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Education and debate

Summary points

The Cochrane Collaboration is divided over drug company sponsorship of systematic reviews

Supporters say Cochrane needs commercial support and could benefit from company perspectives

Opponents say sponsorship will influence research agendas and damage independence and integrity

Mechanisms are being floated for industry to collectively sponsor Cochrane activities and avoid perceptions of influence

will propose a prohibition on industry sponsored reviews when he speaks at the Barcelona meeting.

One important group, until now silent in this debate, are the public agencies who currently provide a large part of the collaboration’s core funding. In England, the Department of Health’s funding is signed off by the director of research and development, John Pattison. “It seems perfectly legitimate for Cochrane to consider industry funding, and it’s healthy to have this open debate,” he said before adding that the proposition did raise some worrying issues. “The worry would be that he who pays the piper calls the tune, and we ended up with a situation where it was industry who were determining the nature of the work done, or worst of all, the possibility that it might have some influence on outcomes.”

Pattison reserved judgment about whether industry funding would damage public support for the collaboration. “If the perception is that by taking industry money this would deter public funders from funding because they thought there was a loss of independence—that’s a legitimate point of view, but I want to see the strength of that argument.” Although declining to advocate a particular path, Pattison did say that mechanisms to minimise influence would be highly desirable if Cochrane decides to accept industry funding. “It’s very much better for any monies to come through a generalist association rather than a specific company—because then you would worry about a hidden agenda. To put it into some activity independent of specific reviews would also be another legitimate way to ensure separation.”

Alongside the debate about industry funding, sits the even more difficult question of the individual financial ties of researchers who produce Cochrane reviews. Where does disclosure end as a management strategy and disqualification begin? In both debates, no matter how deep the complexity or the conflict, the delegates in Barcelona can take some small comfort from knowing they are by no means alone. Indeed, they will generate considerable global interest if they can design a foolproof mechanism for accepting sponsorship and ensuring independence. Perhaps they might even patent it.

Contributors and sources: RM has been reporting on medicine and health care for seven years and is a visiting editor with the BMJ. This article is based on interviews with those quoted plus Iain Chalmers, Mike Clarke, Phil Wiffen, Mark Gibson, and others who spoke on condition of anonymity. Competing interests: None declared.

Recruiting doctors from poor countries: the great brain robbery?

Vikram Patel

An important impediment to achieving health for all in developing countries is the shortage of doctors and nurses. Can the NHS justify schemes to recruit staff from these countries?

An enormous gap in health staffing exists between the United Kingdom and India. India has fewer than 3000 psychiatrists for its one billion population compared with one psychiatrist for every 9000 people in the United Kingdom, a 27-fold difference.1 Despite this inequality, the NHS has launched a scheme to recruit senior psychiatrists and other specialists from India and other developing countries. This scheme will worsen the brain drain and inequities in global health unless it is explicitly linked with measures to enable the flow of doctors back to developing countries.

Opportunities or opportunism?

Overseas recruitment schemes are marketed primarily as an opportunity for doctors to experience one of the world’s best healthcare systems. Yet it is obvious that the NHS is trying to fill jobs in specialties where there is a shortage of staff. Although shortages are acknowledged in the promotional material for the new NHS international fellowship scheme, the difficulties that doctors will face when they attempt to return home are ignored. Experience with previous schemes, such as

1 Mallett S, Clarke M. How many Cochrane reviews are needed to cover existing evidence on the effects of healthcare interventions? Evidence-Based Medicine 2003 Jul-Aug:100-1.


8 Time to untangle doctors from drug companies [theme issue]. BMJ 2003;326 (31 May).
the overseas doctors’ training scheme, suggests that few
doctors returned to their home countries. Indeed,
when I finished my training in psychiatry in the United
Kingdom in 1992, I found that few routes were
available to facilitate my return to India. My work in
developing countries over the past decade has been
totally funded by research grants, mainly from the
Wellcome Trust.

NHS international fellowship scheme

Whereas earlier schemes recruited junior doctors, the
new NHS scheme is taking highly experienced
specialists, reflecting the changing requirements of the
NHS. The international fellowship scheme invites psy-
chiatrists, clinical oncologists, radiologists, hist-
opathologists, cardiac anaesthetists, and thoracic
surgeons to work in the United Kingdom for up to two
years. Doctors will be paid a consultant salary and
given up to £46 000 to assist with relocation and
housing. Although the available materials do not
specify how many specialists will be appointed, there
have been over 400 applications in the first round,
with psychiatrists accounting for the largest pro-
portion of recruits. The promotional material
includes a letter from the British prime minister invit-
ing doctors to take up the new opportunities that are
being created as a result of a “dynamic expansion
programme” in the NHS.

Recruitment is being promoted using the obvious
advantages the NHS has over employers in develop-
ing countries. The code of practice for international
recruitment explicitly states that “there should be no
NHS advertising in developing countries unless that
country has specifically invited the UK to undertake a
recruitment programme” and that recruitment
“should only be undertaken as part of an inter-
governmental cooperation agreement . . . encourag-
ing the exchange of healthcare personnel, healthcare
information, and guidelines.” The promotional
material for the scheme does not indicate that either
condition has been met.

Apart from the immediate effects of the scheme on
human resources in developing countries, the scheme
could perpetuate global health inequalities for genera-
tions. Consider, for example, a country that must
import expatriate doctors using scarce foreign
exchange. Most doctors in developing countries have
been trained in public funded medical schools. The
cost of training is borne by the poor country and the
rich country reaps the benefits. In effect, the people of
poor countries are paying for the health care of those
who live in one of the richest.

Stemming the brain drain

The opportunity to work in different societies is a rich
experience with benefits that go beyond financial
gains. There is no place for creating new barriers to the
movement of peoples between countries. What is
needed is an acknowledgment that institutions in
developed countries have an ethical obligation to
facilitate the return of health professionals to develop-
ing countries (box).

Requirements for ethical recruitment from
overseas

- Flexible training schemes that permit doctors from
developed countries to work in developing countries
- Long term partnerships, including funding and
  training, to strengthen the research, clinical, and
  teaching infrastructure of institutions in developing
countries
- Grants to enable returning doctors to establish
  personal and professional lives
- Audit of the outcome of overseas doctor training
  schemes in terms of proportion of doctors who return
  home

Institutions in developed countries must engage
with those in developing countries to facilitate an
attractive environment for returning doctors to work in.
Doctors from developing countries who go abroad
to train and work have a key role in this process. The
opportunity to choose the country we live and work in
is the result of the opportunities that were available to
us in the country of our birth. Doctors going to work
overseas must search for ways to share their expertise
and resources—for example, by partnering their new
institutions with the ones in which they trained.

Summary points

The developing world has fewer doctors per
population than developed countries

Schemes to recruit doctors from developing
countries risk damaging their fragile health
systems

Working and training in another country provides
valuable experience

Partnerships between institutions in developed
developing countries are needed to
encourage doctors to return

Institutions in developed countries need to
reform to provide more rewarding professional
environments
Institutions in developing countries must acknowledge that doctors leave not only for monetary gain but also to escape from stifling hierarchies and bureaucracies. In India, for example, doctors who want to attend scientific meetings often have to obtain a “no objection certificate” from the head of their institution. Promotions are more likely to be determined by the number of years of service than academic skills and achievements. Institutions must reform to allow professional environments to flourish by rewarding achievements—for example, by reducing routine clinical load and by providing alternative paths for career progression, honorariums, and training opportunities.

Ultimately, all concerned parties need to define the obligations and responsibilities of institutions in rich and developing countries. Unless these steps are taken urgently, the brain drain will continue to fuel the huge inequities in global health.

Commentary: Recruitment is ethical
Debbie Mellor

NHS international fellowships were launched by the Department of Health in February 2002 to give experienced consultants the opportunity to come and work in the NHS in England for two years. This is in addition to the campaign we launched in August 2001 to recruit consultants and general practitioners from around the world into substantive posts. So far, 304 doctors have been recruited through the campaigns, 82 of whom come from India.

Most doctors have been recruited as international fellows and are using the opportunity to sample living and working in England for a relatively short period. The feedback we have received shows that they value the opportunity to work in a different health system, acquire new skills, get wider work experience, pursue research interests, and develop their teaching skills.

We operate an ethical recruitment policy, with all NHS trusts working to a code of practice approved by the Department of Health. We are committed not to recruit from a country if its government has any concerns about the effect on its workforce and work only with recruitment agencies that comply with the code of practice. This list can be obtained from the international recruitment website. 1

It is wrong to suggest that the health service is targeting health staff from struggling countries. Most of the staff we are recruiting come from Europe, with others from the United States and Australia.

Working with developing countries
We have worked closely with the Indian Ministry of Health in the development of the campaign in India, and it has been supportive of the opportunities we are offering doctors. The Indian minister of health and family welfare responded to a parliamentary question in July 2003 by saying that the overall availability of doctors in India is sufficient.

I thank Gauri Divan for the title of this article.

Contributors and sources: VP is a psychiatrist, originally from India, who is presently working on public health aspects of psychiatry in India as a full time researcher from a UK institution, funded entirely by a UK agency.

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Endpiece
A prayer
From inability to let well alone; from too much zeal for the new and contempt for what is old; from putting knowledge before wisdom, science before art, and cleverness before common sense, from treating patients as cases, and from making the cure of the disease more grievous than the endurance of the same, Good Lord, deliver us.

Sir Robert Hutchison (1871-1960), BMJ 1953;1:571

Fred Charatan,
retired geriatric physician, Florida