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

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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.

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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.

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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.

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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