ups and downs of life. He had his mission of life completed by being a living example of a dutiful husband and a responsible father. It is his single-minded devotion that made a man out of me and what I am today, as a humble teacher in a medical school (1).

The story of my life is testimony to the fact that a mentally retarded woman may have the right to bear or rear a child provided that she gets emotional and physical support from her husband or a close family member.

The recent ruling of the Supreme Court asserting the right of the mentally retarded woman to decide whether to medically terminate a pregnancy or continue with it, may be a bone of contention (2). In a world full of emotional limitations, society needs to support such women who need our real care and empathy. I am proud of my mentally retarded mother for she gave me a biological belonging and social identity. There are many such women in our society who are given physical shelter. They need physical as well as emotional shelter. When institutions are commissioned to house such women, the concerned authorities must look into whether the place in which these women are housed is safe for them physically and emotionally.

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Do we need two systems for postgraduate medical education in one country?

The articles on the National Board of Examination (NBE) were informative (1, 2). We would like to draw attention to the farcical manner in which the entry to the Diplomate of the National Board (DNB) is conducted. Admissions to MD/MS programmes are based on the candidate's performance and rank in the entrance exam. However, admissions to DNB programmes are on the basis of a system that is open to misuse. After a common entrance test, candidates are selected by institutes usually on the basis of an interview. As we are all aware, interviews are extremely subjective and members of the interview board are likely to be influenced by external pressures. The system of entry should be similar to that practised for MD/MS entrances - an all-India entrance test followed by a rank-based counselling.

Suptendra Nath Sarbadhikari's article comments on the low pass percentage of candidates (1). The low pass percentage is a reflection of the unsatisfactory state of affairs at the NBE and their causes need to be examined. This might be related to the type of student who enters these courses - as the entry to DNB courses is not purely merit based. Second, these courses are usually run by institutes that do not conduct undergraduate courses, and the lack of proper teaching might be a reason for poor results. The affiliation of institutes which are not running proper teaching programmes should be cancelled.

Regarding the conduct of examinations, MD/MS students are subjected to similar treatment, with no emphasis on regular assessment during the training period of three years. Our own theory examination consisted of essay questions, some of them worth 30 marks. The examination should be objective and there should be a system of continuous assessment during the training period. These changes should also be introduced for MD/MS candidates.

Murali Poduval's article notes that the NBE is an alternate, parallel medical education system (2). It is not clear why one country should have two systems of postgraduate medical education. When the government does not distinguish between the DNB degree and the MD/MS degrees, where is the need to have a parallel system? The solution would be to abolish the DNB and strengthen MD/MS programmes so that the country has a single, transparent system of postgraduate medical education that produces good results.

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Why raise questions on the "ethics" of the Gadchiroli trial?

I congratulate your team on publishing the article: "Was the Gadchiroli trial ethical? Response from the principal investigator". Abhay Bang raised some practical questions for discussion with the international community (1). The following are my views in response to this article:

I wonder how researchers from these reputed institutions can raise questions on the ethics of a study which has clearly provided a ray of hope not only for the poor and vulnerable children in India but also for children in other developing countries. Such debates make me feel that the international community fails to understand the importance of this trial to the lives of innocent children; they do not realise the realities of socioeconomic conditions and the health system in remote areas of India. How much could one expect from a man, with limited resources, who really wanted to help deprived children and give life to theoretical concepts like "the right to life"? Even if he had provided "state-of-the-art" health services in the control area of the study, what difference would it have made in the remaining villages across India? I could also not understand the rationale for calling the standard of care provided in Gadchiroli "unethical".

In fact, following the Gadchiroli trials, various studies were conducted in other south-east Asian countries, and all these studies adopted more or less the same model of "home-based neonatal care" that was adopted by the Gadchiroli trials. Further, none of them provided "standard care" as per the norms of the US or western Europe. Baqui et al, from Sylhet, Bangladesh, reported a 34% reduction in neonatal mortality by training female health workers to provide home-based newborn care as per WHO's integrated management of childhood illness guidelines (2). Manandhar et al achieved a 30% reduction in the neonatal mortality rate in rural Nepal by introducing community-based newborn care through women's groups (3). Bhutta et al in Pakistan engaged and trained an existing cadre of women health workers for community-based newborn care. In addition, trained birth attendants or "dais" were also trained for newborn care. They eventually reduced the neonatal mortality rate by around 19% in four intervention villages (4). If the standard of care in the Gadchiroli trial is described as unethical, then I must say that the standard of care provided in all of the above mentioned trials is also unethical.

However, now we know that the interventions of the Gadchiroli trial have shown the effective way to reduce infant mortality substantially; instead of debating the ethics of the Gadchiroli trials, researchers should come forward and try to mobilise policy makers to adopt home-based neonatal care. I agree with Abhay Bang's challenge to those who call this trial unethical: "Should one wait until the best standards, and the resources needed for using them in the control area, are made available, and allow children to die until such time?"

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Seeking information on doctors and advertising

I would like to approach the readership of your journal through these columns in order to explore an issue that is assuming alarming proportions here in Pakistan. It has become commonplace for physicians here to appear in commercials, directly or indirectly promoting products. Up till a few years ago we would see professional models dressed in white coats with stethoscopes slung around their necks, pretending to be doctors, promoting products. Gradually one saw young physicians appearing in advertisements, obviously to make some easy money. It is now common to see senior physicians displaying their credentials and institutional affiliations giving what appears to be a public health message, but with the brand name of particular products displayed besides them. Often times the "public health message" is also inaccurate and misleading. Some of these physician models are actually serving professors in leading medical colleges. They have appeared in television and newspaper advertisements, on billboards, and on posters selling products ranging from toothpaste, shampoo and medicated soaps to baby diapers and even socks.

A search of the English language literature reveals practically no material focusing on physicians advertising and promoting products. There is much written on self advertisement, an area already covered by clear guidelines of the Pakistan Medical and Dental Council (PMDC). Another area that has been explored extensively in literature is on physicians associations endorsing products, which also raises major ethical concerns.

There is growing concern among many physician circles about this alarming trend. In response to this concern the Karachi Bioethics Group (KBG) wishes to develop a position statement addressing all aspects of physicians endorsing products which we hope can then become a framework for policy formulation by physicians associations including the Pakistan Medical Association and the PMDC.

The KBG consists of individuals from several institutions across Karachi who have a shared interest in bioethics. The group meets once every two months in their personal capacities and discuss ethical issues. The group has recently launched a set of guidelines on physician- pharmaceutical industry interaction. More information can be obtained from www.karachibioethicsgroup.com.

It would be interesting to learn from your readers if there has been a similar trend in India of physicians willing to become industry poster boys, and if so, what has been the reaction by the public and the physician community.

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Delay in publications: new authors and editorial misconduct

An amendment by the Medical Council of India, in 2009, has introduced, as a criterion for early academic promotion, a compulsory minimum number of publications (1).

Given the many medical colleges in India, one would expect many research publications by medical college