was always due to an increase in neutrophils.

4. A decrease in the total WBC. Four samples had a WBC in the range 2.9–3.9 x 10^9 l^{-1}. Blood film examination showed that all had a normal distribution of leucocytes and none were neutropenic.

5. A positive screening test for glandular fever in 14 samples.

6. An erythrocyte sedimentation rate of greater than 20 mm h^{-1} in five samples.

7. A platelet count of less than 150 x 10^9 l^{-1} in three samples. However examination of the blood film showed the presence of platelet clumps in all three samples indicating that the counts were falsely low.

Does the finding of these abnormalities help in the diagnosis and management of the patient? The findings of a modest increase in MCV has been used as a screening test for excess alcohol intake[2] but recently the sensitivity of this test has been questioned.[3,4] The finding of a modest decrease in MCV does not distinguish between iron deficiency and the anaemia of chronic disorders like rheumatoid arthritis.[4,5]

Our results indicate that little additional information is gained by forwarding samples with a normal haemoglobin level to the laboratory, except when glandular fever is suspected, or when bone marrow depression is likely to occur owing to a known haematological malignancy, or to drugs known to depress the marrow.

There is therefore a need for a robust and reliable haemoglobinometer that can be used by general practitioners to exclude anaemia. It should give a direct readout, be cheap and need the minimum of maintenance and calibration and the blood should not need to be diluted.

Three partners in a group practice used the Clandon/AB Leo Haemocue Portable Haemoglobinometer (Clandon Scientific Ltd, Aldershot, Hampshire) for a six-month period. The instrument uses disposable microcuvettes containing reagent in a dry form.[6] Whole blood is drawn up into the cuvette by capillary action either from a finger prick or from a sequestrene venous sample. A haemoglobin estimation can be obtained within 60 seconds. During the six-month period the instrument did not require adjustment. It was easily portable and had a rechargeable battery and a transformer with a mains plug. The results obtained were compared with those from the haematology laboratory Coulter counter and were found to agree very well (coefficient of correlation r = 0.99).

We suggest that group practices would benefit by using a portable haemoglobinometer issued by a central haematology laboratory.

J. LOOSE
C. SOUTHGATE
Church Street Group Practice
Sutton
Hull

C.G.L. RAPER
Department of Haematology
Kingston General Hospital
Hull

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The cost of being doctor dependent

Despite ever greater funding, the National Health Service continues to ail. The two root causes are excessive consumer demand, which is fuelled by unrealistic expectations, and the complicity of the medical profession. This has led to overuse and abuse of the NHS and to essential services becoming impoverished. More and more money will not necessarily improve this situation and, by disguising it, may make it worse.

It is not difficult to explain why so many people elect to enter the doctor's door. Medicine has always had an omnipotent aura, which still flourishes, despite a greater knowledge of medical matters by laymen. Advances in medicine, such as effective anaesthesia, antibiotics and heart transplants buttress expectation, create an imbalanced view of what medicine can and cannot do, and even encourage the absurd belief that medicine can solve every personal problem. Furthermore, circumstances outside the medical sphere have conspired to ensure that the doctor is the first person from whom to seek the sort of help that was once freely available elsewhere. The early dispersal of families means advice and knowledge are less likely to be handed down. The cult of the individual rather than the community leads to surreptitious loneliness. Religion is unfashionable; congregations are more likely to be found in health centres and outpatient departments than in churches.

Doctors, too, when they practise pacifying medicine, are using the NHS for the wrong reasons. Naurally they prefer to keep their patients happy. Furthermore, there is a financial incentive to satisfy patient expectations: general practitioners lose a capitation fee if a disgruntled patient leaves their list. When explanation or counselling fails to satisfy a patient, the process of pacification can take over, often against a doctor's instincts, sapping his morale. The result is inessential prescribing, investigations and referral, which are of doubtful benefit to patients. Here we find, for example, the origins of the problem of overprescribing. A similar situation in hospitals, where, once a patient is referred, a full 'work up' — X-rays, blood tests and so on is virtually automatic; again clinical instinct may be by-passed and resources used inefficiently. The consultant's duty is hence discharged and the general practitioner will continue to refer.

What then are the limits of medicine? We should help the public to understand that some illness is self-limiting and some must be endured, that sometimes things improve when discussed with a non-medical person, that modern medicine is not miraculous and that happiness is not prescribable. The NHS cannot be a surrogate chaplain, neighbour or relation to everyone. If, in response to public demand, it continues to try and accommodate such roles, resources will continue to be diverted from patients with pressing medical needs.

No one should be dissuaded from seeking a medical opinion — accessibility to the NHS is crucial. But no doctor should shrink, for any reason, from relying on medical judgement (rather than a medical ruse) and delivering it. Any resulting disgruntlement by patients is likely eventually to prove educative and beneficial to patients and to the NHS. Unless the nettle of reality is grasped by laymen and professionals alike, there is a danger that to fall sick, to be seen immediately, and to be cared for appropriately — regardless of financial status — will become a thing of the past.

WILLIAM G. PICKERING
7 Moor Place
Gosforth
Newcastle upon Tyne NE3 4AL