Incidentally, some might suggest that taking no further action to diagnose diabetes in elderly subjects (ie aged over 60 by WHO criteria [3]) with RPGs, who may very well have no glycosuria or symptoms, is one way to ensure that the needs of the elderly diabetic person continue to be unmet [4].

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Sir—I was both pleased and disappointed to read the report of the joint working party for the diagnosis and treatment of non-insulin-dependent diabetes (July 1993, pages 259–66). Pleased because the paper emphasises the importance of promoting good standards of diabetic care as a collaboration between all involved professionals, but disappointed because, once again, not enough importance has been attached to the care of the older patient with diabetes by a group of experts in diabetes. One example is the recommendation that if an elderly subject has glucose levels in the 'uncertain' range and is asymptomatic, no action needs to be taken. This recommendation is contrary to published evidence showing that more than half of patients with diabetes do not have elevated fasting glucose levels [1] irrespective of age. Thus, in older patients whose glucose levels are in the 'uncertain' range, a glucose tolerance test should be performed as in younger patients. Many patients with NIDDM have evidence of complications at the time of diagnosis and this is true of older patients as well [2], so it is essential to confirm or refute diagnosis of diabetes.

Good glycaemic control is also important in patients in their late 60s or 70s: they still have an appreciable life expectancy, and to develop disabling complications secondary to poor control is both tragic and preventable.

The elderly outnumber all other patients with diabetes and more recognition of their special needs is urgently warranted [3].

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The MB PhD programme

Sir—In the options set out for the training of clinician-scientists in the UK, it was claimed that an 'MD does not carry the same scientific credibility as the PhD' (April 1993, pages 147–50). We—all with an MD and without a PhD—call ourselves clinical scientists for at least some of the time and were, therefore, slightly disturbed to read this comment. Nor do we understand why 'basic or fundamental scientific work is not usually possible' during research for an MD. There seems to be something of a campaign to down-grade the MD degree in favour of the PhD which should be strongly resisted. After all, in any good department, clinicians who are doing work for an MD get as much—or even more—supervision than people doing a PhD, even though supervision is not compulsory for the MD candidate. Moreover, because it costs the candidate considerably less to do an MD than a PhD, the former is by far the most cost-effective choice.

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Best foot forward

Sir—It is indeed a sad fact that one constant in these changing times is the small proportion of Collegiate Members who vote in elections. It is probably safe to say that most Members regard the College as a citadel for exams and clever people with funny names. (Why does the accreditation of junior training posts fall to the 'Linacre Fellow'; who exactly *was* Linacre?)

Indeed most doctors' first visit to the College is to sit an examination when, nerves permitting, it is hard not to be mesmerised by the sheer glory of the archives, the learned books and the portraits of famous and long dead men.

It is small wonder, then, that most of us feel that personally we have little to offer to it all. Does the College address this anxiety adequately?

When a few Members do come back for reasons