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Points

Women in medicine

DR S E LESSELS (Haematology Unit, University of Aberdeen, Aberdeen AB9 2ZD) writes: I concur with the view that women doctors—indeed all doctors—get out of medicine exactly what they put in (31 July, p 390) and take exception to comments by Drs Susan M and E W Benbow (21 August, p 577).

Firstly, the onus is on women and men alike to make arrangements to accommodate both their work and other commitments, domestic or otherwise, and not necessarily to tailor one at the expense of the other.

Secondly, while I agree that some sacrifice in jobs may have to be made if doctors are not prepared to work on equal terms, this is not necessarily related to the number of hours they work. Some doctors who are committed wholeheartedly to their work for half a day may achieve much more than those working halfheartedly for a whole day. A second-class doctor is not someone who works part-time in hours but someone who works part-time in mind.

Dr T B BOULTON (Association of Anaesthetists of Great Britain and Ireland, London W1H 9LG) writes: I agree with much that Dr P O Leggat has written in his letter on "women in medicine" (14 August, p 514). I am, however, astonished at his incredible statement that married women, "should concentrate their endeavours on specialties *not associated with a frequent emergency content* [my italics], such as . . . anaesthetics. . . ." I note that Dr Leggat is a fellow of the Royal College of Physicians of London. The opinion he expresses is surely as nonsensical as that said to have been given by a certain physician after assessing a patient for anaesthesia and surgery—"This patient is fit for gas provided plenty of oxygen is given."

University cuts

Professor PETER O YATES (Department of Pathology, the Medical School, Manchester M13 9PT) writes: Several recent policy decisions are combining to destroy academic clinical medical departments that have been built up in universities over the past 30 years. The time has come to consider whether clinical education has any place in university faculties and whether it should become an official function of the NHS. . . .

We should recognise what has been happening and that these are not short-term problems. The opportunity is here to restructure our medical educational system. I suggest that the universities confine themselves to providing a three- or four-year medical sciences course leading to an honours degree. This should have a proper university flavour and include deep personal study of one or two "nonclinical" subjects. It is foolish to pretend that today's very intelligent medical students are fully stretched by our present broad pre- and paraclinical courses. Teaching and technology and ethos of clinical practice should become a function of the NHS on an apprenticeship basis as is done in most other professions. In medicine we confuse in one university degree course basic education with the learning of day-to-day practice. . . .

Persistent irritation of the eyelid margins

Professor H IPPEN (Kliniken Universität Göttingen) writes: The comment of Dr Brian Harcourt on this question (10 July, p 118) does not mention an essential cause of chronic blepharitis: the infestation with phthiri (crab lice), which may result in particularly chronic inflammations and is not unusual. Therefore, each patient with chronic blepharitis should be carefully examined with a magnifying glass. Besides removing the lice and nits with forceps I have found it therapeutically effective to apply 2% yellow mercuric oxide in petrolatum.

Let he who is without sin . . .

Dr R I KEEN (Manchester Royal Infirmary, Manchester M13 9WL) writes: Scrutator (14 August, p 521) quotes the acting treasurer of the North Western Regional Health Authority on the subject of efficiency of management of clinical services by medical staff. In his previous incarnation as treasurer of the late but unlamented Manchester AHA (T) and as a high official in his professional organisation Mr Wild was quoted by the media on the effect of the Review Body's recommendation on health provision. He stated that medical staff could be paid more only at the expense of patient care.

He should prove that all 650[1] employees of the health authority are fully, gainfully, and efficiently used to maintain and improve service to patients. Perhaps he could also extend the proof to all the other levels of administration. When, and only when he has done this, should he add another burden to those who have the ultimate responsibility for patients. Clinical staff will willingly submit themselves to a scrutiny of efficiency when those who administer and dispense resources have shown themselves to be beyond reproach. Not before then.

[1] Anonymous. *Manchester Evening News* 1982 Aug 11.

Diabetic neuropathy

DR JULIAN VERBOV (Department of Dermatology, Royal Liverpool Hospital, Liverpool L69 3BX) writes: It should not be forgotten that necrobiosis lipoidica (21 August, p 559), which is generally accepted to occur in 1 in 1000 diabetics, is certainly more common in women (3:1) but does affect men. Moreover in up to 10% of individuals with classical lesions no association with diabetes, either sooner or later, is found.

Diabetic complications: retinopathy

Dr B W FLECK (Princess Alexandra Eye Pavilion, Edinburgh) writes: I was disappointed to find that Dr P W Watkins, in his helpful article on diabetic retinopathy (7 August, p 425), perpetuates uncertainty regarding the use of mydriatics "where there is a suspicion of glaucoma." Dilatation of the pupil is an essential prerequisite to adequate examination of the retina, making confidence in its safety an important issue. The sole contraindication to mydriasis is the presence of an excessively shallow anterior chamber, when acute angle closure glaucoma may arise in a previously healthy eye.

Patients at risk are predominantly older hypermetropes, and it is the shape of the eye rather than its pressure which is crucial. The "eclipse test"[1] allows confident exclusion of such a shape. A beam of light shone tangentially across the iris ought to illuminate iris tissue on both sides of the pupil. Eclipse of half of the iris indicates forward bowing of the lens-iris diaphragm, with a related dangerously shallow anterior chamber. Mydriatics should be avoided in such eyes but are otherwise safe.

[1] Chawla HB. *Essential ophthalmology*. Edinburgh: Churchill Livingstone, 1981:33.

Shortening waiting lists in orthopaedic surgery outpatient clinics

PROFESSOR JOHN A LOURIE (Department of Human Biology, University of Papua New Guinea, Boroko, Papua New Guinea) writes: The paper by Dr R R West and Professor B McKibbin (6 March, p 728) on orthopaedic outpatient waiting lists made very interesting reading. It highlights a most important area with major implications for health service planning. In 1978 I conducted a similar though much smaller study[1] in which 213 patients who had been on the waiting list for "cold" orthopaedic operations for between 16 and 40 months were contacted by letter to establish whether they desired to remain on the waiting list. No response was obtained from 42% of those contacted despite further attempts to reach them. Ten per cent of those on the waiting list had died, another 10% had been treated elsewhere, and a further 10% requested that their names be removed from the list. Thus only 30% of this small sample positively wished to remain on the list. In the same orthopaedic hospital outpatient review of 400 patients on the waiting list inherited by a newly appointed surgeon produced only 20% who finally came to surgery.

These figures accord reasonably well with those of Dr West and Professor McKibbin, and it would appear that the size of hospital outpatient waiting lists, for orthopaedic consultation at any rate, gives an inaccurately overstated picture of the real requirements for treatment in the general population. The subsequent letters from Dr N T A Oswald and from Mr T S Kerr (27 March, p 979) reinforce this view.

[1] Lourie JA. *Br J Clin Pract* 1978;**32**:224-5.

Maternal anti-D concentrations and outcome in rhesus haemolytic disease of the newborn

DR JOHN W CRAWFORD (Department of Obstetrics and Gynaecology, University of Dundee Medical School, Ninewells Hospital, Dundee DD1 9SY) writes: In general it is probably fair to say, "the older manual titration method gives poor reproducibility," as Mr Bowell and others did (31 July, p 327). In practice, however, before automated methods became available there were several centres in the UK capable of producing results which showed clearly that anti-D titre and fetal outcome were related. In this unit amniocentesis was always restricted to mothers with a high titre of anti-D. Less than 50% of Rh-negative mothers with anti-D were