International Journal of Risk & Safety in Medicine 10 (1997) 137–138
IOS Press

Hippocrates

WHO, what and why

If Hippocrates – the one and original – were to be around today, would he wish to become Director-General of the World Health Organization? For much of its history, WHO has been one of the most distinguished and the most useful of the specialized agencies of the United Nations created after 1945. Put on its feet by a succession of wise founding fathers, it was spurred into much more concrete action in the eighties by the energy and eloquence of Halfdan Mahler. One records these things in the perfect – if not the past – tense, because of the lamentable change which came over the Organization with the events surrounding the election of the Japanese Hiroshi Nakajima as Director General a decade ago. The manner in which votes were acquired at that time reflects no credit either on the individual or the nations which backed him. Had the record of achievement which followed been creditable, one might have been inclined to forget and forgive the manner in which the new era began. Sadly, the Organization sank progressively into a condition in which much of its staff were demoralized, trust in the leadership was eroded, and accusations of malpractice, ill-judgement and prejudice remained without anything resembling a credible rebuttal from senior management; it was as if all that mattered was the image, and as if the image could be maintained by fine words alone. That during this lamentable period some individuals and some Units within WHO have continued to serve the world well, despite an understandable decline in financial support from member states, seems to have been achieved in spite of senior management and not by virtue of it. It is intensely regrettable; an organization devoted to health ideals cannot survive forever if it becomes a political plaything.

The question as of mid-1997 is how – and whether – the World Health Organization can recover from the calamity which Dr Nakajima leaves behind. Again the question: would Hippocrates himself be an appropriate and willing Director General if he were around. Probably not. What is urgently needed now is an upright and capable manager to put the Organization on its feet again, if that is still possible. Thereafter one will need to resume the fine tradition in world health leadership set by earlier Directors-General such as Candau and Mahler. Unhappily there is some doubt as to whether member states have learnt the lessons of a decade ago; a battalion of candidates have already been put forward, some all too obviously impelled by national prestige or personal ambition rather than by ability; it may well prove impossible to mobilize sufficient support for any meritorious individual to ensure a majority. One thing seems sure: if the World Health Assembly of May 1998 is not put in a position to elect the brilliant manager which WHO needs it might as well consider the Organization's death warrant already written. The old saying is that if WHO were not there it would have to be invented; the time may becoming to set it aside and set the reinvention procedure in motion.

Hypertension after cerebral infarct

It is well recognized that hypertension should not always be treated; there are situations in which the organism has accommodated to its existence, and apparently others in which hypertension actually provides a defensive or compensatory mechanism with which it is better not to interfere.

One such situation can arise after cerebral infarction [1]. While it may be difficult to assess the extent of post-infarct hypertension (since the blood pressure prior to the infarct may not have been recorded) it seems clear that some two-thirds of patients indeed develop hypertension very shortly after experiencing an infarct, and that as a rule this subsequently declines to reach a stable level within the ensuing week. The fact that the blood pressure often does decline is one reason not to interfere acutely with it. Another is the evidence that around the area of the irretrievably damaged infarct there is a zone of brain tissue which is at risk but which may recover; in this "ischaemic penumbra", the vessels are already maximally dilated because of metabolic mechanisms; how much oxygen they can supply will depend largely on the force with which blood reaches them, i.e., on the blood pressure. In this view, therefore, post-infarct hypertension has an emergency aid function, with which one should not tamper. Indirect support for this view comes from the INWEST study of 1994, in which administration of nimodipine in the hope of reducing neurological damage in these patients proved little short of disastrous; by reducing blood pressure, the drug actually increased neurological damage in a dose-dependent manner [2].

If the rule is indeed to be that immediate post-infarct hypertension should not be treated, then there are at least two exceptions to it. One will apply where the hypertension is extreme, e.g., with a diastolic pressure of 130–140 mm Hg. The other will apply in patients in whom disorders elsewhere in the cardiovascular system demand that blood pressure be reduced.

References

[1] A.H. Van den Meiracker, Hypertensie in the acute fase van het herseninfarct; meestal niet behandelen, *Ned. Tijdschr. Geneesk.* **141** (1997), 1089–1092.

[2] N. Wahlgren, D.G. MacMahan, J. De Keyser et al., Intravenous nimodipine West European stroke trial (INWEST) of nimodipine in the treatment of acute ischaemic stroke, *Cerebrovasc. Dis.* **4** (1994), 204–210.