of $2.9 \times 10^9/l$ and a haemoglobin concentration of $10.9g/dl$. Her blood film report was: "Leucopenia. Neutropenia with normocytosis. Platelets adequate. Red blood cells showing anisocytosis and normochromia." On repetition six days later her white blood cells had recovered to $5.3 \times 10^9/l$ and the haemoglobin concentration was $11.5 g/dl$; her film report was "Hypochromia of red cells but white cells and platelets normal." A third blood count seven days later showed her white blood cells to be $6.7 \times 10^9/l$ and her blood film was reported as normal.

At the time of this marked leucopenia her fasting blood sugar, urea, and electrolytes were normal; calcium was lowered at $2.08 mmol/l$ ($8.32 mg/100 ml$); her protein and albumin concentrations were marginally low at 63 and $33 g/l$ respectively. Liver function tests were normal and the serum thyroxine concentration was at the lower end of the range at $65 nmol/l$ ($5 \mu g/100 ml$).

Thereafter she was examined by a consultant physician, but was not considered to be clinically hypothyroid or to show evidence of any serious condition. The patient was commenced on ampicillin when all other drugs were stopped, and following the reported leucopenia this was continued for six weeks. She has now made a full clinical recovery from a discrete episode of leucopenia, apparently following administration of mianserin hydrochloride.

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Creatine kinase MB estimation in myocardial infarction

SIR,—The study by Dr S P Joseph and others (10 February, p 372) on technetium imidodiphosphonate scanning in myocardial infarction was of considerable interest. Additional diagnostic help is undoubtedly needed in the many patients in the coronary care unit who have equivocal electrocardiogram and enzyme results. The incidence of such borderline cases has been estimated to be as high as 20% of admissions to coronary care units.¹

The authors, however, give scant reference in their discussion to the value of creatine kinase MB (CKMB) in such situations. Estimating concentrations of CKMB is a technically much simpler diagnostic method than myocardial imaging and also permits the diagnosis to be made earlier. It is also probably more accurate. CKMB disappears from the serum 36-48 hours after onset of chest pain² (not 24 hours as Joseph *et al* state) and so a serum sample must be obtained within this period, but this should not present difficulties. A further advantage of CKMB estimation is that it can be measured retrospectively in selected cases presenting diagnostic problems so long as serum samples have been kept frozen. Such selected use of myocardial imaging would not be so easy four to five days, say, after admission.

Our group (at the Victoria Infirmary, Glasgow)³ measured CKMB in 38 patients with borderline myocardial infarction. The ECG was non-diagnostic, the total CK concentration was raised but no greater than $400 U/l$ ($n=100 U/l$), and the serum aspartate aminotransferase concentration was no greater than $63 U/l$ ($n=42 U/l$). CKMB estimation diagnosed myocardial infarction in 14 cases and excluded it in 24. Retrospective analysis, taking CKMB concentrations as the yardstick,

suggested that the original clinical diagnosis had been wrong in about 12 cases.

Certainly further diagnostic methods would be helpful in the coronary care unit, but in this capacity CKMB would seem to have advantages over myocardial imaging.

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¹ Krauss, K R, *et al*, *Archives of Internal Medicine*, 1972, **129**, 808.

² Roberts, R, *et al*, *Lancet*, 1977, **2**, 319.

³ Melville, D I, *et al*, submitted for publication.

ABC of Ophthalmology

SIR,—Myopia is the result of inadequate correlation between the converging power of the refractive media (mainly the cornea) and the axial length of the eye. In most myopes the axial length is within the range found in eyes of normal refraction and myopia has occurred because the cornea has failed to flatten sufficiently during growth. Viewed in this light, Mr T Stuart-Black Kelly's claim (20 January, p 198) that myopia is caused by "increased intravitreal pressure" becomes a little implausible. This same fact is the explanation of the alleged influence of hard contact lenses in preventing progress in myopia. Every contact lens practitioner is familiar with the temporary moulding effect of contact lenses on the cornea, but it is equally well known that the effect is transient.

The argument that close work causes myopia wilts before the unassailable proposition that myopia causes close work. A failure to make this distinction in causal relationships has characterised the controversy for well over a century.

When writing for a non-ophthalmological readership, Mr J Stuart-Black Kelly would do well to avoid unqualified statements such as those in the second paragraph of his letter, which, in lumping together those cases of myopia arising from simple dimensional anomaly (the enormous majority) and those having a pathological basis, are likely to cause a great deal of unjustified alarm and perhaps unjustified hardship to young people.

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SIR,—I am grateful to Mr K D Foggitt (17 February, p 489) for giving a correct description of the mechanism for accommodation. However it is described, the important mental picture to possess is that the elasticity of the lens is the major limiting factor and that it is the loss of this and not any "weakness" or "eyestrain" which causes reading difficulties in middle age.

As for colour values, I believe they are subtly altered when visual acuity is improved with glasses. The duochrome test is an example of this. This has, of course, nothing to do with inherited disorders of colour vision.

I applaud Mr Foggitt's comments on myopia. I agree absolutely with his reasoning and conclusions, but would add two further arguments against the proposition that near vision is implicated as a cause. Firstly, non-reading techniques were in use in special

schools for myopes before the second world war for many years. These were abandoned when it became clear that the myopic process was not affected. Secondly, monocular myopia is acquired and progresses very commonly in children, yet reading is normally a binocular activity. What is the nature of the local resistance in one eye which prevents myopia and of its absence in the other eye? Do we fit bifocal lenses to one eye and plain lenses to the other? Perhaps all children of myopic parents should be given bifocals on school entry.

Until large-scale statistically sound evidence is available—and this would be a very complicated exercise indeed, running perhaps for 20 years or more—nearly all is theory. Such hard facts as are available do not indicate any other way forward. It is my belief that children should be spared the role of guinea-pig even though myopia can have disastrous consequences, unless the strongest evidence supports an experiment and that their parents should not be burdened with the fear of irresponsibility if in most cases they ignore the undeniable attractions of the will-o'-the-wisp.

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College of Anaesthetists?

SIR,—The Association of Anaesthetists of Great Britain and Ireland is canvassing support for the Anaesthetists' Academic Foundation with a view to establishing a college of anaesthetists independent of the Royal College of Surgeons.

We are concerned that the council of the association assumes widespread support for an independent college of anaesthetists although no polling has taken place for a number of years. At least in this part of Essex the concept is anathema and we wonder how much active support there is nationally and whether the general body of the specialty is apathetic. The various documents issued by the association office play to a considerable extent on the emotional argument and at times remind one of the party political broadcast. We are particularly concerned about the reporter in *Hospital Doctor* (24 January, 1979) who quotes extensively from an interview with the president of the association, and we must register bewilderment at some of the sentiments stated.

In our view there is no advantage to be gained by change of the faculty status within the College of Surgeons. The faculty acts as an independent body in all important respects. It influences standards by its hospital visiting programme through the Hospital Recognition Committee. It organises educational events and it determines the regulation of the FFARCS examination and itself grants diplomas under the new charter. It has been suggested that examination fees and fellows' subscriptions are paid straight into college funds and that anaesthetists derive little benefit therefrom. Nothing could be further from the truth. The examination is set to a high standard and is expensive to run. The examination hall has considerable overheads and the ratio of candidate to examiner is high (36 candidates and 18 examiners currently each day so that each candidate is independently assessed by five pairs of examiners). Fellows of the Faculty of Anaesthetists enjoy the same privileges within the college as any surgical or dental fellow. The building is prestigious, is in a convenient site for the main railway termini, and houses artistic treasures. There is a fellows' common room and a cafeteria where lunch may be

obtained at favourable charges. Limited residential accommodation is available for fellows' use. There are several lecture rooms within the college and these are regularly used for anaesthetic lectures in addition to the large meetings in the Edward Lumley Hall. The library facilities are excellent and the Hunterian Museum is unique. Fellows in the Faculty of Anaesthetists are able to use all these facilities as of right. It is theirs, shared on conditions of equality with the surgical and dental fellows.

What has the independent college of anaesthetists to offer in comparison with all this? At present the Association of Anaesthetists has rented offices, with cramped accommodation and no private office for the president, editor, or other officers. The Edward Lumley Hall at the College of Surgeons has its critics as a venue for large meetings, but it is noticeable that the Association of Anaesthetists has not been able to rent better accommodation for its scientific meetings in London.

It has been suggested that anaesthetists are paying too much in their annual subscription to the College of Surgeons. But is £20 per annum a large sum in these inflationary times? It is no more than the present subscription to the association. We suggest that, contrary to the belief of many advocates of the independent college, the ordinary anaesthetist will be paying much more in subscriptions and have less benefit than he does now if the plan comes to fruition. It will still be necessary to maintain and pay for a separate association structure, as the charitable status of a college would prevent it from negotiating with the Department of Health on terms and conditions of service.

Others have emphasised the political advantages of unity within the Royal College of Surgeons. We subscribe to the view that a combined voice is more powerful than separate individual voices and see no reason to believe that an independent college would lead to a greater representation of anaesthetists on national bodies. In any future political controversy it is surely obvious that the power or influence exerted by anaesthetists, fully backed by the College of Surgeons and its council, would be far greater than such power wielded independently by a new college, which, in its early years at least, would be lacking in prestige and tradition, relatively unknown, and therefore held in only moderate esteem.

We submit that both faculty and association are doing an excellent job in their respective fields at the present time. The ink is hardly dry on the revised charter of the Royal College of Surgeons. The specialty has already been honoured in the election of one of its members to the important position of vice-president of the college. It will take time for other changes to become apparent. It is clear, for example, that anaesthetists will have more influence on matters relating to the college funds in the years to come. In 1969 few would have foreseen the changes which have occurred within the college in the past decade. Who knows what can happen by 1989? In our view the new charter must be allowed time for its results to become apparent. The real enemies lie not within the profession, but without.

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Pay and parity

SIR,—No one, surely, will dispute the evidence on pay scales provided by Dr B D Scott (27

January, p 271), but we trust that these figures will not be used for pay parity arguments by our negotiators. These figures relate only to similar Government-repressed salaries. Mr David Ennals was recently heard on television news to state that Health Service workers should have pay parity with private industry. One of us has argued¹ that salaries should be comparable to those of other professional groups such as barristers. We would like to update those figures and would remind readers that many legal fees are paid by the Government for legal aid cases. We are informed that a barrister in the first five years after qualifying may expect to receive £5000-£8000 while senior partners earn around £20 000, against which many expenses may be claimed, and at this stage are comparable in professional status to a hospital consultant. Likewise, solicitors of the same seniority have a similar earning capacity. It is important to realise that the fees that make up these salaries have not been increased for seven years and are soon to be reviewed, no doubt leading to a considerable increase in potential earnings. Thus, while accepting Dr Scott's figures, we must press our Review Body to compare our levels of remuneration with those of professional groups whose incomes lie in the free sector, unfettered by government policies.

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¹ Reece, I J, *British Medical Journal*, 1975, 4, 523.

Industrial anarchy in the NHS

SIR,—The current industrial unrest requires firm leadership, not only by Government and unions, but, as you suggest, by the medical profession. I was therefore extremely disappointed by your leading article (10 February, p 364). Having correctly pointed out the low pay of ancillary workers in the Health Service, you then proceeded to offer as a solution to higher pay a reduction in staffing because "the NHS is overmanned (at virtually every level)." Such a comment would suggest that you have not seen the inside of a hospital for a great many years. The pressures on staff are numerous, and, while I have no doubt there are a few jobs which could be made more efficient and productive, for the vast majority of personnel, in this hospital at least, there is a constant pressure which requires a performance of duties far in excess of the optimum. The cry to "cut out administrators" is often heard, but this would lead to minute savings compared with the total cost of the Service. Your writer offers nothing in the way of constructive proposals to solve the industrial unrest.

I submit that we should support the justifiable grievances of the Health Service workers—while not supporting their industrial action—and we should be considering, as a profession, ways of incorporating ancillary staff into the care of the patient as part of a working team in order to increase job satisfaction, and from this to improve productivity.

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Resignation from the NHS

SIR,—During the lull in our medicopolitical affairs we ought to be thinking about what happens after the Review Body reports. Whether this body recommends an acceptable level of remuneration for the new contract seems to me to be irrelevant. It is the second and third reports which will be vital. From past experience our "independent" Review Body has slowly let our standard of living fall while the various Governments have given us sharp downward prods. The question is whether or not we are going to take any action in protest. The 1975 imposition of a 40-hour week was a fiasco. Only a minority of hospital doctors followed the advice of their leaders. Opinion polls indicate that the public are fed up with industrial action and I think that highly paid doctors would be sitting ducks for the media to pick off.

Thus we are left with accepting passively that which we are offered or considering resignation from the National Health Service. The latter is, I believe, the only honourable course and would be understood by all men who have left uncongenial employment. Resignation would have to be carefully planned with agency arrangements, as most consultants would be terrified of taking such an action unless they were assured that the BMA held the requisite number of signed but undated resignations.

As a member of the Northern Regional Committee for Hospital Medical Services I gain the impression that militancy increases centripetally, and, as in our previous forays, our leaders at centre will find that the troops at the periphery will fail to follow.

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GPs and casualties

SIR,—This practice is 26 miles from a district general hospital and its accident and emergency department. We care for the casualties which arise in our practice area at our surgery, because it is not practical to send them to the district general hospital and because it is not practical to leave our practice premises to treat them at our community hospital, disrupting the work in our own premises by our absence. This way of providing casualty services for remote areas is recognised by the Walpole Lewin report (para 6.4 page 23) but is not recognised financially and the General Medical Services Committee is not at present negotiating for the remuneration of general practitioners who provide casualty care for their own patients.

Doctors who feel compelled to provide casualty care for their patients because of isolation from casualty departments should be financially rewarded for doing so and I believe that the GMSC should negotiate for our proper remuneration.

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* * *The Secretary writes: "The GMSC has recently completed negotiations with the Department of Health for new arrangements for remunerating general practitioners providing casualty services in cottage hospitals. These new arrangements are presently being priced—by the Review Body. The Secretary of State has a responsibility to provide adequate