



The frequency, cost and harms of the procedure must have been weighed up by the British National Health Service (NHS) — usually pretty sensible about their medical recommendations — which proposed 3-yearly screening for women aged between 50 and 64 years. Obviously more cancers would be discovered by 2-yearly rather than 3-yearly screening, and yet more by annual screening. Six-monthly screening, in turn, would clearly yield more cancers than annual screening. This would fit well with Dr Whitehorn's 'simple arithmetic'. However a balance has to be found between benefits and harms, and we chose the NHS one. The following organised screening programmes recommend 2-yearly mammography, most of them for women between 50 and 69 years: Australia, Finland, Iceland, Israel, Netherlands, France, Belgium, Canada, Denmark, Ireland, Italy, Norway, Portugal and Greece. Annual mammography, and mammography at an early age are the usual recommendations of interest groups. They are also the recommendation of the correspondence printed above.

Like Dr Paul Sneider, we conclude with a quote from Boyle: 'Every woman has a right to participate in an organised screening program . . .'. This right, alas, does not apply to this country, where other health care priorities make an organised programme an impossibility. However, should a woman have the privilege of medical aid, or be able to afford mammography, it is her choice to undergo it, a choice open to only a minority of South Africans. The majority of South African women would, in our opinion, be well served by an organised programme of 'breast awareness', a proposal that Dr Russell Whitehorn finds difficult to fathom.

Failed contraception?

To the Editor: We read with interest the article by Van Bogaert regarding contraceptive use among women seeking termination of pregnancy (TOP).¹ Given the high burden of unwanted pregnancy in South Africa this research is of great importance. However we take issue with the specific methodological approach and subsequent inferences that may be drawn regarding contraceptive effectiveness.

Specifically, the use of non-pregnant women attending gynaecological outpatient services as a control group, without statistical adjustment for underlying differences that may confound this comparison, is problematic. Despite the author's assertion that the 'demography was comparable' in the two groups, the data presented in Tables I and II show that the controls are substantially older and have greater parity compared with women seeking TOP. For example, almost 40% of controls were over 30 years of age, compared with approximately 20% of women seeking TOP. While statistical methods could be used to adjust for these differences, no such methods were employed in the study, and only unadjusted

associations are reported.

There is evidence that methods of contraception differ with age in South Africa, with oral contraception (OC) more common among younger women than older women.^{2,4} In this light, the differences described in the paper in contraceptive methods may be attributed to the demographic differences between the two groups, rather than differential contraceptive failure rates. This explanation is also more in keeping with evidence regarding contraceptive failure rates, which suggest that with 'perfect use', injectable and oral contraceptives have comparable failure rates; under 'real life' conditions, OC may fail only slightly more frequently than injectables due to user error.⁵ Furthermore, reporting of contraceptive method use may be different among women seeking TOP and controls. Lack of information on how contraceptive information was collected makes it difficult to rule out this possibility.

Without an understanding of the methodological limitations of this study, readers may draw inferences from these data about a relationship between OC use and failed contraception. From a public health perspective, it is extremely important to avoid statements that could be incorrectly interpreted as suggesting that OC is less effective than injectable contraception. More generally, additional research examining the relationship between contraception, method choice, and the occurrence of unwanted pregnancy in South Africa is clearly needed. We thank Van Bogaert for focusing attention on this important women's health issue.

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Medical practitioners' attitudes towards older patients

To the Editor: Population ageing will see South Africa's population aged 60 years and over increase from 6% to 14% of the total population by 2050. It is projected that the 80-plus age group will more than double, from 8% to 19% of the older population.¹ Longevity and an expanded very-old age group will result in an increased prevalence of age-associated chronic



morbidity and disability, and therefore more demand for health care and a heavier burden on scarce health care resources. Health professionals at all levels should prepare to meet the future health care needs of this group. For one, a stronger geriatric medicine component needs to be incorporated in medical education curricula.

An investigation of health care providers' attitudes towards older people, geriatric medicine and older patients found high levels of negativity in all domains measured on an Ageing Semantic Differential Likert-type scale.² A countrywide postal survey involving a random sample of 942 medical practitioners registered with the South African Medical Association drew a response rate of 21% ($N = 196$). The predominantly male sample (70.9%) with a mean age of 45.4 years (range 25 - 84 years) included general practitioners, medical officers and specialists. The mean number of years of medical practice was 19.7 (range 1 - 59 years) with half the respondents (52.6%) working in the private sector, 21.9% in the public sector and the remainder in both sectors. Nine in 10 attended older patients daily or weekly; only 3.1% had postgraduate training in geriatric medicine and only a minority (6.6%) had ever considered a specialty in geriatric medicine.

Although the respondents' attitudes were negative in all domains of characteristics of older persons and older patients, least negative attitudes were correlated with shorter duration

of practice (< 19.7 years, $p < 0.001$), younger age of the practitioner (< 45.4 years, $p < 0.001$), private sector employment ($p < 0.001$) and frequently attending to older patients ($p < 0.001$). Only 15% viewed work with older patients positively; three-quarters viewed it negatively and the remainder were neutral. Religion and culture, where these embody strong seniority respect norms, and systems-related, institutional and personal factors were cited by the respondents as influencing their attitudes and the way they interact with and render care to older patients.

Contemporary South African medical practitioners' attitudes towards older patients appear to be largely ageist, i.e. based on negative stereotypes. An expanded geriatric medicine component in medical education curricula and more exposure to older patients at undergraduate level should improve the attitudes of future cohorts of doctors.

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