munity based coronary heart disease prevention programme in the world is a unique development and the Health Education Council deserves much praise for it. At the outset it was never intended that the council should underwrite the total cost of the programme but rather that it should provide the core funding to which health authorities, the Welsh Office, and others could add. The £1·5 million contributed over the next five years represents a major part of the Health Education Council's coronary heart disease prevention budget and forms its biggest single development in 1985-6.

Instead of implying that the Health Education Council is in some way at fault for underfunding the Welsh heart programme you might have mentioned that the council itself is an underfunded organisation. Its largest programme concerns smoking education and in 1983-4 the Health Education Council spent £2·6 million on this activity out of its central government budget of £9·3 million. In comparison, however, in the same year the National Health Service spent £8 million on advertising job vacancies, the Department of Transport spent £5·8 million on advertising campaigns for road accidents (which amount to only 5% of smoking deaths), and the Sports Council planned to spend £6·3 million on exercise promotion in addition to other sports programmes. Unlike the Health Education Council, these agencies do not have a powerful adversary undermining their activities. The tobacco industry spends over £150 million annually on encouraging cigarette consumption. Yet despite this David and Goliath competition there has been a dramatic reduction in smoking prevalence in the United Kingdom for which the Health Education Council can rightly claim much credit. Between 1972 and 1982 there was a reduction of about five million smokers—a remarkable story.

The Health Education Council's smoking initiatives and the Welsh heart programme surely demonstrate that rather than an ailing quango the council is very much alive and kicking. These are just two of the Health Education Council's many and varied activities. Sir Brian Bailey, Dr David Player, and the officers of the council justly deserve your constructive support and that of your readers in a continuingly difficult political and economic climate.

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SIR,—Your welcome leader on Dr John Catford's appointment as the new professor of health education and promotion and director of the heart programme in Wales rightly emphasises the underfunding of this and other preventive initiatives. As you clearly emphasise, the urgent need is for the Department of Health and Social Security and the National Health Service to replace rhetoric and exhortation about health promotion and prevention with commitment, resources, and action.

In the same issue of the *BMJ* (p 534) Drs P G Wallace and A G Haines provide evidence of acceptability to patients of health promotional activity by general practitioners, who in turn have been shown to rate advice against smoking, at least, as an important health educational task which they should undertake. Moreover, though dispute continues about the effectiveness of some preventive activities, there is now a substantial basic consensus on the need for changes in lifestyle—especially smoking and diet—and for control of hypertension. No longer is there any excuse for the preventive inaction which has almost uniquely characterised Britain among Western countries over the past decade or more.

The Declaration of Alma-Ata (to which Britain is a signatory) has identified health promotion and disease prevention as the first of eight objectives in the pursuit of its target of "Health for all by the year 2000." Current funding of these activities in the United Kingdom makes a mockery of this. If the "second public health revolution" to which you refer is to be a reality and not just a pious hope then, as with nineteenth century public health improvements, governments must play a major role. In the words of Dr David Owen's 1984 Osler Lecture, "the degree to which this area has been neglected in the rush towards therapeutic and technical medicine is little short of a public scandal."

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Difficult choice of treatment for poorly controlled maturity onset diabetes: tablets or insulin?

SIR,—Drs I Peacock and R B Tattersall describe a trial in which patients with maturity onset diabetes, unsatisfactorily controlled on maximum doses of oral hypoglycaemic agents, showed no appreciable improvement on a single daily injection of insulin (30 June, p 1956). All patients received dietary advice to avoid refined carbohydrate and reduce excess weight. On average, carbohydrate provided 40% total daily energy. This carbohydrate intake is appreciably lower than the present average British intake and is characteristic of that recommended as part of the "low carbohydrate" diabetic diet in widespread use for several centuries. More recently the British Diabetic Association—in line with many other national diabetes organisations—has recommended a substantial increase in fibre rich carbohydrate in the diabetic diet.[1] We and others have shown that such a diet is associated with improved glycaemic control when compared with a low carbohydrate diet.[2-5] Most of the published studies have been carried out on relatively well controlled patients. A recent dietary study, however, is particularly relevant to the Nottingham trial since the subjects studied were similar: poorly controlled maturity onset diabetics (mean haemoglobin A_{1c} 10·6%) despite maximum or near maximum doses of oral hypoglycaemic agents.[6] Initially all patients were on a low carbohydrate diet and reinforcement of this dietary advice made little difference. A high carbohydrate high fibre diet resulted in an appreciable improvement in glycaemic control: a significant fall in haemoglobin A_{1c} (mean improvement 2%) and a re-education in oral hypoglycaemic therapy in several patients. It seems reasonable to expect that the Nottingham patients would have shown a similar response.

We agree with Peacock and Tattersall that there are many poorly controlled maturity onset diabetics in all clinics. They claim that "it is hard to change eating habits, and diet advice is often ignored." We agree with this too but consider that the results of their trial (unsatisfactory glycaemic control on both tablets and insulin) and our study suggest that a key aspect of the treatments for such patients is energetic reduction concerning the principles of a high carbohydrate high fibre diet. Our experience suggests that many patients respond favourably, provided that the doctor and the dietitian can convince patients that diet is at least as important as tablets or insulin and diabetics are shown just how palatable such a pattern of eating can be.

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Possible crisis in radiology departments

SIR,—It is a pity that Dr Wright has not read correctly the letter from the College of Radiographers to members (25 August, p 502). I have read the college's letter again and can find no statement that basic grade radiographers will not be allowed to undertake emergency duties after the end of August unless they have a senior colleague present.

What has happened is that the college, at the request of senior members of the profession, has had to put out a statement because of letters issued by the Department of Health. These letters state that basic grade radiographers should not be undertaking night work, or any other work for that matter, on their own. May I repeat that the statement is not from the College of Radiographers but from the Department of Health, which repeated it at a meeting at which we raised the issue.

If the DHSS makes a statement of that sort presumably employing authorities must comply with it. If superintendents do not do so and an accident occurs will the superintendent radiographer be held responsible? All the College of Radiographers seeks to do is to make it clear that the responsibility must lie with the employing authority for a short while, to give time for negotiations to take place with the Department of Health. Dr Wright's ill informed statements do nothing but inflame the issue.

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