interests of that person. The issue of resource allocation is an important but separate one which should be debated in a separate forum.

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British medicine has lessons for North American medicine

EDITOR,—The editorial on futility by Charles Weijer and Carl Elliott had a distinctly North American flavour, which will limit its relevance to British clinicians.¹ We do not agree that withdrawing life supporting care from a patient in a persistent vegetative state presents a dilemma; it is common sense to us that such care is futile.

The context in which such decisions are made in North America, or in the United States at least, is very different from that in the United Kingdom. As J Bion pointed out in the preceding editorial, in the United Kingdom only 1-2% of the small health care budget is spent on intensive care whereas in the United States 15% of a much larger budget is spent on it.² In the United States "elaborate and uncomfortable therapies of dubious advantage or none to the frail elderly are deployed on a scale unimaginable in Britain."³ Doctors and hospitals get well paid for this, and medicolegal considerations encourage physicians to do more rather than less.³ It is against this background that American physicians promote patient autonomy and scorn paternalism.

In the United Kingdom doctors get paid a salary, not fees for services, and are less likely to be victims of litigation.³ In English law the doctors of incompetent patients rather than relatives have responsibility for making decisions on their behalf. This has led British doctors to behave in an "indefensibly paternalistic"⁴ way in the past, although this is now changing to accommodate a greater degree of patient autonomy. Doctors are realistic enough, however, to accept that medical decisions are never going to be completely objective even if this was desirable; there is always going to be some subjectivity.⁴

Recognising that some interventions are inappropriate because they are futile often requires a simple combination of clinical experience and common sense, not elaborate protocols. In 1990 the editor of the *Journal of the American Geriatrics Society* discussed the use of cardiopulmonary resuscitation in nursing homes: "at long last, we seem to be paying some attention to the winds of common sense blowing eastwards across the Atlantic."⁵ Perhaps in this case British doctors should be exporting ideas to rather than importing them from their North American colleagues.

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WHO in Cambodia

EDITOR,—In one of her articles on the World Health Organisation Fiona Godlee refers positively to the organisation's work in Cambodia, saying that it is "one country programme [that] shows what WHO can achieve at its best."¹ She implies that the success of this programme is at least partly due to the fact that "the project suffered little interference from the regional office in Manila."

As the first three WHO programme managers in Cambodia since the re-establishment of the organisation's office there early in 1991, we take strong exception to this statement. Whatever has been accomplished by the WHO in Cambodia has largely been due to the strong technical and moral support that we and our staff in the country have received from the regional office for the western Pacific; our colleagues in Manila deserve a major share of the credit.

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Incidence of diabetes in children

EDITOR,—Emma Wadsworth and colleagues report the incidence of insulin dependent diabetes in children under 5 years in the British Isles.¹ Their data suggest that the incidence remained stable over four years. The use of "snapshot" years to address the question of potentially increasing incidence must have limited value, even over a large geographical area, when random variation substantially affects annual numbers.

The population based Yorkshire children's diabetes register includes 1650 children and for the years 1978-90 is 97% complete.² A time span of 16 years is likely to reflect true changes in incidence, and data from the Yorkshire register were used to calculate age specific incidences (per 100 000 per year) for 1978-93. The figure shows smoothed rates (three year moving average) for ages 0-4, 5-9, 10-14, and 0-14. Testing for a significant rise in incidence (χ^2 test for trend) showed no evidence of an increase in the youngest age group ($\chi^2=1.23$, $P=0.27$), which supports the observations of Wadsworth and colleagues. A similar non-signifi-

Age specific incidence of diabetes in children aged 0-14 in Yorkshire, 1978-93

cant trend was seen in the 5-9 year olds ($\chi^2=1.22$, $P=0.27$). However, a significant increase was observed in the 10-14 age group ($\chi^2=17.8$, $P<0.001$), which accounted for the increase in all ages combined ($\chi^2=15.29$, $P<0.001$). The incidence over 16 years for the 0-4 year olds is 9.46/100 000/year, which closely matches the rates from national surveys.¹ An underlying constant base rate should not mask the importance of looking at geographical and temporal heterogeneity, which may provide clues to the aetiology of a disease.

Temporal trends in Yorkshire show roughly four yearly cycles of high incidence, with the rates for the 0-4 year olds ranging from a high of 15.40/100 000/year in 1988 to a low of 5.34/100 000/year in 1982. If this was a feature of patterns of incidence on a larger geographical scale then figures from two years separated by a period of four years could be misrepresentative, showing unusually high or low rates.

An interesting finding of the national studies was the significant geographical heterogeneity among British regions, although rates were not consistently high or low in the same areas in 1988 and 1992. These features indicate widespread environmental factors influencing the onset of disease; one candidate might be cyclical variation in infections, which are known to vary geographically. The importance of investigating localised differences in occurrence should not be minimised.

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Specialists in the United States

EDITOR,—I was trained in general surgery in Britain and then spent 10 years training surgical residents in the United States. Having observed the results of this method for the past 15 years in private surgical practice, I can vouch for the fact that it is possible to train bright medical graduates to a high standard of specialist competence in a defined period.¹

In my opinion, the main difference between the British and American systems is that the British method relies heavily on the old apprentice system, which leads to a long, slow, gradual approach to learning. Its final product is excellent, but it is time consuming. The American system, in contrast, is very concentrated practically and theoretically. It is much more labour intensive for the trainers and trainees but produces a similar result in a much shorter time.

To train the "new" British consultants to current standards in a defined period major changes will be necessary. These will include a great increase in full time teaching staff, which will have major consequences for the government and the NHS. The advantage for NHS patients will be that, in future, most will be seen by an appropriately and fully trained specialist. The advantage for trainees will be that training will last for a