The clinical laboratory and general practice

COLLINGS (1950) reported the results of a reconnaissance of general practice. From most points of view his findings were unfavourable and were believed by many to be unrepresentative of the true state of general practice. Nevertheless his report had important consequences and must have been much in the mind of the founders of the College when they were considering the need to provide an academic base for general practice.

Among the many aspects of general practice which Collings observed was the use made by general practitioners of laboratory investigation: he found it to be almost non-existent. Most of the investigations which he encountered were confined to urine tests.

Collings was followed by Hadfield (1953) who was asked by the British Medical Association to check on Collings' findings. Hadfield visited 188 randomly selected general practitioners (Collings' general practitioners had not been randomly selected) and found that 65 per cent of them had access to a pathology laboratory. At that time, however, access to a laboratory did not mean 'open access' in the sense that we understand it today. As those who were in practice in the 1950s will remember, pathologists were prepared to perform only a limited range of investigations at the direct request of a general practitioner; urine and swabs would be accepted for microbiological examination but blood for biochemical or haematological examination was accepted only rarely. If investigations other than urine or swab examination were required, the practitioner was expected to arrange for the patient to attend the laboratory in person, where the pathologist, who often held what amounted to an outpatient session, decided which investigations were relevant. In some places laboratory investigation could be arranged only through a consultant and required an appointment at the outpatient department. If the patient was unable to attend in person, the general practitioner was forced either to ignore the advantages of investigation or to arrange a domiciliary visit by the pathologist or a consultant.

In the face of these difficulties some general practitioners developed an interest in laboratory techniques and carried out some investigations on their own premises, notably Dr Douglas French of Kidsgrove who was a member of the Foundation Council of the College (French, 1960). However, the need for all general practitioners to have access to laboratory investigation facilities was impossible to deny, and even before the principle of open access became national policy local arrangements were often made between individual general practitioners and their pathologist for specimens to be accepted.

During the 1960s the availability of laboratory services to general practitioners gradually increased. By 1971 the position was regarded as reasonably satisfactory (DHSS and the Welsh Office, 1971). It can now be accepted that most, if not all, general practitioners in the UK have access to a pathology laboratory, though the ease of access may be dependent upon the distance between the general practitioner's premises or patient's home and the laboratory.

Conn (1978) describes the function of the clinical laboratory as to provide facilities for the examination of materials from the human body for the purposes of providing information for the diagnosis, prevention, or treatment of disease. Investigation has shown that 68 per cent of the investigations arranged by general practitioners are related either to establishing or to refuting a diagnosis; 20 per cent are concerned with the surveillance of established disease; and 12 per cent are arranged for screening purposes (Acheson, personal communication). Acheson also found that 47 per cent of 230 general practitioners stated that they never performed any tests on their own premises.

Materials, on the strip-test principle, which enable a general practitioner to do some tests in his consulting room, are now available commercially. Most relate to the examination of urine, but tests for blood glucose, serum bilirubin, and faecal occult blood are also available and the range is likely to increase. These tests, when combined with the use of a microscope, for the examination of blood smears, urinary sediment, hair, skin or nail scrapings, and vaginal discharge, the microhaematocrit measurement of haemoglobin and the estimation of the erythrocyte sedimentation rate, provide a range of 'do-it-yourself' investigations (Acheson *et al.*, 1978).

Most of the laboratory investigations arranged by general practitioners are for 'routine' haematology or urine tests, or for cervical cytology. The number of biochemical estimations requested is, by comparison,

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small. The need for biochemical investigations in general practice is less than the need for haematology and urine tests, but it is possible that the advantages of biochemical investigation are not sufficiently appreciated by general practitioners.

If a general practitioner is to derive maximum benefit from modern medical technology, he must be dependent upon people and services, both in the laboratory and in the specialist clinical departments of the hospital, whom he may never meet and knows little about. The advantages of personal contact and discussion do not need to be emphasized, but medical education also has a place. It should be a major concern of medical educators, at all levels, to ensure that the gap, inevitable by geography, between the primary care physician and the laboratory does not increase, and that each has an appreciation of the problems and difficulties of the other. The laboratory function is an integral part of patient care; it should not be confined to reporting figures. Close and frequent contact between clinicians and the clinical laboratory will assist in the development of tests to answer specifically defined clinical questions, the better use of information on drug interference, and similar factors in the interpretative process (Conn, 1978).

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Five hundred in a faculty

THE 1977 *Annual Report* of the College referred to the "healthy upward direction" of the trend of membership and the recorded increase in that year was 5·4 per cent.

The steady rise during recent years in the total membership of the College in the UK is of course being reflected to a varying extent in the different faculties. A recent landmark was reached when, for the first time in the history of the College, a faculty—the South-West England Faculty—achieved 500 members and associates.

There is an old Chinese proverb to the effect that successful organizations require regular revolutions. The truth of this maxim is already being seen as the College nationally and regionally begins to carry out a complete review of its structure and functions in its twenty-fifth Jubilee year.

The founding fathers were obviously most concerned to prevent the new College of General Practitioners becoming over-centralized and dominated by London members. The constitution provides for a majority of the members of Council to be those elected directly by the faculties and thus ensures in the supreme executive body of the College a majority of peripheral opinions. Nevertheless, this structure assumes that faculties are approximately equal whereas in fact very different patterns in geography and numbers have developed over the years. In numbers, for example, in 1977 the smallest faculty—the West of Ireland—had a total of only 20 members and the four Irish faculties combined had a membership of approximately the size of the then biggest English faculty.

Similarly in Scotland the smallest faculty in 1977—the North of Scotland—had only 72 members and associates and the average size of the five Scottish faculties was only 204.

These figures obviously provide a basis for a charge of relative over-representation, particularly by the Celts. On the other side of the coin, the achievements of these faculties, including some of the smaller ones, have been notable. Scotland in particular has for years been a hive of college activity and has made remarkable achievements. Perhaps this apparent fragmentation has had beneficial results, and in this, as in so many other organizations, small may be beautiful.

Certainly the success of the College in attracting as many as 500 doctors in a single faculty is creating organizational problems. It is becoming clear that in practice colleagues cannot attend meetings when a single faculty spans 300 miles and only a tiny proportion of its membership can be involved in the work of the faculty board.

By contrast, the recent development of small groups meeting within a radius of about 20 miles at a focal point such as a postgraduate medical centre seems to be becoming increasingly popular and may be pointing the way to a new focus of college activity. If their structure is to serve function, faculties must identify exactly what they now want to do. Those like the South-West England, Midland, North-West England, and West of Scotland who are at, or in sight of, the 500 mark now have a special responsibility.

Reference

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