least when temperature has stabilised and temporary disruptions have passed, would be beneficial.

Scientific assessments of emotive topics of this kind have in the past been notoriously subject to distortion by public misconceptions. The belief that 100 000 British people died of hypothermia in cold houses every winter persisted for many years, and it still does in some quarters. In fact, recorded deaths from hypothermia never exceeded 500 per year, and such deaths indoors virtually all result from collapse due to other illness.² These misapprehensions seriously delayed scientific work on the subject despite longstanding evidence that many deaths in winter are caused by arterial thrombosis.³ This arterial mortality has been little affected by home heating and is apparently due mainly to haematological changes produced by excursions outdoors in cold weather.^{4,5} Deaths in winter from respiratory causes, which are less numerous, have by contrast fallen with the increase in central heating in Britain in recent years.

Seasonal mortality and age structure of population in England and Wales and Mediterranean countries

	England and Wales	Portugal	Greece
Increase in mortality January-March v July-September (%)	32.6	37.6	34.2
% Of population over 60	20.0	14.3	17.5

Values for 1976-83 from United Nations demographic year-books.

It is right for us to be concerned about possible consequences of global warming, which go much wider than direct effects of temperature on human mortality. It also seems sensible to seek ways to moderate the warming until its size and consequences are better assessed. However, that assessment should not assume an adverse effect of moderate global warming on human health.

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- Haines A. Global warming and health. *BMJ* 1991;302:669-70. (23 March.)
- Woodhouse P, Coleshaw SRK, Keatinge WR. Factors associated with hypothermia in patients admitted to a group of inner city hospitals. *Lancet* 1989;ii:1201-3.
- Rose G. Cold weather and ischaemic heart disease. *Br J Prev Soc Med* 1966;20:97-100.
- Keatinge WR, Coleshaw SRK, Cotter F, Mattock M, Murphy M, Chelliah R. Increases in platelet and red cell counts, blood viscosity, and arterial pressure during mild surface cooling: factors in mortality from coronary and cerebral thrombosis in winter. *BMJ* 1984;289:1405-8.
- Keatinge WR, Coleshaw SRK, Holmes J, Evans S. Changes in seasonal mortality with improvement in home heating in England and Wales 1964-1984. *Int J Biometeorol* 1989;33:71-6.

Abuse of student electives

SIR,—Dr Martin F Wilks reveals remarkable ignorance of what British medical students do on their electives.¹ At Oxford our clinical students mainly go abroad, most to Third World countries, although some go to centres of excellence in Canada, Australia, or the United States. They have been to most African countries, from the Sudan and Ethiopia to Nigeria and Cameroon. They have been to Greenland, China and Japan, Papua New Guinea, India and Pakistan, Brazil and Peru, Thailand, and Iran, to mention but a few destinations.

Dr Wilks may unwittingly be right when he says "British is the best." So many continental medical schools suffer from the curse of misplaced egalitarianism: everybody who wants to read medicine is (or used to be) let in, regardless of ability to benefit from the course. Result: large numbers of students and lack of real contact between teacher and the taught. I have gone

through the whole of the medical course and qualified in Copenhagen, and because just after Hitler's war there was no reciprocity between Scandinavia and the United Kingdom I started again from scratch and went through the medical course and qualified at Oxford. There is no doubt in my mind about which was the better medical school.

Medicine should be fun. Who would want to go to Germany when you can see *real* medicine in Farfarawayistan? .

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- Wilks MF. Abuse of student electives. *BMJ* 1991;302:663. (16 March.)

Problems of new overseas doctors in the United Kingdom

SIR,—Following Dr R S Bhopal's letter on racial discrimination in British medicine,¹ I wish to draw attention to the problems encountered by doctors newly arrived in the United Kingdom. Overseas doctors are an important part of the NHS and they will probably continue to be required for the service to run effectively.

Most graduates from abroad join the NHS by sitting the General Medical Council's Professional and Linguistic Assessment Board examination. This two part examination assesses medical knowledge as well as written and spoken English. Others join through the Overseas Doctors Training Scheme, sponsored jointly by academic bodies in their home countries and the royal college. This exempts them from the GMC's examination.

Most overseas doctors working in the NHS come from Africa and Asia, where English is the language of medical education and practice. Reading medical texts is not difficult for these doctors, but the active language is quite another matter. They face problems understanding their colleagues, nurses, and patients because of regional accents and the speed of spoken English.

Other problems include differences in hospital practices and culture. Requesting investigations and getting results over the phone, and communicating with nurses, relatives, and general practitioners are all part of a new experience that takes time to get used to. Such problems affect the efficiency of new doctors during the first months of their job and create a poor impression on colleagues and consultants. This can lead to diminished professional rapport, lack of confidence, and a sense of inadequacy. It may also affect job references and examination performance. A practical solution would be for overseas doctors to have a run in period of clinical attachment for two to four weeks before starting their job in the same hospital. This would help them get used to the system and the language. They should then be able to perform their duties more efficiently and avoid unnecessary and largely unjustified discrimination.

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- Bhopal RS. Effects of discrimination on careers of British medical graduates. *BMJ* 1991;302:235. (26 January.)

Attendance allowance

SIR,—In his discussion of the attendance allowance Mr Simon Ennals remarks that doctors are ideally placed to spot potential claimants and to help with making a claim.¹ As doctors in a cystic fibrosis clinic we look after children with a condition in which the outcome may depend largely on the amount of parental input. We aim to inform all

parents of the attendance allowance and other appropriate allowances available through the Department of Social Security, and we strongly support their claims.

We asked families in our clinic about their experiences in applying for the attendance allowance. All families with a child receiving full care from us and within the age group eligible for the allowance at the time of survey took part (33 families, 38 children). Of those receiving attendance allowance, 23 had succeeded on the first application and two after appeal. Of those not receiving the allowance, five had applied once, six had appealed, and two had not applied.

We found that younger (and therefore fitter) children were more likely to be receiving the allowance: eight of nine aged 2-5 years, 10 of 17 aged 5-10, and 7 of 12 aged 10-15. This was not necessarily a reflection of recent change in assessment policy as five families of children who had initially been refused the allowance had recently unsuccessfully reapplied. Nor was there an overall correlation between clinical score^{2,3} and success in application.

Good health and improving life expectancy in cystic fibrosis are directly linked to diligent daily treatment. All our patients have the same disease, requiring virtually the same treatment, which is usually delivered by their parents. The attendance allowance is granted on the basis of need, and this survey arose from our realisation that, despite this uniformity of need, not all our patients were receiving the allowance.

We noted that when claiming the attendance allowance parents are often distressed by the lack of understanding displayed by the medical assessor. In several cases the assessor was reported to have "taken one look at the child, and said that he was too well to need the allowance" (the parent's words). Mr Ennals may be right in saying that doctors are in a good position to advise patients about the allowance, but we have come to the conclusion that many of the assessing doctors (possibly retired adult specialists) may simply not understand the special needs of children with cystic fibrosis. Especially relevant is the simple concept that the child appears well as a result of the "attendance" for which the allowance is being claimed.

As medical advances in cystic fibrosis reach the headlines and the prospects for definitive treatment and cure brighten we should not forget the hard work being done every day by the families of affected children. We believe that the attendance allowance should be granted to all these children.

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- Ennals S. Attendance allowance. *BMJ* 1991;302:228-30. (26 January.)
- Schwachman H, Kulczyki LL. Longterm study of one hundred five patients with cystic fibrosis. *Am J Dis Child* 1958;96:6-15.
- Taussig LM, Kattwinkel J, Friedewald WT, di Sant' Agnese PA. A new prognostic score and clinical evaluation system for cystic fibrosis. *J Pediatr* 1973;82:380-90.

Childhood immunisation in the new decade

SIR,—The subtitle of Dr Peter D Rudd's editorial asserts that "Earlier schedules should produce better protection," but the evidence lacks conviction.¹ Dr Rudd mentions outbreaks of measles in vaccinated American children but not the report from 30 schools in Wisconsin showing that 83% of the 170 vaccinated patients had received their measles vaccine before 15 months of age, compared with only 39% of the 144 vaccinated healthy controls.² Likewise, the efficacy of measles vaccine in India increased from 50% in children vaccinated