- All letters must be typed with double spacing and signed by all authors.
- No letter should be more than 400 words.
- For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the *BMJ*.
- We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.
- Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.

A patient's charter for laboratories

SIR,—Clinical chemists have led the way in developing analytical quality control, to the extent that the public can now have considerable confidence in the correctness of the results obtained from properly staffed laboratories. But are we resting on our laurels in respect of our service provision? Experience indicates that the quality of analyses, which looms large in our eyes, is now "unseen" to the user clinician whereas poor turnaround time or receipt (some days later) of a form bearing the result "sample insufficient" causes frustration and anger.

I am aware that some laboratories have now put turnaround at the top of their list of priorities, but others still blame external factors for failing to meet their responsibilities in this. Perhaps it is time for a patient's charter for the laboratories. I suggest a seven point list.

(1) If you are an inpatient in a ward and specimens are sent to the laboratory for urgent analyses the result will be telephoned to the ward within 30 minutes of the sample's arrival at the laboratory.

(2) If you are an inpatient the results of all tests requested will be returned to the ward within six hours of receipt for common assays and within 48 hours for less routine tests.

(3) If the test requested is one that is not urgent the result will be returned to your primary care physician within five working days so that he or she can schedule your next appointment no more than one week ahead.

(4) If you are an outpatient at a clinic that requires rapid results the laboratory will provide or help with an on site analytical service so that changes in your treatment may be decided at that visit.

(5) The laboratory will provide facilities for you to give a blood sample at any time during the working day. Simply bring along a completed request form from your doctor. You will be seen by a trained phlebotomist and given a comfortable place to sit before and after if required. Your specimen will then be processed without any chance of loss or degradation.

(6) All results indicating that your treatment requires urgent alteration will be telephoned to a responsible doctor or nurse as soon as they are available.

(7) In the event of the sample that has been taken being unsuitable for analysis or damaged in transit your doctor or nurse will be contacted by telephone immediately after the specimen arrives at the laboratory.

These may seem unachievable aims to some of us, but I suggest that laboratories that do not try to

improve turnaround may deserve the fate of the dreadnoughts, and few will miss them.

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Prescribing at the hospital-general practice interface

SIR,—Roger Jones and Michael D Rawlins plead for better communications between hospital staff and general practitioners.¹ I wish to add some points to their cogent piece.

Cost shifting assumes that hospital doctors wish to pass the costs of their prescribing on to the community while retaining responsibility for the drugs themselves. Quite rightly, Jones and Rawlins condemn this practice. In Leicestershire we are attempting to turn this pressure to some good. General practitioners are being encouraged to become more involved in true shared care and to increase their skill and involvement in complex care. Hospital consultants have been made aware that general practitioners are no longer prepared to act as their subordinates and are being invited to join working parties in which holistic care in certain diseases is being discussed. We hope to produce guidelines from each of these working parties, which will make full use of the skills of the clinicians on each side of the clinical chasm and help to narrow that chasm.

Our adage is "power with responsibility." General practitioners who are fully involved in the shared care of their patients and are keen to take on the responsibility for those patients' more complex prescribing needs are being actively encouraged to accept that responsibility. If they have reasonable doubts about their involvement or competence in a particular case care will continue to be provided by the hospital doctor.

The cost of treatment is not the prime issue so far as Leicestershire Family Health Services Authority is concerned. Our concerns lie in ensuring that general practitioners are involved in deciding whether a treatment is required, monitoring and adjusting that treatment, and taking responsibility for those actions. The actual choice of a cost effective agent is then left up to the general practitioner, although she or he may be asked to justify that agent at some stage.

We hope that this policy will help to improve the provision of care to patients, improve communications and relationships across the clinical chasm, and raise the profile, standards, and morale of general practice in Leicestershire.

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¹ Jones R, Rawlins MD. Prescribing at the interface between hospitals and general practitioners. *BMJ* 1992;304:4-5. (4 January.)

SIR,—The second of the two papers on prescribing at the hospital-general practice interface ends with a sentence urging that patients' views be sought.^{1,2} Roger Jones and Michael D Rawlins's editorial on the subject agrees that the profession has a responsibility to resolve some of the current difficulties.³ I would like to present the views of patients with arthritis.

When, for reasons of cost, two discrete groups are trying not to prescribe the patients in between are bound to suffer, especially those with chronic diseases. So far, the main effect they have noticed is that smaller quantities are prescribed each time, which means more expense and more frequent visits to the surgery or hospital pharmacy. In many areas people with arthritis are having considerable difficulty getting to hospital for necessary appointments. When every journey causes pain and may aggravate inflamed joints it is particularly unfortunate that administrative disagreements could increase their number.

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¹ Wilkie P, Sibbald B, Raftery J, Anderson S, Freeling P. Prescribing at the hospital-general practice interface. I. Hospital outpatient dispensing policies in England. *BMJ* 1992;304:29-31. (4 January.)

² Sibbald B, Wilkie P, Raftery J, Anderson S, Freeling P. Prescribing at the hospital-general practice interface. II. Impact of hospital outpatient dispensing policies in England on general practitioners and hospital consultants. *BMJ* 1992;304:31-4. (4 January.)

³ Jones R, Rawlins MD. Prescribing at the interface between hospitals and general practitioners. *BMJ* 1992;304:4-5. (4 January.)

SIR,—In their article on hospital outpatient dispensing policies Patricia Wilkie and colleagues make it clear that many hospitals have a policy of prescribing nothing for outpatients or of prescribing up to 14 days' supply, relying on the general practitioner to continue prescribing.¹

A problem for consultants (and to an extent their junior medical staff) that is not addressed is their legal position if a general practitioner declines to prescribe, whether for sound reasons or not, and the consultant continues to see the patient on an outpatient basis. If the consultant really believes that the drug treatment he or she recommended or initiated is necessary but it is not continued by the general practitioner or is altered unacceptably, does that consultant have an ethical and legal duty to prescribe it whatever the hospital policy is? The onus of provision then falls on the hospital