1.16. This suggests that the figure is not statistically significant, but the statistical and epidemiologic fraternities prefer to give their results with the appropriate confidence intervals rather than tests of significance.

Gray also quotes Neil Collishaw of WHO's Tobacco or Health Unit, who points out that a major meta-analysis of 40 studies of passive smoking in lung cancer was published in the *British Medical Journal* in 1997. Unfortunately, positive studies are much more likely to be included in meta-analyses than negative ones. Meta-analyses need to concern themselves not only with published studies but also with other studies that for one reason or another have not been published. Much more importantly, meta-analyses need to review and check the raw data of all published investigations to ascertain whether the data have been analysed appropriately or manipulated to support a particular point of view.

In the hospital where we work, we see 5 or 6 new lung cancer patients each week, or about 250 a year. Yet over the past 20 years or more we have seen only 3 definite cases of primary lung cancer in life-long nonsmokers. It also needs to be emphasized that many smokers, especially those seeking compensation for work-related conditions, are economical with the truth when it comes to their smoking habits. One study indicated that 25% of the smoking histories obtained from subjects exposed to asbestos who were dying of lung cancer were completely incorrect.[1] Many of the men denied smoking when applying for benefits, but an about-turn took place once histories were taken from relatives after the subjects died. It is highly probable that some such alleged nonsmokers are included in most epidemiologic studies.

We loathe and detest tobacco companies for their evasion, lies and attempts to trick adolescents and others into taking up smoking. However, the rejection of truth and the acceptance of unproven hypotheses to further one's concept of ethics or social justice is wrong too. Many studies involving secondhand smoke are not convincing, and answers about whether it causes lung cancer are far from established. Unfortunately, it has become customary to torture the data until they confess. We need more science, less hyperbole and less enthusiasm for unproven points of view. We support regulations banning smoking in airplanes, hospitals and public places, not because secondhand smoke causes lung cancer but because many nonsmokers suffer discomfort as a result of the habit.

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Reference

1. Berry G, Newhouse ML, Antonis P. Combined effects of asbestos and smoking on mortality from lung cancer and mesothelioma in factory workers. *Br J Ind Med* 1985;42:12-8.

[The author responds]:

I quite agree with the concern that any report of a scientific study should stick as close to the given facts as possible. However, in this instance I was reporting not on the WHO study itself, which had not yet completed the peer-review process, but on the way the popular press had already handled it. My reference to "egregious mistakes" was therefore referring to the *Daily Telegraph* reporter's interpretation of the WHO study. I was particularly concerned that the *Daily Telegraph* story did not contain either any comments from an objective scientific source or any reactions from antismoking advocates. Why was that? Nor did any of the subsequent reports in Canadian newspapers include such comments, although in both Ottawa and Vancouver, experts were consulted. These are the points I made in the article. They are also the points that have been made in separate complaints to the press councils of both Ontario and BC. There was indeed hyperbole surrounding this story, but it was found in the pages of the *Daily Telegraph* and its Canadian cousins, not in *CMAJ*.

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Evidence for effectiveness of home care

We agree with Dr. Aidan Byrne, who indicated in his letter "Where's the evidence for home care?" (*CMAJ* 1998;159[2]:135-6) that health care services should be provided on the basis of evidence for their effectiveness and their costs. However, the evidence (or lack thereof) on the cost-effectiveness of home care is not as clearcut as Byrne suggests.

In 1996, the Saskatchewan Health Services Utilization and Research Commission conducted a comprehensive and rigorous review of the literature on the cost-effectiveness of home care.[1] This study was cited by Dr. Peter Coyte of the Institute for Clinical Evaluative Sciences, to whom Dr. Byrne refers for support for his position. We found that for institutional care (i.e., long-term or nursing home care), there was indeed a lack of evidence that home care is a cost-effective alternative. However, with reference to hospital care, we found that for specific services such as intravenous antibiotic therapy, there is no doubt: home care *is* a cost-effective alternative. For palliative care, intravenous therapy for pain management and intravenous rehydration therapy, the research indicates that

home care may be cost-effective under specific conditions. In our report, we recognized that the research in these areas is not extensive and recommended that more be done.

Byrne argues that because of the lack of evidence that home care is cost-effective, the status quo should prevail. This seems a case of misplaced burden of proof. The logic of home care as a substitute for non-acute hospital care is compelling, despite the scarcity of substantiating studies. Should we not be at least as sceptical about the lack of evidence of the cost-effectiveness of much more expensive non-acute care in hospitals?

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Laurence Thompson, MA
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Reference

1. *The cost-effectiveness of home care — a rigorous review of the literature* [background paper]. Saskatoon: Health Services Utilization and Research Commission; 1996.

Confidentiality in medical publishing

The International Committee of Medical Journal Editors, of which *CMAJ* is a member, states that a patient's identifying information should be published only when it is "essential for scientific purposes and the patient (or parent or guardian) gives written informed consent for publication."[1] The guidelines for Experience articles in "Writing for *CMAJ*" state that "The writing should be candid without compromising patient confidentiality."[2] Would we all agree that these principles should apply to photos as well? How, then, did the photograph and references to individual patients by their first names manage to appear in the article "AIDS in Africa: a personal experience" (*CMAJ* 1998;158 [8]:1051-3), by Dr. Meb Rashid? Did the parent or guardian of the boy appearing in the photograph provide written informed consent to the publication of the photo or the egregious violation of confidentiality in the caption? How was this violation essential for scientific purposes? Do the appropriately stringent confidentiality requirements of the international committee apply only to certain sections of *CMAJ* or only to certain patients?

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References

1. International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. *CMAJ* 1997;156(2):270-6.
2. Writing for *CMAJ*. *CMAJ* 1998;159(1): 77-8.

Editor's note: Please see the editorial addressing this topic, on page 503.

Facing reality

The lack of appreciation of the sub-Saharan HIV/AIDS pandemic was emphasized by Dr. Meb Rashid in his article "AIDS in Africa: a personal experience" (*CMAJ* 1998;158[8]:1051-3). When I volunteered in 1995 for 5 months in the mission built and supported by Tebellong Hospital in Lesotho, southern Africa, I had no idea that, according to the World Health Organization (WHO), this region was home to 20 million people with AIDS (two-thirds of all cases worldwide). Nor was I aware that the Minister of Health of South Africa had estimated that 20% of that country's population (i.e., 40 million people) was HIV positive, with men and women equally affected but blacks much more affected than whites. Lesotho, a country completely surrounded by South Africa, appeared to have similar statistics.

When my wife and I arrived in Lesotho, medicine at the isolated 46-bed hospital was primitive: no telephone, no blood transfusions, no assays for hemoglobin or glucose. A retired Canadian family physician was the only doctor. Two-thirds of the $1 million for annual hospital operation came from the Africa Inland Mission. Transport of patients to the referral hospital in the capital city of Maseru, of staff and of any medical supplies was provided by the Mission Aviation Foundation. Pilots flew a 4-seat Cesna over mountains 3350 m high and landed on a short dirt airstrip. Conditions for air travel are treacherous, and our pilot later died in a crash.

About half of the adult patients were being treated for tuberculosis, and a third (probably 50% by now[1]) were HIV positive. This combination is a serious double burden in sub-Saharan Africa and has led to a secondary tuberculosis epidemic.[2] I pricked my finger after taking blood from a patient with tuberculosis. It took a month for his HIV test result to come back: positive. And no drugs for treatment were available.

Relatively few patients had symptomatic AIDS in 1995, but this has changed. A recent letter from the able public health nurse stated that her friends, relatives and neighbours are starting to die from AIDS. Home care has been started, and village health workers and family members are being taught to care for the terminally ill. The increasing number of untreated cases will probably reduce farm output and education and lead to increases in crime and serious government problems.

What can be done? The aim is to prevent transmission by reducing the number of sex partners, promoting condom use and controlling STDs. School education for the children,[2]