



Fig 2 Breakdown of the types and numbers of examinations carried out in each month, January 1964–October 1964

The breakdown of the types of examinations requested each month is shown in Fig 2. In addition there were requests for other examinations between January and October, not normally available in the scheme, which were made up as follows: skull, 5 requests; renal areas, 4 requests; limbs and spine, 24 requests; hips and pelvis, 9 requests; miscellaneous, 21 requests.

Conclusion

There can be no doubt that open access for general practitioners to hospital X-ray departments is a step in the right direction. With time the service will probably expand and co-operation between hospital diagnostic service and practitioners will improve.

In many cases the service avoids delay. When patients are sent to out-patients for consultations some of the necessary X-ray examinations have already been carried out. In some instances the management of the patient is left entirely to the practitioner and hospital referrals are therefore not necessary. It therefore follows that the system is desirable from the patient's point of view both economically and personally.

I have tried to answer the question of how extensive open access should be. Should it be all embracing for all types of examination or should it be limited? I feel that it should be on a limited basis. There is still a lot of room for expansion but we do not want to overdo it. I would like to see the day when practitioners will come into the department as our consultant colleagues do and discuss the examinations and procedures, so that they can have the benefit of our advice and we

can obtain the benefit of a better clinical background to some of the problems of their patients.

A satisfactory and economical radiological service can only be provided in general hospitals. Dispersal of such a service to outside clinics and health centres must be avoided in future planning. Only in this way can an economical use be made of an already hard-pressed organization with staff and space difficulties and the very high costs of equipment and materials. A second-rate service with inadequate facilities is not really in the patient's interest. So far as the patient's interests are concerned we should aim high to provide a comprehensive service for the future.

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The Pathological Laboratory

The background to our experience of providing an 'open access' service in clinical pathology in the National Health Service has been described on two occasions (Murray 1951, 1960). The service in Kingston has been steadily developing for twenty-five years. The principle has been the same throughout, although only the NHS made it obligatory, that every sick person must be able to have all available kinds of laboratory examinations made for the diagnosis and treatment of disease; and this availability must extend to their

homes as much as to different departments of the hospital. In effect this means that every doctor, hospital officer or general practitioner should be able to obtain all the laboratory aid he requires; although it is to the citizen that the right to service belongs. The NHS sets out to provide services for the citizen without necessarily or in all cases defining the source from which these services are to be obtained.

The important question is, however, how readily can the general practitioner obtain the service he requires. We may assume that in Britain all hospital officers can easily obtain the basic investigations in clinical pathology, that most (but still regrettably not all at all times) will be able to obtain all but the most elaborate tests, and that most pathologists can obtain in turn advice on even the most rare and specialized tests. But as soon as we ask the same questions about the general practitioner we will still find enormous variability, and a variability that appears to have nothing to do with geography, nearness to a large hospital or number of pathologists in an area, but is rather related to whether the general practitioners and the pathologists have been working together as a team.

The Kingston Hospital Group is one with 1,100 hospital beds serving a population of approximately 250,000. One hundred and twenty of the beds are served by a branch laboratory which does all first-line investigations but sends certain work to the Group Laboratory. Its figures are not included in those discussed here. The Group Laboratory is neither lavishly staffed nor lavishly equipped, but is capable of carrying out all that can be asked for in a typical large non-teaching hospital. All doctors using it are asked to regard it as the first place of reference for all scientific enquiries, the laboratory staff deciding when opinions or help other than their own are necessary.

Approximately 100 general practitioners use the laboratory and provide about 20% of the total number of 'specimens' but absorb rather more than that proportion of the man-hours employed, chiefly by taking up medical time in 'consultations' and domiciliary visits. The work of the laboratory has been increasing steadily over the years and the use made of it by the general practitioners has followed the total trend. The average work done for general practitioners has been: 53 items in 1949, 112 items in 1959 and 176 items in 1964. That increase is spread over a very wide range which fails to fall into any of the patterns that might be expected: age of practitioners, type of practice or numbers on lists.

The amount of use made of the laboratory appears to be a personal matter except that all practitioners learn to use a service once it is freely provided. This is shown in a glance at how the highest and lowest users of the service have changed over the years (Table 1).

Table 1

The increase and spread in use of laboratory services

	Date	Consultations	Specimens	Total
Five highest	1949	155	119	274
	1959	159	118	277
	1964	142	430	572
Twelve lowest	1949	1	2.5	3.5
	1959	17	9	26
	1964	17	34	51

The consultations are both referrals to the morning appointment clinics at the laboratory and domiciliary visits. The average number of domiciliary visits called for per general practitioner per year is 7. The three practitioners who made most use of the service called for 54, 42 and 24 domiciliary visits in the year 1964.

Attitudes to calling us out to see patients vary very much. Two practitioners collect all blood and other specimens, write excellent clinical notes, visit the laboratory and discuss cases almost daily but seldom refer a patient. The ability or willingness of general practitioners to write good clinical notes, and the converse, are as marked a feature of laboratory referrals as of other out-patient departments. It is one reason, in addition to our desire to keep our clinical observation as sharp as possible, why we prefer to see patients rather than specimens. We believe in general practitioners but some of the clinical notes sent with patients make it hard to believe in all of them.

Our own attitude to anticoagulant therapy greatly influences the number of domiciliary visits we do, but is spread very evenly among our general practitioners and so probably does not affect our averages very much. We do all our prothrombin estimations at the bedside or immediately at our weekly anticoagulant clinic. We believe this service has more than paid for itself by the reduction in the number of admissions to hospital. An average of six to seven visits to a patient at home is usually necessary until the patient is able to come to the weekly clinic. Stabilization has proved relatively simple by this bedside method, coupled with the ability to make immediate changes in the dose of anticoagulant, in the light of the very wide experience we have gained of thrombotic conditions.

When we at Kingston speak of 'open access' to laboratory facilities we think of this in two quite different ways, as open access in the sense that the door is never closed and in the sense that the requirement of the National Health Service Act 'to provide a comprehensive service' is fulfilled. But we also see ourselves as part of that team which the BMA Medical Planning Commission said must assume 'collective responsibility' for the health and medical care of an area. Our records of patients go back twenty-three years – for example, we are now seeing as expectant mothers patients we first saw as Rhesus-affected babies – and our collaboration with some of our practitioners goes back farther. Having once opened the door, we cannot escape our responsibility, for even when patients change their general practitioners they still come to the same laboratory.

We are also brought into close collaboration with general practitioners by other features of our work. We serve some 29 institutions, some only to a very small extent. But six of these are hospitals, which are run entirely or to a large extent by general practitioners, one outside the NHS. These are visited daily or as required and at two of them regular sessions are performed by laboratory consultants. General practitioners who have appointments as factory doctors also use the laboratory for the control of lead, radiation and other hazards. Then our 'sterile syringe service' brings over 40 general practitioners on regular visits. They use on the average 22 'Kingston Syringe' boxes a year, each box containing approximately twelve sterile syringes. This economic and efficient service has been another factor cementing the relationship of general practitioner and laboratory.

We also believe that medicine involves a discipline of continuous re-education. We are continually refreshed on clinical matters by our colleagues, general and specialist practitioners. We have made a conscious effort to provide information and opportunity for discussion by running for many years monthly clinico-pathological conferences. These have always been well attended. They are now incorporated in the programme of the Kingston Medical Centre in the work of which the laboratory staff play an important part.

What effect has all this had on medical practice in the area? We believe it has played its part in raising and maintaining standards of medical care. The general practitioner is still in our view the primary diagnostician and the key to good medical care. We believe that he should have all the services he requires and that given these services he will be a better general practitioner. In conditions in which he is most experienced he still needs laboratory confirmation and control; in conditions which he sees too seldom to be expected to recognize and treat he can often be put in a position to do both by well-trained clinical pathologists whose experience of these conditions is likely to be much greater. So far as new discoveries are concerned the laboratory worker must by the very nature of his specialty do his utmost to be aware of them; and to pass them on wherever he has the opportunity. But like all other people in the health service he can do this only if he has the necessary equipment and staff; and if the Ministry of Health does not recognize this and prepare for the certain increase there must yet be in the provision of laboratory services, then general practice must suffer. The figures show something of what that rate of increase has been in one area and saturation is far from being reached, as the low figures for some general practitioners show. An expanding laboratory service is an essential part of a health service and one that pays a dividend in rising standards of medical care.

REFERENCES

- Murray D S
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(1960) *Brit. med. J.* i, 415

Meeting February 17 1965

A discussion was held on **Rheumatic Diagnosis**. The opening speakers were Dr L J Barford and Dr A St J Dixon.