cancer intervals without relapse and survival rates in patients treated by mastectomy are comparable with those in patients treated by local incision and radiotherapy I hope that the trend towards conservative surgery will continue, so that eventually every woman with breast cancer for whom it is deemed possible may be offered an alternative to a mastectomy. I did not have this choice until six years after the operation, but for the rest of my life I shall remain grateful to the surgeon who enabled me to feel whole again.

GILL A MCCLARE

University of Birmingham,
Birmingham B12 2TJ

Prejudice against doctors and students from ethnic minorities

SIR,—Dr Richard Smith's leading article (7 February, p 328) on the research study by the Commission for Racial Equality has provided a valuable stimulus for further discussion of this important, but sadly long neglected, subject.[1] The main thrust of the study should be the plight of the doctors who were born in this country and wholly trained in British universities but are also being discriminated against. This should not be tolerated, and health authorities that still practise such discrimination should be advised not to do so. Table III of the study shows the percentage of overseas doctors who are consultants in different regional health authorities and highlights the discrepancies that demand an explanation.[1] Regional distribution of consultant posts among doctors born overseas shows an average of 17% for England and Wales as a whole and above average for most of the regions, including the prestigious London postgraduate teaching hospitals, but East Anglia and South Western regions have an unexplained low 9%. This may mean that the people living in these two regions are not getting the best available treatment. It is for the government to act effectively. I have one suggestion, which is that no more merit awards should be distributed to these regions until they mend their ways. There is enough evidence for the government to act immediately through the Department of Health, and the British Medical Association, royal colleges, and faculties should stimulate urgent reform before it is too late for the students and doctors who were born in this country and regard themselves as part of the United Kingdom.

If the names of members of the different regional awards committees on distinction awards could be published yearly, as they were in 1977 by *Anaesthesia*,[2] at least some of the secrecy would be abolished, and a healthy discussion might ensue about the system that has caused anxiety not only in the medical press[3] and in the present study but also in the lay press.[4] More recently, the merit award system has been criticised by both sides in parliament.[5]

B THALAYASINGAM

General Hospital,
Consett,
County Durham DH8 0NB

1 Anwar M, Ali A. *Overseas doctors: experience and expectations.* London: Commission for Racial Equality, 1987.
2 Anonymous. Association news and notices. *Anaesthesia* 1977;32: 939-42.
3 Lester E. Sex distribution of distinction awards. *Br Med J* 1980;280:198.
4 Anonymous. Curing consultants. [Editorial.] *The Times* 1985 July 8:13.
5 Anonymous. NHS merit awards attacked. *The Times* 1987 Feb 10:4.

SIR,—I have not seen the original report from the Commission for Racial Equality, but it seems surprising that Dr Richard Smith (7 February, p 328) did not mention the needs and expectations of minority groups in relation to the training or appointment of doctors in the National Health Service. If doctors from minority groups, whether ethnic, racial, or religious, are not to be appointed to posts in deference to the supposed demands of the majority then members of minority groups will eventually be unable to find like minded doctors to look after them. Those with conscientious objections to abortion have already seen the virtual exclusion of doctors who share their views from consultant posts—and even sometimes from training levels. Recent evidence suggests that unwillingness to provide a full range of artificial contraceptives is proving an impediment to appointment in general practice, and this may also in time pose difficulties for those patients who share the same beliefs. Although it would clearly be very difficult to ensure a fair geographical spread of doctors from minority groups in relation to patient demand, I hope the problem will not be overlooked entirely in any review of appointment procedures.

I M JESSIMAN
Master, Guild of Catholic Doctors

Chislehurst,
Kent BR7 5ES

SIR,—Dr Richard Smith (7 February, p 328) derides "non-academic suitability—whatever that is" as a valid criterion in the selection of medical students. Our selection process alone has been rigorously studied and the results published; we cannot answer for other schools. Shortlisting for interview here depends on three separate factors, which we have called academic ability, interests, and community service.[1-3] Applicants with non-European surnames had lower scores in interests and community service, and therefore a lower proportion of them were interviewed than of those with European surnames.[4] These differences entirely explained the reduced likelihood of acceptance of applicants with non-European surnames by any of the British medical schools to which candidates in our study had applied. The applicants themselves thought that selectors should look for many personal qualities, including ability to listen and to communicate widely, commitment, compassion, dedication, inquisitiveness, and motivation.[5] Furthermore, they criticised strongly excessive reliance on examination grades.

The prospectus of this medical school (which has not been accused of discrimination) makes it clear that we look for students of good academic ability with diverse backgrounds and interests who will contribute to our community here during their training and to a wider world thereafter. Within those guidelines we take no account of sex, creed, politics, ethnic group, wealth, or influence. This is what we understand by "equal opportunity policy." Did Dr Smith have something else in mind when he used this term?

May we repeat what we wrote to you in January 1985. "If, however, society feels that the diminished likelihood of entry of some groups is of sufficient concern to mean that selection should be based entirely on academic achievement, then it must also accept the consequences of that decision, which are that candidates currently regarded in open competition as less suitable for admission would be admitted, and that candidates in general would feel that selection was not based on the wider principles of natural justice, which include selection based on assessments of personal qualities as well as of academic ability."[4]

PETER RICHARDS
I C MCMANUS

St Mary's Hospital Medical School,
London W2 1PG

1 McManus IC, Richards P. Audit of admission to medical school: I—Acceptances and rejects. *Br Med J* 1984;289:1201-4.
2 McManus IC, Richards P. Audit of admission to medical school: II—Shortlisting and interviews. *Br Med J* 1984;289:1288-90.
3 McManus IC, Richards P. Audit of admission to medical school: III—Applicants' perceptions and proposals for change. *Br Med J* 1984;289:1365-7.
4 McManus IC, Richards P. Admission to medical school. *Br Med J* 1985;290:319-20.
5 McManus IC. Medical students: origins, selection, attitudes and culture. London: University of London, 1985:253. (MD thesis.)

SIR,—Dr Richard Smith (7 February, p 328) misquotes the publication on overseas doctors by the Commission for Racial Equality. The North Western Regional Health Authority had the highest number of overseas trained consultants and Mersey Regional Health Authority the lowest number, not percentages, as was stated. The true picture is not surprising in view of the relative sizes of the regions. When percentages are compared the north west was near the top for both consultants and training grades and Mersey about average.

Dr Smith implies that the selection of the regions for study was related to their being at the extremes. There is no indication in the report as to why the two were chosen. At the time of the study there were about 4500 hospital doctors in the two regions, of which about 1650 were from overseas. An unknown number of these doctors were approached by letter, and an unstated and self selected number responded. From these a sampling frame was compiled, but the nature of this frame is not stated. The notes on methodology in the report states: "Each overseas trained doctor was matched, as far as the limited numbers available would allow, with a white British doctor with the same qualifications and, if possible, of the same sex. Grade and age were not used in the matching process." Dr Smith suggests that this might be called a "case-control" study. I suggest that if the report were one of a new method of treatment and the results published after a similar process of self selection it would not be described as an important development.

Criticism of the methodology of the survey should not devalue those parts of the reports that do not depend on comparisons derived from the interviews. Facts reported from official statistics and the beliefs and experiences of doctors are valuable contributions, even if the comparisons of percentages are not. One of the recommendations is that health authorities should implement the race relations code of practice as employers. The North Western Regional Health Authority has already adopted an equal opportunities policy that incorporates this code. Another recommendation, curiously unrelated to the substance of the report, is that the BMA as a trade union should adopt a policy of equal opportunity as an employer. Has it?

D H VAUGHAN
North Western Regional Health Authority

**The BMA is an equal opportunity employer. —ED, *BMJ*.

SIR,—Discrimination on the grounds of sex, race, religion, and nationality is perhaps commonplace in many countries, but it is now fairly clear that discrimination due to prejudice is the main problem for overseas doctors in the United Kingdom.

I find it difficult to accept that "overseas doctors are less well trained, less competent, and speak poorer English than British doctors . . .," as Dr Richard Smith questions (7 February, p 328), as any overseas doctor coming to the United Kingdom since 1975 has had to prove his worth in all of these three aspects in the TRAB test, which has subsequently become the PLAB test. Once such a