Staffing of accident and emergency departments

SIR,—I cannot allow Mr K G Pascall's letter (6 January, p 58) to pass without some comment from an orthopaedic surgeon.

In the recent past, many orthopaedic surgeons were suspicious of or even opposed the appointment of accident and emergency consultants because they feared that, in the multiplicity of activities that are required of him, such a consultant might not prove to be capable of maintaining the standard of treatment of musculoskeletal lesions that would be set by a fully trained orthopaedic surgeon. Many remembered the days before the war when casualty departments run, in all good faith, by general surgeons or general physicians frequently failed to attain satisfactory standards in this respect. It is also true that orthopaedic surgeons were no better than their predecessors in respect of their actual presence in the accident and emergency department except for specific or major injuries, and the teaching and training of casualty staff were not all that they should have been in many centres. Moreover, even in departments with a high incidence of input of injuries, there has been an increase in recent years in the number of non-orthopaedic emergencies coming to accident and emergency departments.

Orthopaedic surgeons do now accept that accident and emergency consultants have come to stay. Their function is well set out in the Lewin Report¹—to organise and administer the department; to provide an initial diagnostic service at high level and arrange for further care if necessary; to provide emergency resuscitation; to provide teaching for those working in the department; and to maintain liaison with ambulance, police, and fire services, etc. It is clearly the function of an accident and emergency consultant not to provide continuing treatment but only to arrange for further care, and this applies as much to musculoskeletal injuries as it does to the further management of diabetics in coma or cardiovascular accidents. The orthopaedic surgeon wishes to be responsible for the management of musculoskeletal injuries right from the very beginning, and should provide a 24-hour service by himself and his staff in parallel with the primary diagnostic and resuscitative function given by the accident and emergency consultant and his staff.

To that extent, the two disciplines are likely to be closely linked and some of the treatment may well take place in the geographic confines of the accident and emergency department, but it should be quite clear that the accident and emergency consultant has a separate and defined function from that of the orthopaedic surgeon treating musculoskeletal injuries. Indeed, it would be quite inappropriate that an accident and emergency consultant should move out of his department to operating theatres or wards, where he cannot continue to fulfil the function for which his discipline and appointment were first intended.

The training of an accident and emergency consultant must cover some knowledge of many fields, but it is quite inappropriate that he or she should receive training in higher surgical skills, or indeed higher medical skills, that are not required of him, and which he might find himself frustrated not to be able to use. Accident and emergency medicine is a new discipline with its own requirements and skills, which should give an individual plenty of activities with which to occupy himself and a

multitude of potential problems and interests. I see him not as a member of an orthopaedic team, a general surgical team, a neurosurgical team, or a general medical team but as an individual who must stand on his own feet and work within the now accepted boundaries of his own discipline.

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¹ Lewin, W, *Medical Staffing of Accident and Emergency Services*, A report prepared on behalf of the Joint Consultants Committee, April 1978.

Management of pathology laboratories

SIR,—Mr J K Fawcett, the secretary of the Institute of Medical Laboratory Sciences (IMLS), thinks (6 January, p 53) that I have been using my imagination. I suggest that he reread a letter (JKF/NJ), dated 15 February 1977, on the subject of professional designation, sent from the executive committee of the IMLS to regional and branch secretaries. The paragraph on advertisements endorsed an earlier request from the IMLS president that "medical laboratory scientist" be included in future advertisements as the profession's chosen designation.

Mr Fawcett continues the campaign to remove the distinction between PTA and PTB staff, presumably hoping that "What I tell you three times is true" (to quote Lewis Carroll) will convince your readers. The IMLS does *not* have responsibility for all medical laboratory staff with non-medical qualifications, despite its oft-repeated claims. The institute is apparently choosing to ignore the existence of the Royal College of Pathologists and of the Association of Clinical Biochemists.

Fortunately, so far, few laboratories seem to have been adversely affected by the institute's mistaken notions. However, it is the incorrectness of the IMLS claim that is the cause of the interprofessional conflict to which I referred (9 December, p 1642), and of the time-wasting arguments that Mr Fawcett's colleague Dr Farr so strongly deplores. In answer to Dr Farr's plea (p 53), he should be prepared to accept that, in Disraeli's words, "Time is precious, but truth is more precious than time."

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SIR,—Professor Roger Dyson in his article "Who manages pathology laboratories?" (9 December, p 1658) refers to the unsatisfactory situation whereby a rigid reliance on "numbers managed" leads to a principal medical laboratory scientific officer having to leave his own department and undertake a "floating role." We endorse his view that this situation needs changing.

Doctors, scientists, and medical laboratory scientific officers (MLSOs) in most hospital pathology laboratories now work within individual, specialised departments (currently clinical biochemistry, haematology, histopathology, microbiology, and, in some hospitals, immunology departments). The rapid development and specialisation of medical science has made these departments in most hospitals increasingly separate from one another. Although co-ordination of certain common services is sometimes needed, this is

generally a minor job, and major common policy decisions can be reached through cog-wheel divisions or their equivalent. The notion that the departments comprising "the path lab" need overall administration whole time by a senior individual is now obsolete for all but small hospital laboratories. It is certainly obsolete if any senior individual has jurisdiction for the scientific or technical work of any department other than one for which he has been adequately trained. It is anomalous therefore that, whereas doctors and scientists almost invariably obtain promotion and fulfil their career aspirations within their own department, promotion to the highest MLSO grades (that is, principal or in some cases senior chief MLSO) requires an extradepartmental role in order that the condition for "numbers managed" may be fulfilled. We strongly support the abolition of any "number managed" as the sole criterion for promotion to principal MLSO. We believe that, with few exceptions, senior interdisciplinary posts should be abolished, and instead promotion to principal MLSO be made possible for senior chief MLSOs exercising exceptionally heavy responsibilities.

As a matter of urgency, the appropriate Whitley Council should undertake a review of the current grading criteria, and should aim to establish a grading structure that allows the most senior MLSO within the department the highest level of remuneration.

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SIR,—I have followed with interest the discussion on "Who manages pathology laboratories?" Most of what has been said has been predictable. However, Professor Roger Dyson's article (9 December, p 1658) contains some proposals which need examination.

There have always been what Professor Dyson inaptly describes as "floating" scientific officers. I have been employed in the hospital service for 35 years in a number of laboratories and have always had a "chief" whose duties were to manage the work carried out in the laboratory as a whole. This is therefore not a new phenomenon as he implies, nor can the presence of such a post be the root cause of present problems. This root cause is, without doubt, the rapid growth in the complexity of medical laboratory technology.

The present level of knowledge and expertise of the medical laboratory scientific officer has been reached by an evolutionary process and during this process a large majority of pathologists have gradually withdrawn from the working laboratory scene. This withdrawal is a natural development and it is now difficult to see the relevance of a medical degree to the actual practice of medical laboratory science.