discuss the subject openly. Fourthly, if deprived of confidential professional advice, and of contraception and abortion if indicated, these patients will face the prospect of completing unwanted pregnancies, or of seeking non-medical termination of pregnancy, both with disastrous consequences. Fifthly, this decision is a fundamental threat to the confidential relationship that must at all times exist between doctor and patient. Finally, this decision is a fundamental threat to the ability of doctors to provide treatment which, in their clinical judgment, is best for the patient. It is earnestly to be hoped that the courts can be persuaded to reverse this potentially disastrous decision.

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SIR,—I was tremendously relieved about the recent judgment in the Appeal Court on the Gillick case, in which three judges "outlawed" a Department of Health and Social Services circular advising doctors that they can give contraceptives to under age girls without the consent of parents.

The judge said that it was clearly established law that parents had rights to "control the manner in which, and the place at which, the child spends his or her time. No one, apart from the court, could interfere with these rights." Presumably he meant not even the medical profession or its BMA spokesmen. Personally, I feel very strongly that the authority of parents should not be undermined by so called "clinical" judgment. As a BMA member I am dismayed by the self righteous attitude of the BMA towards parents' legal rights concerning the conduct of their children. The decision to prescribe or not to prescribe the pill is not only a clinical but a moral and legal matter, which should leave practitioners no room for manoeuvre outside the law as far as parental consent is concerned. Obviously an unwanted pregnancy or septic abortion is very regrettable, but two wrongs never make a right, not even in the medical profession. Therefore, it is very important that the doctor should not assume authority which is legally vested in the child's parents.

The argument that failure to make available the pill to children will result only in an increase in the number of unwanted pregnancies and a return to the days of back street abortions should be utterly rejected.

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Pathology laboratories, management, and the future

SIR,—In his provocative Talking Point on the management and the future of pathology laboratories (15 December, p 1706) Dr G W Pennington certainly achieved his aim of making people talk—and think—about the future of the service. It was no surprise that it was a chemical pathologist who was moved to write such an article, for that discipline is more noted than most for its history of interprofessional rivalry and antagonisms. However, Dr Pennington did start with a basic misconception.

While heads of pathology laboratories have long been drawn from medically qualified staff it is not traditional that they may also be non-clinically trained scientists ("of equivalent standing"—whatever that means), and perhaps this is part of the trouble. It seems to have been only during the last 10 years (since the issue of the DHSS circular HSC(IS)16) that a touch of magic has existed that can transform a scientist with no clinical training into one who possesses it merely by promoting him within a non-clinical hierarchy (that regulated by the Whitley professional and technical Council A (PTA)). Or was a new decision made that a clinical training would no longer be necessary for a role as head of department, and HSC(IS)16 was used as the means of announcing this?

In the latter case the DHSS was singularly inept if it really did intend to single out one of the two non-clinical categories of laboratory staff to group along with pathologists, while apparently seeking to exclude the other. Perhaps this was not so irrational after all though, for pathologists and PTA scientific officers do share one common attribute: an almost total lack of any formal qualification in management studies—unlike very many scientific officers employed under the regulations of the Whitley professional and technical Council B (PTB). Indeed, the principal role of the (then grade of) chief technician "as 'general manager' of the laboratory, without prejudice to the overall responsibility of the chief pathologist" was recognised as long ago as 1967.[1]

In any event HSC(IS)16 was the direct cause of much of today's unrest, in that it polarised attitudes among traditionally friendly and cooperating colleagues. Nevertheless, as Dr Pennington and others have noted,[2-4] "in most laboratories a happy and stable relationship exists between the various types of staff," which makes it difficult to understand why he attributes the recent issue of the equivalent Scottish circular (1984(GEN)4) to "the number of industrial disputes in Scottish laboratories." (Personally, I know of only three such disputes in the last 23 years.) That the long running dispute in Fife has become a cause célèbre is unfortunate, but it is certainly not typical of Scottish laboratories and probably reflects local difficulties rather than an inate antagonism between medical and non-medical laboratory staffs.

Perhaps Dr Pennington put his finger on the pulse more accurately than he realised when he described the possibility of individual consultant medical staff holding senior managerial posts for extended periods as being "unpalatable." Most medical practitioners are not trained for, and do not wish to undertake, such work: unfortunately, too many of them—like the dog in the manger—do not want to see anyone else doing the job either.

Certainly, largely as a result of widespread clinical abuse of the service, a thorough survey of the provision of laboratory services within the National Health Service will soon become inevitable; and the results of this will necessarily determine patterns of medical and scientific staffing and training for well into the future. (And yes, there is life outside the NHS.) Maybe if those who get so wound up over the (supposed) status of the word manager were to worry less about the word (and about internecine warfare with their colleagues) and more about the concept of co-operating to provide the most efficient service possible to the patient then we would all have less to worry about when a survey is finally undertaken.

The person who is best trained, and has the greatest aptitude, for management should be allowed to manage, while it must not be forgotten that the element of overstaffing to which Dr Pennington referred is at least as prevalent among pathologists as among "the highest technological levels." Self interested claims for a "*rightful* role as head of department" (my italics) for one's peer group, coupled with a denigration of certain of one's professional colleagues, will convince objective critics no more than will the threat of that Luddism which (without due cause) he seems to fear from others. Let he who is without sin cast the first stone.

If ever there was a time for all laboratory staffs—medical and scientific—to pull together rather than against one another, it is now. After all, we are all here for the patient's benefit rather than for sectarian ends. Dr Pennington has performed a valuable service in highlighting some of the issues which should concern us all and it is to be hoped that the debate will proceed objectively and constructively and without the rancour which one too often detects among many pathologists today.

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1 Ministry of Health. *Pathology, organisation, management, and methods.* London: HMSO, 1967:19.
2 Dyson R. *The management of pathology laboratories.* London: Association of Clinical Pathologists, 1977: 23.
3 Royal College of Pathologists. *Management of pathology laboratories in the National Health Service.* London: Royal College of Pathologists, 1977:7.
4 Farr AD. *Learn that you may improve: the history of the Institute of Medical Laboratory Sciences.* Billingshurst: Denley, 1982:161-4, 188-9.

First clinical use of penicillin

SIR,—Professor Charles Fletcher's article (22-29 December, p 1721) vividly describes the atmosphere of excitement in medical circles in Oxford at that time. I venture to add a few details to the story. I arrived as house surgeon at the Wingfield-Morris Orthopaedic Hospital (now the Nuffield Orthopaedic Centre) in January 1941 to find Florey and Fletcher there, deciding with Professor Seddon to try penicillin for a 10 year old with acute osteomyelitis of the femur. It was given by duodenal tube but sadly was not effective. The boy later developed a pathological fracture and lost his leg. Shortly afterwards Mr Girdlestone of the Wingfield offered a young man with a theatre acquired infection of a pinned epiphysiolysis. Pus was pouring from the incision, and he had had a temperature of 102°F for about six weeks. I well remember Florey's anxiety as he handed me a small bottle containing some damp orange coloured powder—his entire stock of penicillin—with instructions to weigh out 5000 unit doses on the laboratory balance and give it intravenously every three hours. After 36 hours the penicillin was all used up (doubtless it was subsequently recovered from the urine and reused). The boy's temperature fell to normal by crisis and the incision healed. It was an unprecedented result. The surgeons at the Wingfield gave Florey enthusiastic support. Professor Seddon even packed his baby Austin saloon to the roof with bedpans and raced down to the laboratories when there was an urgent need for larger surfaces to culture the mould.

The following year Florey visited the army in Algiers. He brought us small supplies of penicillin-sulphonamide powder. As penicillin was still on trial we queried the addition of sulphonamide as confusing the issue, but were told it was the only vehicle which did not inactivate penicillin. Patrick Clarkson and I found that insufflation with this powder significantly improved the success rate in grafting burns. A year later, in Naples, limited supplies of penicillin for injection arrived. It was said that for military expediency it was at first reserved for treatment of the resistant Naples gonococcus and was only later released to us for battle casualties.

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