rates for CHD[6] variously for 1984 to 1987, of 21 developed countries, gives correlation coefficients of 0.56 ($P<0.01$) for butter, 0.68 ($P<0.001$) for all dairy fat, and 0.79 ($P<0.001$) for estimated lactose[7]; and from the same data sources the results for refined sugar and total sugar and sugar products are respectively 0.61 and 0.62 ($P<0.01$). Moreover, worldwide, CHD falls heavily only on populations who have a high prevalence of lactase persistence in adult life and the associated high intake of milk[8]; while populations without these linked genetic and dietary characteristics are relatively little affected despite a high intake of sugar (eg in Jamaica) or high prevalence of insulin resistance (eg Pima Indians)[9].

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References

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2 Kritchevsky D, Davidson LM, Kim HK, *et al.* Influence of type of carbohydrate on atherosclerosis in baboons fed semipurified diets plus 0.1% cholesterol. *Am J Clin Nutr* 1980;**33**:1869-87
3 Wells WW, Anderson SC. The effect of dietary lactose on the serum cholesterol level of human subjects. *Fedn Proc* 1962;**21**:100
4 Keim NL, Marlett JA, Amundson CH. The cholesterolaemic effect of skim milk in young men consuming controlled diets. *Nutr Res* 1981;**1**:429-42
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8 Segall JJ. Hypothesis: is lactose a dietary risk factor for ischaemic heart disease? *Int J Epidemiol* 1980;**9**:271-6
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The author replies below:

It is appropriate that Dr Segall's letter draws our attention to the fact that lactose as well as sucrose can produce raised concentrations of plasma lipids.

It has been suggested[1] that insulin resistance is the most important abnormality that characterizes atherosclerosis, and its clinically related conditions of hypertension and diabetes.

However, it then becomes difficult to explain the situation in the Pima Indians.

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Reference

1 Yudkin J. Sucrose, coronary heart disease, diabetes and obesity: do hormones provide a link? *Am Heart J* 1988; **115**:493-8

The Edinburgh Declaration

In his interesting article, 'The Two Faces of Medical Education, (October 1992 *JRSM*, p. 598) Tauber wrongly attributes the Edinburgh Declaration to the World Health Organization. WHO was a main co-sponsor of the World Conference on Medical Education in 1988. However, the Declaration should be attributed to the World Federation for Medical Education. While the 12 principles of the Declaration remain fully operative, a follow-up World Conference on 'The Changing Medical Profession', again at Edinburgh on 8-12 August 1993, will deal with the interface between medical education and the health care delivery services. WHO again is a main co-sponsor, with UNICEF and UNESCO.

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Non-sexist statements in medical literature

I refer to the recent article by Finn on Food Allergy (September 1992 *JRSM*, p 560), and correspondence in the same issue regarding the need for non-sexist pronouns in the medical literature (p 586). Finn comments on the 'guilt by association' that may affect reputable investigators in the field of food allergy, and opines that this 'tends to discourage young men from entering this field'. Does Dr Finn mean to suggest that 'young women' are not discouraged from working in the field of allergy, or does he rather not recognize the existence of his female colleagues? I would propose that the time has come for us to guard against such sexist statements in otherwise excellent review articles.

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The author replies below:

I stand corrected.

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What's in a title - Mr or Dr?

Messrs Lever, Hornick and John (November 1992 *JRSM*, p 658) note that since the 'Free Circulation Directive' of December 1976 there has been mutual recognition of different Member States' relevant diplomas. This, however, does not go far enough; the qualifying degrees should also be seen to be equivalent. The fact that the qualifying degree in other EC countries is the MD is a common cause of confusion as people there often cannot understand that they are dealing with a real doctor when he or she only has an MB - indeed, graduates of other British universities sometimes do not appreciate the significance of the Oxford BM.

So should the British doctorate in medicine continue to be an academic degree? - particularly as the requirements for an MD thesis fail to reflect all-round ability in the subject. Theses are based on original research, a requirement that would seem inherently flawed on two counts: one, the innate narrowness of most topics and two, the fact that research calls for different skills to those required for dealing with patients. Admittedly, some people are fortunate in possessing both, but the validity of the generalization is well shown by the observation that 'On average only three of 30 000 British general practitioners gain an MD each year'[1].

But since the MD is for us a higher degree we would need to have a replacement doctorate. I would suggest a PhD(Med) for clinically orientated theses and a DSc(Med) for those more scientifically inclined.

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Reference

1 Williams WO. A survey of doctorates by thesis among general practitioners in the British Isles from 1973 to 1988. *Br J Gen Pract* 1990;**40**:491-4