and never has had, "a waiting time of up to nine weeks" except for non-urgent outpatient ultrasound scans. This waiting time was fairly static and, to address what was seen by the staff of the department, general practitioners, and the clinicians providing the outpatient services as an unacceptable situation, extra ultrasound sessions were introduced by some of the consultant staff of the radiology department. Three extra lists per week were arranged, two in the evenings and one on Saturday mornings. Extra resources were not made available; the extra lists were performed without cost to the department or trust. To maintain the waiting time at less than six weeks as required by the quality standards set out by the Grampian Health Board, internal reorganisation has created extra ultrasound lists, again without any extra resources being made available.

Within three months, the waiting time for non-urgent ultrasound scans was reduced to four weeks, where it has remained. The evening and weekend ultrasound sessions were no longer necessary.

Wisely also mentioned the use of a fax to deliver urgent reports. We are uneasy about the use of such an insecure method for transmitting what might be sensitive information relating to patients, and we would much rather telephone urgent reports to practices.

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1 Wisely ICF. General practitioner fundholding: experience in Grampian. *BMJ* 1993;**306**:695-7. (13 March.)

Non-fundholding a positive choice

EDITOR,—Duncan Keeley has concisely outlined some of the areas of concern about fundholding that prospective fundholding practices should consider.[1] He is rightly concerned about the emergence of a two tier service in which fundholders' patients obtain preferential access to elective surgery. He questions whether the profession should accept the inevitability and permanence of this state of affairs. Some fundholders are explicitly stating that not being a fundholder means offering a second class service.[2] The pressure is on to fundhold. Are there other options? Keeley suggests that if enough practices stay out of fundholding then a more rational and cost effective embodiment of the purchaser-provider split will emerge. He is absolutely right to say so, and we trust he will be heartened by developments in Nottingham.

We have recognised that *planning* and *purchasing* are separate issues. Our local medical council, representing all general practitioners, fundholders and non-fundholders, is already actively involved in the planning role. Strategy groups, involving the local medical council, district health authority, and provider units, have been running for over a year. When it comes to actually purchasing secondary care, however, fundholders negotiate directly with providers to secure preferential access for their patients. To redress the balance Nottingham Non-Fundholders was formed with the single objective of empowering the district health authority in its purchasing role.

After an open meeting of general practitioners and district health authority staff last November over 180 principals in the Nottingham district, more than 60% of all general practitioners in Nottingham, gave a written support to this initiative, as has the Nottinghamshire local medical council. With a purchasing base of more than 300 000 patients the district health authority will be able to exert a powerful influence on providers. Empowerment comes through the commitment of general practitioners to provide accurate referral data through a revised, centralised, referral mechanism. Non-fundholding general practitioners can inform and influence the decision making process while avoiding the bureaucracy associated with fundholding. Equity of access to quality secondary care should result.

We hope Nottingham's model of locality purchasing on a district scale will be successful and believe it merits serious consideration by non-fundholding general practitioners in other areas. Non-fundholding is a positive influential choice.

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1 Keeley D. The fundholding debate: should practices reconsider the decision not to fundhold? *BMJ* 1993;**306**:697-8. (13 March.)
2 Slingsby C, Barr F. Can you get by without a budget? *Medeconomics* April 1993:70-9.

Racial discrimination

Prejudice exaggerated

EDITOR,—Many doctors experience difficulty obtaining posts in hospital medicine, and this often applies particularly to the first senior house officer post, when the doctor is inexperienced in applying for a job. I had great difficulty obtaining my first post until I asked a colleague, who pointed out that my curriculum vitae was inadequately presented. It is so easy for a member of a minority group to blame bias in other people rather than to examine possible deficiencies in oneself. Thus although there may "seem" to be inequalities in job selection, it is as A Esmail and S Everington point out,[1] important that the matter is studied in a totally fair and impartial way. It is sad therefore that the authors of this paper have set out to prove a particular point rather than keep an open mind, for it is reflected in the interpretation of their results.

There is a major flaw in the study. To know whether the proportion of candidates selected for interview is a fair representation of the cross section of doctors who applied for the post, one needs to know what the cross section of doctors who applied was. If the study had been designed properly with the cooperation of personnel departments, as the editorial comment previously highlighted,[2] this information would have been available to us. If twice as many doctors with Anglo-Saxon names are applying for the posts as are doctors with Asian sounding names, the proportion selected for interview is entirely appropriate. In fact the data in their present form suggest that there has been positive discrimination in favour of the ethnic minorities. At medical school the proportion of students with Anglo-Saxon sounding names compared with ethnic minority sounding names far exceeds the proportion of two to one. The fact that the ethnic minorities have managed to reduce this deficit and are now outnumbered at interview only by two to one indicates that there has been positive discrimination in their favour at some point, presumably in selection for interview.

A second, albeit less important flaw, was the decision to exclude posts that required an application form. An application form standardises candidates' applications, thus helping to eradicate inequalities in presentation that might prejudice the impartiality of the study. It seems more likely that apparent inequalities in the applications would be eradicated by an application form than by any attempt to write individual curriculum vitaes that would appear similar.

Clearly the subject requires a better designed study, but the current results would suggest that any unfairness is directed towards the "Anglo-Saxon" graduates of our universities.

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1 Esmail A, Everington S. Racial discrimination against doctors from ethnic minorities. *BMJ* 1993;**306**:691-2. (13 March.)
2 Smith R. Deception in research, and racial discrimination in medicine. *BMJ* 1993;**306**:668-9. (13 March.)

Author's reply

Everington and I carried out the research to expose what we knew from anecdotal evidence was a widespread practice: discrimination against doctors from ethnic minorities. It is precisely because some people believe that differences are due to deficiencies in the quality of some candidates rather than systematic bias that we used a research design that controlled for all factors except the name of the candidate.

All the curriculum vitaes that we used were equivalent in every respect and this was confirmed independently by consultant colleagues and referees. The excuse that it was inadequately presented curriculum vitaes or inequalities in presentation that were responsible for the English candidates being shortlisted twice as often as their ethnic minority colleagues therefore does not apply. It is also important to emphasise that we were comparing British graduates from British medical schools, with the only important difference being the name of the candidate.

It is true that there are more doctors with Anglo-Saxon names applying for posts than doctors with Asian sounding names. What is at issue is that all candidates should have an equal chance in being selected for interview, irrespective of sex or race. Because we used matched pairs of curriculum vitaes we were able to show that candidates with an Anglo-Saxon name were twice as likely to be shortlisted than if they had an Asian name. If there were twice as many doctors with Anglo-Saxon names applying for hospital posts, discrimination against ethnic minority doctors in the ratio that our research suggests would result in four times as many doctors with Anglo-Saxon names being shortlisted than their ethnic minority colleagues.

If ethnic monitoring was carried out by all personnel departments as we suggested in our paper then we could easily see if the proportion of black and ethnic minority doctors being interviewed was similar to the cross section of doctors applying for these posts (which it should be if everyone had an equal chance). The fact that it is not is one of the reasons why we had to use the methods that we did.

To suggest that "unfairness" is directed at "Anglo-Saxon" graduates is a travesty. Our research was stopped by the intervention of the police and the General Medical Council. It would have been fascinating to extend the survey to posts at registrar, senior registrar, and consultant level.

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Consultants to blame

EDITOR,—It is ironical that in the research sponsored by the Medical Practitioners' Union into racial discrimination in medical appointments procedures it should have been Aneez Esmail and Sam Everington who were arrested, and later proceeded against by the General Medical Council,[1] rather than those whose criminal and unethical behaviour had been uncovered. If it is unlawful to pose as a potential victim of an unlawful act I would have thought that the work of the fraud squad would be rendered almost impossible.

For a long time the medical profession has