establishing confidential inquiries into the circumstances in which young patients die from their disease—in a similar manner to the inquiries currently performed into maternal deaths. In this way we may identify risk factors more certainly and eventually prevent more deaths.

1 British Medical Journal, 1978, 1, 973.
3 MacDonald, J B, Seaton, A, and Williams, D A, British Medical Journal, 1976, 1, 1493.

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Emergencies and the laboratory

The much-publicised rise in the work load of laboratories has been accompanied by a parallel increase in requests for emergency tests throughout the 24 hours. In most British laboratories, out-of-hours emergency requests are dealt with satisfactorily, albeit expensively, by arrangements such as on-call rota. Conflicts seldom arise provided the rota is adequately staffed, though on occasions clinicians request a test in the middle of the night that is not normally regarded by the laboratory worker as an emergency procedure.

Conflicts are more common when, during normal working hours, the result of a test is demanded more quickly than the normal turn-round time for that test, so that “urgent” becomes equated with “emergency.” Difficulty occurs, especially in clinical chemistry, because logistic problems develop from the laboratory trying to handle “one-offs” at the same time as processing its daily work. The competing demands on both staff and equipment induce stress, and if the number of urgent requests during normal working hours is high they can hinder the routine service, thereby increasing the demand for urgent answers even further.

This chain reaction appears to have occurred in the Ontario teaching hospitals, where recently one in four requests for general clinical chemistry was classed as urgent. To overcome this problem Henderson introduced two additional forms: one which he called a priority test request form and another the telephone results form, which is printed on the back of the priority request form. The first of these lists the tests available as priorities, permits up to five to be ordered, indicates the time by which the result is required (15 minutes, 1 hour, 2 hours, 3 hours, or today), and to whom and at what number the results are to be telephoned. The telephone request form is used for non-priority tests, and gives only two times (three hours or today). Henderson claims that in many cases “urgent” has been misinterpreted or even misused by the clinician, and that by categorising the test request into a known time-scale the test can often be accommodated within routine batches. Since the introduction of the new forms laboratory staff have been able to organise their work more effectively, while the clinicians’ real needs have still been met. Resistance to introducing the new forms had to be overcome by intensive education. The number of urgent requests fell almost to nil for the first 10 days but is now back to its previous level, though the number of tests per request has halved. Relations between clinician and laboratory are said to have improved though no objective evidence is presented.

Are there lessons here for British laboratories? Undoubtedly the number of urgent requests is higher than necessary. This is probably due to several factors, including too slow a turn-round between requesting and receiving the report, misunderstandings about how long certain tests take, covering up previous omissions, and simple convenience. Is the concept of priority for requests the answer? Making priority more difficult may, in fact, mean that only real needs are met. Telephoning too many results is not only time-consuming but may interrupt a clinician at an unsuitable time—and as a means of accurate communication the telephone leaves much to be desired. Is it really necessary to introduce special forms? The required time-scale can be indicated on existing forms, and if a request really is urgent, the clinician should make personal contact with the laboratory physician. Henderson’s study might have been more convincing had it shown that the clinicians actually used the results on the time-scale they requested them and had he removed rather than reduced the current misuse of the “urgent” request, thereby reducing or at least containing laboratory costs.


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Review Body reports

The Review Body has done as it promised last year. The delayed ninth report (p 1577), published as the BMJ went to press, recommends an average increase of 25% for NHS doctors and dentists from 1 April 1979, an award that will add £199m to the professions’ pay bill. This is made up of a 12% cost-of-living increase in addition to the second instalment of the three-phase increase (corrected in the light of updated information), which the Review Body recommended last year was necessary to bring NHS doctors’ incomes back into line with comparable groups. So hopes that the Review Body might bring forward phase three of the award from 1 April 1980 to this year, as requested by the BMA (p 1579), have not materialised. The profession will look askance at the reason given, namely, to contain inflation, because it conflicts with the Pilkington Commission’s recommendation that NHS doctors’ pay should not be used as a regulator of the national economy. But with long queues at medical schools and comparability pay reviews for other NHS staff still under way doctors will not be unduly surprised that the Government has failed to do for them what it did for the police and armed Forces and pay off its debts now.

This report is a special one on two counts. Firstly, consultants had submitted extensive evidence for the pricing of their new contract and, secondly, the juniors had not submitted any evidence, as their representatives want no part of the Review Body system and are seeking, unsuccessfully so far, direct negotiations with the DHSS on pay. Nevertheless, the Review Body has pronounced on hospital junior staff pay, recommending straightforward increases of around 22%. While the juniors, however, are dealt with in one short paragraph, the consultants’ present and new contracts occupy several pages of the 127-page report.

Because consultants would be given a choice of staying with the present contract or changing to the new one—if it was accepted by the profession—there are two sets of recom-
Tory health

"The heart of a good health service must be a medical profession whose morale and job satisfaction are high." Thirty years of the NHS have made doctors wary of political statements from whatever quarter. But the tenor of Mr Patrick Jenkin's speech at the BMA's council dinner last week (p 1584)—from which this quotation came—suggests that the new Secretary of State for Social Services understands one priority. The medical profession can be forgiven for wondering whether in the 'seventies doctors are still at the heart of the Health Service: if the DHSS's new political chief can ensure that they are and restore their morale he will have done medicine a service. Dr Gerard Vaughan, Minister of Health, was himself a consultant (at Guy's Hospital), and, as Mr Jenkin publicly declared his intention to delegate, the new minister is uniquely placed to make a major contribution to boosting the profession's battered morale. It will not be an easy task, for, as the Chairman of Council, Dr J C Cameron, warned in his speech, staff morale in the NHS has sagged and "poor morale is as infectious as the plague."

Apart from the important issue of adequate pay (and the Review Body's Ninth Report was published as the BMJ went to press (see above)), doctors will look for less interference by administrators and greater local freedom in running the NHS. On this Mr Jenkin made some encouraging noises. "The main thrust of our policy," he promised, "must be to make our NHS more of a local service than it is at present... doctors... are trained to take professional decisions off their own bat and do not need the torrent of advice which has poured out of Alexander Fleming House in recent years." (Our italics.) He also called for more local leadership, which, he argued, could have avoided or mitigated the recent industrial problems. Mr Jenkin will make no decisions on these matters until the Royal Commission has reported—he forecast mid-July as a likely date—but his first publicly uttered views since entering the Elephant and Castle will give doctors some cause for hope that the NHS's deterioration will be checked or even reversed.

What did the Secretary of State have to say about the patient? He spoke, as might be expected, of the value of preventive medicine and health education, particularly in relation to smoking and drinking, but perhaps the key to Tory thinking on health is contained in the comment: "...The cardinal principle must be to emphasise the individual's personal responsibility for his own health. It is a perversion of good practice to allow let alone encourage people to live in a way which seriously damages their health while comforting them with assurances that it does not matter because someone else will meet the financial cost of the consequences." This is an admirable sentiment but one not easily translated into deeds. Experience has shown that people do not readily change their life styles, however potentially damaging these may be. Given that the principle of the NHS as a service providing free access to medical care has wide electoral support—and no political party shows any sign of challenging the principle—it will be interesting to see how the new administration intends to effect this philosophical objective. Exhortation, or "ministerial nannying" as he labelled it, was ruled out by Mr Jenkin, though he spoke vaguely of the "joint responsibility of the Government and the medical profession to see that people know the basic facts about health." Does he envisage an injection of Saatchi and Saatchi expertise into the Health Education Council, which he wants to see become a more effective force for the promotion of good health? Or will he and his advisers be pondering on possible incentives to lead the population towards better health? The French, for example, have been successful in their policy of linking State maternity benefits to attendance at antenatal clinics. Would Britain tolerate such an innovation, along with perhaps more generous child benefits for those parents who bring their children for regular developmental screening?

With Britain's continuing economic weakness realistic doctors will not be expecting more real resources for the NHS. But Health Service staff will be thankful that health is to be spared the Thatcher axe. Encouragement of efficient spending is, however, essential, and one stimulant would be to allow local savings to be spent locally. This should be a logical result of restoring some local autonomy in organising health care, a move which should also prompt more voluntary support, both financial and practical. Furthermore, if the influence of doctors can be restored this should contribute to greater efficiency. That Mr Jenkin acknowledges the value of this is clear, for he states: "Moreover, in the management at local level it is not right that the voice of the doctor should be drowned amid the clamour of competing interests. People come to the Health Service to be treated by doctors and nurses, and other professions and disciplines need to be reminded of that." Dr Cameron could hardly have put it better.