to his or her own expectations, this will allow continuous accurate medical audit. The definition of computer protocols for care and the feedback of comparisons between the protocols and the realities achieved offer the best opportunity available for improving the consistency and quality of patient care in general practice.

This then is the agenda for the next phase for computers in general practice—clinical recording, communication, and computer aided medical audit, all aimed at enhancing the quality of patient care. The technology exists now. It requires only that the medical profession and the suppliers of general practice computer systems should work together to make it happen.

MIKE PRINGLE

Senior Lecturer,
Department of General Practice,
Nottingham University Medical School,
Nottingham NH7 2UH

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Selling the pathology service

Based on an incomplete understanding of what it does

Last month the Department of Health issued two small booklets that illustrate a profound ignorance of the way that parts of the NHS work and contain within them suggestions that, if adopted, would soon open the way to a two tier health service.

The booklets are *Pathology Guide* and its accompanying *Pathology Workbook*, produced by the department's income generation unit and issued by the NHS Management Executive, and they outline ways in which managers can generate extra income from pathology (and radiology) services. In launching the scheme, Stephen Dorrell, Parliamentary Secretary for Health, cited a potential market of £100m: "All that is needed to get this money working for us is a pathology service which is efficient and used to its full capacity." The booklets were produced without consultation with pathologists' professional bodies, and, although the booklets are entitled "pathology" they also include radiological services. I doubt whether the radiologists were consulted either.

The documents represent poorly thought out management concepts on the marketing of services crudely applied to pathology laboratories and radiology departments. Laboratories (and radiology departments) fulfil a far wider role than simply providing a "results" service, but there is no hint here of the consultative role provided to both the hospital and general practitioner services; of the importance of the service

in the training of medical and non-medical staff; and of the way in which high standards of teaching and research are maintained. The philosophy summarised in these documents is of a supermarket style diagnostic service.

Moreover, I do not believe that "spare capacity exists in most laboratories." Many consultant pathologists still work single handed with a workload far above the recommendations of the Royal College of Pathologists and are faced with an ever increasing workload from the outcome of the white paper—population screening, management, and medical audit. Undoubtedly there are departments that could take on additional analytical work, but this will usually be at the expense of teaching, research, and development. The emphasis on throughput will inevitably result in a conflict with quality as individuals may try to solve problems on the periphery of their experience and in some cases outside it. Emphasis on throughput will particularly affect pathology subspecialties that cannot generate additional numbers through population screening programmes and the like. If financial incentives are offered for this additional work this will also have a serious effect on recruitment into specialised areas that cannot generate it.

All professional groups will need to assess carefully how these incentives are presented by managers. Even now many employees in the NHS have to undertake non-NHS work without personal gain, and it may not be long before undertaking this additional work will become part of local contracts. Staff undertaking this additional work may also have little say in how the profits are used. There is always a delay, often long, between undertaking or developing excessive workload and showing a manager that this has happened and that it is having a deleterious effect on other aspects of the service. That is why nationally agreed and accurate performance indicators are so important.

The most worrying aspect of these proposals, however, is their implications for the future of the health service. The *Pathology Guide* claims that providing some services will need extra resources—for example, separate receptionists, separate waiting areas, and a system for rapid interpretation of results for private patients. This undermines the principle that the NHS should be equally available to all and will probably be distasteful to most NHS staff. The only criterion for access to facilities should relate to the urgency of clinical need; the same principle should apply to the distribution of results.

The guide rightly emphasises the quality of the service that the NHS can offer as a competitor and that the key factor in determining price will be value. Value should be beyond question, and with the increasing commitment of the royal colleges to medical audit, external quality assessment schemes, and accreditation of laboratories that value will continue to increase. Sadly, its biggest threat is excessive pressure for increased throughput without a proper understanding of the broader responsibilities of a pathology and radiology service.

W R TIMPERLEY

Consultant Neuropathologist,
Royal Hallamshire Hospital,
Sheffield S10 2JF

Correction

Hypercalcaemia in malignancy

A printer's error occurred in this editorial by Dr D A Heath (1989; 298:1468). The dosage of disodium etridonate should be 7.5 mg/kg/day and not 7.5 mg/g/day as printed.