adherence to the definitions of NHS codes for source of admission and discharge destination, coupled with a simple change in one of the codes, could dramatically improve the quality of the data and provide a meaningful tool for audit on a national scale.

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1 Lewis PA, Dunn RB, Vetter NJ. NHS and Community Care Act 1990 and discharges from hospital to private residential and nursing homes. *BMJ* 1994;309:28-9. (2 July.)

No significant change in discharges

EDITOR,—Peter A Lewis and colleagues confirm several conclusions that were drawn from a small pilot study carried out in Dundee.² Admissions to medicine for the elderly wards for the three months 1 April to 30 June 1992 were compared with those in the same period in 1993. The percentage of patients discharged home, although slightly higher in 1993 (122/166 (73%)) than in 1992 (134/197 (68%)), was not significantly different. There were no differences in the proportions discharged to residential homes or to nursing homes, and the length of stay was similar for both years.

When delay in discharge (defined as days when a patient was in hospital but not receiving treatment) was examined it was found to be associated with referral to a social worker in both years. Delay was most likely to be due to the time taken to organise an appropriate outcome, but the client's choice of care was also an important factor. There was no significant change in the number of patients experiencing a delay after the implementation of the NHS and Community Care Act; in fact, numbers fell slightly in 1993 (23/166 (14%)) compared with 40/197 (20%) in 1992). Though the problems may have been similar in both periods for individual cases, there is a danger that because of the need to refer many more cases to social workers, more patients will have extended stays in hospital.

This pilot study is now being followed up by a more detailed investigation. Further information can be obtained from us.

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1 Lewis PA, Dunn RB, Vetter NJ. NHS and Community Care Act 1990 and discharges from hospital to private residential and nursing homes. *BMJ* 1994;309:28-9. (2 July.)
2 Easton PM, Oliphant JB. *Closing the gap: the pilot study on geriatric assessment. A collaborative project between Tayside Health Board, Tayside Regional Council and the University of Aberdeen, Priority Services Research Team.* Dundee: Tayside Health Board, 1994.

Juvenile onset inflammatory bowel disease

Is more common in people with Turner's syndrome

EDITOR,—I believe that, in their paper on inflammatory bowel disease of juvenile onset, Anne Ferguson and David M Sedgwick do not adequately consider the possibility that the female patients who were growing particularly slowly had Turner's syndrome.¹ They report on three women with a height of 140 to 145 cm, which is around the 50th centile for Turner's syndrome. They make no

mention of chromosomal studies being performed on these women, and I do not believe that their assessment of pubertal status would necessarily help in diagnosis of the syndrome. Crohn's disease is many times more common in people with Turner's syndrome than other people.^{2,3}

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1 Ferguson A, Sedgwick DM. Juvenile onset inflammatory bowel disease: height and body mass index in adult life. *BMJ* 1994;308:1259-63. (14 May.)
2 Cola JA, Grant DB. Crohn's disease in Turner's syndrome. *BMJ* 1981;282:950.
3 Price WH. A high incidence of chronic inflammatory bowel disease in patients with Turner's syndrome. *J Med Genet* 1979;16:263-6.

Author's reply

EDITOR,—Clinical monitoring of our geographically based cohort of patients with juvenile onset inflammatory bowel disease has shown a continuing high morbidity during the 14 years of follow up, particularly in Crohn's disease.¹ We had anticipated that this would lead to permanent growth failure, with abnormally short stature in adult life, in a significant proportion of these young people, but it emerged that only three of the 70 were thus affected. We could not identify any common factors in the three, but it had not occurred to us to consider Turner's syndrome and we thank A M Scammel for drawing the matter to our attention. None of the three women had the classic clinical appearances of Turner's syndrome, but this would not exclude mosaicism. Chromosome studies were not performed.

However, Turner's syndrome does seem unlikely. One young woman has recently been delivered of twins; a second was noted to have normal uterus, fallopian tubes, and ovaries at a laparotomy at age 19 and has since menstruated regularly. The third patient had onset of Crohn's disease at age 12; menarche was at age 14, and she has had entirely normal menstrual cycles for eight of the 10 years since then.

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1 Ferguson A, Sedgwick DM. Juvenile-onset inflammatory bowel disease: Predictors of morbidity and health status in early adult life. *J R Coll Physicians Lond* 1994;28:220-27.

Overseas Doctors Training Scheme

NHS reforms are causing problems

EDITOR,—The intercollegiate committee of the royal colleges discussed the Overseas Doctors Training Scheme in May. The objectives of the scheme, criteria for recruitment, method of organisation, financial implications, and evaluation deserve urgent consideration. It is exceptional to be able to provide a structured training with clinical participation.

Difficulties are compounded because the plans for postgraduate training in Britain (the Calman scheme) and the arrangements for staffing the health service are not coordinated. A reduction in middle grade posts—traditionally training posts—is occurring at a time when consultant posts are to be expanded. With the reduction in registrar posts some "visiting registrar" positions are being created, which are suitable for overseas doctors who already have a sound clinical grounding. These posts should give training comparable to that of career registrars (this grade will metamorphose into the unified training grade). The Royal

College of Physicians of Edinburgh is promoting this scheme and plans to identify and probably interview doctors in several overseas centres.

Costs and funding were inadequately considered in the articles by Stella Lowry and Heather Cope¹ and Tessa Richards.² For many years the NHS has benefited from the work of overseas doctors, whose training it has not had to fund. The royal colleges have run the Overseas Doctors Training Scheme, finding training positions for the doctors, many of whom also provide valuable service. The government should fund the scheme before training becomes a "marketplace" issue. Some colleges believe that trainees should pay as it is less expensive for them to obtain posts through the scheme than by sitting the examinations of the Professional and Linguistic Assessment Board. Other colleges argue that hospitals and trusts should pay them as they reduce the costs of advertising, interviewing, etc.

Richards is not correct when she says that the Edinburgh college "mostly takes on inexperienced doctors." We attempt to find training places for those who have passed part I of the examination for membership of the Royal College of Physicians and require clinical experience in preparation for part II. She is right when she says that the scheme is often "run by a skeleton staff." The most successful placements for overseas doctors are with consultants known personally who have empathy, run busy active units, but sometimes have difficulty filling posts. Matching requirements and opportunities is a continuing but worthwhile challenge. After gaining useful experience in Britain many trainees return to important positions in their own countries.

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1 Lowry S, Cope H. Postgraduate training for overseas doctors in Britain. *BMJ* 1994;308:1624-6. (18 June.)
2 Richards T. The overseas doctors training scheme: failing expectations. *BMJ* 1994;308:1627-31. (18 June.)

Really an employment scheme

EDITOR,—Training received in Britain is of little use in the Indian subcontinent; this is especially the case in orthopaedic surgery, in which recent advances depend on instruments and implants. Because of the economic conditions in the Third World these are rarely available. The primary aim of the Overseas Doctors Training Scheme is to train doctors and send them back to practise in their own countries,^{1,2} but this aim is seldom fulfilled. All the scheme achieves is that experienced junior doctors (most of whom are considered senior doctors in their own countries) are placed in vacant slots to "achieve the balance" for the British government.

On the other hand, the scheme gives these doctors a chance to spend the initial four or five years (after postgraduate qualification) earning much more than they would in their own countries and in a pleasant work environment. These initial years are difficult in the doctors' own countries as jobs are few for postgraduates. Either they set up in private practice (which is financially difficult) or they get government jobs with meagre salaries. Most doctors who come to Britain on the Overseas Doctors Training Scheme try to extend their permit free training (four years) on flimsy grounds and take up long running registrar posts, which culminate in their taking staff grade posts or moving to greener pastures in the United States. This is because of the enormous career difficulties they face when they return home.³

I speak from personal experience: I trained in Britain, went back to India, was dissatisfied, and was then fortunate enough to get a job as a consultant in Britain. Perhaps the scheme should