minority actually take up study leave opportunities. Such an exercise would provide useful data as a basis for a more acceptable approach. But I would still like some answers to my questions.

G H HALL
Exeter

When the earth screamed

Sir—I much enjoyed my old friend David Grahame-Smith's broadside on CME (July/August 1994, pages 347–8). So far I have heard no screams, though from time to time I detect some seismic rumblings well down on the Richter scale.

Whilst the profession does have a duty to society to show that it is keeping up to date I, too, hope that sanctimony will not displace good sense. Physicians are now constrained, more tightly than ever before, in a straitjacket of clinical and administrative practice. By formalising CME we hope to ensure that everyone in the profession, including staff grades, not only has access to educational activities but the time to enjoy them. As director of CME I will certainly strive to keep the bureaucracy to a minimum.

There is nothing new about CME and I need to remind Professor Grahame-Smith that nearly 40 years ago he was an enthusiast for what are now called the 'buddy schemes' of professional development. At that time we were both fresh-faced young regimental medical officers in the RAMC. If I remember rightly, I was a captain and he a mere first lieutenant! Between us we organised mutual 'viva voce' sessions in our neighbouring medical centres to brush up for the MRCP examination. To use the current educational jargon, we had an action plan, the sessions were learner centred, inter-reactive, peer reviewed, cost effective and regularly subjected to audit. I am glad to report that the outcome was (eventually) satisfactory. Partly as a result of our pioneering efforts in the late 1950s, 'buddy schemes' for CME are currently on trial by the RCPath in the Wessex region.

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Sir—For the sake of completeness, the highly entertaining account of Beethoven's cleaning lady (July/August 1994, 347–8) should have included some allusion to the clerical standard of the hospital case notes. To paraphrase Talleyrand, the clerical management of the case notes is 'much too serious a thing to be left to ward clerks'. Indeed, the 'reports' section of the notes is sometimes in such profound chaos that it is this aspect of the management of the patient which takes precedence over clinical assessment and clinical decision making. This crucially important aspect of continuing medical education is often neglected by senior staff and an important educational tool is thereby marginalised by default. Well maintained medical records are more instructive about grass roots medicine than multiple attendances at distant seminars or 'membership' courses. The medical literature would also be better served by properly maintained case notes, because accessible 'raw data' would make it easier to validate claims made in a case report.

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Management of acute myocardial infarction

Sir—Following our correspondence on guidelines and audit standards in the management of chronic stable angina [1], we were disappointed that nuclear cardiology techniques received such scant consideration in your report on the management of acute myocardial infarction [2].

Myocardial perfusion imaging may be helpful in two main areas. First, it can contribute rapidly and reliably to diagnosis of acute infarction in the emergency room [3], although this application has so far been limited by the lack of suitable facilities in many hospitals. Second and more important, myocardial perfusion imaging can be used to assess the site and extent of infarction, to detect viable myocardium in the infarcted territory, to assess whether jeopardy to such myocardium remains, and to quantify ischaemia in territories unrelated to the infarction [4]. These capabilities give myocardial perfusion imaging a role in determining prognosis and hence management after infarction, especially when the exercise electrocardiogram would be uninterpretable or the patient is unable to exercise adequately.

References

1 Underwood R, Caplin J, Pennell D, Prvulovich E. Investigation and management of stable angina. [Letter] *J R Coll Physicians Lond* 1993;**27**:477–8.
2 de Bono DP, Hopkins A. The management of acute myocardial infarction: guidelines and audit standards. *J R Coll Physicians Lond* 1994;**28**:312–7.
3 Christian TF, Clements IP, Gibbons RJ. Noninvasive identification of myocardium at risk in patients with acute myocardial infarction and nondiagnostic electrocardiograms with technetium-99m-sestaMIBI. *Circulation* 1991;**83**:1615–20.
4 Zaret BL, Beller GA (eds), *Nuclear cardiology.* St Louis: Mosby-Year Book Inc, 1993, pp227–50.

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Past Chairman
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Sir—In the management of suspected myocardial infarction with non-diagnostic electrocardiographic changes, the alternative diagnosis of unstable angina deserves more attention than hitherto accorded to it