demic bioethics centres in the USA funded solely or even in any great way by pharmaceutical companies. The only centres, programmes, or people funded solely by private sources involve conservative religious sources or political groups that tilt to the right—a state of affairs concerning which Cooter offers no comment, presumably because he is of the view that only pharmaceutical money can be the source of conflict of interest.

Contrary to what Cooter claims, finding out which bioethics centres, programmes, or people have accepted grants or contracts or gifts is fairly easy, either by asking them or searching their websites for sources of funding. No academic bioethics centre or medical ethics programme I am familiar with has received more than a small proportion of funding from drug companies. Some in the specialty, including me, think these companies ought to be providing more funding in the way of general, unrestricted gifts. In America where various universities and medical schools that do superb research have been built on money derived from tobacco, chemical, oil, fast-food, and the pharmaceutical industries, it is a bit disingenuous to start pointing a finger at the pittance sent towards bioethics by pharma and pronounce it afflicted with ethical putrefaction that must lead to its inevitable death.

Cooter is wrong again when he says the social sciences are excluded from bioethics. In fact, there is some danger that empirical bioethics might come to dominate all other modes of inquiry in the specialty, although quantitative social science seems to lie outside Cooter's ken.

Is it true, as he claims, that there is intolerance of the emotions on the part of bioethicists? Well not exactly. There is an intolerance among many bioethicists of using emotional responses as a form of argument, as well there should be. Cooter's analysis is a prime example.

Cooter does get one fact right—there are divisions and spats within the specialty of bioethics. These are, however, a sign of intellectual vitality, not demise.

Information on funding sources for the Center for Bioethics at the University of Pennsylvania for 2004 is available at www.bioethics.upenn.edu/. ALC has received honoraria for lectures given during 2004 at the Mt Sinai School of Medicine, Syngenta, Dupont, Kincaid School, Massachusetts General Hopsital, Denison University, College of Physicians of Philadelphia, Drug Information Association, University of Minnesota-Mankato, University of St Thomas, Elizabethtown College, Columbia University, Medical College of Virginia, SUNY-Stony Brook, IBM, Temple University, Astra Zeneca, and the Care Consortium of the Delaware Valley.

Arthur L Caplan
caplan@fast.net

Center for Bioethics, University of Pennsylvania, 3401 Market Street, Suite 320, PA 19104, USA

1 Cooter R. Historical keywords: bioethics. *Lancet* 2004; **364:** 1749.

HIV-infected women in ART programmes

We are confident that James Shelton and Anne Peterson (Nov 27, p 1916)[1] appreciate the broad reproductive health needs of women in developing countries. However, by focusing their Comment solely on the promotion of contraceptive use for women on antiretroviral therapy (ART), their discussion overlooks the importance of supporting reproductive choice among individuals infected with HIV and greatly oversimplifies women's reproductive health-care needs in the context of ART programmes.

The Comment outlines several compelling reasons for promoting effective contraception among women infected with HIV. Although these concerns are appreciated, this strictly preventive approach to reproduction focuses only on reasons why infected women should not have children, overlooking the important role that fertility has in women's lives, individual and social, especially in many parts of sub-Saharan Africa.[2] There is growing evidence that despite stigmatisation by health-care providers, childbearing is an important feature of life for many women infected with HIV.[3] In some settings, an infected woman's decision not to have children can exacerbate HIV-related stigma and discrimination. Although there are few insights into how the availability of ART might affect the fertility intentions of HIV-infected women in the developing world, a substantial proportion of women who receive ART will probably want to consider having children.

The exclusive promotion of family planning among women on ART, therefore, could be short-sighted and prove counterproductive. Despite their best intentions, health-care providers and policy makers who follow the approach proposed by Shelton and Peterson might pressure HIV-infected women to use contraception rather than focusing on appropriate counselling with respect to reproductive choices. If the health-care needs of women who wish to have children are not taken into account, the provider-patient relationships that are particularly important in the context of long-term care such as HIV care and ART could be jeopardised.[3] Furthermore, free and informed reproductive choice is a vital component of human rights[4] and there is a clear ethical imperative to avoid pressuring women infected with HIV to use contraception; with limited access to ART across Africa, individuals seeking expensive, life-prolonging therapy might be particularly vulnerable to this type of coercion.

Instead of promoting contraception in isolation, we propose ART programmes support the reproductive choices of women. ART programmes, in Africa and globally, should incorporate a range of reproductive health services to address women's needs. The types of services that should be linked to ART programmes will vary, but should include either integration of or referrals for emergency contraception, antenatal care, abortion and post-abortion care, and counselling on condom use as well as dual protection, in addition to access to contraception. This approach allows the informed choices of HIV-infected women, rather than the opinions of providers or programme donors, to drive decisions about fertility. By investigating and addressing women's

reproductive choices, ART programmes will better meet the primary health-care needs of HIV-infected women, and ultimately improve their long-term health outcomes and quality of life.

We declare that we have no conflict of interest.

*Landon Myer, Chelsea Morroni, Jean Nachega, Di Cooper
lmyer@cormack.uct.ac.za

*School of Public Health and Family Medicine, University of Cape Town, Faculty of Health Sciences, Anzio Road, Observatory 7925, Cape Town, South Africa (LM, CM, DC); and Department of International Health, Bloomberg School of Public Health, Johns Hopkins University, Baltimore, MD, USA (JN)

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2 Harrison A, Montgomery E. Life histories, reproductive histories: rural South African women's narratives of fertility, reproductive health and illness. *J South Afr Stud* 2001; **27:** 311–28.
3 Feldman R, Maposhere C. Safer sex and reproductive choice: findings from "positive women: voices and choices" in Zimbabwe. *Reprod Health Matters* 2003; **11:** 162–73.
4 Berer M. HIV/AIDS, sexual and reproductive health: intersections and implications for national programmes. *Health Policy Plan* 2004; **19** (suppl 1)**:** i62–70.

The long and creative arm of the drug industry

In May, 2004, we separately received, in two US cities, taxi receipts that promoted prescription drugs. The receipt shown in the figure represents advertising for Zelnorm (tegaserod), a prescription-only medication for the short-term treatment of women with irritable bowel syndrome. The second receipt was for Lipitor (atorvastatin). Then, in November, 2004, one of us received a hotel room key advertising Zymar (gatifloxacin) and Acular (ketorolac trometamol), both ophthalmic solutions (figure).

These "reminder ads", often targeted at conference attendees but also reaching consumers, make no claims and thus are not required in the USA to include information about benefits, harms, or safety, unless the drug has a boxed warning.

Although marketing to physicians and consumers of prescription drugs in magazines and on television and the internet is becoming part of US and world culture, we find the extension of marketing in venues like this to be particularly worrisome. First, it shows that no scrap of paper or surface is safe from the reach of pharmaceutical manufacturers in their efforts to have patients exert pressure on their physicians to prescribe certain drugs. This pervasiveness reinforces the impression that drugs are little different from other consumer items, for which choice is more a matter of taste than of the difficult balancing of possible benefits against potentially serious, unwanted effects. Because reminder ads do not indicate what the drug is used for, some view them as benign, but such advertisements would not be used if they were not effective in promoting sales.

Second, advertisements such as this have no "sell by" date and could still be distributed without change after a product's withdrawal or after warnings are issued. In the case of Zelnorm, in April, 2004 (the month before the taxi receipt was given), the US Food and Drug Administration (FDA) announced the addition of new risk information to the drug's health professional labelling. The specific labelling revisions included a new warning about the serious consequences of diarrhoea associated with the medication, and a new precaution about ischaemic colitis and other forms of intestinal ischaemia.

Finally, reminder ads can be an effective way to market not only a drug, but a condition. The largest markets for many new drugs, particularly "me-too" treatments, come from convincing a small segment of the healthy population that it has a symptom complex that is newly considered a treatable medical disorder or risk factor. Thus, direct-to-consumer marketing is aimed not just at those with diagnosed diseases or conditions, but to anyone with a set of symptoms (or fears) who might be led to believe that they have a treatable condition needing medical intervention. Although drug companies laud the health promotion aspects of such campaigns, legitimate campaigns are better done for conditions about which the medical community agrees there is concern, and should be undertaken without naming the treatment.

Figure: **Taxi receipt (left) and hotel room key issued during American Academy of Ophthalmology conference (right)**

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*Kay Dickersin, Steven Goodman
kay_dickersin@brown.edu

Center for Clinical Trials and Evidence-based Healthcare, Brown University, 169 Angell Street, Box G-S2, Providence, RI 02912, USA (KD); and Department of Oncology, Division of Biostatistics, Johns Hopkins Schools of Medicine and Public Health, Baltimore, MD, USA (SG)

Department of Error

Carlberg B, Samuelsson O, Lindholm L H. Atenolol in hypertension: is it a wise choice? Lancet 2004; ***364:*** *1684–89*—In this Article (Nov 6), the third column of figure 2 (p 1688) should be headed "Other drug (n/N)". The e-mail address for correspondence (p 1684) should be "LarsH.Lindholm@fammed.umu.se".