

by as deep a division as that separating them from staff holding medical qualifications is based on there being two different Whitley Councils (PTA and PTB) with responsibility for them—an irksome anachronism to most of the staff concerned but a matter of little relevance to others. Miss Warner confuses readers further by her misuse of the term graduate scientist in an attempt to segregate herself (a PTA scientist) from medical laboratory scientific officers (PTB scientists). The ludicrous confusion this provokes is simply illustrated by the fact that there are more graduate scientists in PTB posts as medical laboratory scientific officers than in PTA posts.

Medical laboratory scientists share a common desire to serve the patient, by making the best possible use of relevant academic and vocational scientific training, and to complement and not compete with the work of those who practise medicine. Most care little for the separatism displayed by militants contributing to your columns. An advertisement by a Scottish health board in the current number of *The Gazette*, published by this Institute, for a "basic grade biochemist/medical laboratory scientific officer" demonstrates more frankly than usual the unreality of distinctions between PTA and PTB staff.

Even within the last three months, one medical laboratory scientist previously holding only PTA posts was appointed as a principal medical laboratory scientific officer (PTB), while in the same laboratory a colleague hitherto employed only in PTB posts was appointed to a PTA grade. Both qualified as fellows of this Institute, one by a doctorate and the other by examinations specifically in medical laboratory sciences.

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### Training of pathologists

SIR,—I entirely agree in general terms with the comments made by Dr C A J Brightman (8 August, p 440) on the lack of training offered to pathologists. But I cannot agree with his suggestion of a multiple-choice question examination for everyone.

In theory, he is absolutely right and a far better general pathological education would be acquired if there were no exemption from any part of part I of the MRCPPath examination. I too have entered pathology in my 30s with the MRCP behind me, and I too am finding it very difficult to receive an adequate training. However, at present I am entitled to exemption from all parts of part I of the examination and am entitled to take the final part after four years' full-time training. Adopting Dr Brightman's suggestion of only limited exemption from part I would mean at least a further two years' training in addition to the present four years. Though in theory I agree with him, in practice I am thankful that there are only four years until I take the final examination. As an alternative, I would like to suggest a reduction of the four years to three years, with a preceding year spent in the three major specialties that are not being pursued for the final.

Finally, I very strongly endorse Dr Brightman's recommendation for structured teaching, which appears to be non-existent

in most pathology departments in the entire country.

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### Who does what in the pathology laboratory?

SIR,—In her definition of the role of the clinical pathologist Dr Eva Lester (8 August, p 420) states that "the job of a pathologist is the organisation and management of the laboratory service." She then adds that "it is because he has a medical background that other things being equal he is the best person to relate the work of the laboratory to the needs of patients."

I consider that Dr Lester's addendum is the first priority of the clinical pathologist, and would agree with Mr J B Burns (13 June, p 1943) that the way ahead for the pathologist is to face the clinician and not be buried within technology.

As a microbiologist, I consider that facing the clinician does not imply attendance at time-consuming ward rounds or taking clinical responsibility for patients. It does mean being readily available to give advice on interpretation of laboratory results and on diagnosis and treatment of patients with various infections. For this purpose, the microbiologist must know the current pattern of micro-organisms isolated from such patients in the area and the current "best-guess" antibiotics to use before bacteriological results are available. With such up-to-date epidemiological information he or she can advise on suitable antibiotic policies for a hospital or an area.

Analysis of laboratory results for clinical purposes also demands a working knowledge of the reliability and limitations of the methods used in the laboratory, and a regular perusal of current microbiological literature to decide when clinical and scientific evidence justify change of techniques or methods in a particular laboratory. In this way the clinical microbiologist is certainly concerned with organisation and management but, hopefully, in an acceptable way for all concerned.

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### Medical advice and management in the Scottish Health Service

SIR,—The recent article (8 August, p 452) "Medical advice and management in the Scottish Health Service" is welcome, not least because the Scottish scene has tended to be obscured by the dust raised in the wider reorganisation in progress in England and Wales. There is a risk that we in this northern peninsula will miss the opportunity of remedying the flaws in management apparent since the major reorganisation of 1974.

The article emphasises the general nature of the reforms we require when it cites the need "to shorten lines of communication" and upholds the value of "a positive medical input to management" while avoiding "the intricacies of an elaborate committee structure." But I wish that the need to match task and organisation deliberately and knowledgeably was

expressed more often and with greater force. I also wish that the fact that different medical specialties have different needs met clearer recognition. In psychiatry, for example, the administrative structure has great influence, for good or ill, on the kind of treatment patients receive. The nature of psychiatric intervention is concerned with influencing the behaviour and attitude of patients. Often treatment is aimed at encouraging both personal and joint responsibility for the running of the ward or unit, and (by extension) running the patients' own lives more satisfactorily. This is difficult to achieve in a strict hierarchical medical or nursing structure, which may be suitable for an acute surgical unit but defeats the purpose of growth-learning in a therapeutic community setting.

In Scotland there seems to have been a steady whittling away of responsibility for appropriate decision making at unit and hospital level. This is wasteful, impairs morale, and gives evidence of poor management. In psychiatric hospitals, at least, could we not have some recognition of our particular tasks and our especial needs? The value of multidisciplinary teams and the enfranchisement of patients in this area of work is difficult to exaggerate. Moreover, wise policy-making and planning is likely to happen best if it arises naturally from this basic process.

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### Should doctors be budget holders?

SIR,—With reference to the "Talking Point" article by Dr J R Bartlett and others (8 August, p 450), it is not true to say that "... most doctors have no direct control over the demands made of them and therefore their expenditure." This is an elision of two separate ideas. It may not be possible to control the number of patients attending a clinic or referred for diagnostic procedures. It is possible to determine what is provided or done for each patient.

If it were true that "the functional budgeting system... [applies only to]... the variable costs" and that these are linearly related to the numbers of patients seen, then clearly apportioning budgets would be useless. The point, however, is that "fixed and semi-fixed costs" for equipment and staff are not ordained by some immutable "national law," and it is only here that there is a possibility of making real gains in efficiency because, as the authors show (fig 2), these costs are of the order of 87% of the total.

Much of the muddle arises because of confusion between the functions of administration and management. An administrator is concerned with the day-to-day running of an institution. A good administrator provides the infrastructure without which the institution cannot function properly at all, let alone efficiently. Management involves taking decisions, not just following standard procedures, and taking responsibility for getting things done.

The authors' use of a laundry as an illustration is interesting—presumably intended as a non-emotive example—"recently, as a result, the laundry... ran out of cash." We are not told whether this was due to an insufficient budget or to inefficient management.