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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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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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]

for whom I was told sexual activity often starts at age 11 or 12, needs much improvement. High school graduates asked me if I believed that AIDS existed. The government has avoided taking responsibility. Political and tribal leaders and traditional doctors must play a role through educational radio programs and village visits. More medical staff is needed. The hospitals should make more educational videos about HIV, AIDS and STDs, featuring local residents, and show them on battery-powered televisions in hospitals and villages.

Drugs might start as gifts, such as those used for tuberculosis in Lesotho's mission hospitals. For example, I am sending recently outdated drugs. If only zidovudine were available for HIV-positive pregnant women, even for short periods.[3] Unfortunately, a diagnosis of HIV can mean violence if the woman's husband finds out, and without treatment such a diagnosis yields no benefit.

Considering the drug-related improvement in AIDS mortality in the US[4] and the worsening statistics in most developing nations, which bear over 90% of the world's HIV/AIDS burden (a reflection in part of social inequities[1]), governments, pharmaceutical companies, international agencies and philanthropists will have to give very generously if this pandemic is to be controlled.[1]

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Marathon's success

One objective of a small group within Ontario's Ministry of Health in the 1970s was to develop a type of group practice for Northern Ontario communities that would not wither and die after a few years. The underserviced-area program of the time did not venture into a long-term plan for Northern health care, so the article "A Marathon session: A town's MDs develop a philosophy to call their own" (*CMAJ* 1998;158[11]: 1516-7), by Michael OReilly, about the family physicians in Marathon, Ont., cheered me immensely.

Their success has been made possible, in part, by the local hospital. Doctors in another Northern paper town had an opportunity in the 1970s to integrate doctors, hospital and community care in a single organization to provide coordinated service. It was too radical a move for the doctors — the Ontario Medical Association nearly had a seizure!

The use of small-town hospitals as walk-in clinics is not confined to Northern communities, as I noted recently.[1] In places like Marathon the doctors' offices belong in the hospital unless there are specific distances to overcome. The duplication of facilities wastes money and effort, and so does the separation of medical and hospital services. Night phone calls need go only to the duty doctor in the hospital, since all doctors would be familiar with most patients in a small town (aided by computerized records, of course).

Seven doctors may be a little much for the 5500 would-be patients in Marathon, but I agree that a major cause of failure of previous efforts to provide care in the North has been a shortage of doctors. An underserviced, isolated community does not need a doctor: it needs doctors. Any medical group in the North must be able to function effectively with one doctor away consistently.

My praise for Dr. Gordon Hollway and all the family physicians in his group, and to Dr. George Macey and the entire community of Marathon — your creativity and energy are heartening.

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Received by email

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Understanding Quebec's policy on nursing training

I was surprised by the reaction to Quebec's new proposal to reduce the level of nursing training, as described in the news brief " 'Dumbing down' of Quebec RN education irks nurses, MDs," (*CMAJ* 1998;158 [10]:1262), by Barbara Sibbald. This proposal, which goes against the current worldwide trend to increase the level of nursing training, is perceived as being unsound, a policy that can only lead to an overall reduction in the quality of care offered to Quebecers.

However, the critics forget that this new policy is perfectly consistent with Quebec's current efforts to control health care spending. Few of those who graduate as nurses from junior college programs will find it cost-effective to complete an additional 4 years to earn a degree, to end up with only a modest increase in overall income. What better way to control health care costs than to keep absolute control over a body of minimally trained health care workers who are among the lowest paid in the world but are forever stuck in Quebec because their credentials are not transferable. Similar policies affect Quebec physicians: their training options are restricted, and they receive profes-