorkian walked out of a Michigan courthouse, probably free at last from the lawsuits he has brought on himself over the past six years. Dr Kevorkian has admitted to assisting in the suicides of 28 people since 1990. And despite the best efforts of the legislature and the court of his state of Michigan, he has apparently won his crusade.

Some, including the American Medical Association, question his goal of legitimising physician assisted suicide. Some of his "patients" have not had what would be called terminal disease. Among them have been sufferers of multiple sclerosis, chronic pelvic pain, emphysema, and motor neurone disease. The one thing they all shared was a sense of suffering that was so bad that they felt they had no choice but to end their own lives. And so far, not one of their relatives has had anything but praise for Dr Kevorkian's role.

Dr Kevorkian stands outside the mainstream of medicine because of actions that most of us find dubious. But he stands outside the mainstream in another way. Jack Kevorkian is a hero. No one has demonstrated any discernible motive from him except that he believes his work is right. Greed for money is absent because he has charged no fees. Greed for fame, too, seems unlikely because he has shunned the media except to explain his position. And no one has accused him of sadism in ending the lives and, according to him, the suffering of his patients.

Until Jack Kevorkian began his crusade, physician assisted suicide and euthanasia could be found in two places in America. One was in the medical literature: 1564 articles written in the 10 years before 1990. This is a safe world where authors can wring their hands, stare piously at the sky, and make declarations to those in practice about what is and what is not correct ethics. Few of them have direct responsibility to people in need. The other place was the real world of medical practice. Doubtless, doctors have helped patients to end their lives before now, but they did so behind closed doors, perhaps properly in order to safeguard their patients' confidentiality.

Then, in 1990, a man who had practised pathology in relative obscurity focused what had been a diffuse discussion into a passionate debate that has resulted in at least the partial legitimisation of physician assisted suicide. Dr Kevorkian did not stop at words. He acted to end what he perceived as suffering and then turned to the law and said, "I dare you to stop me." And he seems to have won his dare. In the name of the people of the state of Michigan, prosecutors sought to jail him six times, and the juries that represent the people of Michigan six times said "No." In Oregon a state law was passed that legalised physician assisted

suicide, and this year two federal courts have refused to declare the practice illegal.

Whatever else Jack Kevorkian has done, he has been "a man of action" who has lived "by a personal code of honour that admits of no qualification." His actions have been "instinctive, predictable, and inevitable." He has accepted challenge and even courted disaster.

Consider how rare such heroism is in medicine. Conservatism is usually a noble path, especially when we consider the harm that we can do. Secrecy, too, is usually a virtue that protects the vulnerable patient. But doctors see injustice every day—from patients suffering pain unnecessarily to those who cannot afford doctors' care to those who are sick due solely to the ills of society.

But only a few doctors have stood up and said "Enough!" to their profession and society. Kevorkian seems to be one. Some would place Che Guevara in the category. Certainly, Nicolaus Copernicus would make the list, although he kept his controversial theory of heliocentricity sealed until after his death. So too would the young anatomist Andreas Vesalius, whose disputation of Galen's anatomical theories forced him from his home in Padua, and Ignaz Semmelweis, who was driven from his post in Vienna for requiring his students to wash their hands.

To be a hero does not mean being right—even the Greeks understood the tragic nature of the hero—but it does mean being honest with yourself and acting on your own morality. It means risking the fall from the pinnacle on which society has placed doctors. The hero's morality tests the morality of each of us. He demands that we choose either to stay safe among the pack or stand up and be counted among the few. One of Dr Kevorkian's gentler critics is Dr Timothy Quill, a general internist at New York's University of Rochester, who has acknowledged his own role in physician assisted suicide.¹ He believes that Dr Kevorkian should now "step aside to allow calm discussion and avoid polarisation" over this difficult question. But this might allow us to sidestep hard questions. We need the hero to make us uncomfortable.

Medicine needs heroes today. Patients who suffer need their pain to be heard and felt. Those who are dying need our commitment to stay with them throughout their journey. Those who suffer sickness because of society's injustices need us to speak out for them. At a time when both personal and social suffering seem to be rising, more of us need to stand up and be counted among the few who have said "Enough!"

JOHN ROBERTS
North American editor, *BMJ*

Baltimore, MD 21218-2804,
USA

CARL KJELLSTRAND
Professor of medicine and bioethics

University of Alberta,
Edmonton, Alberta,
Canada T6G 1B3

¹ Quill TE. Death and dignity. A case of individualized decision making. *N Engl J Med* 1991;324:691-4.