Phutke Diagnostic ultrasonography access in rural India

**REVIEWER COMMENTS:**

Comments of Reviewer 1:

1. The paper addresses the topic of USG access, ostensibly for rural India, but never really elaborates on the ethical issues involved

We are surprised by this comment and would appreciate a mention of specific examples where an ethical concern was missed in any critical arguments. References to established ethical principles are made liberally in the piece. Nonetheless, we have extended the phrase “justice concerns” to include “ethical and justice concerns” throughout the revised piece to be more explicit.

2. While it is India specific, but again not from the ethical point of view, it does not ever mention patriarchy or gender discrimination nor acknowledge the role played by radiologists and Ob/Gyn in sex determination over the decades. In fact, it asks for policing, not necessarily a good thing.

We agree with the reviewer that gender discrimination is the root cause of sex-selective abortion, pre-natal sex determination and PCPNDT. Social reform is needed to address this, and that will take time. We intentionally did not address patriarchy or how to counter that because it is beyond the scope of this article. Our article is about access to diagnostic ultrasound in primary healthcare in rural India. We focus on the PCPDNT in as much as it is critical implications relating to access to a basic diagnostic service for the rural poor.

3. The point made about PCPNDT having reduced access to USG access to the rural poor in India is never substantiated. Despite referring to social justice, the authors do not demand that improved USG access should be available at the lower levels of rural public health sector facilities. They also need to distinguish between public and private sector access for the rural poor.

Reviewer is correct that our claim about lack of ultrasound access in rural areas is anecdotal and not supported by data in public domain. We have included our experience from rural Chhattisgarh in the revised manuscript.

Also, we appreciate the suggestion for clarifying public and private sector. We firmly believe that ultrasonography services should be available at peripheral levels including primary health centers (PHCs) and community health centers (CHCs) and have revised the manuscript to make this point clear.

4. The article seems to be more from the perspective of radiologists than of the rural poor. The suggestions are not backed up with data.

We take this suggestion (that we are more on the side of radiologists than our patients) as an affront. None of us are radiologists. We are advocating for making the ultrasound diagnostic technology accessible to non-radiologists. As such, our argument runs counter to the interests of radiologists.

Perhaps the reviewer meant that we are advocating for a technology-based solution instead of social intervention for the rural poor. If so, then we reiterate that these are not either-or scenarios -- both social and medical interventions have their place -- a rural Indian deserves both preventive as well as curative care.

5. The title may be misleading since it does not indicate that the main focus of the article is a criticism of the PCPNDT Act. Of course, many activists are of the opinion that the Act has not done what it was expected to do , not because it was not implemented strictly, but mainly because the solution it is trying to offer ( reduced misuse of technology for sex determination) does not address the problems it iosuse of technology for sex determination) article is the PCPNDT ACt.e and in fact repeatedly asks for more policings expecting to solve ( gender discrimination, patriarchy devaluing women, practice of dowry). The authors do not have an in- depth understanding of the issue and use phrases like ‘female feticide’.

Our piece is primarily about advocating for increasing access of rural poor to an appropriate diagnostic technology. The manner in which PCPNDT is regulated is a barrier to the above objective.

We do not claim to have a full understanding of patriarchy or gender discrimination issues or other issues the PCPNDT was designed to address. Our criticism of the PCPNDT Act only relates to its unintended, negative consequences in terms of the diagnostic armamentarium available to India’s rural poor.

Reviewer #1 does raise a fair point about the use of terminology throughout this piece. The PCPNDT only uses the term “sex selection” and we have modified the piece to reflect this same focus, though we recognize that the “sex selection” performed with the ultrasound is only the first step in a series of steps that the PCPNDT attempts to prohibit.

6. The authors need to include some in-depth discussion on the public and private sector radiology practice in rural India and recommend policy changes to address the lacunae in those, in order to improve access to USG facilities. Currently, the authors do not distinguish between public and private sector access for the rural poor.

The PCPNDT does not make any distinctions between hospitals in the public or private (or any other) sector. In that sense, this piece also does not strive to make such distinctions since access to ultrasound for the rural poor is an issue in all sectors. However, we have included relative lines about the public sector (namely access at PHCs and CHCs) in the revised manuscript as noted above.

7. On the one hand they share data of how task sharing is easy with the new technology but completely miss addressing how the changes in the PCPNDT Act will ensure that these short -term trainings will help foster more ethical or moral behavior that the 3 years radiology MD was unable to do.

We do not claim nor do we believe that the shorter trainings will correct the waylaid moral compasses of an unethical practitioner; just like a three-year PG training in Radiology cannot ensure that for its graduates. The strategy of task sharing neither strengthens nor worsens any individual’s ethical compass. The universal monitoring of all individuals (Radiologists, Obstetrician Gynecologists, those now certified through the shorter, more local coursework) with tamper proof and wireless internet accessible technology is our solution to these unethical practices.

Further, we believe task sharing is, in itself, an ethical act.

Comments of Reviewer 2:

1. The paper is relevant both for fields of law and ethics, and is very relevant to IJME.

Thanks, no further comment

2. It brings in critical evidence from the field and can influence policy and is well presented and supported.

Thanks, no further comment

3. It is very well developed and balanced. Indeed, the law must not act as a barrier in access to medical technology, rather clear guidelines for its use as well as certification for health workers is the way forward.

Thanks, no further comment

4. It would be good if the authors can access the evaluation of “Silent Observer” that was used in Maharashtra. This was not recommended as the district officials used the information to track pregnant women.

For this revised manuscript, we have researched more about the state of Maharashtra’s experiment with the silent observer in the Kolhapur District in 2011 and how they ultimately decided to not make use of this technology. We dedicate an entire paragraph to this concern with multiple references. Thereafter, we attempt to make suggestions to learn from the shortcomings of the previous device (how it could be over-rode easily or detached from the ultrasound machine) to improve the potential efficacy of the silent observer technology.

Nonetheless, we recognize that people with nefarious intentions are very intelligent and will often stop at nothing to break rules for personal benefit; no suggestion we make will be perfect. However, we believe that new technology developed since 2011 can allow both for a greater efficiency in policing the PCPNDT and, most importantly, allow for much broader access to ultrasonography especially for India’s rural poor.

4. No loose generalisations or omissions have been found.

Thanks, no further comment

5. Would the authors like to expand on the existing petitions in SC by cardiologists and other specialists for the amendments in PCPNDT? That would make it more contextual. And if they can also look at the recommendations made in these petitions and refer/reiterate those in their own problem solution/conclusion, it would make this paper more robust.

We have been able to get primary texts of two decisions (one from an important regional court, one from the Supreme Court) relating to the PCPDNT that further support the arguments in the manuscript. These verdicts are now cited as primary sources.