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Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Reconstruction of general practice

SIR,—I am surprised at the lack of response to Dr F Honigsbaum's two articles (16 March, p 823; 23 March, p 907). I believe that he has got it wrong, and his paper is flawed by a series of incorrect assumptions about British GPs' attitudes to their job. What is the evidence that "general practitioners are demoralised," that "they do not feel that general practice offers the opportunity to exercise skills acquired in nine years of study," or "that they need relief from routine work"?

Dr Honigsbaum takes a global view and draws his conclusions mainly from a study of published reports. I speak from the position of a principal of 25 years' standing in a group practice in inner city Liverpool. The practice does, surprisingly, believe in continuity of care and never uses any form of locum service. As a GP who enjoys every minute of his work and as a trainer and examiner for the Royal College of General Practitioners I see little evidence of the so called demoralisation of general practitioners in the present generation of trainees and new entrants to general practice.

Where he goes wrong is in his assumption that the self image of the British GP is similar to that of his American counterpart and that the eight years of hospital socialisation has produced a doctor who still defines himself in hospital terms and sees himself as a hospital doctor working in the community. I do not think this is any longer true. The change began in the 1950s with the work of Balint and his colleagues.^{1,2} Balint started the movement which gave back general practitioners their self respect and identity, and he has had a profound impact on much of the education

for general practice; his influence in vocational training is still discernible to those who know where to look.

The concept that routine work is drudgery and inappropriate to the work of the general practitioner is wrong. Every contact between a doctor and his patient is important and is one piece in the emerging jigsaw of the doctor-patient relationship, a relationship which may continue for the whole professional lifetime of the GP and extend over several generations of his patient's family.

I have nothing against the employment of nurse practitioners within the practice team. Again, my experience tells me that such a member of the team is likely to be less permanent than the general practitioner. In our own practice the same doctors have been in partnership unchanged for 25 years but the

nurses and health visitors come and go. On average a health visitor moves on after three years and a district nurse changes every 10.

Our practice is soon to change. Partners are leaving and the incoming doctors have already been identified. Their morale is high and they have consciously chosen to work in the inner city. They have confirmed their belief in continuity of care in rejecting outright any suggestion that a locum service be used in future. British general practice does not need reconstruction; it does need resources and reinvestment.

L RATOFF

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- 1 Balint M. *The doctor, the patient and the illness*. London: Pitman Medical, 1957.
- 2 Balint M, Balint E. *Psychotherapeutic techniques in medicine*. London: Tavistock Publications Ltd, 1961.

Asian patients with diabetes

SIR,—Drs Olabiyi Odugbesan and Anthony H Barnett (6 April, p 1051) have described some features of diabetes among Asian patients as seen in a hospital clinic. We feel our observations in a general practice consisting of

4143 Asian patients would be of interest to your readers. The total number of diabetic patients was 104 (2.5%). The age profile of the practice (see table) shows that 62% of the population was below the age of 30 years.

Age distribution of Asian diabetics

	0-9	-19	-29	-39	-49	-59	-69	≥70
Age profile of practice	870	881	834	530	402	322	195	109
Non-insulin dependent	0	0	0	10	13	33	32	8
Insulin dependent	0	0	1	2	1	3	1	0
Prevalence of diabetes (%)	0	0	0.1	2.3	3.5	11.2	16.9	7.3

The prevalence, therefore, would be much higher in practice population with a normal age distribution.

Over three years none of the diabetic patients were admitted with either diabetic ketoacidosis or hyperosmolar diabetic coma. Over the same period four diabetic patients died, two of myocardial infarction, one of cerebrovascular accident, and one of respiratory failure due to pulmonary fibrosis. Three of the 104 diabetics had pulmonary tuberculosis but none had been found to have tuberculosis at the time of diagnosis.

Maturity onset, non-insulin dependent diabetes is a major health problem among adults of Asian origin. We feel that many of these diabetic patients are poorly controlled due to non-compliance with dietary advice. The non-compliance is partly due to language difficulties. It is evident from the prevalence table that most of the diabetic patients (74%) are over 50 years old. They are mostly first generation immigrants who are either completely illiterate or unable to understand English.

Also there is a wide variation of traditional Asian eating habits. For Asian diabetics dietary advice should be given in the relevant language during personal interviews and should take account of the patient's traditional eating habits. Screening for diabetes in Asian patients over the age of 50 years would be worth while.

D K MISTRY
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SIR,—The paper by Drs Olabiya Odugbesan and Anthony H Barnett (6 April, p 1051) is most important because of its conclusion that Asian diabetics have a low prevalence of insulin dependent diabetes. Unfortunately their conclusions are based on a relatively small sample of patients attending a diabetic clinic without any true knowledge of the numbers in the population served. Their results could be equally well explained by a high prevalence of non-insulin dependent diabetes.

A C BURDEN
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* * Drs Odugbesan and Barnett reply below.—
Ed, *BMJ*.

SIR,—Our results were based on a study of Asian diabetics from the east of Birmingham. While it is impossible to have a true knowledge of the prevalence of diabetes in the population served, there is no reason why this should be particularly skewed to select out insulin dependent diabetics. From our experience Asian diabetics on insulin tend to remain in Britain more than do non-insulin dependent diabetics.

In our district the vast majority of insulin treated patients are looked after in the local hospital diabetic clinic, although some non-insulin treated subjects are looked after entirely by their GPs. Consequently, if there is any bias in our hospital based study it would be due to over-reporting of insulin dependence in comparison to non-insulin dependence—that is, the prevalence of insulin dependence in Asian diabetics in this country is probably even less than 4%.

The Asian patients of Drs Mistry and Sihota have a low prevalence of insulin dependent diabetes—in agreement with our figures. Their criteria for true insulin dependence, however, and age at diagnosis are not given and perhaps not all their patients on insulin are truly insulin dependent (according to the accepted criteria used in our paper).

We agree that non-compliance with dietary advice is a major reason for poor diabetic control in Asian and white diabetics alike. In our clinic a special Asian diabetic diet has been formulated to try to improve compliance.

O ODUGBESAN
ANTHONY BARNETT

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Further report from a refugee camp in the Sudan

SIR,—A few weeks ago I sent a report from this refugee camp on the conditions in the camp and what it was like to work as a physician in such an emergency situation (4 May, p 1325). This letter is written as I prepare to leave this assignment and return to my ivory tower.

Some things have changed radically. Malnutrition has been largely beaten, and although half the children in the camp are still registered for supplementary feeding, they are graduating from this at the rate of 10 or 15 per day, and the skeletal picture of marasmus is now rare in this camp. With one convulsive effort, we have vaccinated all 8500 refugees against meningitis, have reviewed everyone's nutritional status, and have issued vitamin A to everyone in the camp. It is now evident that our death rate is down to 1.6/10 000/day, twentyfold less than it was three months ago. Over half the deaths are in adults with long term chronic diseases such as tuberculosis, and deaths in children are now relatively rare.

Tuberculosis? Well, that is a thorny issue since treatment for that disease is a political decision. We have no approval to start a tuberculosis programme, although we now have the means to identify cases. It is a political decision in so far as the plan requires a stable population and a stable drug supply for one year, and the plan is that these camps may be disbanded within a few months, or even within weeks if the rains begin properly in Ethiopia. In fact 2000 people have been registered by the Relief Society of Tigré (REST) to return to their homes to start the planting season in the hope that food, rain, and seeds will be available to sustain them through to harvest time. We think that the first people will be leaving within the week, but we, as the expatriates responsible for running the whole medical aspect of this camp, will be the last to know who is going, and when.

Two major signs of the improvement in the health of the refugees are seen in the activities going on in the camp. Children are running around, laughing, playing tag and football, and can be seen, alongside their elders, sitting daily in classes in schools organised by REST. The other sign can be seen in my hospital, where occupational therapy has become a major activity. The hospital garden is growing, faithfully tended and admired by these peasant farmers. Inside the hospital patients and parents sit embroidering panels of cloth into exquisite designs of traditional patterns,

most based on a cross motif inspired by the deep religious convictions of these people. If the designs are not perfectly symmetrical it is because we cannot obtain enough coloured threads to allow consistency throughout the design. This simple, sophisticated art should be seen by the outside world. It could bring income and occupation for many people in this camp. Next week we hope to start weaving raw cotton spun on hand spindles within the camp and we shall use our sewing machines to make clothes, and then this cycle will be complete. It gives me greater happiness to have been able to achieve this activity than to have made any number of exciting diagnoses and dramatic cures.

Do not believe from this report that the crisis is over, the battle won. More refugees are still coming from Tigré than are ever registered to return, and if the rains fail, here or in Ethiopia, what the world has seen to date will be a pale foreshadow of the crisis to come. In my last communiqué my plea was for better planning and the development of systems of emergency relief that look past the initial dramatic stages of a catastrophe, so we do not have to remake the same mistakes each time. The cry is still the same. For example, we pray for rain but if it comes the camp and the hospital and our own lives here may become impossible. We shall be knee deep in mud. Is there any plastic, corrugated iron, or waterproof material anywhere? We shall need it, we hope, in less than a month. One day, perhaps, we shall have the foresight to have such basics available before the crisis swallows us.

NEIL R M BUIST

Fao 1 Camp,
Eastern Sudan

Rehabilitation of patients with cardiac conditions

SIR,—Ms Daphne Gloag's article on cardiac rehabilitation (23 February, p 617) shows unjustified optimism about the widespread availability of rehabilitation courses. Half the hospitals in Birmingham may have formal exercise programmes, but I doubt whether this percentage is echoed throughout the country.

Ms Gloag suggests that general practitioners working in community sports centres would be appropriate for supervising cardiac rehabilitation. I have been running just such an exercise programme in Alton Sports Centre for the past nine years and during that time over 500 patients have been through the course.^{1 2} The lack of similar facilities for many miles around is reflected by the referrals I receive from as far afield as Southampton, Andover, Reading, Camberley, and Guildford. I have recently completed a randomised, controlled trial of the effects of our exercise programme on 200 patients who had suffered myocardial infarctions. The results have not been fully analysed yet, but preliminary figures suggest a real benefit to the exercised patients, who showed improved general well-being, more sexual activity, less angina, and greater physical fitness.

The benefits of exercise for patients who have suffered infarctions are clear, but the exercise courses are far too few. I hope that other GPs will be stimulated by Ms Gloag's article to start new courses in their own areas and thus spread this facility, which most hospitals fail to provide. They should not be put off by the supposed need for