and edited by two non-psychiatric physicians, no reference is made to neuropsychiatric disorders as such in its 334 pages, nor is there any mention appropriate to them in the long index of subjects. No mention is made of the ubiquitous untreated epileptic, the explosive amok-runner, the frequent bipolar affective disorders, the episodic dyscontrol individual, the *epigugu, deki, manga, buwa, bandovisi, dabanapaia, longlong, jirodusari* and many others defined as such by the people themselves and not by any decontextualised doctors. In short, the fuller account of interaction to which Dr Littlewood refers does not exist.

Dr Littlewood refers to what he calls 'dated attacks'. A historical record cannot be referred to as 'dated' nor are any attacks made on anyone.

He refers the reader to an alternative book on betel chewing without reference to the more comprehensive and broader account given in one of the author's *Arecaidinism* (*Canadian Journal of Psychiatry*, **24**, 481–488, 1979).

He states that the book is one "independent of any apparent knowledge of local social structure". This also is incorrect. He ignores the fact that three of the contributors are professional anthropologists, others have university qualifications in anthropology and still others are well versed in the social sciences. His use of the phrase 'social structure' implies a belief in a single such entity, a further apparent lack of knowledge of local circumstances. There is no such single entity; there are in fact 800 distinct and separate social structures, each one stemming from its own language.

I can appreciate and sympathise with Dr Littlewood in his attempt to write about a geographical area from such a limited database. There is a solution, however, if he wishes to continue in this fashion. He could, for example, abandon his London office and peripatetic yo-yo visits to various developing countries and get a permanent job of work in one of them. In this manner, his way would be easier, with at the same time an opportunity to make a worthwhile contribution to the traditional peoples themselves.

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AUTHORS' REPLY: Given Sir Burton's comments, it may be helpful for any reader to compare them with my review. I am concerned that I am taken perhaps as criticising his pioneering development of Western psychiatry in Papua New Guinea. I am not. The problem is his book.

"Yo-yo"? Brilliant trope, but I myself have never claimed any expertise in Melanesian studies, have never visited the area, kinetically or otherwise, nor published in the subject. Nonetheless, I have considerable reservations about *A History of Medicine in Papua New Guinea* which the space available for correspondence in the *Journal* allows me to consider at somewhat greater length than in its conventionally brief reviews.

I take Sir Burton's witty comments on national nomenclature (cf. Van der Veur, 1966), 'medic', 'structure' and 'Whiggish' as a pastiche of a position commonly advocated in the newer studies in cultural psychiatry: how much can we use a 'universalist' (etic but often Western) terminology to characterise the patterns of life in societies other than those of the observer? If 'psychosis' is a concept elaborated within Western psychiatry to describe and understand certain patterns which we understand as psychopathology, what does one lose – or gain – by applying them elsewhere? One of the famous instances of emic–etic confusions is the 'Seligman error': the anthropologist C. G. Seligman (1926) on this reading having denied the existence of severe mental illness in New Guinea for its patterns were apparently incorporated into existing social institutions. By contrast, Professor Burton-Bradley (1977), following F. M. Williams (1934), has articulated local religious movements in terms of psychopathology, an issue which developed into a notable debate in the *Transcultural Psychiatric Research Review*. My own position would be that we cannot reduce the etic to the emic, the naturalistic to the personalistic; nor the reverse. Both are equally valid and appropriate within their own limits of application.

The term "Whiggish" (and perhaps a larger dictionary would be helpful) refers to a type of writing, exemplified in 19th century "Whig historians" like Macaulay, which argued that historical development showed a clear, perhaps inevitable, progression to the modern and the liberal (Butterfield, 1931); the historical record is read through this virtually teleological assumption of the victory of contemporary rationalism. Objections to Whiggery are not only about its assumptions that what has happened was generally desirable, but that such history is not written by the 'losers'. In the issue under discussion, Burton-Bradley's book does not examine how the non-Europeans perceived and dealt with competing medical systems, how they made health-related choices, or indeed any serious consideration of what local medical practices were or are.

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The book is certainly 'dated', both in its reluctance to cite any arguments after 1980, and in its cavalier treatment of local understanding (let alone the anti-colonial struggles). Sir Burton's own chapter on 'Traditional medicine' simply lists those local terms which can be glossed by approximately similar biomedical conceptualisations together with recipe lists of local plant remedies: local medicine is perceived in terms of 'malevolent spirits' or 'sorcery' without the reader gaining any understanding of what these terms might mean. Whether one wishes to call Tamarua and Burton-Bradley's critique of "the doctrine of cultural relativism" an attack or not is perhaps debatable; it certainly does not begin to deal with the issue of whether 'cultural relativism' (whatever that was) did indeed elide the evaluative and the descriptive. The volume's account of the theoretical issues stops short after a consideration of Rivers, Roheim, Benedict and the Malinowski-Jones debate of the 1920s.

There is, however, a considerable body of more recent work, central to the relevance of the development of Western medicine in Papua New Guinea, which deals with the relations between anthropological and biomedical theory. Given the limits of a short *Journal* review, it is a little strange that Sir Burton now complains of my omission there of his 1979 paper: his own volume with 23 pages of references does not cite the obvious general work (Lewis, 1975, Frankel, 1986; Frankel & Lewis, 1989), nor recent theoretical debates (Lewis, 1980; Brunton, 1989), let alone the influential if arguably flawed earlier work of Bateson, Mead and Fortune. One suspects that the book's progression through the publishing house was somewhat leisurely.

The development of psychiatry in Papua New Guinea has justifiably been regarded as a heroic achievement for which Professor Burton-Bradley has been rightly recognised. His volume, regrettably, does no justice to the complexity of the issues involved, nor to the life of its local inhabitants. Its subtitle is *Vignettes of an Earlier Period*: perhaps it was unfair of me to complain that it omitted certain questions; to claim that they are indeed there is however astonishing.

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A full list of references is available from the author.

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Immigrants from the Indian sub-continent

SIR: Earlier this year I reported that a cohort of 86 first-generation immigrants from the Indian sub-continent spent a significantly lower proportion of a defined follow-up period as in-patients at the Bethlem Royal and Maudsley Hospitals ('Joint Hospital') than a matched group of indigenous English-born controls (Gupta, *Journal*, August 1991, **159**, 222–225). Subsequent analysis of follow-up data may shed some light on the reasons for this difference.

The average number of out-patient visits to the Joint Hospital during follow-up, and the proportion of patients who were seen exclusively in the Emergency Clinic, was very similar in both groups. Thus there does not appear to have been a compensatory increase in the use of non-in-patient psychiatric services by the immigrants. Nor was there any evidence, contrary to the findings of some previous studies (e.g. Pinto, 1970), that the migrant group were more likely to discharge themselves against medical advice, or to lapse from follow-up. A higher proportion of the immigrants were described as 'much improved', 'recovered' or 'well' at the time of their final contact with the Joint Hospital, but the difference failed to reach statistical significance.

Attempts were made to trace both groups through the hospital records and the NHS Central Register. The general practitioners of patients who were registered at the time of follow-up were sent a questionnaire, and 55 were able to provide some information about course and outcome (22 from the immigrant group, and 33 from the controls). There was no evidence that the migrants were more likely to have been seen at or admitted to psychiatric units elsewhere in the country. However, nearly twice as many of the immigrants either could not be traced to a general practitioner (GP) or family practitioner committee (FPC), or were traced but found to be no longer registered with the GP or FPC when direct inquiries were made. Thus, enhanced geographical mobility (either within or outside the UK) among the migrants remains a distinct possibility.

However, the lower rate of registration in general practice at time of follow-up may also reflect a failure of services at primary care level to maintain contact with immigrants with a prior history of psychiatric disorder. Among those who were still registered,

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