protein cholesterol concentration. This would have necessitated a fasting sample being obtained from all patients, which was not within the protocol. Screening measurements that were abnormal, other than cholesterol, were repeated in line with good clinical practice. The additional yield of abdominal ultrasonography, as suggested by Peter Schwandt and Werner O Richter, would also need to be investigated in a further study in primary care.

Reynolds and colleagues comment on the exclusion of 54 patients who seemed to have a secondary cause for their hyperlipidaemia. Our yield, however, was stated in terms of new diagnoses. The table showed that 54 patients had an abnormal result in the battery of tests, yet this was ascribed to pre-existing disease processes or other clinical problems. These 54 patients were therefore not included in the yield. The denominator should also be kept at 330 because one cannot predict whether patients with one secondary cause may also have an additional yet undiagnosed cause.

Screening by generalists in primary care¹ and screening in a hospital or community setting may differ considerably. Much may depend on how fully generalists have investigated their patients for other disorders before any screening programme as the amount of previously undiagnosed disease and hence the yield may vary. The more comprehensive the practice's baseline investigation rate the lower will be the yield of subsequent abnormal findings. Our low yield of new cases of hypothyroidism may be explained by the fact that the prevalence of known hypothyroidism in this population is 1.8%, which already approximates to figures found in community studies.²

We concur with A N Siriwardena and R Thomson that this form of screening is fraught with ethical difficulties and that the costs are only part of the problem. We agree that the subject warrants further discussion, particularly as other, similar clinical issues exist in primary care.

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Doctors from ethnic minority groups

EDITOR,—As the current chairman of the Overseas Doctors' Association, I wish to comment on whether doctors from ethnic minorities should form separate associations.¹ The Community Relations Commission, which existed from 1968 to 1977, was perturbed by the difficulties that overseas doctors faced in pursuing their goal of higher training and education. They faced discrimination at all stages. Frustration, which built up because these doctors lacked any say in the policy affecting their training, career, and job prospects, was further fuelled by the publication of the Merrison report in 1975² and a medical directive of the European Economic Community debarring them from practising in member countries. It created a crisis of confidence. They were no longer willing to be used as a pair of hands or as easy scapegoats for shortfalls in the NHS. They decided to stand up and be counted.

Accordingly, on 11 May 1975, at a meeting in Birmingham, the Overseas Doctors' Association was established. I convened and chaired the meeting and was elected chairman of the working group

that was set up; a national conference was held in October. The executive committee was elected by universal franchise. I was elected the general secretary and served for the formative first two years. Our popular slogans used to be "the ODA is working to work itself out of office"—an ultimate measure of its success.

Sadly, after nearly two decades the situation is no different, although substantial material progress has been achieved. The increasing number of local graduates of overseas origin entering the workforce face disadvantage and discrimination similar to those faced by doctors who graduated overseas; this has been proved repeatedly by various studies.^{3,4}

The association has not yet achieved its goal and is still much needed; it still has a long agenda.

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Diabetes in the developing world

EDITOR,—K G M M Alberti does well to make us look beyond the cocooned world of medicine we know in the West.¹ I recently returned from working in a rural mission hospital in western Uganda, where I started a diabetic clinic. I was faced with large numbers of patients with poorly controlled diabetes, who had often travelled long distances when they could eke out their insulin no longer. Although we subsidised the cost of insulin at £1 per phial, this was still a great burden to many and cost them their lives.

Alberti concludes that it is up to the diabetic community and health care professionals to ensure that governments take responsibility for making insulin available to those who need it. How is a diabetic peasant far out in a village or a hard pressed medical officer going to make a government listen to yet another great medical need? In Africa life is cheap and governments have no money. Uganda is relatively fortunate to be receiving substantial help from Western countries, especially for AIDS. Let us continue to support the developing world; we need to do more with more wisdom. And let us not forget diabetes, for which we know that a lifesaving treatment exists.

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Purchasing vascular services

Looking after one's own?

EDITOR,—F G R Fowkes makes the important point that purchasers must obtain well informed independent advice regarding the pattern of services that they purchase.¹ This would clearly be ideal, but I do not think that the Scottish National Medical Advisory Committee's report on vascular surgery services is a particularly good example of this.² The members of this working group were from Ninewells Hospital, Dundee; Aberdeen Royal Infirmary; Edinburgh Royal Infirmary; and

Gartnavel Hospital, Glasgow. They recommend that the major specialist vascular units in Scotland should be at Ninewells Hospital, Dundee; Aberdeen Royal Infirmary; Edinburgh Royal Infirmary; Gartnavel Hospital, Glasgow; and Glasgow Royal Infirmary. Glasgow Royal Infirmary was not represented in the working group but could hardly be omitted as it is recognised as the pre-eminent vascular surgery unit in the west of Scotland.

It is particularly unusual that the working group has recommended two specialist vascular units within a short distance of each other in Glasgow while patients from Dumfries and Galloway will face a difficult, 100 km road journey to an intermediate (general) vascular unit in Ayr.

Fowkes states that clinical directors and vascular surgeons in trusts will inevitably provide advice that accords with the level of service available. They are not the only people open to this charge, as the report on Scottish vascular surgery shows.

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2 Working Group of the National Medical Advisory Committee. Vascular surgery services. Edinburgh: HMSO, 1993.

Centralisation could result in two tier service

EDITOR,—The proponents of a centralised vascular service highlight the advantages to surgeons of working in large, highly specialised groups.^{1,4} There is a risk, however, that their proposals would result in a two tier service. Provision might be enhanced for patients who lived close to major vascular units. The remainder would be less well served, since there is less take up of specialist diagnoses and treatments in districts that lack local skill in vascular surgery.

Vascular surgery has shown considerable growth. In 1979 the inaugural meeting of the South West Vascular Surgeons in Exeter attracted a dozen singlehanded surgeons. Since then the membership has increased fourfold and many hospitals have two and some three vascular surgeons. A corps of vascular surgeons and interventional radiologists now practise in the mainstream of district hospitals. Even a singlehanded vascular surgeon provides great benefit to local communities, and it is not long before the workload builds up and a colleague is appointed.

The degree of specialisation of a vascular surgeon's practice depends on the local circumstances. This is as true in Britain as it is elsewhere in Europe and in the United States. In view of this, Roger Greenhalgh's call for greater dialogue among the subspecialties of general surgery¹ will strike a chord with many who believe that senior registrars should retain generalist skills as they focus on their principal interest. Meanwhile we should try to have good audit systems² so that our patients and those who commission our services continue to have confidence in the quality of the services we provide.

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4 Darke SG. Provision of vascular services. *Br J Surg* 1994;81: 1110-1.

5 Earnshaw JJ, Hayward JK, Horrocks M, Baird RN. The importance of vascular surgical audit to surgeons, patients and purchasers. *Eur J Vasc Surg* 1992;6:540-4.