of cigarette[3-5] and have also shown that smoking behaviour is influenced by personality characteristics.[6] Alterations in smoking behaviour involve changes both in puffing rate and in depth of inhalation, each of which may modify the amount of nicotine, tar, and carbon monoxide absorbed. The present subjects decreased their puffing rate as pregnancy progressed but presumably inhaled more deeply, with the result that they managed to obtain the same amount of nicotine but apparently less carbon monoxide.

The cause of these changes is not clear, but the findings illustrate the dangers of extrapolation of data obtained during structured smoking regimens to real-life situations.

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Prevalence of thyroid disease in the elderly sick

SIR,—Dr A W Burrows and his colleagues (22 November, p 437) appear to have got themselves into a complete muddle regarding the prevalence of thyroid disease in the elderly sick. They "disagree with reports that thyroid disease is prevalent (5% or more of cases) in the elderly" as found by Jefferys[1,2] and Green[3] (note corrected reference). They cite Bahemuka and Hodkinson[4] and Thomson *et al*[5] in support of their claim.

Their own study related to the investigation of a heterogenous group of 88 geriatric in- and out-patients, selected as being clinically euthyroid. None the less, they found two hypothyroid subjects, giving a thyroid prevalence of 2·3% with "exact" 95% confidence limits of 0·3-8·0%. In other words their result is compatible with a prevalence of 5% or more despite their exclusion of clinically apparent thyroid disease.

Their comparisons are biased ones as they did not compare like with like. Jefferys's[1,2] prevalence of 5·7%, based on study of 317 unselected geriatric admissions to this department, referred to *all* thyroid disease, known, suspected, or unsuspected before investigation, and so did Green's[3] of "rather more than 7%," based on a small inpatient series. The prevalence of 3·4% found in 2000 unselected admissions to this department by Bahemuka and Hodkinson[4] referred to suspected plus unsuspected cases. The work of Thomson *et al*[5] refers to well old people at home and is in no way comparable.

The only appropriate comparisons are with the findings of Jefferys and of Bahemuka and Hodkinson, with consideration only of the prevalence of unsuspected thyroid disease. These are shown in the table. Confidence limits are very wide for the smaller series so that useful conclusions cannot be drawn, but the large series of Bahemuka and Hodkinson indicates that the true prevalence of *unsuspected* thyroid disease is unlikely to be as high as 5%. There is no justification for saying that the *total* prevalence of thyroid disease in geriatric patients might not exceed this figure, however.

Prevalence of unsuspected thyroid disease in sick elderly patients

Authors	No of cases/total	Prevalence (%)	Confidence limits (%)
Burrows *et al*	2/88	2·3	0·3-8·0
Jefferys[1,2]	9/308	3·0	1·4-5·4
Bahemuka and Hodkinson[4]	44/1986	2·2	1·6-3·0

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Medical training in developing countries

SIR,—May I comment on the observations of Dr Joyce E Leeson and Professor R S Illingworth (1 November, p 282) and Dr A J R Waterston (15 November, p 406) on our article on undergraduate medical education in a developing country (4 October, p 27)?

Dr Leeson and Dr Waterston feel that the British curriculum is a "historical relic" and "a probably outdated structure." Before we replace it with some new and untried alternative I think it worth remembering that this "historical relic" has trained some of the best doctors in the world. These are people who were able to function equally effectively in Harley Street as well as in the depths of Africa over the past century.

What seems remarkable is that many of our reformists seem to have forgotten that preventive and social medicine was taught (and is still taught) by good teachers of *general medicine*. I was a "victim" of this "outdated structure" but when I received instruction in pulmonary tuberculosis by an ordinary common or garden physician (also a product of the outdated structure) in Dr Leeson's own country a discussion on drug therapy was followed by a discussion on the preventive and social aspects of this disease. I am glad that Professor Illingworth has pointed this out. We decried the *over-emphasis* of preventive and social medicine and the italics in our article were not accidental. It is interesting to note that this over-emphasis seems to be creeping into the new British curriculum. Professor Illingworth's fear that with some modern curricula new graduates will be unable to recognise an ill patient is, I am afraid, already a reality, and if a halt is not called the disease will spread.

Dr Leeson, having spent some five weeks in Ceylon, questions the validity of the figure of 973 hours spent in the teaching of preventive medicine in Colombo. This figure was quoted from one of the most extensive and exhaustive studies on medical education ever done in Ceylon. The members of the working group responsible for this report were the professors of psychiatry of Colombo and Peradeniya, the registrar of the university, the professor of obstetrics and the dean of medicine, Peradeniya, and the professor of physiology and the new head of the Postgraduate Institute, Colombo. These people, who were here when Dr Leeson visited this island, could have answered her queries.

Dr Leeson doubts our contention that tuberculosis presents the same problem in diagnosis and management everywhere. The disease was chosen after careful thought and we reaffirm that the management of this disease consists of recognition of the disease, therapy with effective drugs for a specified period, and the tracing of contacts and their management. These principles must be taught to medical students all over the world and this is what we meant when we said that there should be no difference in the basic training of doctors in developed and developing countries.

I do not disagree with Dr Waterston that poverty plays a major role in the causation of disease, but I fear the solution is more political than medical. To extend the example cited by him, consider an unemployed ex-tea-estate labourer suffering from protein malnutrition admitted to my ward. He is treated in hospital and returned to the street as Dr Waterston indicates. But why? It is not because my training has been such that I cannot appreciate the problem but because I am aware that until suitable employment is found and protein made available at a reasonable price there is no other alternative. He is returned to the street and not sent to a nutrition rehabilitation unit (leading article, 1 November, p 246). Even if they existed there would be only standing room since nearly half the population (and in Bangladesh almost the whole of the population) would be in them. That we in this fertile island, with water outside (by definition) and water inside (by the grace of God), are unable to provide an adequate supply of protein for our people is more a reflection of the way the country is run than on the way the doctors are trained. Changing the medical curriculum cannot provide either protein or employment.

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British postgraduate qualifications in India

SIR,—Better late than never. At last, the Indian Medical Council (IMC) has "de-recognised" the so-called "high reputed" British postgraduate qualifications like the MRCP and FRCS. It was a move that had been pending for a long time, but no doubt hastened thanks to the GMC's recent decision about foreign doctors. It is a right and positive decision for the following reasons:

It is certainly going to dispel the illusion that exists in the minds of many Indian graduates about British postgraduate diplomas and thereby reduce the influx of overseas doctors into Britain. It will come as a great relief to those many immigrants who have wasted time, energy, and money over these postgraduate examinations—more so for those who doubt their impartiality. It will also, perhaps, stop the harassment of newcomers in having to undergo the General Medical Council's examination and the humiliation by the media of those overseas doctors who have already settled here. Many senior British doctors have the impression that the only reason immigrant doctors come to this country is to gain these postgraduate diplomas. This is far from being always the case and it should not therefore be such a prominent feature in interviews for medical posts. Many immigrant doctors come to Britain simply looking for better prospects in life—just like the British medical graduates who emigrate from this country.