rural poor setting in Tamil Nadu, this is the group least likely to access safe abortion services in a clinic setting, and most at risk of an 'unsafe' abortion. Was the researchers' experience in Maharashtra different, and were they able to interview this group of women in a clinic setting? If yes, could they speculate on why their setting is different?

9. The use of 'dummy' interviews seems to be an unsatisfactory strategy to protect the 'case' for several reasons. One, having a group of interviewers conducting several simultaneous interviews could have been intimidating for the household concerned. Did all these members give informed consent to be interviewed? If they did, then using them as dummies amounts to misleading respondents who so willingly give their time to answer questions, and appears to be a breach of trust. Two, it must be possible to find other ways of ensuring privacy even in a rural community, such as finding a room (the Balwadi on a non-working day or in the evening, the panchayat office, etc.) in which respondents are interviewed in private, one –by-one. We have done this as part of several research studies in villages in Tamil Nadu, and wonder what made this impossible in the researchers' setting. Three, were the considerably higher costs that this strategy is likely to have entailed justified? And finally, if the issue was not very sensitive (because it is not sensitive for most married women and other women were in any case interviewed only in a clinic setting), why was it even necessary to have dummy clients?

10. There are many instances in the article where the authors single out qualitative methods as intrusive, potentially threatening, leading to 'coercive participation' and posing 'complex ethical dilemmas', and by implication, that quantitative methods can be absolved of these traits. (Paragraphs 1 and 4 on page 7 and the concluding paragraph on page 8). Or have we misunderstood their stance?

11. What is the researchers' responsibility towards those in need of services for abortion-related morbidity? Referring them to a medical facility may not be meaningful, because women may not be able to access these for the same reasons that prevented their using these facilities for a safe abortion in the first place.

12. It would be of value for researchers like ourselves to learn about the ways in which findings from this study have been (or will be) utilised to enable equitable access to abortion services for future abortion seekers.

13. We find the authors' concluding remarks rather disconcerting. Why strive for an accurate estimate of rates of utilisation or of morbidity at the cost of participants' dignity and autonomy? Is not this concept rooted in benign paternalism that assumes 'we know what is good for you (even if you don't)'.

To conclude, we agree with the authors that we researchers have a responsibility to be up front about the ethical dilemmas we confront. The questions above have been raised with a view to continue the debate in the same spirit.

TK Sundari Ravindran, Mala Ramanathan and Shiney C Alex, Achutha Menon Centre for Health Science Studies, SCTIMST Medical College , Thiruvananthapuram 695 01.

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Globalisation and doctors advertising

The unspoken background of the debate on the ethics of doctors advertising (1, 2, 3, 4) is globalisation and how it affects the medical profession, whether it is their right to advertise, their obligation to provide information, their opportunity to earn foreign exchange, or their duty to provide care.

Any model of development which addresses the task of providing health care to all must presuppose a social commitment by medical professionals. Why build hospitals in rural and tribal areas if doctors are going to settle in the West, or pack themselves in metropolises? Unfortunately, most doctors are driven by the profit motive. They leave rural areas unattended, confining themselves to a few cities where their increased density draws them into unhealthy competition — hence the call for advertising.

At the heart of the problem are deep-rooted weaknesses in our culture and education system. We are made only technically proficient; our education does not instil in us an ethos by which we live our lives. Nor do we understand the philosophy and history of the subjects we learn in schools and colleges. 'Specialisation' means technical compartmentalisation of a subject in our minds. That is why the pursuit of science in our universities and national research and development institutions has failed to generate great contributors like Raman and Bose in the latter half of the last century. It seems that even medical education suffers from this problem. Teachers have failed as a community to inspire students; they have failed to convince, by setting an example, that competition amongst doctors by advertisement in any form is unethical.

It is true that word of mouth by a doctor is a form of low-key advertisement. However, when done among patients, their relatives and friends, it is a fair reflection of a patient's direct experience with the doctor. It is also a check to doctors' efforts at self-promotion.

The power of the electronic medium enables it to reach many more potential clients than can word of mouth. But without equally available information on doctors' failure rates, and their patients' evaluations, people looking for doctors through internet advertisements risk being misled by savvy doctors. Only if such an electronic check exists, and is provided alongside the ads (something doctors are unlikely to accept), could advertisement by doctors be considered fair and ethical. We cannot count on an alert media to protect patients from incompetent doctors.

Dr Malpani equates 'advertising' with 'providing information'. Information can be provided on the internet

without advertisement. Doctors can use the electronic media to place a mega directory on a website. Software allowing people to help locate the doctor they need would make information accessible without fancy personal advertisements to lure patients. This scheme would take care of Dr Malpani's (3) major objection that word of mouth does not favour younger doctors. The 'grey beards' who unfairly use their weight against freshers as contended by Mamdani and Mamdani (4) will lose their grip.

Those who support doctors' advertising quote Western codes which permit the practice (2,3). Jesani has pointed out that the call for advertising in the US stems from the insecurity of corporate-controlled health care with its own serious problems (4). Besides, should we equate the Indian and American situations just because globalisation has forced us into a free market economy? The American system offers some consumer protection; we are not able to do this.

Dr Malpani refers to 'the demands of changing times', to advocate advertisements by doctors. Our health care system is not effective beyond urban limits because doctors have ignored the demands of the changing times for several decades. Now, globalisation seems to apply a much needed balm to our pricked conscience.

I would like to cite the example of Baba Amte, a lawyer by profession. He attended a six-month course in tropical medicine and then established a home for leprosy patients at Warora, called Anandwan. Cured leprosy patients earn their living and run the village with a self-confidence that has to be seen to be believed. Baba Amte's sons and their wives have acquired medical degrees and devoted their lives to rural and tribal health care, at times against the government's serious antipathy towards the cause.

One son, Dr Prakash Amte, along with his wife Dr Mandakini, has worked since 1973 amongst the inaccessible Madia Gonds at Hemalkasa, promoted education and even produced two Madia doctors who have decided to go back to work for the tribals in the jungles instead of starting clinics in a city or abandoning the country. Dr Vikas, the elder of the two sons, looks after the growing activities of Anandwan and several other major projects. The next generation of Amtes has also committed itself to this development programme.

Unfortunately, Dr Vikas and his wife Dr Bharati are hard pressed to find permanent doctors to help run the hospital even at Anandwan, though this beautiful village is close to the Warora railway station between Nagpur to Delhi. Unlike the Amtes and their dedicated teams, scores of urban doctors don't seem to sense that 'the demands of the changing times' are to serve the rural and tribal populations. They seem to be eagerly looking forward to the patriotic feat of earning foreign exchange to eradicate the nation's poverty.

S.K.Bhattacharjee, molecular biology and agriculture division, Bhabha Atomic Research Centre Mumbai - 400 085.

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Change is inevitable

The practice of medicine has undergone many changes over the years and will continue to undergo many more changes - in concepts and in practice - in future. It is, therefore, unrealistic and unfair to expect the medical profession to accept and adopt all of the ethical principles that were laid down years ago (1). Modifications must be made by the governing bodies and physicians must accept the changes.

I propose that — as is the practice in the United States — doctors in India should be allowed to advertise their services. Before I proceed further, let me make it clear that I would personally not advertise: either because I find it difficult to totally shake off old, established beliefs or because my own field (pathology) does not require advertising. However, I would defend the right of other physicians to advertise.

Dr Pandya argues that medical professionals have peer-reviewed journals to produce their research papers in and thus "advertise" themselves to their peers. However, as he himself has pointed out some years ago (2), Indian doctors rarely publish. Moreover, Sahni et al (3) showed some years ago that only five per cent of Indian doctors read medical journals. This avenue of spreading information about oneself is thus blocked for most physicians.

The argument has been made that allowing advertising will permit doctors to make tall claims. The cure, then is to make our medical councils, advertising agencies, and the Advertising Standards Council of India more accountable. Preventing advertising because of the existence of misleading advertising is like banning cricket because of some matches are fixed. The solution is to prevent the fixing, not the game.

Finally, the change in medicine is exemplified by the fact that many hospitals, especially the private or corporate ones, have marketing departments. There have even been suggestions that the word "patient" be replaced by "client" or "customer" (4).

But this much is clear: change is inevitable. In an age when patients are considered to be consumers and when doctors can be sued for poor services, surely it is incorrect not to allow doctors to advertise. The same rules have to apply to all the players of the game.

Sanjay A Pai, consultant pathologist, Manipal Hospital, Airport Road, Bangalore

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