Rehabilitation and manual medicine

SIR,—May I join the discussion on rehabilitation (12 January, p 111), and make a plea for the linkage of rehabilitation and manual medicine in the United Kingdom in 1980? The manual medicine physician concentrates his skill on attention to posture, exercise, and manipulative therapy. He restores a normal range of mobility, thereby satisfying an essential requirement of rehabilitation.

"Country house" rehabilitation is wholly admirable, but there is a gap in our nation's health care system with regard to the specialist examination and treatment of back pain. Rehabilitation as a subject is incomplete without acknowledging the part manual medicine has to play, just as the service to back pain sufferers will remain second class if manual medicine expertise is ignored.

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Abortion (Amendment) Bill

SIR,—Mr D B Paintin, of the department of obstetrics and gynaecology at St Mary's Hospital (26 January, p 248), has every right to oppose my Abortion (Amendment) Bill. He does not, however, have the right to publish inaccuracies about the Bill. The words "serious" and "substantial," contrary to Mr Paintin's claim, do appear in the Abortion Act 1967.

Mr Painton's main concern appears to be the effect that clause 4 of my Bill will have on private practice, but he has misunderstood the point. Before the last war doctors practised what was called "fee splitting." This was an arrangement whereby the referring doctor received money from the consultant to whom he had referred a private paying patient. As a result of BMA disapproval, this practice disappeared shortly after the war. The Select Committee on Abortion in 1975 objected to the practice of certain abortion counselling services receiving cash payments in respect of patients sent to abortion clinics. The purpose of clause 4 is to end this modern version of fee splitting.

The Standing Committee on my Bill was told that a charge for counselling of £16 was made by the British Pregnancy Advisory Service, for which the counsellor's fee was £6·60 per session. This counselling is normally done by lay persons. Mr Paintin's reference to counselling by two doctors must be a relatively rare practice. The purpose of my clause 4 is to ensure that the pregnant woman receives unbiased counselling, free from pressures of a financial nature.

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The clinical chemist and the future

SIR,—I read the letter by Mary Warner (15 December, p 1581) with interest; as I reread it I was assailed with a growing feeling of dismay. As an ardent anti-letter-writer I quelled my stirring breast, filed the journal and returned to the less arduous task of writing Christmas cards. The letter of Dr R D Eastham (12 January, p 116) has, however, awakened my dormant literary instincts: the two letters taken together demand a riposte.

Miss Warner regards self-monitoring of blood glucose as "the tip of an enormous iceberg" and appears to be doing her best to melt it or at least push the iceberg back under the water. She expresses, quite rightly, a certain distrust of "diagnostic kits" and reagent strips, but equally correctly points out that the DHSS plays an important role in evaluating such kits and strips. She then, however, takes a quantum jump in logic and makes the basically false assumption that the clinical chemistry laboratory as the home of chemical expertise should be the place where tests are performed and the aforementioned kits used.

Sadly, this defensive territorial reaction bedevils modern clinical chemistry. Obviously clinical chemists are trained to perform chemical tests reproducibly and accurately, but is it in the best interest of the patient to have all these tests performed in a recognised laboratory? In many cases it would be to the advantage of the patient to have tests performed at the bedside with results immediately available rather than two to 24 hours later. Would it not be a clinical improvement to have serum amylase values available immediately when one is faced with a patient with possible acute pancreatitis, or cardiac enzymes for the patient with suspected myocardial infarction? Those who, like me, do a Monday morning ward round would also, I am sure, appreciate Monday morning tests rather than the stale results of tests from the preceding Friday. The potential time saving and increased speed in diagnosis and management, with lessening of patient distress, are obvious.

Dr Eastham, in his mildly icteric attack on blood glucose meters (which in the North-east of England cost less than £100—inflation must be worse in the South-west), is guilty of a similar logical fallacy. One of the benefits of home monitoring of glucose is to enable the patient to make decisions about his or her therapy and diet immediately. Using filter paper methods removes this benefit—there is an inevitable delay of 24 hours or more before the result is available. It is also worth commenting that we are no longer routinely dispensing meters in that the new Boehringer test strip can be read visually with acceptable accuracy. This last development shows incidentally that the best of the manufacturers exist not only to make a profit but also to provide the best service for the patient (rather than the contrary, as suggested by Miss Warner).

So where should the clinical chemist stand if tests are to be done at the bedside? I am far from suggesting that we should climb out on to a metaphorical limb and then hand a well-honed axe to our Scrooge-like administrators. Instead we should be doing our best to provide the necessary foolproof methods for our junior (and even senior?) clinical colleagues to use. Clinical chemistry is in the process of being revolutionised by the new solid-phase chemical methods, as used in test strips, which are eminently suitable for side-ward testing. Miss Warner's salutary experience with glucose test strips in the South-western Region should serve not as a bar but as a challenge. I am convinced that if a diabetic can perform self-monitoring of glucose accurately then it should not be beyond our wit to devise methods that even a sleepless house surgeon can perform reproducibly and with clinically acceptable accuracy. Our staff can service the necessary machines and perform the appropriate quality control tests. Having devised such methods for the more routine tests, what joy we can have in our laboratories developing new tests, working on tissue biochemistry, and performing the more complex assays, uncluttered and unhampered by the burden of our present routine workload.

At present clinical chemistry is like a camel with an ostrich head—a beast of burden with its head firmly implanted in the mire. Is it not time for us to stop pretending to be a collective Duke of Plaza Toro, and to lead from the front for a change?

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Diagnostic kits and the clinical chemist

SIR,—As Dr M S Walker (12 January, p 115) mentions my name and accuses me of unbalanced statements I feel challenged to reply even though he merely picks a few nits off the main body of my letter (15 December, p 1581).

He states that manufacturing companies have made a significant improvement in the services that hospital laboratories can offer. Is this true? Well, yes and no. Taking diagnostic products away from us would leave my laboratory offering a very much reduced service in that people would be pottering away in the balance room rather than actually doing tests. However, the example he gives of radioimmunoassay kits do not in fact benefit our patients as we cannot justify a gamma counter and so these tests still have to be sent away. In any case, some results are uninterpretable just as an isolated number; we need the big population groups and the interpretative expertise lurking in those teaching centres, no matter how the results are produced.

Dr Walker also states that significant scientific advances come from manufacturing companies. This I do support and am convinced that this percentage of total advances will increase as NHS scientists become more and more starved of funds. One could even say that the wasting of money on "side room" testing will make matters worse. Our hospital spent £2400 on stick tests last year; our total allocated budget for the whole pathology laboratory chemicals and gases was £9000. Also, of course, money spent on ward testing could mean less for companies such as Serono producing valid and important products for a laboratory environment.

Dr Walker's paragraph bringing in the quality control schemes I am not certain I completely understand, except that he would appear to be saying that even laboratories can fail—and this too I support. If we take a blunder rate of about the national average of 1% the number of tests we send out that are wrong is 1200; on the other hand, of course, we do get 118 800 about right. But my point would be that heads of departments are extremely aware of the virtual impossibility of scientific accuracy: just minimum bias is our aim—we know we are imprecise and by how much, and we know we blunder. The whole atmosphere of the laboratory is geared to reduce and control these errors; clinicians laugh as we worry over 0·3 mmol/l out on a glucose control test but we know that this may