The combination of overseas patients and homelessness is an established phenomenon in London. Yet London continues to lose capitation funding despite the awful social statistics of the inner city areas.

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Tackling general practitioners' depression

Know your boundaries

EDITOR,—In a recent Personal View an anonymous general practitioner suggested that she should have been more selfish. She believed that she had failed to look after herself while successfully juggling the combined roles of general practitioner, wife, and mother. She should be encouraged by the fact that she has succeeded in these three roles, which those of a previous generation were often not even permitted to attempt. I shudder, however, at the thought of more selfishness being advocated: modern society has ample already. Medicine, marriage, and parenthood are all vocations that require selfless giving, but this should not destroy the giver. A more positive phrase would be to propose self protection. This recognises the value of giving and caring but acknowledges individuals' need for space to reflect and recharge their batteries. It also needs the hope of change and growth during a career.

I am grateful to a breast cancer specialist nurse who curbed my youthful zeal as a house officer and told me that I could not do everything for everyone. She taught me the need to pace myself and set limits—that is, to protect myself. So I am now going to ignore all the other things I could do and sit down and do some embroidery before tackling the research project that should help the practice progress in the future.

When did you last take up a new or an old hobby or sport? Don't be selfish; but do be self protective.

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1 I should have been more selfish. *BMJ* 1995;311:957. (7 October.)

Educational strategies to prevent depression

EDITOR,—The recent Personal View by a general practitioner with depression made sad reading.[1] It seems to me that many of the factors that contributed to the author's depression are causing other general practitioners to become depressed and burnt out. Many young doctors are voting with their feet and not risking entering general practice. Obviously, no single answer to these problems exists, but two educational initiatives in which I am involved have proved valuable to a number of colleagues.

The first initiative is the Balint movement. Balint's work in the 1950s and 1960s helped even those general practitioners who were not directly involved in it to understand their patients better and to realise that general practitioners had many skills that specialists do not have. Balint's ideas enormously improved the morale of general practice at the time. I believe that they still can. The "classic" Balint group, meeting weekly for several years, may not be appropriate for most general practitioners in the 1990s, but an occasional "taster" meeting in a supportive group can provide renewed understanding. The secretary of the Balint Society, Dr David Watt, would be happy to provide further information on available courses, for which no experience is necessary. His address is Tollgate Health Centre, 220 Tollgate Road, London E6 4JS.

The second initiative is cotutoring. This is flourishing in East Anglia and develops ideas originating from Andrew Eastaugh, Marion Barnett, and Paul Paxton. A small group of general practitioners meets for two days so that they get to know each other and learn how they might offer mutual support and educational guidance. They then meet in twos or threes, the agenda being left entirely to them. Supervision is offered by the facilitators, and the whole group has occasional follow up meetings. The first cohort has now been working for one year, and most participants want to carry on for the foreseeable future. The feedback has been encouraging, with virtually everybody feeling greatly supported and many feeling empowered to make major improvements in their professional and personal lives. I should be happy to supply further details of our programme; we are hoping for invitations to extend it to other parts of Britain.

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1 I should have been more selfish. *BMJ* 1995;311:957. (7 October.)

Obesity in Britain

Lifestyle data do not support sloth hypothesis

EDITOR,—The question of whether obesity in Britain is due to gluttony or sloth may be even more obscure than Andrew M Prentice and Susan A Jebb allow.[1] A particular concern is the apparent doubling of adult obesity (body mass index >30) during 1980-91, from a prevalence of 6% to 13% in men and from 8% to 15% in women. A puzzling feature of these statistics, however, is the absence of a corresponding increase in the prevalence of overweight (body mass index >25-30).[2] This increased from 33% to 38% in men during the period and from 24% to 26% in women. Is there something peculiar in obesity and obese people as defined?

With regard to aetiology, the authors suggest that "modern inactive lifestyles . . . possibly represent the dominant factor." The main concern here is not the long established low levels of physical activity in the population but the situation in recent years, "during the dynamic phase of weight gain," 1980-91. Available data—for example, the suggested proxies for population activity or sloth (rising car ownership and television[1])—do not support the authors' thesis. Television viewing has been falling for some time in middle aged people, from 27·56 hours weekly in 1986 to 26·24 in 1993. Walking in middle age has not declined.[3] Indeed, walk(s) of ≥2 miles (3·2 km) in the past four weeks were recorded in 1987 for 41% of men aged 45-59 and 60-69. By 1993 the figures were 47% and 45%, respectively. The increase in women has been comparable. Rates also rose between 1977 and 1986, though not so strongly.

In general, the Sports Council sums up recent history as follows: "participation is increasing across all age bands and all social groupings . . . much of the growth has been in women . . . the major growths . . . have been those most generally associated with a healthy lifestyle (for example, cycling, aerobics, walking and swimming)."[5] Campaigners may be permitted a small cheer.

Nevertheless, familiar deficiencies continue, and the overall situation is far from satisfactory. Might large slothful groups be becoming even less active? There is no evidence. Meanwhile, present evidence suggests that increasing sloth is not an important factor in the current steep increase in obesity.

Finally, when looking at national food intake the problem is to marry the many data from the national food survey on domestic consumption (which show a persistent decline) with the slight data on increasing meals outside home. The authors' text and figure 4 do not quite match, and the actual figures would be appreciated.

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1 Prentice AM, Jebb SA. Obesity in Britain, gluttony or sloth? *BMJ* 1995;311:437-9. (12 August.)
2 Department of Health. *The health of the nation: one year on.* London: DoH, 1993:50.
3 Department of Transport. *National travel surveys 1975/6, 1985/6, 1989-91.* London: HMSO, 1993:37-40.
4 Office of Population Censuses and Surveys. *General household survey, 1977-93.* London: HMSO, 1979-95.
5 Sports Council. *Trends in sports participation. Facilities factfile 2: planning and provision for sport.* London: Sports Council, 1993.

Authors' reply

EDITOR,—The increase in moderately overweight people in Britain has been somewhat greater than that quoted by J N Morris. Data from the Office of Population Censuses and Surveys quoted in a recent report on obesity show that overweight (body mass index 25-30) increased from 33% to 42% in men and from 24% to 29% in women between 1980 and 1991-2.[1] The total number of overweight and obese people combined (that is, those with a body mass index of >25) rose from 39% to 54% in men and from 32% to 45% in women. There are complexities resulting from a progressive skewing of the distribution curve for body mass index as the mean index of a population increases,[2] but these do not diminish the seriousness of the epidemic facing Britain.

In our paper we were careful to caution against overinterpretation of trends in data over time. Obesity is progressive, taking years, and sometimes decades, to develop. The prevalence will therefore always lag behind any changes in aetiological factors. Accordingly, we maintain that the secular trend data are perfectly consistent with our thesis that physical inactivity has a major role in causing obesity. In this respect Morris misquotes our phrase concerning "the dynamic phase of weight gain": we were referring to obese people, while Morris has interpreted it as referring to the whole population.

We agree that there is some evidence from the Sports Council of a recent upturn in rates of participation in some sports (just as there is some evidence of a slight decline in the proportion of energy in the nation's diet that is derived from fat), and these might ultimately help to retard the rise in the prevalence of obesity. We are among the most enthusiastic campaigners for active lifestyles and would not wish to withhold credit for any gains that have been made—but there is no room for complacency, since we are starting from a very low base. Levels of activity are still extraordinarily low, as indicated by the numerous surveys of physical activity now available. For instance, in the 1993 health survey for England 36% of men and 43% of women recorded fewer than four occasions of any moderate activity in the previous month.[3] It is the very people who never appear in the Sports Council's statistics who are at greatest risk of ill health arising from a lack of physical activity. Here there is an important distinction to be made between sport and exercise, which may be critical determinants of cardiovascular health, and a more general absence of activity, which may be the