First, $100,000 to $150,000 is an adequate income. The median family income in the United States in 1992 was $30,000. If we remind our prospective students (and ourselves) of the substantial nonmonetary rewards of being a physician, our profession should be assured of an adequate pool of future physicians. Lower compensation will be more palatable if coupled with reforms that lessen educational debt, reduce administrative hassles, and eliminate undeserved lawsuits.

Furthermore, as physicians work with political and health care–industry leaders to negotiate health care reforms, we risk not being taken seriously if we advance proposals that do not control the growth in the costs of physicians' services. To ask for a larger piece of the pie during this time of economic crisis is to endanger the credibility and good will that the profession still receives from the public. Such avarice would threaten our social contract with our patients, confirming the fear of some that physicians are abandoning their Samaritan traditions for the entrepreneurism of the medical–industrial complex.[2]

MARK GRUNWALD, M.D.
University of Missouri
Columbia, MO 65212 School of Medicine

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To the Editor: Whitcomb and Desgroseilliers overlook one important aspect of primary care when they recommend that "internal medicine should focus again on the general internist's traditional role as a diagnostician and consultant" — inpatient care. In my experience, an increasingly larger and disproportionate segment of inpatient medical care is provided by internists as greater numbers of family practitioners choose to provide office care only. Continuity of care between the outpatient and inpatient settings is important to the quality of care, the minimizing of unnecessary, redundant testing, and the efficiency of communication between the physician and patient, as well as to the patient's satisfaction.

It would be intriguing to compare other important aspects of primary care practice in Canada and the United States — namely, the relative amounts of inpatient care provided by the various specialties and the extent to which the obligations of on-call duties impose on primary care physicians.

MARK R. LENTZ, M.D.
Indiana, PA 15701 Indiana Hospital

To the Editor: Many articles in the *Journal* on the practice of medicine in other countries, such as those by Iglehart and by Whitcomb and Desgroseilliers, concentrate on the provision of medical services rather than the persons to whom those services are provided. Perhaps some of the problems in the U.S. system relative to the systems in other nations arise from tremendous differences in societies. I suspect that the characters of Canadian, British, and German society and perhaps even Japanese society are more similar to each other than any one of them is similar to ours.

Perhaps investigative resources could be devoted to comparing nations in terms of such variables as the average age, the number of lawsuits per capita, the number of guns per capita, the number of violent deaths per capita, the number of cases of drug addiction per capita, the number of cases of the acquired immunodeficiency syndrome per capita, an index of ethnic diversity, a measure of the migratory patterns of employed persons, the number of homeless persons per capita, the number of illegitimate births per capita, and the number of single-parent homes per capita. Such a comparison might illuminate the issue of whether health care programs that are successful in these countries would apply to a country that is more restless, impatient, violent, and chaotic than any of the societies whose health care systems have been profiled in previous articles in the *Journal*.

J.B. BENEAR, II, M.D.
Tulsa, OK 74136 Cancer Care Associates

To the Editor: Drs. Whitcomb and Desgroseilliers have provided an excellent analysis of the inadequate supply of primary care physicians in the United States. With somewhat mixed feelings, I must report that relief from British Columbia may be on its way.

Recent changes in U.S. immigration law have made it relatively easy for primary care physicians to immigrate to the United States and practice medicine there. The newly revised H-1B visa regulations require the physician to pass the Federation Licensing Examination or its equivalent as determined by the Department of Health and Human Services and to have an appropriate state license in order to perform clinical duties. Medical school graduates not approved by the Liaison Committee on Medical Education (LCME) must also show competence in English by passing the test of proficiency in English given by the Educational Commission for Foreign Medical Graduates.

For graduates of most Canadian medical schools, immigration may become even easier: there is a rumor that the Immigration and Naturalization Service has draft operating instructions that will allow a graduate of an LCME-approved medical school who has been issued a state medical license on the basis of reciprocity to qualify for an H-1B visa without having to pass the Federal Licensing Examination. Most Canadian medical schools have been approved by the LCME. At last count, 41 states will grant medical licenses on the basis of reciprocity to Canadian physicians who have passed the examination required by the Medical Council of Canada.

My physician clients in British Columbia tell me that they are eager to immigrate to the United States because the provincial government has attempted to ration health care services and cap doctors' fees. The economics of practicing primary care medicine in the United States look very attractive when one is escaping from a 52 percent tax rate and a 13 percent sales tax (federal and provincial).

My physician husband and I both feel that although this trend may be beneficial to the United States, it will have a devastating effect on the delivery of primary care services in British Columbia.

Vancouver, BC V7Y 1A1, Canada TERRY T. PRESHAW, J.D.
1500–701 W. Georgia St.

INFORMED CONSENT IN AFRICA

To the Editor: IJsselmuiden and Faden (March 19 issue)[1] describe a paper by one of us[2] as implying that there is only one African culture and that that culture is static. The paper does not make these claims. Rather, the paper is premised

on two basic sociological principles: first, although culture is multiform, peoples with common traditions in an area such as Central Africa share certain values, beliefs, symbols, and rituals of overriding importance,[3] and second, although culture is plastic and variable, it does not change rapidly or rampantly. We therefore do not consider the data cited in the Christakis paper to be as irrelevant or obsolete as IJsselmuiden and Faden claim.

IJsselmuiden and Faden state that there may be 900 different cultures in Africa, a proposition that is unsupported by history, social theory, and empirical observation.[3] Ironically, the authors, while criticizing others for assuming that there is a single African culture, make the same simplification when they draw an explicit analogy between pancontinental meetings "to bring together . . . African expertise to help redefine research ethics" and meetings leading to the Belmont Report, as if Africa as a whole and the United States were comparable sociological entities.

The authors base their critique of ethical pluralism on a refutation of the contemporaneity of the Central African idea that a person is "an extension of the family and . . . an intermediary between ancestors and future generations." Unfortunately, they present no new data contravening this finding, and they misconstrue research from Central Africa accumulated over the past few decades. They incorrectly allege that primarily as a result of urbanization, education, industrialization, civil war, and the acquired immunodeficiency syndrome (AIDS), traditional patterns of life in Africa have been not only disrupted, but also virtually swept away.

IJsselmuiden and Faden's overinsistence on the supplanting of traditional African cultural patterns by modern ones, as well as the dichotomous, traditional-versus-modern way in which they present these patterns, gives the impression that they consider "modern" to be superior to "traditional." Their argument appears to assume that first-person informed consent is both the most modern and the most moral way of proceeding, and that the two are interconnected. We reject this claim.

The same tendency to dichotomize inappropriately characterizes the authors' treatment of the rural and urban aspects of African societies. Their claim that modern urban life has removed Africans physically and socially from traditional village existence overlooks not only the continuing contact that urban dwellers have with their natal villages, but also the tendency for urban residents to live in village-like enclaves with persons of the same tribal and rural origin. Rural culture and urban culture in Central Africa are neither as discontinuous nor as different from one another sociologically and morally as the authors suppose. Indeed, even in terms of location, most Central Africans are rural.[4]

The authors' article points to a general problem in American bioethics: the paucity of social and cultural analysis.[5,6] This is partly a consequence of what bioethicists themselves describe as "the sacrosanct status given to the autonomy of the individual in the United States."[7] We believe that cultural analysis is an essential component of the ethical design of clinical research, particularly when the subjects and investigators come from different cultures.[8-12] Such analysis opens up new vistas on basic assumptions in American bioethics, which are only now beginning to be challenged.

NICHOLAS A. CHRISTAKIS, M.D., M.P.H., M.A.
RENÉE C. FOX, PH.D.
Philadelphia, PA 19104 University of Pennsylvania

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To the Editor: I am an obstetrician-gynecologist, since 1987 in charge of a prospective cohort study on the effect of maternal human immunodeficiency virus (HIV) infection on the outcome of pregnancy in Nairobi, Kenya. In the initial phase of the study, the principles of pretest counseling, informed consent, post-test information and counseling, and health education were strictly applied. Pregnant women at a clinic were given pretest counseling and health education on HIV and AIDS, and they were subsequently invited to participate in the study. Before blood was removed, oral informed consent was solicited. Less than 5 percent of more than 5000 pregnant women declined participation.

In my situation, I would like to emphasize that most patients consent to nearly anything if asked by a trusted authority — in this case, a medical person who is supposed to know what is best for the patient. Subsequently, HIV-seropositive women and seronegative controls matched for age and parity were referred to the research clinic. The women were informed of their HIV status, and the HIV-infected women were counseled in order to help them cope with the news. Health education was given to prevent further transmission and also to influence their subsequent reproductive behavior. It is striking that despite intensive information and education campaigns, only 4 percent of our patients ever asked spontaneously for their results.

Since 1991 we have changed our policy and inform only the women who ask for their results. Why? First, more than 80 percent of our patients are married women in stable relationships. More than one third do not want to inform their partners, fearing serious repercussions. Thus, the spread of the epidemic will not be influenced by trying to inform and educate this group with a low frequency of transmission. Second, influencing these women's subsequent reproductive behavior by informing them and counseling them to use family planning has not been very successful so far.[1,2] Since a cure is not available yet, there is nothing we can offer our patients. They did not ask to be "selected" for a research project and to be brought the bad news that only puts an additional burden on their lives. We often hear "I wish you had never told me."

MARLEEN TEMMERMAN, M.D.
Nairobi, Kenya University of Nairobi