be renamed the Overseas Doctors Employment Scheme.

RAMESH K NAYAK
Consultant orthopaedic surgeon

Louth County Hospital,
Louth LN11 0EU

- Lowry S, Cope H. Postgraduate training for overseas doctors in Britain. *BMJ* 1994;308:1624-7. (18 June.)
- Richards T. The overseas doctors training scheme: failing expectations. *BMJ* 1994;308:1627-31. (18 June.)
- Patel V, Araya R. Trained overseas, unable to return home: plight of doctors from developing countries. *Lancet* 1992;339:110-1.

Fine tuning required

EDITOR,—*Achieving a Balance* and the recent Calman report on postgraduate training affect the way in which overseas doctors fit into the training system in Britain. The establishment of the Overseas Doctors Training Scheme was necessary to prevent overseas doctors being used merely as pairs of hands in inappropriate placements with little supervision. As Tessa Richards suggests, however, it is time to review the workings of the scheme for two reasons: to assess whether it continues to offer what it set out to do and to update its function in accordance with the current changes in the NHS.¹

For the past year I have been the coordinator for overseas trainees in psychiatry in the Yorkshire region and have become aware of their problems. In my opinion, the committees running the scheme should be more aware of the needs of the overseas trainees before deciding on placements on rotational schemes in Britain. The interests of the overseas trainees are even conflicting at times. The trainees might already have worked in the specialty for some time and have acquired specialist status in their own country. Slotting into a rotational scheme that is introducing trainees to psychiatry, for example, over three years might be regarded by overseas trainees as unnecessary. Prior knowledge of the overseas doctors' training needs could result in a more appropriate placement being made. The overseas sponsor must make more explicit recommendations, not only regarding the trainee's work and character but also regarding what he or she specifically needs to gain from training in Britain. Once the training placement is found the tutor on the scheme must help the trainee with adjusting to the new culture, language, and workplace.

D S HOLMAN
Coordinator, overseas trainees, Yorkshire region

Department of Psychological Medicine (Children),
General Infirmary,
Leeds LS2 9NS

- Richards T. The Overseas Doctors Training Scheme: failing expectations. *BMJ* 1994;308:1627-31. (18 June.)

Should take better qualified doctors for shorter periods

EDITOR,—As a trainee on the Royal College of Psychiatrists' Overseas Doctors Training Scheme, I wish to comment on several issues raised by Tessa Richards.¹ The scheme can result in trainees repeating much of what they have already done, and its duration—four years—can make resettlement difficult. Almost all developing countries have postgraduate training programmes of their own, even in subjects such as psychiatry.² Faced with increasing competition from doctors who qualified in their own country and have maintained continuity in their careers there, overseas doctors will have great difficulty in finding a suitable job on their return, even with British qualifications. Thus it is important to provide higher specialist training to well qualified, experienced graduates for a shorter duration.

Three changes are needed in the scheme. Firstly, only overseas trainees with a postgraduate

qualification (preferably equivalent to membership of the royal colleges) obtained in their own country should be selected for the scheme. Secondly, the period of training in Britain should be limited to two years. This would comprise a six month induction period—for example, in general adult psychiatry—followed by one and a half years in a subspecialty in which the trainee wants higher training. Thirdly, the sponsor's commitment to provide a suitable position for the trainee on his or her return should be monitored closely and used as a criterion for the provision of training positions in future.

These changes would facilitate resettlement of overseas doctors at the end of their training and would also increase the number of training posts, thus meeting to some extent the heavy demand for such training in Britain. I am optimistic that the training authorities in many developing countries could contribute to the extra cost of implementing these changes. At present many of these institutions—for example, the College of Physicians and Surgeons in Pakistan—send qualified trainees for similar placements in many subspecialties, funding them for the whole training period.

If the current trends in the Overseas Doctors Training Scheme continue Britain will continue to gain experienced and well qualified doctors. Trainees will, however, continue to trickle from developing countries and perhaps be uprooted from a career in their own country.

S F FAROOQ
Registrar

Academic Unit,
Department of Psychiatry,
All Saints Hospital,
Birmingham B15 5SD

- Richards T. The Overseas Doctors Training Scheme: failing expectations. *BMJ* 1994;308:1627-31. (18 June.)
- Orley J. International collaboration for post-graduate psychiatric education. *Social Psychiatry and Psychiatric Epidemiology* 1990; 25:65-6.

Definition of the sudden infant death syndrome

Keep current definition

EDITOR,—In 1992, at the second international conference on the sudden infant death syndrome in Australia, it was decided to keep the 1969 definition: "the death of an infant or young child, which is unexpected by history and in whom a thorough necropsy examination fails to reveal an adequate cause of death." Caroline Rambaud and colleagues regard this definition of exclusion as "questionable,"¹ but we consider that it is essential until more is known of the causes and mechanisms of sudden death in infancy. Although opinion differs over what constitutes "thorough" necropsy examination and what is an adequate cause of death, Rambaud and colleagues understate the wide international agreement on these issues that has been achieved over the past decade.²

Minor histological abnormalities are frequently seen in victims of the sudden infant death syndrome at necropsy. Less than a fifth of sudden unexpected deaths are explained by "diseases of poor prognosis" in most countries, whereas in the French reference centre these abnormalities are perceived to have caused three quarters of sudden infant deaths.³

To overcome these differences in interpretation Rambaud and colleagues propose adding to a modified definition of the syndrome a subclassification based on minimal pathological features. The World Health Organisation's rules for selecting underlying cause of death require, however, that specific diseases and disorders are given preference over non-specific causes such as the sudden infant death syndrome. This means that when the syndrome is reported together with

another disorder the rules require that the other disorder is selected and classified as the cause of death. The proposed definition would be a considerable step backwards as far as international comparisons are concerned.

Rambaud and colleagues argue that many "so called" but unspecified epidemiological studies are misdirected and will include many cases of the sudden infant death syndrome which they would have classified differently. If the studies misclassified cases this would reduce their likelihood of identifying differences between cases and controls. Yet these epidemiological studies have contributed much to our knowledge of the condition, have led to prevention programmes, and have resulted in a substantial reduction in the number of deaths, many of which would not have been classified as due to the syndrome by French pathologists.

If adopted, would their modified definition be useful? If the epidemiological characteristics of babies dying of the syndrome who had minimal inflammatory changes were different from those of babies who did not have inflammatory changes then changing the definition might be worthwhile. Until this has been shown we should keep the 1969 definition, which has been shown to be useful and has stood the test of time.

E A MITCHELL
Associate professor of paediatrics

Department of Paediatrics,
University of Auckland,
Auckland,
New Zealand

D M P BECROFT
Paediatric pathologist

Department of Obstetrics and Gynaecology,
National Women's Hospital,
Auckland,
New Zealand

R W BYARD
Pathologist

Department of Histopathology,
Adelaide Children's Hospital,
North Adelaide,
Australia

P J BERRY
Professor of paediatric pathology

Department of Paediatric Pathology,
University of Bristol,
Bristol

P J FLEMING
Professor of paediatrics

Institute of Child Health,
Bristol

H F KROUS
Director of pathology

Children's Hospital—San Diego,
San Diego, CA,
USA

K HELWEG-LARSEN
Associate professor in pathology

Vital Statistics,
Danish National Board of Health,
Denmark

M VALDES-DAPENA
Professor emeritus of pathology and paediatrics

Department of Pathology,
University of Miami School of Medicine,
Miami, FL,
USA

- Rambaud C, Guilleminault C, Campbell PE. Definition of the sudden infant death syndrome. *BMJ* 1994;308:1439. (28 May.)

- Valdes-Dapena M, McFeeley PA, Hoffman HJ, Damus KH, Franciosi RR, Allison DJ, et al. *Histopathology atlas for the sudden infant death syndrome*. Washington, DC: Armed Forces Institute of Pathology, American Registry of Pathology, and National Institute of Child Health and Human Development, 1993.

- Cheron G, Rambaud C, Rey C, Mahut B, Canioni D, Lavaud J, et al. Morts subites au berceau. Experience d'un centre de reference, 1986-1991. *Arch Fr Pediatr* 1993;50:293-9.

Message about supine sleeping slow to catch on

EDITOR,—The sudden infant death syndrome remains the commonest cause of death of infants over 1 week old, and publicity for research has been renewed with the recent observation by

Howat *et al* of immunopathological changes in infants who die of the syndrome.¹ While such findings undoubtedly merit public attention, we believe that the simple message that babies should sleep supine, rather than prone or on their side, has not received the publicity that might be expected given the dramatic decrease in the incidence of the syndrome that may result.²

We were alarmed to find that many of our non-medical counterparts put their babies to sleep on their side or front. We have since found that there is much misleading popular literature advising parents to put their baby in positions that may increase the risk of the sudden infant death syndrome. A brief perusal of seven of the larger "mother and baby" books widely available showed that six failed to recommend the back as the safest sleeping position. Five recommended the side or back, and one recommended the prone position. Only one specifically suggested that babies should sleep supine to reduce the risk of cot death.³ The myth that babies who sleep supine may aspirate seems to be perpetuated; this ignores the dramatic reduction in the incidence of the sudden infant death syndrome that was observed after a campaign to educate parents resulted in more mothers putting their babies in the supine position.²

Even in the region where Howat *et al* work the guidelines currently issued to all new mothers recommend that babies should sleep on their side and make no mention of cot death.⁴

JOHN KNIGHTON
Senior house officer

Shackleton Department of Anaesthetics,
Southampton General Hospital,
Southampton SO9 4XY

K KNIGHTON
Assistant general practitioner

Lake Road Surgery,
Verwood,
Dorset

1 Howat WJ, Moore IE, Judd M, Roche WR. Pulmonary immunopathology of sudden infant death syndrome. *Lancet* 1994;343:1390-2.

2 Wigfield RE, Fleming PJ, Berry BJ, Rudd PT, Golding J. Can the fall in Avon's sudden infant death rate be explained by changes in sleeping position? *BMJ* 1992;304:282-3.

3 Hilton T, Messenger M. *Great Ormond Street book of baby and child care*. London: Bodley Head, 1993.

4 *Child health and development book*. Southampton: Southampton Community Health Services, 1989.

Independent advice needed for legal aid

EDITOR,—The Legal Aid Board recently published a report on multiparty actions.¹ This has wide implications for medical and pharmaceutical litigation.

It is usual for the board to rely on the advice of plaintiff lawyers in deciding whether to fund medical and pharmaceutical claims. Such advice cannot be independent as the lawyers have a financial interest in advancing the claim. The board asserts, "it is wrong to assume that opinions obtained on behalf of applicants would necessarily give a misleading or overoptimistic assessment of a case. Most lawyers are well aware of their duties to the fund to provide an objective assessment." However, the success rate of publicly funded pharmaceutical claims is zero (independent survey for the Association of Personal Injury Lawyers, December 1993).

The board concedes that it has "doubts over the extent to which legal aid lawyers can have regard to the costs of litigation." Furthermore, it admits, "there is no incentive on the solicitor to act as a responsible filter for dubious cases as there is no effective sanction available for shoddy work or bad cases being taken. It is simply not possible for the Board to exercise detailed control over all publicly

funded litigation. The Board has to rely on the assisted persons' legal advisers to act responsibly and competently."

The board admits that many funded actions are "weak" or "hopeless." It describes a "bandwagon effect" with "legal advisers getting carried away by everything surrounding the action and losing sight of the viability of individual cases." It recognises that "applicants may often feel that they have nothing to lose by giving it a go." The lawyers are paid whatever the outcome.

The board's decisions not only affect the legal aid fund but also result in irrecoverable expense to drug companies and the health service. Ultimately, patients' care may be compromised as funds are diverted to meet legal bills. The report raises more questions than it answers. If public confidence in the board is to be restored the expenditure of millions of pounds of legal costs must be based on independent, objective, and truly expert advice.

ANTHONY BARTON
Solicitor

London N1 0RB

1 Legal Aid Board. *Issues arising for the Legal Aid Board and the Lord Chancellor's Department from multi-party actions*. London: Legal Aid Board, 1994.

Joint commissioning

EDITOR,—I take exception to Christopher Heginbotham's criticism of the slow development of commissioning in Scotland and Northern Ireland.¹ The fact that commissioning in Northern Ireland was not approached with the breakneck speed too often seen in England and Wales allowed us to develop a model and negotiate it with our local general practitioners, which we believe addresses most of Heginbotham's recommendations.

Under the model, five general practitioners were appointed jointly by the local medical committee and the health board to represent designated localities and help shape our purchasing plans and contracts. A general practitioner commissioner was also appointed to serve as a member of the board's commissioning forum. As it turned out, two of the five locality coordinators appointed are fundholders. Because of our responsibility in Northern Ireland for both health and social services, several of the board officers appointed to liaise with these general practitioners are social workers. The early evidence suggests that this system is able to deal with the full range of health and social service problems, from community care to acute hospital medicine. We believe that in practice the objectives set by Heginbotham are being achieved—that is, achieving a seamless service, avoiding cost shunting, and promoting innovation. I recommend that my English colleagues should take a look at Northern Ireland's models to obtain a complete picture of the possibilities and potentials for structural change.

C A HAMILTON
Consultant in public health medicine
Western Health and Social Services Board,
Londonderry BT47 1TG,
Northern Ireland

1 Heginbotham C. Some versions of joint commissioning. *BMJ* 1994;309:215-6. (23 July.)

Postmarketing surveillance

Is not used to promote products

EDITOR,—Simon Voss and Fiona Harris's concerns about postmarketing surveillance need to be challenged.¹ Without producing any evidence the authors imply deceit by pharmaceutical companies in three ways: firstly, by using "so called" independent research companies that do not acknowledge their link with the pharmaceutical companies;

secondly, by using postmarketing surveillance to promote their products; and, thirdly, by effectively paying general practitioners to prescribe particular drugs. The implication, which the evidence clearly refutes, is that postmarketing surveillance is not carried out to acceptable moral, professional, or scientific standards.

We undertake major postmarketing surveillance studies and clearly acknowledge the sponsor when recruiting doctors. These studies are conducted according to all applicable regulations and guidelines, and include review of data; double entry of data; and audit of selected sites, data handling, and statistical procedures. Such rigorous standards, which are not adhered to in most academic research, makes postmarketing surveillance expensive. Postmarketing surveillance is not used to promote products: the guidelines prohibit this,² and the costs make it uneconomic. If evidence to the contrary exists it should be taken to the General Medical Council or Association of the British Pharmaceutical Industry, which investigate and deal with such matters openly and fairly.

Voss and Harris's concern that the payments made to general practitioners for completing the paperwork is an inducement to prescribe is an insult to the professional standards of doctors and undervalues their time. Payment for this work is appropriate and morally acceptable and is clearly guided and suppressed by the Association of the British Pharmaceutical Industry—until recently to only £7.50 for a form that takes 15 minutes or longer to complete. The ability to undertake prospective observational cohort postmarketing surveillance is limited by this small fee. When we recruit general practitioners to conduct postmarketing surveillance more refuse to take part when they see the amount of work necessary, on the basis of inadequate payment, than berate us for our generosity.

Voss and Harris's letter does not add to the debate on how the safety and wellbeing of patients can be increased. This will best be achieved by the use of proper scientific and organisational methods for rapid assessment of the ratio of risks to benefits for all new compounds. Postmarketing surveillance in general practice in Britain, although not ideal, contributes much to this knowledge.

MALCOLM VANDENBURG
Chairman

MCRC Group,
Romford,
Essex RM7 7DA

1 Voss S, Harris F. Postmarketing surveillance. *BMJ* 1994;309:194. (16 July.)

2 Association of the British Pharmaceutical Industry. *Guidelines for company-sponsored safety assessment of marketed medicine (SAMM)*. London: ABPI, 1993.

Avoid promotional studies

EDITOR,—Simon Voss and Fiona Harris cast doubt on the motivation behind drug companies' postmarketing surveillance studies, suggesting that they may be promotional rather than genuine attempts to assess safety.¹ While I have no quarrel with properly conducted phase IV postmarketing clinical trials among fully informed volunteers, I have been campaigning for some eight years against promotional studies, masquerading as research, that entail initiating or changing patients' treatment without their informed consent. In such studies the doctor is remunerated while the patient is exposed to potential risks and often pays the prescription charges. These studies have been shown by the Medicines Control Agency to be virtually worthless.² They are nevertheless effective in boosting the sales of new drugs.

Last year a colleague and I published the results of a large survey of prescribing of new drugs.³ More than half a million prescriptions for 27 new drugs prescribed by more than 28 000 doctors were included in the survey. We found that, during the