

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 Wiffin, Mark Gibson, and others who spoke on condition of anonymity.

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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

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MARK HENLEVIN/ANOS PICTURES

Waiting for treatment: shortage of medical staff is an important barrier to health in India

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.² My work in developing countries over the past decade has been entirely 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 psychiatrists, clinical oncologists, radiologists, histopathologists, 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.³ 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 proportion of recruitments.³ The promotional material includes a letter from the British prime minister inviting doctors to take up the new opportunities that are being created as a result of a "dynamic expansion programme" in the NHS.⁴

Recruitment is being promoted using the obvious advantages the NHS has over employers in developing 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... encouraging the exchange of healthcare personnel, healthcare information, and guidelines."⁵ The promotional material for the scheme does not indicate that either condition has been met.⁴

Apart from the immediate effects of the scheme on human resources in developing countries, the scheme could perpetuate global health inequalities for generations. 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 developing 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 and 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.

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Commentary: Recruitment is ethical

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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.

We are working with India and other developing countries to support them in developing programmes to retain their staff. In some cases, we are assisting them in offering fixed term placements in the NHS as part of career planning for healthcare professionals.

In addition, individual NHS trusts are putting a great deal back into developing countries. Much of this work is voluntary and receives little publicity. Many NHS volunteers spend considerable time and resources developing and providing diverse services in countries such as India, Ghana, Russia, Iran, and China. In India, for example, volunteers are providing services in mental health, leprosy prevention, neonatal resuscitation, women's health, sexually transmitted infections, and HIV.²

Competing interests: None declared.

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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;1:671

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