schedules, etc., are required. Unless proper management skills are acquired by laboratory staff more and more of these roles will be taken over by outside administrators. Medical laboratories are complex organisations which require a great deal of scientific skill allied to a high level of managerial skill—by and large the organisation works well. It is unlikely that the vast changes which have occurred in laboratories over the past 20 years have been equalled anywhere else in the Health Service, either for the rate at which they have occurred or for the ease with which they have occurred, a matter on which the professional bodies concerned should be congratulated. There has been the right training—the right skills have been there when they were needed, unlike the rest of British industry, which even now is short of skilled workers. My hope is that the professional bodies will realise what has been achieved by co-operation in the past and will come even closer together to continue the record of success and unity within medical laboratories.

The past 20 years have seen great change; who knows, the next 20 years may see even greater changes. For this reason the professions within medical laboratories should welcome HSC(1S)16, which with minor modifications is already practised in the large proportion of the leading laboratories within the National Health Service.

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SIR,—We noticed with interest the statement in your leading article (21 October, p 1108) that “divisions between the work of junior scientists and technical staff (medical laboratory scientific officers, MLSOs) are blurred.”

Ignoring the gratuitous misuse of the terms scientific and technical we would like to make an observation. On the last occasion that we advertised for a senior medical laboratory scientific officer in chemical pathology we received an application from a senior biochemist. Could it be that there is no distinction between the work of the “scientists” and MLSOs and that the appearance of blurring only occurs where artificial distinctions are contrived?

B WEEKS
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SIR,—Your leading article (21 October, p 1108), while giving an admirably objective review of the proposals for reorganisation within the NHS scientific service, regrettably deteriorates towards the end into a rather sad attempt to irritate further—or perhaps it might be more correct to say “resurrect”—antagonisms which have sometimes existed between medical and non-medical staff in hospital laboratories.

Perhaps it might be worth pointing out in the context of your naval analogy that the *Ark Royal* has now been scrapped and there is no longer a captain in command of her. Similarly, many of us hope that the old inter-professional antagonisms are also well on the way to being obsolete and that instead of a crew of officers and ratings (or, as a few people tend to see it, “us and them”) the pathology service is

moving into an era when laboratories are indeed managed by consensus as a team effort directed towards the ultimate benefit of the patient.

Irritating and unsubstantiated comments such as that to the effect that graduates only enter the medical laboratory scientific officer grades because they are “unable to obtain posts as scientists” are doubly regrettable both for their inaccuracy and for their apparent attempt to keep alive an antagonism which can benefit nobody and which few enough of either professional group seem to desire. The attitude of most medical laboratory scientific officers towards pathologists was made perfectly clear in the Institute of Medical Laboratory Sciences’ statement “Pathologists and ourselves.”¹ From this it is perfectly clear that the profession has a deep-seated desire to work in friendly partnership with pathologists but that it does suffer from time to time from misinterpretation of its attitude by some of those with whom it seeks to co-operate.

Surely there can be no suggestion that clinical pathologists feel their role in any way threatened by the non-medical staff who do the vast bulk of the scientific work of medical laboratories. If that role is in any way threatened it would seem to many of us that the threat comes rather from the “scientists” and biochemists to whom you refer who are employed under Whitley Council PTA regulations rather than the large majority of graduates entering the service who are employed under PTB regulations as medical laboratory scientific officers.

It is a pity that those who seek to perpetuate dissension between the two main professional groups in the medical laboratory do not come forward and identify themselves by name in order that their colleagues among both medical and non-medical staff may know just who it is who still seeks to stir the troubled waters of a recent past which most of us believe would be better forgotten.

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¹ *Gazette of the Institute of Medical Laboratory Sciences*, 1977, 21, 238.

Effect of propranolol on HDL cholesterol concentrations

SIR,—We were interested in the report of Dr P J Jenkins and others (5 August, p 388) concerning the inverse correlation between plasma high-density lipoprotein (HDL) cholesterol concentration and the severity of coronary artery disease. However, in the same issue Dr A Helgeland and others (p 403) reported an association between low HDL cholesterol and treatment with propranolol and thiazide diuretics. This raises an important

question, since subjects with severe coronary artery disease are more likely to be treated with propranolol.

We have studied 37 male Caucasian patients with coronary artery disease who were euthyroid, non-diabetic, and on no lipid-lowering agents. The diagnoses were: myocardial infarction (12), myocardial infarction and angina (13), angina (10), and aortocoronary bypass graft (2). Propranolol in the dosage range of 40-240 mg/day was being administered to 16 patients for treatment of angina and/or hypertension. Fasting blood samples were obtained on three different occasions separated by at least a four-day interval. The results obtained are shown in the table.

Only two subjects in the propranolol-treated group received thiazide diuretics, and the HDL cholesterol concentration in both was higher than the mean of the group.

It would be of interest to know if propranolol therapy can account at least in part for the lower HDL cholesterol observed in subjects with severe coronary artery disease.

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Terminal symptoms in children dying suddenly and unexpectedly

SIR,—The Department of Health and Social Security’s multicentre study of postneonatal mortality must be welcomed as a major long-term commitment to the elucidation of the causes and prevention of cot deaths. However, the study group’s preliminary report (4 November, p 1249) has a number of aspects which give cause for concern. These relate both to the methodology of the study itself and to the conclusions regarding intervention that derive from it.

In respect of methodology, as the investigators acknowledge, the retrospective assessment of symptoms is difficult and is especially problematic in this context because parents are likely to search for symptoms to explain their child’s death. The symptoms sought are also likely to be open to considerable variation in interpretation—for example, “irritability” or “altered character of cry.” The controls selected were apparently matched only for age, although other variables (for example, sex, social class) might be expected to affect the frequency of symptoms and their reporting. Further, the symptoms recorded for the controls were those present at the time of interview, which might be more readily recalled than or differently interpreted from the retrospective data obtained for the study group. Taken jointly, these criticisms would seem to cast some doubt on the reliability of the findings regarding the extent and severity

Findings (mean $\pm$ SEM) in 37 male patients with coronary artery disease

	Propranolol	No propranolol	Significance
No of subjects	16	21	—
Age (years)	55 $\pm$ 2	53 $\pm$ 2	NS
Weight (kg)	77 $\pm$ 2	79 $\pm$ 2	NS
Sum of four skinfolds (mm)	46 $\pm$ 2	46 $\pm$ 3	NS
Plasma glucose (mmol/l)	5.38 $\pm$ 0.17	5.38 $\pm$ 0.22	NS
Plasma insulin (mU/l)	15.1 $\pm$ 1.4	14.9 $\pm$ 1.1	NS
Plasma triglycerides (mmol/l)	2.33 $\pm$ 0.18	2.34 $\pm$ 0.57	NS
Plasma cholesterol (mmol/l)	5.70 $\pm$ 0.21	6.03 $\pm$ 0.23	NS
Plasma LDL cholesterol (mmol/l)	3.76 $\pm$ 0.23	3.86 $\pm$ 0.23	NS
Plasma HDL cholesterol (mmol/l)	0.86 $\pm$ 0.03	0.98 $\pm$ 0.04	P < 0.05

Conversion: SI to traditional units—Glucose: 1 mmol/l $\approx$ 18 mg/100 ml. Triglycerides: 1 mmol/l $\approx$ 89 mg/100 ml. Cholesterol: 1 mmol/l $\approx$ 39 mg/100 ml.