Thus, what may be unacceptable medical care in the cities may be acceptable in the jungle. What may be unacceptable to a wealthy patient, who can afford to obtain first-class medical care, may be tolerated by a peasant or an inhabitant of the barrios, who exists on an average per capita income of $200 a year.

It must also be recognized that many Latin American patients--for whatever the reason--do not have ready access to a physician. If they or their children are stricken, they seek help from the pharmacist. In many communities, there is no physician, and the pharmacist is the only health professional available. Accordingly, even though this may be in violation of the law, the pharmacist has no other recourse: he must diagnose, he must prescribe, and he must dispense. Tragically, the drug information available to the pharmacist is usually no better than that supplied to physicians, and he may be dangerously uninformed or misinformed.

Here, then, is the crux of the problem: it is not whether a physician or a pharmacist will be influenced in his prescribing decisions by such factors as poverty, cultural attitudes, and the like. It is whether or not he is given ready access to the scientific facts on which he can base the appropriate prescribing decision. It is whether or not the drug companies tell the truth--and all the truth.

The problem is not simply a matter of violating laws in the developing nations, as important as that may be. It is that what should be the objective presentation of knowledge is being