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The fluoride debate

Publication of an article in *CMAJ* is, or should be, a sign that the manuscript has been carefully reviewed. An exception appears to have been made with "Appropriate uses of fluorides for children: guidelines from the Canadian Workshop on the Evaluation of Current Recommendations Concerning Fluorides" (*Can Med Assoc J* 1993; 149: 1787–1793), by Dr. D. Christopher Clark. It was no surprise to read Clark's contradictions in the journal of the Canadian Dental Association,[1] but it was disturbing to see them repeated in *CMAJ*.

Jill Rafuse's article "MDs call for more study before endorsing dentists' new recommendations on fluoride," on pages 1820 to 1822 of the same issue, was an inadequate attempt to set forth the elements of the dilemma. These are that, first, "one likely cause of dental fluorosis is compliance with fluoride regimens advocated by dental professionals for the prevention of caries";[2] and, second, that water-borne fluoride at a level as low as 0.1 mg/L is a known cause of dental fluorosis, a process that new information has shown to be an arrest of enamel maturation whose severity is dose-related.[3]

Clark presents two new concepts: first, that for the prevention of dental caries topical administration of fluoride after the teeth have erupted is more important than supplementation in infancy so that fluoride is incorporated into the tooth surface, the practice traditionally recommended; and, second, that the primary effect of fluoride is "more therapeutic than preventive."

One would think that these ideas, added to the obvious concern over the excessive amounts of fluoride ingested from all sources, would lead Clark to conclude that adding fluoride to drinking water for the avowed purpose of preventing caries in children is no longer appropriate. Instead, he informs us that "water fluoridation continues to have unique advantages." The source for this conclusion is an unpublished paper by Lewis and Banting.

Clark presents another finding, based on unpublished data, that the average 12-year-old in an area with nonfluoridated water has "about six decayed or filled tooth surfaces." He proceeds to illustrate how the situation could be improved if supplements were given from birth or from 3 years of age.

Why does *CMAJ* publish nonsense rather than admit that we may have been in error and examine all the published evidence in an unbiased way that reflects the integrity of the medical profession and the precept that in pursuit of our therapeutic efforts we are to do no harm?

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[CMAJ responds:]

When we were considering Dr. Clark's synopsis of the guidelines, the papers on which the guidelines were based were in press with *Community Dentistry and Oral Epidemiology*. Unfortunately, most of them were not published in that journal until June 1994. The paper referring to the average 12 year old has been accepted for publication in a future issue of the same journal. The following are the full references to the now-published papers.

1. Clark DC: Trends in prevalence of dental fluorosis in North America. *Community Dent Oral Epidemiol* 1994; 22: 148–152
2. Levy SM: Review of fluoride exposures and ingestion. *Community Dent Oral Epidemiol* 1994; 22: 173–180
3. Ismail AI: Fluoride supplements: current effectiveness, side effects and recommendations. *Community Dent Oral Epidemiol* 1994; 22: 164–172
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5. Lewis DW, Banting DW: Water fluoridation: current effectiveness and dental fluorosis. *Community Dent Oral Epidemiol* 1994; 22: 153–158
6. Limeback H: Enamel formation and the effects of fluoride. *Community Dent Oral Epidemiol* 1994; 22: 144–147
7. Stookey GK: Review of fluorosis risk of self-applied topical fluorides: dentifrices, mouthrinses and gels. *Community Dent Oral Epidemiol* 1994; 22: 181–186

Reverse sexism

I was unpleasantly jarred to find that *CMAJ* allowed one of my female colleagues, Dr. Diana Wyatt, to come across as a sexist bigot in the article "Women show growing preference for treatment by female physicians" (*Can Med Assoc J* 1994; 150: 1466–1467), by Susan Thorne.

I know Wyatt to be a level-headed physician and sense that she is quoted out of context in the following: "[female] doctors . . . are better communicators. We're socialized to take care of people, and we [communicate] better." Elsewhere, the quotation that female physicians have superior "people skills" is attributed more generally, but the impression is that Wyatt believes female physicians to have an edge in the practice of medicine.

This kind of edge has been claimed over the ages by practitioners of alternative and peripheral medicine. Until a few decades ago we believed men to have more than an edge and barely allowed women to practise medicine. It seems to me reactionary to reverse our prejudices

and thus to deviate again from the recommendation that patients should select their physician on the basis of merit rather than sex, race, religion or sexual orientation.

I certainly hope that women will not develop and maintain for long the prejudices we men harboured for centuries.

C. Frederik Stassen, MD
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I would like to comment on a statement by Ms. Thorne about a finding of the 1991 study of the Sexual Assault Assessment Service (SAAS) in Vancouver: "77% of patients presenting to this emergency service indicated a preference for a female examiner. The authors concluded that emergency services for women who have been sexually assaulted should aim to have female physicians available whenever possible."

In fact the official policy of the SAAS in Vancouver has been to restrict male physicians from being on the service altogether. This formal, blatantly sexist policy, which I am attempting to rectify, implies to the victim that a male physician cannot provide the same quality of care as a female physician, while at the same time conveying the message to the male physician that he should avoid assessing a female victim of sexual assault. This ultimately undermines, albeit unintentionally, the delivery of health care to victims of sexual assault.

Another potential pitfall of a policy that formally restricts men from serving on the SAAS roster is a question of legality: although the policy has yet to be challenged in court, it is difficult to imagine a ruling in its favour.

Perhaps a more accurate method of determining patients' satisfaction with the quality of care is to examine satisfaction with other sexual assault assessment services that have accepted or been formed by male physicians. Our colleagues in San Luis Obispo, Calif., who assess more than 1000 victims per year, have not found that victims of sexual assault relate differently to the physician solely on the basis of the physician's sex. A similar experience has been reported by our colleagues in Victoria.

It is my sincere hope that ongoing efforts to change this policy will succeed and that male physicians who have expressed an interest in serving on the SAAS roster currently at the Vancouver Hospital and Health Sciences Centre (Vancouver General) will be welcomed.

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Methotrexate and misoprostol used in abortions

Contrary to the claims of Dr. Ellen R. Wiebe in her letter (*Can Med Assoc J* 1994; 150: 1381–1382) the *Compendium of Pharmaceuticals and Specialties*[1] clearly indicates that methotrexate is contraindicated during pregnancy. If Wiebe and the University of British Columbia Ethics Committee have information on the safety of this drug during pregnancy perhaps they could share it with readers.

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Reference

1. *Compendium of Pharmaceuticals and Specialties*, Canadian Pharmaceutical Association, Ottawa, 1994: 772

[The author responds:]

Of course methotrexate is contraindicated for a wanted pregnancy: it causes abortion in approximately 95% of pregnancies of less than 7 weeks' gestation. This is why we are using it as an abortifacient. Single-dose methotrexate has been found to be safe for ectopic or unwanted pregnancy.[1–3] However, if abortion failed in a women given methotrexate and she refused to undergo surgical abortion, there would be a risk to the fetus.[4,5] From the experience with RU 486 in Europe we know that women rarely change their minds about abortion in such cases.

In my study the risks of methotrexate are clearly stated in the consent form each woman must sign.

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2. Stovall TG, Ling FW: Single-dose methotrexate: an expanded clinical trial. *Am J Obstet Gynecol* 1993; 168: 1759–1765
3. Stovall TG, Ling FW, Buster JE: Reproductive performance after methotrexate treatment of ectopic pregnancy. *Am J Obstet Gynecol* 1990; 162: 1620–1624
4. Ross GT: Congenital anomalies among children born of mothers receiving chemotherapy for gestational trophoblastic neoplasms. *Cancer* 1976; 37: 1043–1047
5. Kozlowski RD, Steinbrunner JV, MacKenzie AH et al: Outcome of first-trimester exposure to low-dose methotrexate in eight patients with rheumatic disease. *Am J Med* 1990; 88: 589–592

Cutting costs by targeting prescribing practices [correction]

This letter (*Can Med Assoc J* 1994; 151: 13–14), by Dr. David Rapoport, should have referred to "Diltiazem SR, 90 mg, a newer drug for hypertension," in the third paragraph. As well, in the seventh paragraph the third sentence should have read as follows: "One common, dangerous and expensive example of this is the use of NSAIDs [nonsteroidal anti-inflammatory drugs] *and* peptic acid suppressors," with the corrected word in italics. We apologize for any confusion our editing may have caused readers. — Ed.