of conflicts that occur between the community and the hospital.

As with any new scheme or idea, problems are encountered. Assessment of patients by doctors of house officer grade, prescribing by pre-registration doctors and lack of continuity of care for patients are the three problems most often mentioned by those introduced to the idea for the first time. In practice, these and other problems are largely surmountable by the availability of the partners, the house officers' appreciation of their increased responsibility and regular discussion between the partners and house officers.

Those people who have heard about the scheme vary, from those who feel all doctors should rotate to a post in the community to those who feel that any time spent out of a hospital during the pre-registration year is completely unacceptable. At present, my own view lies somewhere in the middle. I do not believe that all house officers would want to spend time in general practice and not all general practices would want house officers. Even if it were possible, such schemes should not be compulsory as their success depends largely on the enthusiasm of the house officers and general practitioners involved. However, there are real benefits for the individual house officers, for the practices and for health care in general. Where the enthusiasm exists the scheme can and does work. The impetus for the establishment of such schemes is likely to have to come from general practitioners themselves.

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## Knowledge of health issues among Asian and white schoolchildren in Glasgow

Sir,

Asians (people originating from the Indian subcontinent) in the UK have been shown to have different morbidity and mortality rates to whites.[1-4] However, comparatively little has been written on health and related issues concerning Asian teenagers.

In 1986 I undertook a self-completion questionnaire survey of 385 13- to 16-year-old schoolchildren at three Glasgow schools to study a number of health and social issues. These included questions about their general practitioner; their own health; and knowledge about two health campaigns in Glasgow — 'Glasgow 2000' and 'Good hearted Glasgow'. In the sample there were 191 Asian and 194 white schoolchildren, matched by age and sex.

The response rate among Asians was 182 out of 191 (95.3%) and among whites 180 out of 194 (92.8%). The overall response rate was 362 out of 385 (94.0%). The responses were consistent with a preliminary interview study and the administration of questionnaires to schoolchildren in school is a reliable and valid method of data collection.

The response to questions on health and health services are shown in Table 1. Asian schoolchildren were significantly more likely to know their general practitioner and recall his or her name than their white peers were. One explanation is that Asian children are used as interpreters by parents and other relatives in consultations with general practitioners. Certainly the need for professional health interpreters in Glasgow has been documented (Gardee MR, Greater Glasgow Health Board internal communication, November 1986).

**Table 1.** Percentage responses to questions on health and related issues.

| | Asians ($n = 182$) | White ($n = 180$) |
|---|---|---|
| 1. Know own GP | *91.1* | *77.5**** |
| 2. Consulted GP in past 2 weeks | *17.3* | *17.9* |
| 3. Take regular medication | *17.1* | *13.0* |
| 4. Have anxieties about health | *21.4* | *18.1* |
| 5. Know about 'Good hearted Glasgow' | *4.4* | *5.1* |
| 6. Know about 'Glasgow 2000' | *16.1* | *25.3** |
| 7. Regard NHS as something to be proud of: | | |
| Yes | *53.9* | *40.4** |
| No | *15.0* | *21.9** |
| Don't know | *31.1* | *37.6** |

$n$ = total number of respondents. *** $P<0.001$; * $P<0.05$; Asians versus whites.

Over one in six schoolchildren in both groups had consulted their general practitioner in the two weeks prior to the survey and similar proportions were anxious about their health including worries about weight, height and death. One in six Asians and one in eight whites took prescribed or non-prescribed medications regularly — mostly vitamin pills.

Relatively small numbers of children knew about 'Good hearted Glasgow' because the study was undertaken shortly after its launch in May 1986. Significantly fewer Asian than white children knew of 'Glasgow 2000' but both proportions were relatively low for a community based smoking prevention campaign then in its third year.

More Asian schoolchildren thought that the NHS was something to be proud of than their white peers did. This may be due to an awareness of the benefits of a state health service fostered by their parents who would be aware of the shortcomings of medical care on the Indian subcontinent.

The information from the survey indicates that race and ethnicity of children should be taken into consideration when providing primary health care and health education.

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## Continuing medical education

Sir,

The 1989 spring conference of the Royal College of General Practitioners is to have continuing medical education as its theme. Continuing education is part of a learning experience involving keeping up-to-date with appropriate knowledge and skills and fostering the right attitudes. The focus at present is practice based learning for the entire team and bringing about behavioural change. Drury[1] has remarked on the higher uptake of distance learning, audit within practices and small group activity while Ridsdale[2] rightly points out that the work of a general practitioner may make continuing learning difficult.

The appointment of course organizers with special responsibility for continuing medical education will facilitate the educational needs of general practitioners particularly those who are isolated. It is encouraging to see the creation of fellowships by the MSD Foundation to develop initiatives, innovative workshops, courses and research in continuing education.

Savile[3] has commented that accountability in medical education provides an opportunity for general practitioners to show they can manage their own continuing medical education effectively. The

Eastbourne 'new things' courses have demonstrated that a course for general practitioner principals can be devised and planned by general practitioners using only the resources available to a district postgraduate centre.

In a recent College publication[4] patterns of attendance at continuing medical education meetings were analysed. Lunchtime lectures and audit assessments still retain popularity but whether attendance at meetings made any difference to competence is debatable. Programmes should incorporate general practitioners who speak from their own experience and special expertise and the importance of small group teaching needs to be emphasized. Improved quality of care resulting from continuing medical education can only enhance and enrich practice.

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## Incidence of mumps

Sir,

We were interested to read of the comparability of the weekly returns data and the Oxford regional sentinel practice scheme (October *Journal,* p.461) since we believe that such surveillance systems have an important place in communicable disease control. For example, evaluation of the success of the measles, mumps and rubella vaccine programme will require population data on the incidence of measles, mumps and rubella.[1] Mumps was made a statutorily notifiable disease in October 1988 but the main source of surveillance data is that collected by the Royal College of General Practitioners surveillance scheme and other similar schemes.[2] Since 1986 general practice surveillance of common infectious diseases including mumps, has been carried out in Wales, and we report data for mumps for the first year of the project.

From December 1985 to January 1988 practices throughout Wales, with a total patient population of about 200 000, have been recruited to report cases by age and sex each week. Fifteen practices with a patient population of over 100 000 reported throughout 1986 and their data for mumps are shown in Table 1. The age specific incidence rates for males and females were similar. For Wales as a whole there was a peak from June to August and a later peak in December. The peak incidence in the summer for 0–4 year olds was in June (3.8 per 1000 population) and for 5–14 year olds in July (1.9). The December rates for the two age groups were 4.7 and 1.5, respectively.

**Table 1.** Incidence of mumps in Wales in 1986 by age of patients.

| Age (years) | Number of cases | Incidence per 1000 population |
|---|---|---|
| 0–4 | 146 | 25.5 |
| 5–14 | 150 | 11.6 |
| 15–24 | 22 | 1.3 |
| 25–34 | 9 | 0.6 |
| 35–44 | 6 | 0.4 |
| 45–64 | 3 | 0.1 |
| >64 | 2 | 0.1 |
| Totals | 338 | 3.3 |

The crude incidence of mumps in 1986 estimated from data reported by the College's Birmingham research unit,[3] which covered a population of about 200 000 people mainly in the Midlands, was approximately 3.2 per 1000 population, compared with 3.3 in Wales. Our data confirms the reliability of the College data published in the Office of Population Censuses and Surveys *Monitor* series as an accurate index of national trends. The incidence in 0–4 year olds in Wales in 1986 was similar to that calculated for the period 1974–81 from College data,[2] but the incidence in 5–14 year olds in Wales in 1986 was only 12 compared with 16 for the period 1974–81 from College data. Our data confirm that mumps is increasingly an infection of pre-school children. It has been suggested that the introduction of mumps vaccine may change the age incidence of mumps so that a greater proportion of cases occur in older age groups[2] when complications are more frequent. However, if there is a high uptake of vaccine the risk of disease in teenagers and adults should be less than at present.

Surveillance data from general practice will be an important means of monitoring the effectiveness of the measles, mumps and rubella programme and of assessing the completeness of notifications of mumps.

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## Medicine in South Africa

Sir,

I am writing first to add my support to Dr Reissmann (Letters, June *Journal,* p.278) who suggested that the College should be breaking links with South Africa rather than encouraging them, and secondly, to draw readers' attention to avenues of positive action they can take to support the victims of apartheid.

*The Star* has reported that state medical expenditure for blacks in South Africa is less than one third that for whites. Medical services in the country are provided on a racially discriminatory basis and even the most progressive doctors cannot overcome the overwhelming effects of starvation, poor housing, harassment, torture and inhumanity. In effect, apartheid compromises medical ethics and by associating with bodies that work within the system, we compromise ourselves.

Norman Levy (Letters, September *Journal,* p.425) states that members of the South African Acadamy of Family Practice/Primary Care are practising independently and free of any constraints. The independence of the medical profession is limited by the acceptance of the stringent conditions of working under the apartheid regime's state of emergency. For instance, collation and publication of injuries inflicted by the South African police is prohibited (Proceedings of the National Medical and Dental Association Conference, 1987). Seventy doctors who signed a letter[1] outlining the appalling conditions at Baragwanath Hospital last year were forced by the authorities to sign an apology. Those who did not sign were not reappointed to their jobs and have had difficulty in furthering their careers.

We know that many South African doctors are assisting victims of apartheid and these doctors need our support. By failing to recognize official bodies that collude with apartheid, whether overtly or covertly, we support those doctors within the country who oppose apartheid. In addition, international academic boycott has