negative, and full blood counts and serum folate estimations were normal.

On close questioning the mothers had noticed that the children held the Pancrex powder (given in orange juice) in the mouth for some time before swallowing it, and in the third case the child crunched the tablets before swallowing them. The ulceration was thought to be due to digestion of the mucous membrane by the Pancrex extract in the alkaline medium of the mouth, and rapid clinical responses were obtained by stopping the Pancrex therapy and administering bland mouth washes.

It would seem important therefore to stress to parents and children the need to swallow these extracts quickly to prevent their activation in the mouth. The manufacturers, Paines and Byrne Ltd., have been informed and are labelling the preparations accordingly.—I am, etc.,

CARYL W. DARBY.
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Long-term Anticoagulant Treatment after Myocardial Infarction

SIR,—Your leading article on long-term anticoagulant treatment after myocardial infarction (28 February, p. 514) unfortunately and unnecessarily alarmed physicians who safely treat their patients with anticoagulants and patients who benefit from these drugs on the condition that they are administered with the proper care.[1 2]

In Holland an organization known as the "Thrombosis Service"[3] is available to help the physician achieve a level of hypocoagulability which lowers the mortality and the morbidity significantly in outpatients suffering from coronary and peripheral atherothrombosis.[4] Several other studies have been performed outside Holland which confirm the statement that stable and intensive anticoagulation results in an improved prognosis for coronary thrombosis.[5 6] One of the most recent reports referring to women appears to prove that even moderate anticoagulation is successful.[7]

Finally, it must be stated that the extensive experience in Holland, covering many tens of thousands of patients, has proved that the risk of haemorrhagic complications is small and perfectly acceptable. A reasonable interpretation of the available data might read as follows: adequate anticoagulant treatment has proved to offer a clearcut, although minor, contribution to longer and better survival of patients suffering from atherothrombosis.—I am, etc.,

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The Ophthalmic Service

SIR,—A publication entitled *The Ophthalmic Service* (February, 1970) from the Office of Health Economics describes the functions of the General Ophthalmic Service. It is perhaps unfortunate that it did not before publication receive the agreement of the representatives of all the interested groups taking part in this service, since this would have ensured the greatest possible accuracy of the text. It describes the history of the Supplementary Ophthalmic Service, which has become the General Ophthalmic Service, and the routine examination of sight which the service provides. There is perhaps some doubt whether all the facts are quite accurately presented.

It becomes evident in the latter part of the publication that the General Ophthalmic Service is heavily subsidized by the sale of private spectacle frames to patients who have been examined under this part of the National Health Service. This, it states, "heavily weights his (the ophthalmic optician's) activities in favour of dispensing and militates against a trend towards general eye care." It appears that if ophthalmic opticians are to develop the role of general eye care, "restructuring of the system of fees" will be required. It seems to be unfortunate that the ophthalmic opticians are unable for economic reasons to carry out the primary work for which they have been trained.—I am, etc.,

A. G. CROSS.
London, W.1.

Second Green Paper

SIR,—At a special meeting which the medical advisory committee of the Durham Group of Hospitals called to discuss the second Green Paper[1] the proposed administrative structure was rejected because:

(1) It failed to provide a logical and cohesive structure to replace the existing patterns of management;

(2) It advocated a separate statutory organization for the family practitioner service which militates against the unification it seeks to achieve; and

(3) The administrative and political expedient of relating the new structure to a reformed local government would offer no particular benefit in the provision of total health care.

If the service is to be re-structured to meet the objectives of the Green Paper there is a need first to evaluate the opinions now being collected as a result of this stimulus to discussion, and then to produce recommendations which will provide a clear and logical structure for a new service. This exercise requires the skill and judgement of experienced people from all branches of the existing services. For this reason we have written to the Secretary of State urging him to set up a national working party to consider the views and opinions collected in response to the second Green Paper, taking whatever further evidence is considered necessary, and thereafter advising on the future pattern to be adopted for providing comprehensive health care. That working party should be fully representative of all the organizations concerned with this massive re-structuring of a social service, and should include management consultants.

We ask for support for this suggestion from all medical advisory committees, because we believe that this is the only way in which a properly structured health service can be achieved.—We are, etc.,

A. ZINOVIEFF,
Chairman,
Medical Advisory Committee.

ALAN WILSON,
Honorary Secretary,
Medical Advisory Committee.
Dryburn Hospital,
Durham City.

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1 Department of Health and Social Security. *The Future of the National Health Service*. London, H.M.S.O., 1970.

Function of "Medical Register"

SIR,—Major C. K. Davies (18 April, p. 181) raises the question of the inclusion in the *Medical Register* of additional qualifications such as M.R.C.O.G. and F.F.A.R.C.S.

Such qualifications have hitherto been excluded from the *Register* as a result of the inflexible terms of the Medical Acts. The General Medical Council has been unhappy about this for many years, and accordingly sought and obtained, in section 11 of the Medical Act 1969, authority to include in the *Medical Register* "any additional qualification which the council determine ought to be registrable." The council is currently considering which postgraduate qualifications should be registrable under this new power, and it seems likely that, before the *Medical Register* 1971 is published, a wide range of additional qualifications including the M.R.C.O.G. and the F.F.A.R.C.S. (which he mentions) will have become registrable.

The G.M.C. has recently abolished the fee of £1 formerly charged for the registration of an additional qualification, but problems of identification would make it difficult to implement Major Davies's suggestion that all qualifications obtained by doctors should automatically be entered against their names in the *Register*. In future however any doctor who holds a registrable additional qualification need only inform the G.M.C. in order to secure its entry in the *Register*.—I am, etc.,

M. R. DRAPER,
Registrar,
General Medical Council
London W.1.

Vocational Registration

SIR,—Some of your readers may think the representatives of hospital doctors have been dilatory if the letter from Dr. P. J. Heath and Major P. J. Thompson passes without challenge (4 April, p. 52). The proposals in Sir George Godber's letter have by no means been accepted by the hospital side of the profession (see C.C.H.M.S. debate, *Supplement*, 7 March, p. 71). Seniors and juniors alike reject compulsory general professional training and specialist registration. Equally, we agreed that the proposed Central Council for Postgraduate Medical Education and