on the waiting list. Medical inconvenience occurred in 92 cancellations and social inconvenience in 147. Financial loss to patients amounted to £7356 and 370 working days were lost. All the patients commented that the letter they received after the postponement of their admission was useful and it reassured them that attempts were being made to admit them.

For a patient to be admitted and an operation performed several facilities must be available. The most important of these are beds, staff, and laboratory and theatre services. Although availability of beds is not the only critical factor, it was the most frequent reason for cancellation of admissions in this study. This study did not quantify the severity of medical and social inconvenience, but it demonstrates that many patients suffered physically and socially because their admissions were cancelled. The mean financial loss for each cancellation was £43 but it was borne by the patient and those for whom financial loss caused hardship could not claim this money back.

If the extent of cancellations in this hospital is typical of others across the country, the loss of working days must be considerable. The cost of this loss is borne largely by the government which pays sickness benefits, and by employers who pay for temporary replacements. The reasons why patients did not return to work immediately after their admissions were postponed were obscure but health planners must be aware of the potential cost involved, for it may offset some of the savings made in closing beds. It is my view that if a patient's admission is cancelled it is humane and courteous on the part of the hospital to offer him an explanation for the cancellation and a new date of admission without delay.

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History of problem drinking in older adult male diabetic patients

Sir,

For nearly a decade my practice has compiled and maintained a modified disease register of selected major chronic health problems presented to, and recognized by, the family doctors in order to improve the long-term clinical management of patients with these diseases. The disease register has also been used to try to estimate the annual prevalence of health problems such as diabetes, hypertension and problem drinking.[1] Some patients were found to suffer from more than one of the conditions listed in the register. Looking at the register it seemed that a large proportion of older adult male diabetic patients also had a history of problem drinking. I decided to test the significance of this observation when all patients aged 40 to 74 years were invited, by letter, to attend for a blood pressure and urine test as part of other research projects in the practice.

The three-partner training practice has 5550 patients with an average age–sex distribution. Our criteria for the diagnosis of diabetes are: an abnormal glucose tolerance test, or repeated fasting blood glucose levels greater than 7 mmol l^{-1}, or repeated two-hour post-prandial blood glucose levels greater than 10 mmol l^{-1}. Diastolic pressures (phase 5) of 100 mmHg and 105 mmHg were used as the cut-off levels for the definition of hypertension in the age groups 40 to 59 years and 60 years or more respectively.[2] The confidential register of patients found, by case-finding alone, to have a history of problem drinking — the list includes those patients considered to be 'dry' at the present time — is based on the Shetland practitioner survey[3] check list of at-risk categories.

The number of patients aged 40 to 74 years with a recorded diagnosis of diabetes and/or hypertension (using case-finding and screening) and/or problem drinking (using case-finding alone) in the practice disease register was compared, for each sex, over a year. The prevalence of both hypertension and diabetes increased with age up to 55 years but appeared to be fairly stable thereafter. Thirty out of the 39 patients with more than one condition were over 55 years of age and therefore the statistical tests for association between any two of these conditions were done on the relatively homogeneous 55 to 74 years age group only (Table 1) using the binomial distribution with a null hypothesis of independence.

Eight of the 24 male diabetics (including two type I diabetics) had a known history of problem drinking; this association is statistically highly significant ($P<0.01$). Three of these male patients had been diagnosed as alcoholics some years before developing diabetes; five other diabetic patients had recorded abnormal liver function tests, including an elevated gamma glutamyl transpeptidase level. There was no evidence of problem drinking for 26 out of the total group of 36 diabetic patients. The occurrence of a history of problem drinking was statistically significant ($P<0.05$) for male hypertensives (Table 1), three of whom had been diagnosed as problem drinkers before becoming hypertensive. No statistically significant association between diabetes and hypertension was found for either sex.

Table 1. Occurrence of problem drinking or hypertension in diabetic patients aged 55 to 74 years (expected number, on the basis of no association, in parentheses).

Population at risk[a]	Hyper-tension	Drinking problem[b]
Diabetic patients		
Male ($n=24$)	3 (3.2)	8 (2.3)**
Female ($n=12$)	4 (1.5)	1 (0.4)
Hypertensive patients		
Male ($n=59$)	–	11 (5.7)*
Female ($n=71$)	–	3 (2.2)

*$P<0.05$. **$P<0.01$. [a]Total population at risk: 447 males, 568 females. [b]Number of known problem drinkers: 43 males, 18 females.

The association between problem drinking and diabetes has been described previously.[4] In a group of 541 white diabetic men aged 20 to 59 years attending a hospital outpatient clinic it was found that 15% drank heavily, while a further 7% had frank alcoholism.[5] There exists even stronger evidence for an association between hypertension and excessive alcohol consumption.[6-8]

Alcoholics who come into frequent contact with the family doctor for reasons other than alcoholism are probably more likely to be detected than problem drinkers who are otherwise fit and well. Nevertheless, these data show a high prevalence of a history of problem drinking in male diabetic patients between the ages of 55 and 74 years and I should be interested to know whether other general practitioners can confirm this finding.

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Doctors and nuclear war

Sir,
As a member of the Medical Campaign against Nuclear Weapons I take issue with Dr Ridsdill Smith (February *Journal,* p.87) who supports the *laissez-faire* policy of our College on the question of nuclear war. He does not fully appreciate the magnitude or imminence of the threat of nuclear annihilation which is confronting humankind today. The prevention of nuclear war is not merely 'a very complex political problem' — it is the greatest challenge of preventive medicine that has ever presented itself to our profession, and if we as doctors turn our backs on that challenge, we are betraying the trust of our fellow creatures who look to us to do all in our power to protect their health and safety.

Dr Ridsdill Smith is clearly a democrat who puts his faith in the ballot box and far be it from me to argue otherwise, but opinions, even when held by the majority can be proved erroneous, as in Nazi Germany, and attitudes are not always correct or immutable. However, if he is arguing that majority opinions should be respected then I would ask him to consider that the 1985 Nobel Peace Prize was awarded to the International Physicians for the Prevention of Nuclear War (to which the Medical Campaign Against Nuclear Weapons is affiliated) after meticulous consideration of 100 nominations for the prize.

And while it may be true that not all our colleagues are with us on the question of nuclear disarmament the majority certainly are. This was demonstrated by the resolution passed by an overwhelming majority at the 1984 Annual Representative Meeting of the British Medical Association calling for 'massive and progressive reductions in world arms spending' with the resources saved being diverted into health care and welfare 'at home and in developing countries'. Dr Ian Fingland (February *Journal,* p.87) has pointed out that increasing arms expenditure is hitting our health service; we are witnessing an appalling and continuing erosion of what was once the finest health service in the world. Hospitals are being closed down, nursing and other staff curtailed and funding of medical education and research cruelly cut back.

This surely cannot be allowed to continue and I would urge our College Council to think again about where it stands on this vitally important issue.

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Sir,
The RCGP should not confine its activities in the field of preventive medicine to areas which have the full support of all its members or even the majority support of the country. I would hope that where scientific evidence points to an unmet medical need, the College would respond appropriately and encourage its members to do likewise.

That said, Dr Ridsdill Smith (February *Journal,* p.87) should perhaps be reassured that on nuclear issues at least, the general public is in no doubt about what policy it would prescribe.

In the last general election the majority of the population voted for the three opposition parties, all of which support a nuclear freeze and two of which actively oppose the Trident programme. Since then independent polls have shown that around 80% of the population are in favour of a nuclear freeze and 70% are against Trident.

At a time when the British Medical Association is unable to persuade the Government to find an extra £300 million for the National Health Service and the Government presses ahead with its £10 000 million (plus) Trident programme, the continuing insistence of the College in sitting on the fence looks like the very opposite of political neutrality.

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Apartheid in South Africa and the medical profession

Sir,
The admirable aims of the 1986 WONCA Conference — to discuss primary care 'Towards 2000' in the light of the Alma-Ata declaration — are somewhat marred by the invitation to South African doctors to join the conference.

I write to express my deep dismay that doctors who, except for a tiny minority (including the newly-formed National Association of Medical and Dental Workers), have resisted changes which would lead to improvement in the health of the black majority, should be permitted to display their hypocrisy in our midst at an event conceived to discuss the promotion of good health care for everyone. In the 1930s the medical profession did not speak out against Nazi fascism and was later seen to have actively collaborated with it. Apartheid too is based on a philosophy of superiority of a racial group.

The South African medical profession has repeatedly failed to speak out against the apalling standards of health and health care provision for black people. It has actively colluded with the South African Government: for example in the case of Steve Biko a few years ago. He was brutally beaten up and then on 'medical advice' transported for hundreds of miles in the back of a van, in an unconscious state, to another prison. His subsequent death led to international uproar but the South African medical profession exonerated the doctor concerned. As one prominent member of the South African Medical Profession said: 'As the matter stands now our previously impeccable standing overseas has been placed in doubt. This can only lead to the closing of doors to the SAMP'.

In a country where there are some of the world's most excellent physicians and surgeons, the black population continues to have one of the highest infant mortality rates. Life expectancy is short. Preventable diseases such as tuberculosis and gastroenteritis are present in epidemic proportions with high mortality. Malnutrition in some areas is more than 50%. Mental illness is frequent; commonly organic, functional or following the widespread practice of torture. The facilities for psychiatric health care are sadly lacking — the Society of Psychiatrists of South Africa say that black mental patients 'prefer not to wear shoes and to sleep on the floor' (*Jerusalem Post,* 12 June 1979).

These differences arise not only through poverty, a migrating labour force and bantustanization (the process by which wives and children are forced to live in areas where they are unable to support themselves, while their black male