become more important—thus explaining the common finding of young patients with acute myocardial infarction without any measurable risk factors. With the failure of multiple risk factor intervention in those at moderate risk,^{3,4} there is little immediate alternative but to focus particularly on those found to be at high risk. The yield is now partly identifiable and the motivation of physicians and individuals is high.^{5,6}

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¹ Rose G, Reid DD, Hamilton PJS, McCartney P, Keen H, Jarrett RJ. Myocardial ischaemia, risk factors and death from coronary-heart disease. *Lancet* 1977;i:105-9.

² The Pooling Project Research Group. Relationship of blood pressure, serum cholesterol, smoking habit, relative weight and ECG abnormalities to incidence of major coronary events. Final report of the Pooling Project. *J Chron Dis* 1978;31:201-306.

³ Multiple Risk Factor Intervention Trial. *JAMA* 1982;248:1465-8.

⁴ Oliver M. Should we not forget about mass control of coronary risk factors? *Lancet* 1983;ii:37-8.

⁵ Hjermann I, Holme I, Byre KV, Leren P. The effect of diet and smoking intervention on the incidence of coronary heart disease. *Lancet* 1981;iii:301-10.

⁶ The Lipid Research Clinics Coronary Primary Prevention Trial Results. 1. Reduction in incidence of coronary heart disease. *JAMA* 1984;251:351-64.

Treatment with insulin pumps is no better than intensive conventional treatment

SIR,—I agree with the conclusion of Dr J J Bending and others (21 April, p 1187) that maximisation of diabetic control in diabetics with nephropathy is more difficult and less safe than in other diabetics. What I regret is that the authors imply that pump treatment of diabetics is better and more effective for maximisation of metabolic control than intensive conventional treatment with multiple injections. They have not shown that to be the case, and they undoubtedly know that many reports have failed to show a clear advantage for the pump.¹

We must remember that: (a) pump treatment is appreciably more expensive than intensive conventional treatment; (b) in general there is no clear cut advantage of one over the other; (c) the audience of the *BMJ* is made up to a large extent of general practitioners interested in good but pragmatic and economic approaches to treatment; and (d) that economic issues are even more important in Great Britain than in the USA. The authors should clearly acknowledge that what they call conventional insulin treatment can be maximised in order to achieve metabolic control similar to that achieved with insulin pumps.

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¹ Kitabchi A, Fisher J, Matteri R, Murphy M. The use of continuous insulin infusion delivery systems in treatment of diabetes mellitus. *Annual Reviews of Medicine* 1982;33:449-90.

Pulmonary aspiration: high dose steroids should be abandoned

SIR,—In any discussion of aspiration (2 June, p 1631) it is important to identify a group of patients who inhale non-toxic substances such as water or blood. This does not result in lung damage but in airway obstruction and hypoxia, and no specific treatment apart from relief of these problems, including perhaps ventilation, is required.

The classical acid aspiration syndrome (and for that matter alkali inhalation) is still a cause for major concern in obstetric anaesthesia and is associated with a high mortality. Bacterial studies do suggest that following chemical pneumonitis the lung is vulnerable to serious infection in between 25-45% of cases¹⁻³ and giving steroids may be a contributing factor.⁴ I believe, therefore, that antibiotics should always be administered.

Steroid treatment has a role in relieving bronchospasm, but I cannot support the recommendation for high dose steroid treatment. Dr John S M Zorab quotes animal work and accepts the evidence is "equivocal" but has failed to look at investigations in man. In two carefully controlled studies, one of aspiration⁴ and one of the allied condition of the adult respiratory distress syndrome,⁵ massive doses of steroids were given without benefit. High dose steroid treatment has become fashionable in the past decade, not only in serious respiratory problems but also in septicaemia⁶ and head injuries.

It is perhaps the frustration of dealing with these conditions with such a high mortality that led to this, but it is time for some realism to enter the matter. A clinical benefit would undoubtedly have appeared, and we are deluding ourselves that any good is being done. This is an extremely expensive treatment with an intimidating array of side effects and I would recommend that it be abandoned.

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¹ Bynum LJ, Pierce AK. Pulmonary aspiration of gastric contents. *Am Rev Resp Dis* 1976;114:1129-36.

² Arms RA, Dines DE, Tunstman TC. Pulmonary aspiration. *Chest* 1974;65:136-9.

³ Murray HW. Antimicrobial therapy in pulmonary aspiration. *Am J Med* 1979;66:188-90.

⁴ Wolfe JE, Bone RC, Ruth WE. Effects of corticosteroids in the treatment of patients with gastric aspiration. *Am J Med* 1977;63:719-22.

⁵ Lucas CE, Ledgerwood AM. Pulmonary response of massive steroids in seriously injured patients. *Annals of Surg* 1981;194:256-61.

⁶ Bihari DJ, Tinker J. Steroids in intensive care. *Br J Hosp Med* 1982;28:323-30.

Mutiny over Bounty?

SIR,—Despite its somewhat misleading title I found the article "Mutiny over Bounty?" (9 June, p 1737) both fair and constructive, with one important exception. It was stated that participating hospitals are not consulted about the content of the pack. This is untrue, and every effort is made to ensure that the contents are fully approved. At the time of writing there are over 100 variations in our pack content, which is mainly a reflection of the varying opinions of individual hospitals. As a result of consultation with hospitals, the Delrosa sample and Evian Water leaflet are no longer included in Bounty packs.

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SIR,—On booking for a second pregnancy at the hospital antenatal clinic we were presented with a Bounty "mother to be" pack by a midwife (9 June, p 1737). Its contents included: a sample of cream "which would prevent stretch marks"; a single disposable nappy plus a calculation proving that this particular brand

would work out cheaper than terry nappies—assuming that only four nappies a day were required (an ideal recipe for nappy rash); and a sample of an infant drink containing mainly glucose and fennel extract said to be "suitable for babies from age one week."

Though we eventually spotted the small print stating that these things were not being recommended by the hospital, the fact that Bounty packs were distributed in the antenatal clinic would undoubtedly imply just such a recommendation to most patients. If hospitals are going to continue to distribute these so called gift packs surely they must exert firmer control over their contents. How else can they attempt to provide consistent health education for pregnant women? In our view they would do better to dissociate themselves altogether from commercial interests. An excellent alternative is now available—the Health Education Council's *Pregnancy Book*.¹ The common sense contained in this book is worth more than any number of free samples.

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¹ Kohner N. *The pregnancy book*. London: Health Education Council, 1984.

The GMC should be more concerned with the postgraduate rather than the primary qualification of overseas doctors

SIR,—Professor J A Strong draws attention to a problem of vital importance for the medical education and training of many developing countries (12 May, p 1460). The state of higher training in medical sciences in Bangladesh is an outstanding example.

The health services and the medical education system in this country were built up by people who had their training in the United Kingdom in the past, when their qualifications were registrable with the General Medical Council. The need for more doctors has led to expansion of the system. There are now about 12 000 medical graduates for a population of about 100m. Postgraduate medical education was started in 1966 for the following reasons: (1) It was felt necessary to train specialists oriented towards medical problems prevailing in their own country. (2) Training abroad of the larger numbers of specialists needed with the expansion of health services would have been prohibitively expensive. (3) Graduates venturing abroad for specialist training were often lost to the country because they failed to obtain qualifications and did not return, or took up jobs elsewhere in the world after qualification.

The postgraduate education system in this country was modelled on the UK system. Sir J D S Cameron was the first director of the postgraduate institute, and we continue to have examiners from UK for various postgraduate examinations.

Eighteen years after opening facilities for postgraduate education we have about 1000 specialists, of whom 800 have had their postgraduate training locally. Although this has gone a long way towards fulfilling the requirement for medical teachers and specialists, there still remains the need for further training of many of these specialists. This is because the country lacks facilities for advanced training in many specialties. Moreover, medical science is advancing. The standards of medical education and health care in this country can be kept up to date only by having channels for advanced training abroad for these specialists. These channels were open in the past, and many local postgraduates are contributing importantly towards the development of medicine in this country after advanced training abroad. For the past six years, however, these avenues have

been blocked as GMC registration is no longer granted to graduates from Bangladesh.

Medical education in Bangladesh now faces an uncertain future. It is felt here that recognition of postgraduate qualifications by the GMC would have several advantages. (1) It would re-establish the links that medicine in this country traditionally had with the UK and would improve the standards of medical education and practice here. (2) It would select for training those who have proved their capability and aptitude by obtaining postgraduate qualifications locally. (3) It would ensure that these people return to their own country after training. Figures from this country show that with rare exceptions local postgraduates who were sent abroad for higher training have returned. This would also prevent stagnation of overseas doctors in the UK.

Bodies concerned with postgraduate education in this country (the Institute of Postgraduate Medicine and Research, and the College of Physicians and Surgeons of Bangladesh) have already made approaches to the GMC and the royal colleges. It can only be hoped that the points raised by Professor Strong receive the consideration that they deserve.

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SIR,—Postgraduate students from Pakistan have been facing a dilemma which might serve to bring to light the present absurdity of the GMC's position on registration of overseas doctors. The fellowship of the College of Physicians and Surgeons, Pakistan, modelled on British qualifications, has been favourably commented on by the external examiners who have come from the British royal colleges. As a result of the rigid standards the Joint Committee of Higher Medical Training (JCHMT) has recognised the FCPS in medicine and paediatrics to be a suitable qualification for postgraduate training without having to pass the MRCP.

But the trainees must pass the Professional and Linguistic Assessment Board (PLAB) before they get the necessary limited registration for the purpose of training. We were recently told of a sponsorship scheme (19 November, p 1492), but countries like Pakistan which are no longer in the Commonwealth are not likely to benefit from this scheme for financial reasons. More than that, it is the present rules of the GMC which are going to be a major hurdle to any collaboration between the UK and other countries. I think that the longstanding links have to continue for the benefit of both countries, and it remains the moral responsibility of the UK to pass on its clinical and technical knowledge to those countries which were dependent on it until yesterday.

There is clearly a need for rethinking by the GMC. Countries like Pakistan which have established their postgraduate diplomas should be treated differently, and their postgraduate diplomas should not be treated as the same as primary undergraduate qualifications. These diplomas need to be accorded a higher status than an MB, BS degree. I hope that the various royal colleges as well as the JCHMT will voice their opinion in support of overseas postgraduate diplomas which have been found to be of a standard commensurate with their own diplomas—leaders in medical education in the UK owe it to the newly established colleges.

I hope that the views of Professor Strong, which I support unreservedly, will be

supported by the other colleges and will change the thinking of the GMC. Furthermore, I endorse his view that if legislation is to be changed the question will have to be considered in responsible circles. Without change, postgraduate training in the UK will remain a mirage for Pakistani students with postgraduate diplomas.

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SIR,—Professor J A Strong deserves thanks for bringing to light one of the most important issues concerning the qualifications of overseas doctors and the responsibility of the General Medical Council (12 May, p 1460). It is now almost 100 years since the GMC established the principle of registration based on basic or primary medical qualification.

Medical education in the developing world has undergone revolutionary changes. Medical institutions have proliferated, postgraduate institutions have developed, and colleges of physicians and surgeons have been established. Many developing countries today discourage their graduates from taking overseas postgraduate examinations and encourage them to take postgraduate qualifications at home. Many countries in south east Asia have organised postgraduate courses leading to various qualifications. Pakistan and Bangladesh, for example, have their colleges of physicians and surgeons. The one in Pakistan was established as early as 1962, while the Bangladesh College of Physicians and Surgeons came into being in 1972, soon after the liberation of Bangladesh.¹ It takes a minimum of five years after graduation for a postgraduate to obtain the FCPS (Fellowship of the College of Physicians and Surgeons of Bangladesh). At home these fellowships are considered equivalent to British qualifications.

Professor Strong rightly states: "Many postgraduate colleges and academies overseas are well known to and respected by UK doctors who have participated in their training programme or served as external examiners." Describing his visit to Bangladesh (and India), Dr R F Robertson remarked: "The FCPS diploma is the hallmark of completed training as a specialist and is awarded after what we would in the UK call an "exit" examination. . . . Those who believe that the MCQ part I of the MRCP (UK) is a hard examination might well change their minds after having a go at the Bangladesh college part II. . . . I was honoured by being asked to examine in medicine in which there were seven candidates of whom two passed. I was satisfied that the standard in medicine is as high as in the MRCP (UK) part II. The written papers, of essay and short answer type, are perhaps slightly 'old fashioned' but the clinicals and orals are basically no different from corresponding examinations in the United Kingdom, Singapore, Nigeria, and Pakistan."² Similar opinions have been expressed by Sir Francis Avery Jones (personal communication) and Dr S C Truelove.³

Whatever may be the standard of primary medical qualifications there is no doubt that the postgraduate education in many developing countries like Bangladesh has maintained the quality which has been recognised by the participant examiners from the UK. It is unfortunate that because of our obstinate conservatism we are still adhering to the principles enunciated a century ago.

We are grateful to the Commonwealth Foundation and to the Ministry of Overseas Development for the award of various scholarships for advanced training in medicine in the UK. But alas these are all in vain. Our postgraduate qualified doctors are deprived of these opportunities on the grounds that they do not have a registrable qualification.

It is therefore a matter for serious consideration by the GMC whether "it should be more concerned with the postgraduate rather than the primary qualifications of overseas doctors." The plea made by Professor Strong is backed by facts which should remove our prejudices if we really wish to have an academic link between the UK and some of the developing countries like Bangladesh.

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¹ Islam N. Postgraduate medical education in Bangladesh. *Bangladesh Quarterly* 1983;3:7.

² Robertson RF. Visit to Bangladesh (and India). *Journal of the Royal College of Physicians of Edinburgh* 1982;12:14.

³ Truelove SC. Quoted in: Islam N, ed. *History of the Institute of Postgraduate Medicine and Research*. Dacca: IPGMR, 1978:144.

Doctors and pharmacists

SIR,—The call for a more professional role for pharmacists from the General Medical Services Committee in its evidence to the Nuffield inquiry will be greatly appreciated by most pharmacists in general practice.¹ Our "efforts on the retail side of the business to maximise remuneration" do not, I assure you, "militate against . . . development as dispensers and advisers on medicine."

When I qualified as a pharmacist our period of academic training in dispensing and as advisers on medicines was two years. At that time the dispensing course for a medical student at the local university was 24 hours. Things may have changed in the past four decades, notably in pharmacology and biochemistry; medical and pharmaceutical students now devote comparable time to these subjects.

About 70% of the retail pharmacist's income is derived from dispensing NHS prescriptions, the remaining 30% from sales. The fact that goods are sold under specialised supervision over a counter as distinct from services and medicines supplied from a surgery does not put us in a different category professionally from GPs.

Much of the 30% of counter sales is derived from recommended medicines for minor ailments, first aid applications, toiletries, and specialised foods. All but a few "pharmacy only" category medicines are sold in intense price competition with multiple stores and supermarkets.

The 70% of pharmacists' income from NHS dispensing comes from between 2500 and 3000 prescription items on average each month. From personal experience in a rural practice until retirement recently I could have acquired an average income of £17 000 a year by dispensing the lower figure of 2500 items. This was not possible as the local dispensing doctors did not agree to my offer of a dispensing and delivery service within a three mile radius of my pharmacy in distinction to the one mile radius decreed in 1911 and still enforced 70 years later to the advantage of the dispensing doctor. This conflict, with rich rewards for doctors with 2000 or more patients, has prejudiced cooperation between both professions for many years and has been publicised freely since 1977.

The recommendations of the Clothier Committee, accepted reluctantly by pharmacists under threat of withdrawal by doctors over a year ago, purported to resolve this antagonism. Yet since then the NHS Ombudsman, Sir Cecil Clothier, has found that rural dispensing regulations have been wrongly applied by the Dorset Family Practitioner Committee in the issue of multiple option forms and the transfer of patients to doctor dispensing lists.

The rural dispensing committee under the chairmanship of Sir Alan Marre has medical and pharmaceutical members who are actively engaged in rural dispensing and have not been required to