



placebo-treated patients, were 42 - 61% less likely to have significant arterial calcification (as measured by computed tomography).² These publications are in stark contrast to earlier publications by the same investigators that implied HT as a cause of CAD, without taking into account that this did not apply to the typical patient, who initiates HT at the age of 50 - 59 years.³

Dr Rapeport further falsely assumes that SAMS promotes the use of HT for the prevention of CAD, even though it is not included in the list of approved indications in the revised guidelines. We maintain our position that if the only aim of treatment is protection against CAD, HT is an inappropriate choice in view of other proven methods. However, it is important to be able to assure the patient in the age group 50 - 59 years, who starts HT for the control of vasomotor symptoms or the prevention or treatment of osteoporosis, not only that HT will not cause CAD, but that protection can be expected. This also needs to be taken into account when deciding on termination of treatment.

We stand by our statement that the initiation of HT for the indications as provided is safe for the patient in the age group 50 - 59 years and that the small risk of any complication can be further reduced by using the lowest effective dose.

1. Rossouw JE, Prentice RL, Manson JE, *et al.* Postmenopausal hormone therapy and risk of cardiovascular disease by age and years since menopause. *JAMA* 2007; 297: 1465-1477.
2. Manson JE, Allison MA, Rossouw JE, *et al.* Estrogen therapy and coronary-artery calcification. *N Engl J Med* 2007; 356: 2591-602.
3. Rossouw JE, Anderson GL, Prentice RL, *et al.* for the Women's Health Initiative Investigators. Risks and benefits of estrogen plus progestin in healthy postmenopausal women: principal results from the Women's Health Initiative randomized controlled trial. *JAMA* 2002; 288: 321-333.

'Opi-phobia' among doctors leads to unnecessary suffering

To the Editor: Francois Venter and Chris Bateman are to be commended on this piece.¹ Basic training of South African doctors and nurses in palliative care has been poor. Therefore few have raised their voices to improve palliative care, despite the great need for it in a developing country where many patients present with far advanced disease. This applies particularly to people with HIV because of denial and stigma.

An important step towards the development of good general palliative care in Australia and the UK has been the formation of departments of palliative care in teaching hospitals, through which all students must rotate during their training. I suggest that pharmacology students also have a short rotation. With the enormous need for such care, it seems an urgent priority to establish such departments in all our teaching hospitals. These should also bring past graduates up to speed in this discipline.

Another serious public sector hospital problem is the lack of effective links between district hospitals and community

structures offering home-based care. Too often, medical staff end up saying to patients, 'There is nothing more that we can do for you', because the doctor has decided cure is not possible. In most cases, no thought is given to linking patients to community carers, or to empowering the carers with medications to reduce the suffering of their last days. No help in controlling symptoms is provided to home-based carers who appeal to district clinics when the scheduled drugs needed are not available to clinic staff. This has two effects. Firstly, hospital staff are never really confronted with the patient's palliative care needs, so they never grow in that expertise. Secondly, there is an assumption that palliative care in HIV is simple (which it is not), just as the rest of the medical care of people with HIV is difficult and requires considerable experience and expertise.

A solution to this problem could be the development of palliative care facilities in every district hospital, staffed by medical and nursing staff who are part of the training team of home-based carers in the district. They could assess the patient's palliative needs, access the necessary medications, and link the patient and family to a designated carer, or non-governmental organisation. They should also identify patients with HIV wrongly consigned to terminal care when they have a manageable infectious condition. Such a facility could have regular follow-up clinics in each of the district clinics, and be empowered to carry and dispense the necessary scheduled drugs. This should be a high-priority project for co-operation between district health services and the medical staff of every district hospital, including those in metropolitan centres serving rural communities.

J V Larsen

181 Amberfield
Private Bag X010
Howick, KZN
jonvl@netactive.co.za

1. 'Opi-phobia' among doctors leads to unnecessary suffering [Lzindaba]. *S Afr Med J* 2007; 97: 399-406.

Achieving the Millennium Development Goals in sub-Saharan Africa

To the Editor: The UN has released a mid-term report on progress towards achieving the Millennium Development Goals (MDG), eight pro-poor goals contained in the Millennium Declaration of 2000, to be achieved by 2015.¹ It paints a gloomy picture of health in sub-Saharan Africa. Child mortality rates declined globally, but the improvement was uneven, with sub-Saharan Africa recording the highest rate and the slowest pace of progress. In 1990 and 2005 in sub-Saharan Africa, 185 and 166 children respectively died, mainly from preventable causes, before their 5th birthday for