the former, parents may be inadvertently increasing the likelihood of the latter.

The advice that 'the infant should be kept in the parents' room at night' may not be necessary. I am not aware of any evidence that the room in which the child sleeps makes any difference to the rate of sudden infant death syndrome. In contrast, having the infant in the parents' bedroom may contribute to parental anxiety by obliging parents to respond to every noise and movement in the cot, a feature which is likely to increase as the child gets older. Perhaps it would be less frightening to suggest that parents, for their convenience, consider keeping the infant in a cot by the bed while the infant is still being breast or bottle fed. This would probably cover the age of maximum risk of sudden infant death syndrome.

The greatest short-term benefit in the prevention of sudden infant death syndrome is likely to come from advice which attempts to reduce the following: infants sleeping in the prone position; maternal smoking; bottle feeding (by encouraging mothers to breast feed). Much evidence demonstrates that the prone sleeping position is associated with increased risk of sudden infant death syndrome.[2,3] This is also supported by evidence that sudden infant death syndrome rates are relatively low in groups which normally let their infants sleep in the supine position, for example, Hong Kong Chinese and Pacific Islanders in New Zealand.[4,5] Many studies have shown that maternal smoking is associated with an increased risk of sudden infant death syndrome, indeed in one extensive epidemiological study, maternal smoking gave the highest odds ratio of any risk factor for sudden infant death syndrome.[6] One study has demonstrated a dose response relationship between the number of cigarettes smoked by the mother and the relative risk of sudden infant death syndrome.[7] The evidence supporting breast feeding is not as strong as that of the other two factors, although case control studies have shown that sudden infant death syndrome cases are more likely to have been bottle fed at one month than the control infants.[8]

Practitioners need to give a great deal of thought to the advice they give parents and prospective parents regarding the prevention of sudden infant death syndrome. It should be clear and consistent, as over-complex advice may serve only to confuse at a time of high anxiety.

ANDREW H RILEY

31 Caiystane Terrace
Edinburgh EH10 6ST

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Patients' and doctors' sex and ethnicity

Sir,

Ahmad and colleagues recently reported that Asian patients were more likely to consult a doctor of similar ethnic origin, whereas for non-Asians, the sex of the general practitioner was more important.[1] However, other factors not studied by the authors may have contributed to this difference, such as the age of the doctor, his or her personality and his or her ability to deal with specific complaints, such as psychosocial problems. Such qualities are irrespective of ethnicity and may have influenced whom the patient consulted.

No account was taken of availability of appointments for different partners — perhaps the woman doctor's appointments were fully booked so the consulting patterns may not reflect the patient's 'first' choice of doctor. This clearly would have some bearing on the results. Although the numbers studied were adequate (1633 consultations were analysed), the duration of the study was short, lasting for four weeks. This may not accurately reflect consulting patterns throughout the year. It is important to know individual general practitioner policy in terms of patient review — could different review policies have caused this apparent difference in consulting patterns? This difficulty could be overcome by studying only those patients attending for their first consultation about a new problem.

It is important to appreciate that there may be other, more subtle but important, factors influencing patients' choice of doctor, not just sex and ethnicity.

NARESH BALKRISHNA

49 Silvertonhill Avenue
Hamilton
Lanarkshire ML3 7NB

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Side effects of influenza immunization

Sir,

I was interested to read the letter from Drs Robinson and Rayani (November *Journal,* p.476) concerning the side effects of influenza immunization.

Four patients in my practice who had been given influenza immunization (MFV Ject® , Merieux) in 1991 each developed acute gout approximately 10 days after the injection. These four patients had a history of gout, had raised urate levels, were taking diuretic medication but were not taking regular uricosuric medication owing to the infrequency of acute episodes (less than one episode of gout per year). One patient said she noticed that her last acute episode of gout had taken place at a similar time during the previous year — 10 days after the influenza immunization. I have reported these cases to the Committee on Safety of Medicines but would also be interested to hear from other general practitioners who may have noticed a similar trait.

GEORGE YOUNG

Greenbank Surgery
1025 Stratford Road
Birmingham B28 8BG

Working in partnership with nurses

Sir,

In his editorial (October *Journal,* p.398), Dr Salisbury discussed the role of community nursing and, in particular, its organization and development. A meeting was convened for members of the Royal College of General Practitioners in the Burnley area to discuss the editorial.

The five options put forward by Dr Salisbury in his editorial were examined. The majority of members felt that the ideal model would be for the community nurses to be managed by a large