Future work will have to define which groups of patients will benefit from anabolic treatment and at what cost. In severely burnt children treatment with growth hormone lasted 32 days¹⁰; a similar course of treatment for an adult would cost about £6000. Critically ill patients and those who are hypercatabolic because of long term treatment with steroids, chronic liver and renal failure, or burns are the groups in whom anabolic treatment might have the greatest impact.

No serious complications of treatment with recombinant growth hormone have been reported so far, and, although such treatment consistently raises concentrations of insulin,^{10 11 17} insulin resistance has not proved to be clinically important. Insulin-like growth factor 1 is a potent mitogen in vitro, and the possibility that it might potentiate the spread of cancer requires long term evaluation.

"Eating people is wrong," sang Michael Flanders and Donald Swann, and autocannibalism may also be bad for you. Treatment with growth hormone or insulin-like growth factor 1 holds out the prospect of preventing autocannibalism by improving the efficiency with which the body handles nutritional supplementation.

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Patient's charter

New rights issue

England (p 1153),¹² Scotland,¹⁴ and Wales⁵ now all have their own patient's charters. Should this new initiative be welcomed, and will it make any difference? The answer to both questions is a qualified "Yes."

Like its parent the citizen's charter,⁶ the patient's charters recognise the importance of public services, a welcome change from the past decade. It also emphasises that the NHS belongs to the public, which has a right to know what to expect. Giving patients more power is not stated explicitly, but the charter should help to achieve this.

The charter sets out seven existing rights in the NHS. These may surprise some patients if not health professionals. For example, the charter states the right "to be given a clear explanation of any treatment proposed, including any risks and any alternatives before you decide whether you will agree to the treatment." The Welsh charter goes slightly further, stating that a patient may expect "to help choose care and treatment appropriate to you." After seven existing rights come three new ones, including the right to treatment within two years of joining a waiting list. Missing from the list, however, is any mention of a right to be referred to a consultant or hospital of the patient's or general practitioner's choice.

Another theme running through the charter is the right to

information about what health services are available locally and to what standards these will be delivered. Patients will now have the right to have their complaints about NHS services investigated promptly and to receive a written reply from the chief executive or general manager. This emphasis on providing information should be welcomed: poor communication and lack of information are patients' commonest complaints about the NHS.

The charter then goes on to give nine "charter standards," which are more intentions than rights. Dividing rights from standards like this is understandable: the nature of health care means that governments, regardless of political complexion, are loath to draw up too many rights because of the open ended commitment this might entail. In addition, there are problems of definition: perhaps for this reason "respect for privacy, dignity and religious and cultural beliefs" is included as a standard rather than a formal right.

The Labour party has already criticised the standards for their leniency. Some of them—a 30 minute waiting time in outpatients, a maximum waiting time for treatment of two years, and a waiting time for an ambulance of 14 minutes (urban area) and 19 minutes (rural area)—are already being bettered in many places. No doubt departmental officials wrestled with setting standards that would bring the poor

performers up to scratch while not overloading staff already trying hard. The seriousness with which any government takes quality in the NHS will become obvious only when these standards are toughened up and become more encompassing. So the charter should achieve substantial changes, although not immediately. More work will be needed than merely disseminating the charter widely. (Every household will be receiving a copy.)

Some more serious charges may be levelled at the charter in its current form. The first is that it is something of a middle class charter: standards for waiting times and so on are important only if you already have reasonable access to health care. For a substantial number of people from ethnic minorities or with disabilities or who are homeless the charter may seem irrelevant. Despite the emphasis on information nothing in the charter suggests that patients should have a right to written information in a language they understand and personal communication through interpreters if necessary. Respect for religions and cultural beliefs is included, but not the right of women to be examined by another woman in sensitive specialties such as obstetrics and gynaecology.

The other concern is the omission of anything on standards of clinical care, which seems odd given that this is what the NHS is about and that what people want, above all, is the

most effective treatment for their condition. Patients would like a guarantee that standards are being monitored and poor performance is being weeded out.

The charter ends by telling people how they can help—by keeping outpatient appointments, donating blood, carrying organ donor cards, and becoming voluntary helpers. On this point the Welsh charter is more innovative: "Try to be well-informed about your health or condition. Ask questions so you can make decisions based on a better knowledge and understanding." That begins to sound much more like a partnership between patients and professionals and acknowledges that people have responsibilities for their health care too. At present the charter concentrates on what the NHS should be doing for the patient, but this is only one side of the bargain.

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Surgical pathology and general practice

Send all specimens for histopathological examination

Under the terms of their new contract principals in general practice may earn up to £1200 a year from doing minor surgery. Fifteen surgical procedures are eligible for payment. General practitioners are paid £100 each session for up to three sessions of at least five procedures a quarter. Only general practitioner principals who have been accepted on to the minor surgical list held by their family health services authority may perform minor surgery, although those who are on the list may take up the quota of those who are not. Departments of histopathology, which will have to finance themselves on the work that they attract, are also affected by the new regulations: contracts with local practices may add 4% to their workload (p 1179)¹ or income.

Opportunities exist for maximising the financial benefits from minor surgery, such as concentrating on quick procedures that do not produce specimens (for example, incising abscesses, injecting joints, and freezing warts). Fundholders may also benefit by not sending—and therefore not having to pay for—any specimens for histopathological examination. If laboratories don't provide collection systems general practitioners are even less likely to send specimens for examination.

Three papers in this week's journal look at the histopathological work resulting from general practitioners doing minor surgery (pp 1177, 1179, 1180).^{1,3} Skin biopsies accounted for most of the specimens submitted for examination. Should all excised tissue be submitted for examination or is it legitimate to discard skin tags and other apparent trivia?

Certainly, death from metastatic melanoma after previous removal of unexamined "moles" is well known. Indeed, pigmented and suspected malignant lesions should probably be off limits to general practitioner surgeons unless they have had dermatological training. Hillan *et al* were worried that,

although they did not know what proportion of specimens general practitioners did not submit, more than two thirds of the specimens removed in their surgical day theatre were not submitted for examination.² Their concern is echoed by many dermatologists who submit every excised bit of tissue because they have been caught too often.

McWilliam *et al* found that in only 41% of cases was there good agreement between general practitioners' clinical impression and histopathological findings (the figure for hospital cases was 62%). For malignant specimens the hospital was right nine out of 10 times; general practitioners were right, however, only three out of 10 times. These rates are based on small numbers but make the point that all tissue, regardless of source, should be examined.

Incomplete excision is another problem. McWilliam *et al* found this occurring in 36% of all specimens excised by general practitioners and in 16% of all specimens excised in hospital. The figures for malignancies were even more worrying: excision was incomplete in 80% of specimens originating from general practice and in 10% of cases from hospital. (No comment was made whether those patients with incomplete excisions were followed up.³) This study also found that the common bleat by pathologists about inadequate clinical data was justified. On this count, hospital doctors were as bad as general practitioners: about two out of five requests from both groups lacked adequate data. (This can usually be remedied by a telephone call.)

Hillan *et al*'s study found that 16% of specimens from general practitioners came in the wrong fixative or were unfixed—all, however, were interpretable. On all these counts Shrank asks whether patients would not be better dealt with by one visit to the experts in the dermatology clinic.⁴

General practices may earn the extra payment for minor surgery only after investing in suitable space, equipment, and