ACB News

The Association of Clinical Biochemists • Issue 441 • 20th January 2000

Jobs . . . We Investigate

Education Committee Training Day

Academic Pay Anomalies

Poetry in Grasmere

About ACB News
The monthly magazine for Clinical Science

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Front cover:
Mike Thomas and Helen Smith of the Royal Free Hospital. See Millennium Topics.
Photo: Dr Gwyn McCreanor.

Pathology 2000
BIRMINGHAM 15-17 MAY

For details of Pathology 2000 please contact the Congress office:
Tel: 01223-516103
Fax: 01223-500978
email: office@pathology2000.org
www:pathology2000.org

Analyse-it Follows Defunct Astute

Many laboratories found the Astute statistical package, which ran with Microsoft Excel to be extremely useful. This package was developed and brought to us by Dr Rick Jones and colleagues from Leeds and was marketed by DDU software at Leeds University. As you upgrade your laboratory PCs you will find that this software needs to be updated but Astute itself is no longer marketed.

A new statistics package, Analyse-it, has the basic character of Astute and is being further developed. Analyse-it software also works with Excel and is very simple to use. The software came out at the start of 1998 and has been supplied to over 1200 sites around the world. It is possible to download a trial copy of Analyse-it from the Internet. You can find out full details of the product at www.Analyse-it.com

A single site licence for the general statistic modules is £95 + VAT. For the clinical laboratory module the price is £175 + VAT with the full package being £225 + VAT.

Upgrades from the Astute base module are £65 + VAT or £95 + VAT for the whole module.

If you wish to have further details on the package, then please contact James Huntingdon, Analyse-it Software Ltd, PO Box 77, Leeds LS12 5XA.
Tel: 0113-229-5599. Fax: 0113-263-2101.
Email: jh@Analyse-it.com
Web site: http://www.Analyse-it.com ■

The Professors' Prize Applications for the 2000 Award

The Professors of Academic Departments of Clinical Biochemistry established this prize as a prestigious award for research achievement within the field of Clinical Biochemistry. Applications are invited from Clinical Biochemists, or those in related disciplines, such as Biochemistry, Molecular Biology or Clinical Medicine.

Applicants should be under 40 years of age on 30th April 2000, and will not yet hold a Professorial appointment. Applications will consist of a 500 word summary of research achievement, curriculum vitae and three best publications, together with a supporting statement from a senior scientist or clinician sponsoring the application.

The prize will consist of engraved cut glass and an honorarium which will be presented at the Chemical Pathology Day at the Royal College of Pathologists in September 2000. The Prize Lecture will be delivered at that meeting.

Applications (five copies) should be submitted to: Professor G.H. Elder, Department of Medical Biochemistry, University College of Medicine, Heath Park, Cardiff CF4 4XN, by 31st March 2000. ■

Clinical Biochemistry of Intensive Care

Princess Margaret Hospital, Swindon
Thursday 16th March 2000

South West & Wessex ACB Region

Topics will include:

Nutritional Therapy in Critical Illness
Multiple Organ Failure and Endothelial Dysfunction
Is Lactate a Useful Marker of Tissue Hypoxia?
Investigation and Monitoring of Acute Renal Failure
Methods of Cardiovascular Monitoring in Intensive Care
Adrenal Dysfunction in Critical Illness

Registration fee: £15.00

For further details, please contact:
Dr Andrew Day, Department of Chemical Pathology, Weston General Hospital, Grange Road, Uphill, Weston Super Mare, Somerset BS23 4TQ. Tel: 01934-647019

ACB Training Course No. 6

Sunday 9th - Friday 14th April 2000

Allen Hall, University of Manchester

The following topics will be included in the programme:

- **Pituitary**
- **Paediatrics**
- **Adrenal**
- **Dry Chemistry**
- **Thyroid**
- **Near Patient Testing**
- **Gonadal function**
- **Biosensors**
- **Infertility**
- **Equipment Purchase**
- **Pregnancy**
- **Laboratory Planning - short and long term**

For further information contact:

Dr Martin Myers, Department of Clinical Biochemistry, Royal Preston Hospital,
Sharoe Green Lane, Fulwood, Preston PR2 4HG
Tel: 01772-710121 E-mail: martin.myers@mail.pa-tr.nwest.nhs.uk

Application forms are available from the ACB Office:
Tel: 0207-930-3333 Fax: 0207-930-3553

ACB Satellite Meeting – Pathology 2000 Thursday 18th May, Birmingham

The format for the ACB satellite meeting to be held in Birmingham on Thursday 18th May, after Pathology 2000 has now been agreed. The day has been organised to have something to appeal to all members of the Association. It will begin at 09.30 with the Association's KoneLab Lecture, which this year has been awarded to Professor P. L. M. Jansen from the University Hospital of Groningen, who will give his talk entitled 'The molecular basis of jaundice'. This will be followed by three parallel sessions before lunch:

- Clinical Audit
  Convenor: Dr Julian Barth
- Update on Paediatrics
  Convenor: Dr Anne Green
- Bayer Award Presentations

After lunch there will again be three parallel sessions on different topics:

- Down's Screening: Current controversies
  Convenor: Dr David Worthington
- Update on Toxicology
  Convenor: Dr Robin Braithwaite
- Members' Papers

The day will finish with the Association's Foundation Award lecture entitled 'Increasing the power of antibodies as diagnostic and therapeutic tools', to be given by Professor Colin Self from Newcastle.

The Annual General Meetings of the ACB will be held after the scientific sessions on Wednesday 17th May 2000, the day before. A social event is being arranged for that evening with the usual ACB hospitality!

Details about costs and booking arrangements are in the Pathology 2000 'Invitation to Participate'.

Further details of the programme will be published in the next issue of ACB News. ■

“He says he works here and he’s contracted the millennium bug!”

Four Jobs . . . Any Takers?

By Richard Spooner, *Associate Editor and Investigative Reporter*

For some time the ACB News Situations' Vacant section has had very few adverts for high Grade B Scientists. Much has been made of this, with blame being placed at the door both of NHS Advance Letter, ALSP 1/90, leading to a series of "artificial" promotions, together with senior colleagues who have allowed posts to be lost or upgraded in post. Another view is that many entering the profession may not have had aspirations to become a Consultant Clinical Scientist. Interestingly, many of the Top and Principal Biochemists, who were upgraded under ALSP 1/90, are now starting to retire. There would appear to be every opportunity for fast-track advancement from the lower Grade B posts for those with suitable training and experience.

With this background, I was pleasantly surprised to see five attractive vacancies in the Situations' Vacant section of the July ACB News. I thought it would be interesting to follow the appointment process for these posts. The Consultant Scientist post at Boston, Lincolnshire, went to the internal candidate Philip Hyde. Philip's post is now advertised and so the chain continues. So, let us concentrate here on the four Grade B posts which were all at point 17 or higher and thus at the Principal Biochemist end of the scale.

Pathology Directorate

Clinical Biochemist

Grade B Points 17 - 19

Applications are invited for this newly created post of Principal Biochemist in the Department of Biochemistry. The postholder will act as Deputy to the Head of the Department with responsibilities covering all services provided by the Department including the provision of pre-natal screening.

Candidates should possess suitable professional qualifications. They will be expected to have general training in Clinical Biochemistry and have developed an interest and expertise in a specialised area.

For further information about the post please contact Dr Gwyn McCreanor, Consultant Clinical Biochemist on 01536 492692.

Application form and job description available from Chris Pallot, Directorate General Manager, Kettering General Hospital NHS Trust, Rothwell Road, Kettering, Northants NN16 8UZ. Telephone: 01536 492671.

Closing Date: 11th August 1999 **www.personnelnet.com**

Kettering General Hospital NHS Trust

Accredited by King's Fund Organisational Audit

We operate a No Smoking Policy which limits smoking to designated areas. An Equal Opportunities Employer.

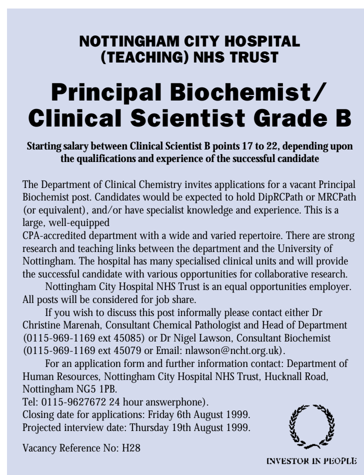
Delivering the Best Possible Healthcare

Kettering General Hospital

Dr Gwyn McCreanor

Gwyn was appointed as a single-handed Consultant Scientist in February 1999, following the retirement of Richard Aitken. Gwyn has moved out of The Royal Free in London and reports that working in Kettering is both challenging and very enjoyable. As a condition of her appointment Gwyn secured the promise to appoint a Grade B Clinical Scientist.

After the advert only three applications were received for this Grade B17-19 post and two were interviewed. Kettering is within commuting distance of Birmingham, but interestingly no-one from this area of high-density Clinical Scientists applied. At interview no appointment was made and the post was re-advertised at lower scale points.



Nottingham City Hospital

Dr Nigel Lawson

When Jean Wardell moved to become Head of Department at Doncaster over the summer, the City Hospital management quickly agreed to a replacement. Jean's specialty was in paediatrics, but an advert was placed seeking to appoint an experienced scientist to Grade B17-22. The untimely death of Colin Selby created a second

Angela Whitehurst working in the Nottingham City Laboratory

vacancy. Seven applications were received, and four people were interviewed.

The successful candidate, conditional upon her obtaining her part 1 MRCPath, was Angela Whitehurst, an internal candidate at Grade B16 who had deputised in Paediatrics. Angela was an MLSO before taking an Open University degree and has since done an MSc in Nottingham. Certainly Nottingham City continues to demonstrate that the Clinical Scientist grade is open to everyone with relevant qualifications and experience.

No candidate had the necessary endocrinology experience to fill the second vacancy and this has now been readvertised. Nigel Lawson has now created a further position, a three year higher specialist training post, and this continues the emphasis on quality Grade A Training at Nottingham City Hospital.

The Royal Free Hospital, Hampstead

Mr Mike Thomas

After a previous difficulty with an appointment to Gwyn McCreanor's position when no shortlist was drawn up, there was a good response to this inner London post. From nine applicants, seven people were short-listed. Candidates were willing to move from as far afield as the North West.

Half of the candidates sought appointment at Grade B17-19 and half at Grade B22-24. This was an unusual situation arrived at after discussion with the assessors. The preference was to replace like with like, Gwyn had been a Grade B24, but the department was willing to downgrade the post for the right candidate and the three who applied at the lower grade were judged to be excellent candidates.

Helen Smith was the successful candidate. Having moved across London to her current post, she wanted some teaching hospital experience and hopefully some more academic experience to help career progression. Helen is able to commute to the Royal Free and hopes to maintain her existing life-style in Ilford.

ROYAL FREE HAMPSTEAD NHS TRUST
DEPT OF CLINICAL BIOCHEMISTRY

CLINICAL BIOCHEMIST
GRADE B

(Scale within range 17-24 depending on experience and qualifications)
Salary £28,208-£36,404 pa inc

Applications are invited for this vacancy whose duties will include particular responsibilities for a part of the routine analytical service and the possibility of becoming deputy to the Top Grade (Consultant) Biochemist.

You should have considerable experience in all aspects of clinical biochemistry and possess an appropriate higher degree and relevant postgraduate qualification. You should already have the Diploma of the Royal College of Pathologists and be actively seeking to complete full membership of the College at the earliest opportunity.

A particular interest in, and experience of, one or more of the following areas would be advantageous: endocrinology, oncology including the use of tumour markers, toxicology and TDM or near patient testing.

For further information contact: Dr Michael Thomas, Top Grade (Consultant) Biochemist on 0171-830-2991.

For an application pack and full job description please contact the Human Resources Department at the Royal Free Hospital, Pond Street, Hampstead, London NW3 2QG. Tel: 0171-830-2064. Please quote ref: OP/CB/674.

Closing date: 3rd August 1999

Committed to Equal Opportunities

South Durham Healthcare NHS Trust

Dr Stuart Smellie

There were 25 expressions of interest for this post, but ultimately only three applicants, all of whom were interviewed. The post became vacant on the retirement of a Grade C. After much internal discussion it was agreed that the best use of the money was to appoint to the top of the B scale and add to the technical complement to help handle a growing workload in Bishop Auckland and Darlington.

The successful candidate was Jenni Johnston. Currently a Grade B18, she has been in Glasgow for 23 years. In fact this was the only post of the four advertised in July that she applied for, feeling she had the appropriate experience for this post in particular. With no ties and a difficult situation developing as Glasgow continues to restructure, Jenni felt that this move was appropriate for her lifestyle.

SOUTH DURHAM HEALTH CARE NHS TRUST

CHEMICAL PATHOLOGY

Clinical Biochemist

Grade B

Scale Points up to 24

£18,188 - £34,065 pa - Ref 420/99

This Trust includes two acute sites at Bishop Auckland and Darlington General Hospitals. The department is seeking a senior grade B biochemist to play a lead role in developing and providing biochemistry services to the Trust and district general practices.

You will be expected to participate in all aspects of district general hospital biochemistry, with a specific emphasis on the following:

Supervision of internal and external quality control issues across both sites.

Quality issues relating to CPA accreditation.

Development of common investigation strategies for the two sites.

You will also be expected to participate in all aspects of routine biochemistry reporting.

You should possess the MRCPath and have proven experience in management of quality issues and preferably an interest in laboratory computing.

For further information and to visit the laboratory, please contact Dr Stuart Smellie on 01388 454064.

For application details please contact (01325) 743 654 (24 hour answering service) Closing date: 15.8.99

We positively welcome applications from all sections of the community

Jenni Johnstone of Bishop Auckland and Darlington

Conclusions

It would appear that there are presently about 30 people in the profession who feel they are ready to take on the responsibilities associated with a high Grade B Clinical Scientist appointment. However, only about 25% are willing to commit themselves to an application and many of these may not have the depth of experience required by the responsibilities. These low numbers may reflect a "comfort factor", perhaps a working partner or children at school. Anecdotally, there appears to be problems with removal expenses and, unlike the 1970s and 80s, the triplet structure makes it hardly worth the personal upset for a few thousand pounds. This theme is expanded in the Personal view below. However, middle Grade B's hardly ever make a direct move to Grade C.

Appointments Notified

	Advertised Posts			Internal Regradings/ Not Advertised		
	Grade C	Grade B	Grade B	Grade C	Grade B	Grade B
1997-98		4	5	2	8	1
1998-99	1	2	4	5	1	1
1999-Oct 99	2	3	2	1	1	1

The assessors continue to influence the shape of the profession and time-serving in lower grades would appear to be an important factor in the decision-making process. However, this should not stop those with the training, qualifications and flair from being able to move swiftly up the career ladder. It is clear that there are a lot of excellent candidates bubbling through the lower ranks and the one benefit of suggesting downgrading posts is that we can keep more of these people in the profession. Perhaps the assessors themselves need to revisit their criteria for appointment to high Grade B posts. This was a small survey, but the three successful candidates were all female. ACB News wishes them well in the future and wonders whether we need another article on "glass ceilings"?

A View from the Middle of the Ladder . . .

Name Withheld but details are: Female, FRCPath, Clinical Scientist for more than 20 years.

As someone who is suitably qualified for the posts in the July ACB News and didn't apply for any of them, may I offer a comment or two.

I accept that from the point of view of honing professional skills the experience of having worked in several departments around the country is probably invaluable. Different departments will vary in their priorities and ways of delivering a service. There are the advantages of having more people to share inspiration and enthusiasm with and the opportunity to gain a wider experience of specialist services. All good stuff I have no doubt, but at what personal cost?

The days of a family or couple with a single career to follow are fading

fast. I still feel somewhat heretical in saying this, but I do not think that the profession can expect the pursuit of a career in clinical biochemistry to remain the overriding objective in the lives of its members. For those that still propose this, might I suggest that such single-minded ambition could be seen as selfish.

Compromise for working couples is inevitable. Managing two careers and a family is hard work. Reliable child-care arrangements and schooling are very important. Being known in a neighbourhood provides support and being near elderly parents is reassuring. Who has the largest salary and who has the best prospects? Can we afford two 'homes'? Do we want to live apart and spend the weekends travelling? Is this really a good idea for us? Is it financially worthwhile. How long could we do it for? Could you persuade your partner to jeopardise their career for the progression of your own? These are some of the choices that I suspect an increasing proportion of the profession are having to face when they see vacancies in the ACB News for which they would like to apply, but which may be hundreds of miles away. I suspect these choices are even starker for women just because of the way that the dice can be loaded.

We share these problems with other specialist professions and gradually even the medical profession is trying to do something about it. Some people do make huge personal sacrifices in the furtherance of a partner's career but maybe they know that it is only for a couple of years and then something else will 'come up'. Often for them the ultimate prize is bigger. How far would the extra salary of a high Grade B post go in paying for extra week-time accommodation and weekend travelling not to mention extra childcare?

If there are others in our small profession who relate to my comments, what can we do about it? Working on the premise that a clinical biochemist with wide experience is a better clinical biochemist why, with limited opportunity for promotion, can't we start using words like 'exchange' and 'rotation' much more often in our job descriptions? Why can't ways be found to maximise professional experience within a geographical area? If the current situation continues, promotion to the top will become restricted to the singularly unattached, the one career family and the fortunate. . . and how many of those are there in real life? To improve professional development and prevent loss of highly trained scientists from the NHS the profession must adapt to modern lifestyles.

Comment Invited: In the year 2000 ACB News will be looking at a number of key areas. Articles are meant to stimulate a response and discussion so please do send us your thoughts. ■

ACB National Training Day for Trainees, Pathology 2000

Austin Court, 19 May 2000, Birmingham

At Pathology 2000 next Spring a Training Day will go ahead as usual. The major change this time is that it will take place at the end of Pathology 2000 week on **Friday May 19th.**

Format

Following last year's successful format of the ìsplitî Training Day, this will be continued. There will be two groups: Group A (largely Grade A's and lower Grade B's) will receive lecture-based presentations. Group B (largely pre-MRCPath Grade B's and Specialist Registrars) will receive a more interactive, tutorial-based presentation. One improvement this year will be an attempt to accommodate all applicants for Group A (Last year group size was limited to about 20).

Venue

Teaching will take place in rooms at Austin Court which is adjacent to the International Convention Centre. Full details will be circulated to all Trainees registering to attend.

Teaching topics

Topic 1: Acid-base	*Dr J Hooper, London*
Topic 2: Clinical Governance	*Dr D Freedman, Luton*
Topic 3: Quality Assurance inc. NEQAS interpretation	*Dr G Challand, Reading*
Topic 4: Liver disease	*Dr W Marshall, London*

Arrangements

Teaching will begin at 10.30 a.m. Those registered for Pathology 2000 should book accommodation through the Birmingham Convention and Visitor Bureau (details will be circulated to all delegates registered for Pathology 2000). Trainees intending to come *only for the Training Day* and needing overnight accommodation should seek advice from the Pathology 2000 Office.

Cost

The cost for the day including food (but exclusive of any accommodation) is £45. Applications should be made on the form in this issue of ACB News and returned to the ACB Office. ■

ACB National Training Day for Trainees, Pathology 2000

Austin Court, 19 May 2000, Birmingham

BOOKING FORM

Title: .... Surname: .... Forename: ....

Departmental Address: ....

....

....

Grade: .... Qualifications: ....

Present Position: ....Years in Clinical Chemistry: ....

Exams to be taken and the proposed date: ....

Registration

❑ Group A Suitable for grade A and lower grade B Clinical Biochemists

❑ Group B Suitable for pre-MRCPath grade B Clinical Biochemists and Specialist Registrars
Numbers for Group B are limited to 20 so bookings will be dealtwith on a first come, first served basis.

Please tick the appropriate box.

Please state any special dietary requirements:

Payment

I enclose a cheque for £45
(made payable to the Association of Clinical Biochemists)

This form and payment should be returned to the ACBAdministrative Office, 2 Carlton House Terrace, London SW1Y 5AF, by March 31st 2000

Signature: .... Date: ....

The Royal College of Pathologists

Part 1 Examination – September 1999

Chemical Pathology
First Paper

Candidates must answer FOUR questions ONLY
Time allowed – Three Hours

1. Discuss the advantages and disadvantages of point of care (near patient) biochemical analysis in a district general hospital and describe how you would ensure appropriate laboratory input to this process.

2. Give a critical account, with examples, of the methods available for the assay of bioactive amines in body fluids.

3. Discuss the role of the clinical biochemistry laboratory in the management of patients with poisoning.

4. Write an account of the acquired causes of dyslipidaemia.

5. Discuss the biochemistry and physiology of magnesium in health and disease.

Second Paper

Candidates must answer FOUR questions ONLY
Time allowed – Three Hours

Either

1. Discuss the clinical presentation, diagnosis and management of thyrotoxicosis.
   Or
   Write a specification for a biochemical analyser to measure 'electrolytes', urea, creatinine, glucose, calcium, phosphate and 'liver function tests' in a district general hospital with a present workload of 700 requests daily but predicted to increase at a rate of 8% over the life of the instrument.
2. Discuss the syndromes of renal tubular acidosis with particular reference to their pathogenesis and diagnosis.

3. Give an account of the principal causes and consequences of hypophosphataemia.

4. Write a protocol for the laboratory investigation of delayed puberty in boys.

5. Write short notes on:
   a) soluble transferrin receptors
   b) free prostate specific antigen
   c) cystatin C. ■

Council Delighted with New Chairman

Reported by Dr Sandra Rainbow, *Assistant Secretary*

The Autumn meeting of the Council took place on the 28th October 1999. This was a busy meeting with important topics being discussed

Association of Clinical Scientists

The creation of a single professional organisation, the Association of Clinical Scientists (ACS), had been suggested. This will be the body to which the Clinical Scientists Board will refer to for issues relating to education, training and competency for registration. The ACS will be completely separate from the Clinical Scientists Board and all Professional Bodies with a minimum membership of 50 will be entitled to nominate a member for the ACS; larger organisations will be entitled to further seats for each additional block of 500 members. The draft memorandum of association of the Association of Clinical Scientists was presented to Council for discussion and comment. As a consequence of the creation of the Clinical Scientists Board, the NHS has asked CPSM to broker a meeting between the Clinical Scientists Board and the MLT Board to discuss the setting of standards for each board and procedures to allow individuals to transfer between professions. The first meeting has been held and there was useful dialogue about setting of standards. In due course, there will be guidelines sent to Trusts about employment of clinical scientists and their need to be registered. More detailed information on registration issues will be reported in ACB News in due course.

Professor Price, Chairman of the Registration Council for Scientists in Health Care presented a paper on the recent developments regarding the creation of a Clinical Scientists Board on CPSM. Professor Price has been asked and has agreed to chair the Clinical Scientists Board. The details of when the new register will be opened and how initial registration is to proceed has still to be established. The summer period had been a busy time and a meeting took place between the professional organisations whose members would be registered on this board.

ACB Organisation

The structure and functions of the ACB organisation had been discussed (in view of boundary changes to NHS Regions) at Executive Meetings over the summer and letters had been sent to all Regional Representatives and National Members asking for their personal opinions of this issue for discussion at Council. Discussion indicated a split between a desire to reorganise the Regions round one or more NHS Regions and a wish to retain existing ACB Regions due to geographical and transport constraints and existing relationships. The problems that had been previously flagged up related to negotiations for Regional funding of training posts where the ROELs wished to deal with one person across the whole NHS Region and some were unwilling to

talk to regional tutors who were still representing cross boundary areas. The workload for a single regional tutor across an entire NHS Region was acknowledged to be too great. There were two issues to be addressed; working with members and regional representation. It was agreed that regional representatives needed to be co-terminus with NHS Regions and that Wessex was the main problem in that it was now transferred to the new Southern NHS Region. It was agreed that this topic should be further debated at the executive retreat in November so that proposals could be circulated to regions and formally debated at the Spring meeting of Council with any changes being presented for ratification at the AGM in May 2000.

Hallworth to Become Chairman

The succession planning of the executive officers was discussed and executive reported that it was increasingly difficult to find people who were able to commit the time to take office. This was particularly a problem with the position of Chairman. Council was therefore delighted to hear that Mike Hallworth had indicated his willingness to stand and the meeting unanimously voted in favour of electing him as Chairman.

The Chairman reported that he was not intending to propose any major changes for the next AGM, but there were a few byelaws that needed refining for housekeeping purposes. Council Members were reminded that any nominations for emeritus and honorary membership of the Association needed to be sent to the Honorary Secretary prior to the Spring Council Meeting.

Award Lectures and Pathology 2000

The National Meetings Secretary reported that there had only been single nominations for the award lectures this year. The Roche Lecture would be part of Pathology 2000 and the Kone and Foundation Awards would take place during the Satellite Meeting. Council approved the award nominations. The organisation of Pathology 2000 was progressing well and the ACB satellite meeting was being booked through the Pathology 2000 organisation. The scientific programme was being organised by Janet Smith and David Worthington. It was hard to incorporate all the elements of Focus into the satellite day, but the Bayer Award would be held on the Thursday and a training day for trainees was to be held on the Friday. Management and update sessions for senior members of the profession were not going to take place this year.

Focus 2001 would take place in London at the beginning of May 2001 and Mike Thomas from the Royal Free Hospital was chairing the local organising committee. A request for nominations for the 2001 award lectures was being placed in ACB News in the next month.

Financial Position

The Association Treasurer reported that he was now preparing quarterly financial reports that were being discussed as a formal item at Executive and he was intending to extend this to the Standing Committees. The current financial situation of the Association was currently £26,000 down on the same period last year. We are currently in a 'cash-light' position due to the lack of income from an up-coming Focus meeting and there was still

the need for further loans to Pathology 2000. The VAT inspectors had visited in the summer and the final situation was that we owed them £2000 and this has been paid. The Association Treasurer was happy to report that Focus 99 had been a financial success.

There were reports from Scientific, Publications, Work Force and Education Committee Chairs, which should be reported elsewhere in ACB News. This was Professor Noor Kalsheker's last attendance at Council as Chair of the Scientific Committee and the Association Chairman thanked him for all his efforts in restructuring the committee and his contribution to the committee. Dr Bill Fraser was the new Chair of the Scientific Committee.

The Association Treasurer gave a brief report on the central Modernisation of Pathology (England) committee on which he had been invited to sit. The committee had invited outline business cases from a selected group of bids and they had recommended to Ministers that money varying from £40,000 to £1.8 million be awarded to the successful Trusts. The capital available for this year had already been cut in half (only £5 million for this year) at the Ministry prior to being released, and there was no guarantee that money would be available next year. Dennis Wright will write further articles on this topic.

Hilary Returns to Wales

The Corporate Members Chairman reported that a very useful meeting regarding future development of Focus had been held between the National Meetings Committee and the Corporate Members Executive prior to the Corporate Members Meeting at the RAF Club in October. They were fully in favour of continuing the associate specialist sessions that had been instigated at Focus 99, but agreed that they needed to be more proactive. Judy Jackson was taking over as Chair of the Corporate Members and Chris Savory as Secretary and Maggie Throup had been persuaded to remain as National Meetings representative.

The Association Chairman reported that Dr Graham Beastall had been elected to the Royal College of Pathologists Council and Professor Chris Price had been elected to the Board of the American Association for Clinical Chemistry and Council congratulated both of them.

The Association Chairman reported that he had met with members of AACC and co-signed a draft Memorandum of Association between the two organisations, which would cement the arrangements for working together in various areas.

The Association Chairman reported that Hilary Crosweller had written to inform him that she intended to resign and leave the employment of the Association at the end of March 2000, when she would be returning to live in Wales. ■

Post Mortem Toxicology Fees Payable by HM Coroner

Joint Negotiating Committee for Doctors Assisting Local Authorities

From Annex to DC Circular No 30 effective from 1st October 1999 and published 5 November 1999.

Fees Payable by the Coroner

Under Section 24(2) of the Coroners' Act 1988 local authorities "may from time to time make a schedule of the fees, allowances and disbursements which may be lawfully paid or made by a coroner in the course of his duties". The following fees are included in that schedule:-

Mileage Allowance

Rate per mile payable to a medical practitioner who travels, at the request of the Coroner, to view a body where it has been found - 54.4p per mile.

Medical Report

For a full written clinical report, without an examination, furnished by a medical practitioner at the request of the Coroner (the payment of this fee is not to be contingent upon the holding or otherwise of an inquest) - £29.50

For an extract from a doctor's records (other than over the telephone) - £ 21.00

Special Examinations

For carrying out a special histological examination at the request of the Coroner (under Section 20(1)(b) Coroners' Act 1988) - Not exceeding £149.90 (or £16.30 per block whichever is less)

For carrying out special bacteriological investigations at the request of the Coroner, not including those provided by the Public Health Laboratory Service in the course of investigations which fall within the overall responsibility of the service - Not exceeding £149.90 (or £16.30 for each direct examination and culture whichever is less)

For carrying out a special toxicological examination of organs for identification of unknown poison (under Section 20(1)(b) Coroners' Act 1988) - Not exceeding £410.70

For examination of blood, urine or other body fluids for a specified substance (quantitative) - £48.80 (£33.30 each subsequent fluid in relation to the same case)

Other Services

Nothing in this schedule prevents a Coroner from paying an appropriate fee (in consultation with the paying authority) in respect of professional services not covered by a nationally prescribed fee.

Dr S J Evans
On behalf of the Regulating Committee
November 1999

Notes

My interpretations of the above fees are given below.

1. The fee payable for an ethanol and a paracetamol determination on a single whole blood sample is 2 x £48.80 = £97.60

2. The fee for an ethanol determination on both whole blood and urine samples is £48.80 plus £33.30 = £82.10 ■

Continuing Education in Clinical Biochemistry:

A Personal View of Grasmere '99

By Edmund Lamb, Kent & Canterbury Hospital

On Man, on Nature, and on Human Life

I attended the tenth "Continuing Education in Clinical Biochemistry" symposium at the end of November. As usual the topics selected covered a range of contemporary issues and allowed ample time for discussion both inside, and outside, the lecture programme.

In the opening lecture, Professor Geoff Holly from Bristol Royal Infirmary, gave an up-to-date account of the biochemistry of the insulin-like growth factors (IGFs) and of the binding proteins and proteases involved in their regulation. Choosing not to dwell on the clinical applications of IGF measurement, Professor Holly presented us with the recent strong epidemiological evidence linking IGFs with various types of hormone-dependent cancer. The Health Physicians' Study (Science 1998) has shown that each 100 ng/mL increase in IGF-1 is associated with a doubling of the risk of prostate cancer. Similarly, increasing levels of IGF-1, in The Nurses' Study (*Lancet* 1998; **351:** 1993), were strongly positively associated with breast cancer risk. The relationship may be explained by nutritional influences (possibly early in life) on the ratio of IGF-1 to its main binding protein (IGFBP-3), which in turn influences the rate of cellular apoptosis. Clearly IGF-1 has significance far beyond its use as a marker of growth hormone secretion, although for practising clinical biochemists this would still appear to be its main use.

Turning to more familiar ground, Professor Larry Demers (Penn State University) described his work, as part of the United States Standards of Laboratory Practice Symposium on Thyroid Disease (*Clin Chem* 1996; **42:** 119), in developing National Academy of Clinical Biochemistry Guidelines for laboratory support in the diagnosis and management of thyroid disease. Whilst these guidelines have much in common with UK practice, there were some clear differences. For example, screening for hypothyroidism in individuals over 60 years of age was advocated. Thyroid antibodies did not seem to have a major role in diagnostic decision making on the other side of the Atlantic, particularly in the context of sub-clinical hypothyroidism. More recently, and perhaps controversially, the US Endocrine Society (http://www.endo-society.org) has recommended screening all pregnant woman for thyroid disease due to an association between maternal hypothyroidism and intellectual impairment in the offspring (*NEJM* 1999; **341:** 549). Although the practical details of this screening programme have yet to be worked through, several delegates questioned its value, given that foetal neurogenesis is most likely to be dependent on an adequate maternal

thyroid hormone supply in the first trimester. Whilst consensus guidelines on thyroid testing developed in the US should, in theory, be transferable to the UK, the ensuing discussion confirmed what we all know; that all clinical biochemists have strongly held individual views on thyroid function testing!

Not choice
But habit rules the unreflecting herd

The following morning Professor J Connell (Gardiner Institute, Glasgow) treated us to a superb exposition of the role of the genetics of the renin-angiotensin-aldosterone system in the development of hypertension. This talk was packed full of fascinating information: for example that individuals who are homozygous for the ACE "insertion" allele (II, low serum ACE activity) are more likely to complete an army training and become top mountaineers than those with a double dose of the "deletion" allele (DD, high serum ACE activity). Conversely, DD individuals are at increased risk of heart disease, stroke and peripheral vascular disease and are less likely to show a sustained fall in blood pressure in response to ACE inhibitors.

The good die first,
And they whose hearts are dry as summer dust
Burn to the socket

The mechanism of these effects may relate to local growth promoting effects of angiotensin 2, concentrations of which are increased in DD individuals. Similarly, aldosterone concentrations are higher in DD than II individuals. It is also clear that interpretation of a one-off serum ACE activity measurement is meaningless in the absence of genotypic information. However, sequential monitoring of patients with known sarcoidosis may still be of value.

O joy! that in our embers
Is something that doth live
That nature yet remembers
What was so fugitive!

Professor Connell went on to describe commoner polymorphisms of rare inherited tubulopathies (e.g. a defect of the amiloride-sensitive sodium/hydrogen exchanger which may account for a common form of low renin hypertension in the black population) and a polymorphism of the 11-β-hydroxy steroid dehydrogenase gene which may account for "salt-sensitive" hypertension. Unsurprisingly, the discussion which followed this talk focused on the diagnosis of Conn's syndrome. Professor Connell argued for a lowering of the threshold of suspicion: for example, any hypertensive patient resistant to treatment with more than two

anti-hypertensive agents should be investigated. Further, he argued that although drug interferences cause problems in the interpretation of renin and aldosterone results, they were unlikely to cause false negatives: a random renin and aldosterone request without drug restrictions was therefore reasonable in the out-patient setting. Any positive results could then be followed up with all of the normal drug restrictions. Finally, normal serum potassium should never be a criterion on which any patient is excluded from investigation. Time to re-write those SAS handbooks?

By Grace divine,
Not otherwise, O Nature! we are thine.

Dr Waring (University of Birmingham) began by describing genetic variation in the smell of urine following asparagus ingestion. This was an early example of pharmacogenomics (asparagus has a diuretic action), a field which promises to make pharmacotherapy more sophisticated by tailoring it to the genetic composition of the individual. Individual responses to drugs are the result of polymorphic variation around the cytochrome p450 series of enzymes and the second-phase sulphation, acetylation and glucoronidation metabolic pathways. For example, patients with low levels of the cytochrome p450 enzyme 2C9 are more likely to have an adverse response to warfarin. Dr Waring predicted a future in which individual genomic and proteomic information was included in patients' hospital records (hopefully electronic by then!).

Cold, pain, and labour, and all fleshly ills;
And mighty Poets in their misery dead.
–Perplexed, and longing to be comforted,
My question eagerly I did renew.
'How is it that you live, and what is it that you do?'

A breath of fresh air was called for and this came in the form of an early afternoon walk around Rydal Water. The persistent rain, which had threatened to dampen spirits, stopped within five minutes of the start of the walk giving way to a wonderful fresh afternoon spent in good company.

Of all that is most beateous – imaged there
In happier beauty; more pellucid streams,
An ampler ether, a diviner air,
And fields invested with purpureal gleams.

This was followed by Dr Peter Gosling (Selly Oak Hospital, Birmingham) describing his experiences of providing laboratory support to an intensive treatment unit (ITU). Dr Gosling concentrated on his work using urinary

albumin as a marker of the vascular response in ITU patients suffering from systemic inflammatory response syndrome. Albuminuria on admission predicts outcome in ITU patients. Further, it can be used as a marker of the efficacy of various infusion systems (e.g. starch infusions) for maintaining vascular integrity and preventing capillary leak. It would seem that there really is a clinical role for urinary albumin measurement in this setting, at a time when its value in the management of diabetes is being questioned.

The moving accident is not my trade;
To freeze the blood I have no ready arts:
'Tis my delight, alone in summer shade,
To pipe a simple song for thinking hearts.

The afternoon ended with a series of clinical cases which generated lively debate. These included cases of non-accidental injury (biochemical evidence used in court), MEN1 (hyperparathyroidism and insulinoma), familial hypercholesterolaemia (both parents affected), hyperkalaemia (due to heparin), acaeruloplasminaemia (due to reduced hepatic synthesis), positive triple test (due to an acardiac twin) and possibly the first ever reported case of a patient with primary hypothyroidism and a TSH'oma.

On the final morning, the second of our international speakers, Dr Peter Wilding (University of Pennsylvania), described the progress that has been made towards miniaturisation of diagnostic devices and the problems which have been encountered in their development. These devices use reagent and sample volumes of <1 µL and have a range of applications including point of care testing, *in vivo* monitoring and genetic testing. Despite the large amounts of money being invested in these developments, one was left with the impression that diagnostic applications in the market place were not imminent. Hold on to that sluice!

Enough, if something from our hands have power
To live, and act, and serve the future hour;

This excellent meeting ended with a change in its traditional format, allowing presentation of four audits that had been conducted by delegates. Dr Michael Murphy (Derriford, Plymouth) described an audit of urgent test requesting. Interestingly, the vast majority of out-of-hours requests were deemed appropriate. The majority of inappropriate requests (mainly "in-hours") arose for administrative reasons (e.g. result required for ward round, but sample had missed porter's round). This latter problem may be superseded by moves towards extended hours; the majority of delegates had some pattern of extended service operating in their laboratories. Dr David Stansbie (Bristol Royal Infirmary) had used an on-line questionnaire to develop junior doctors knowledge of non-thyroidal illness. With a sharply witty edge, this had proved an excellent audit tool although, as always, lessons were soon forgotten. Mr Colin Samuell (UCLH, London)

presented a breakdown of the reasons why a laboratory may fail to report a result. Only 0.61% of all requests failed to be reported (for example due to inadequate labelling, incorrect sample or sample timing, inappropriate request). Despite user perception, a problem with which we are all familiar, laboratory mishaps occurred with <0.001% of requests. Finally, Dr Gordon Challand (Royal Berkshire Hospital), gave an account of his "Cases for Comment", which he hopes to develop into a formal quality assessment scheme. His cases have now attracted participants from 26 countries, been translated into 4 languages, and attract 40-50 replies each week. From Dr Challand's presentation, it is clear that we have a professional problem with interpretation. Perhaps of most concern, is a tendency for participants to over-interpret when they have inadequate clinical information. Whilst a QA scheme may help, there are problems (lack of gold standard, expert opinions will differ, it will not mimic real life and some clinical biochemists may feel threatened by it). Additionally, over the two years that his current scheme has been operating, there is very little evidence that the quality of interpretation has improved.

As usual, this meeting provided much food for thought and enabled one to focus on professional matters with colleagues facing similar challenges, in an atmosphere that is unique. The organisers are again to be congratulated. I would like to extend my thanks to Instrumentation Laboratory for supporting this meeting and to the staff of the Wordsworth Hotel for providing the perfect setting. ■

A genial hearth, A hospitable board,
And a refined rusticitiy.

Dr Joyce Lilian Bell

1931–1999

Joyce Bell (who used her surname from her first marriage professionally) came to the Department of Chemical Pathology at the Royal Free Hospital in 1955 as its first Hospital Biochemist: she had completed a PhD at the Institute of Psychiatry. She stayed until her retirement as a Top Grade Biochemist/Consultant Clinical Chemist in 1990, being in charge of the ever-expanding scientific side of the analytical work, and of the increasing number of hospital biochemists. She had a major role in planning the department for the new hospital in Hampstead. In 1981-83 she went on study leave to organise Clinical Chemistry at the Armed Forces Hospital in Riyadh, Saudi Arabia. She was much liked and respected in the department and throughout the hospital; extremely good at her job, committed to the contribution of the department to clinical care, always cheerful despite the inevitable stresses of her position, and a pleasure to have as a colleague.

In addition to her analytical responsibilities, she took a share of medical student and postgraduate teaching in the department (as an honorary senior lecturer and of administrative committee work in the hospital and region. Her research work with colleagues within and outwith the department, leading to many publications and conference talks at home and abroad, concentrated on diabetes mellitus especially in Saudi Arabia, and on clinical enzymology. She was the biochemist member of the team that first published in the UK on using serum aspartate transaminase, then called S-GOT, in the diagnosis of myocardial infarction.

She was an expert sailor despite her diabetes, and in recent years concentrated her talents on music and gardening. She leaves a daughter and grandchildren, and made a happy second marriage in 1978 to Dr Robby Bacchus whom she met at the Royal Free. She died from carcinoma of the lung on 17th October 1999.

D.N.B.

Letters

Readers speak out

Disgraceful Academic Anomaly

Receipt of a letter from Administration at ACB Head Office appears, at last, to recognise the discrepancies that exist in the remuneration of Academic Clinical Biochemists. As a general rule the Federation does not represent the interest of those members of the Association who are not employed in the clinical scientist designation and who, nevertheless, pay a full subscription to the Assocation.

It may interest the Association to know that non-clinical senior lecturers/readers at the top of their salary scale earn £10,000 per annum less than Grade C scientists without advancement, and £25,000 less than a clinical senior lecturer without a merit award. Unlike non-consultant clinical scientists and medical specialist registrars, academic clinical biochemists are not paid for more than 37.5 hours work, nor do they enjoy 30 days statutory annual leave, and don't let anybody kid you that university staff disappear at the end of June and are not seen until the first week of October! Oh, and by the way, you may well have heard of the Research Assessment Exercise, QAA and teaching assessment!

I am sure the biggest anomaly of all has already been pointed out, i.e. net of tax, consultant scientific and medical staff pay a smaller subscription to the ACB than the vast majority of the Association members.

To declare my interest and answer the question of the aforementioned letter, I am a non-clinical senior lecturer, at the top of the scale, earning less than a Grade B clinical scientist at the top of his/her scale.

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Emphasis on Communication Skills

I read with interest the various comments on the recent article by Dr Marshall on reporting of biochemical tests. It appears to me that there is not much emphasis on the need to take into account the overall clinical condition of the patient in the interpretation of biochemical tests. Recently, whilst authorising the endocrine list, I came across the results of a young lady whose thyroid function tests showed hyperthyroid levels. On further discussion with the general practitioner, I found out that she was on suppressive doses of thyroxine (which was appropriate) for a previous thyroidectomy for Ca thyroid. She did not have Grave's disease.

Clinical Chemistry here at the Royal Liverpool University Hospital is very 'clinical' in many ways. We play a significant role in the investigation and management of patients with mineral metabolic disorders in addition to other services. Our interaction is not only limited to general practitioners but also to hospital medical staff as well. Most of the time this communication is over the telephone but occasionally we have had to review the patients and their treatment sheets in the ward. Quite a few have had hyponatraemia with a diagnosis of syndrome of inappropriate antidiuresis who actually were on diuretics!

Except for the obvious, laboratory tests may not be interpreted correctly, as Dr Marshall has pointed out, without taking into consideration the overall clinical picture of the patient. This requires that we possess good communication skills as we liaise with out colleagues, as the overriding goal is that the correct interpretation of laboratory tests should result in further investigations and/or appropriate treatment of the patient.

Maybe (my experience is very limited!!) this requires some emphasis.

Dr E. Abu
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Is Chemical Pathology a Scientific Speciality?

As a non-member of the Association I am grateful to have the opportunity to comment on the issues of appropriate training in clinical biochemistry. As Professor Reynolds describes, the profession has very diverse interests and a clinical straight jacket examination (MRCP) might not be appropriate for all. It opens to a profession notable for its low clinical status to service as a repository for those not good enough to get substantive Specialist Registrar jobs in clinical medical specialities while disadvantaging those who wish only to practice scientific laboratory medicine. This pre-qualification also serves to homogenise chemical pathology into the medical specialties such that, like many consultants in haematology, eventual laboratory involvement will be virtually zero. MRCP status will also probably eventually mean that chemical pathologists end up on the general medical on-call rotas in district general hospitals (DGHs) given the shortage of consultants for a consultant-based service.

Chemical pathology is supposed to be a distinct speciality with special kills in assays and pathway interpretation, laboratory automation and management. Thus its entry qualifications should be those best suited to identifying people with a talent for the interpretation of numbers and biochemical pathways. This is not the point of the MRCP which is designed to identify doctors with the skills for making obscure diagnoses based on clinical symptoms and signs. If chemical pathology is supposed to be a scientific specialty then the qualifications for entry should b a MSc standard degree or higher in academic or clinical biochemistry with some evidence of exposure to general hospital medicine. There is a shortage of posts to which academic physicians or scientists can aspire or realistically fill given heavy clinical workloads and these people are generally those with the greatest skills in assay interpretation and design. Opening the profession to those with these qualifications and encouraging their entry by granting exemption for more than one year's training for a PhD would make chemical pathology the choice profession for academic clinical scientists. As Professor Reynolds and others have themselves demonstrated, being in a DGH is not a disincentive to performing good clinical research. The MRCP is not the way forward, especially when attempts to make it compulsory demonstrate the lack of confidence of the profession in its own strengths. Scientific entrants need to be encouraged to enter chemical pathology and to make the profession distinct, scientific and laboratory-based but heavily clinically-orientated.

Dr Anthony Wierzbicki MA BMBCh DPhil
Senior Lecturer in Chemical Pathology
St Thomas' Hospital
London SE1 7EH

Gas Bombs Sent to Laboratories

In the light of three documented cases of sealed plastic transport containers exploding under pressure from evaporating dry ice (one associated with the Guildford Laboratory), correspondence from the Health and Safety Executive has referred me to - The Carriage of Dangerous Goods and Use of Transportable Pressure Receptacles regulation 1996. I quote from this document:

> *"...for substances consigned refrigerated or frozen, ice or dry ice shall be placed around the secondary packaging(s). Interior supports shall be provided to secure secondary packaging(s) in position after the ice or dry ice has dissipated. If ice is used, the outer packaging needs to be leakproof. If dry ice is used, the outer packaging shall permit the release of carbon dioxide gas. The primary receptacle and the secondary packaging needs to be able to maintain their integrity at the temperature of the refrigerant used."*

In each of the documented cases no injuries were sustained. The graphic descriptions given of these incidences leaves little doubt in my mind that unless basic laws of physics are appreciated by those responsible for transporting laboratory specimens, death or serious injury will shortly be reported.

Stephen P. Halloran FRCPath
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Yorkshire ACB Tutorials 2000

Wednesday 9th February
Pontefract/Huddersfield
Marika Jordaan — Cholesterol Screening
Hugh Griffiths — Lipid Case Presentations
Discussion topic: Discuss the arguments for and against near patient testing by non-laboratory staff.

Wednesday 8th March
York/Halifax
Hazel Wilkinson — Running a Renal Stone Clinic
Robin Marks — Iron Metabolism and Iron Deficiency
Discussion topic: Discuss the statement that many test performed in chemical pathology departments are unnecessary. Assuming the statement is true how would you try to improve the situation.

Wednesday 12th April
Leeds General Infirmary
Julian Barth — Obesity and Leptins
Steve Goodall — Alkaline Phosphatase Conundrums

May and June – no tutorials organised.
Pathology 2000 in May and Paediatric Biochemistry meeting at St James's in June.

Wednesday 12th July
York/Scarborough
Ian Holbrook — hCG and Related Cases
Philip Poon
Discussion topic: Discuss the proposition that an 'out-of-hours' emergency biochemistry service is best provided by a shift system.

The meetings are held in the Waterton Room in the Postgraduate Medical Centre at Pinderfields Hospital, Wakefield. The first talk begins at 2.00pm and the second soon after tea at around 3.00pm. The second talk finishes about 4.00pm. There will then be a discussion about the topic outlined above for about 30 minutes

CPD credits – 2 per afternoon for RCPath scheme, 0.3 afternoon for IBMS scheme.

European Meeting on Biomarkers of Organ Damage and Dysfunction (EMBODY 2000)

Robinson College
Cambridge
3rd-7th April 2000

The conference will begin with an overview of modern methods to evaluate objectively the diagnostic and/or prognostic power of biomarkers in the context of the growing demands for evidence based medicine. This will set the scene for the main conference programme which has been designed to address new developments in the use of biomarkers in diverse organ systems including: renal, hepatic, skeletal, cardiovascular and central nervous systems. The final day will focus on organ transplantation and biomarkers of toxicology. Chairpersons and lecturers have been selected from all over Europe to ensure the programme attains the highest standards.

There will also be oral communication sessions and poster presentations. For a full scientific programme and other information about the conference visit our web site.

Full week registration (including registration and all social events):
Early (before 15th February) £495
Late (before 24th March) £595
Non-resident full week registration fee
(entry to scientific programme and all lunches):
Early (before 15th February) £250
Late (before 24th March) £330
Day registration
(entry to scientific programme and lunch):
Early (before 15th February) £65
Late (before 24th March) £75

For more information please contact the conference secretary: Vikki Hughes, Department of Clinical Biochemistry, Bos 232, Addenbrooke's Hospital, Hills Road, Cambridge CB2 2QQ. Tel: 01223-217337. Fax: 01223-217705. Email: vfh@eng.cam.ac.uk
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Career Opportunities for

Grade A Trainee Clinical Biochemists

in The National Health Service

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Trainees will follow a training programme of about three years duration in which formal training and practical training in hospital laboratories are combined. Some programmes also include an appropriate MSc course.

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Successful completion of this scheme leads to eligibility to apply for a Grade B Clinical Biochemist post.

For vacancy details and an application form contact: The National Clearing House for Clinical Scientists, Hyder, Old Road, Headington, Oxford OX3 7QU. Tel: 01865-226662. Email: clearinghouse@hyder.com

Closing date: Thursday 24th February 2000

Black Country Education & Training Consortium
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Higher Specialist Training in Clinical Biochemistry

Clinical Biochemist

Grade B (9-13) £18,915-£22,127 (pay rise pending)

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The appointee will preferably have successfully completed a grade A training course and will be expected to obtain the MRCPath while in post. As well as contributing to the service commitment of the department, the appointee will be involved in clinical liaison, audit, teaching and research and development.

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For further information or to arrange for a visit, please contact Mr E.F. Legg, Heartlands Hospital, Birmingham on
Tel: 0121-766-6611 ext 4377.

Closing date for applications: 14th February 2000

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Euro/DPC is the European manufacturing and distribution organisation of the Los Angeles based Diagnostic Products Corporation, the world-wide independent manufacturer of immunodiagnostic kits and instruments for hospitals and veterinary laboratories. Euro/DPC is an ISO 9001 registered company.

A vacancy has arisen for an **ACCOUNT MANAGER** to work within the UK Sales Department. Due to a high sales growth we are currently seeking to recruit an Account Manager servicing South East England.

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Closing Date: 18th February 2000

Department of Clinical Biochemistry
Royal Free Hampstead NHS Trust

Clinical Biochemist

Grade B 17-19

£28,208-£30,326 pa. inc.

Applications are invited for this post within this leading London teaching hospital. Your duties will include particular responsibility for a section of the analytical service with appropriate technical support. An interest in endocrinology, trace metals or toxicology would be an advantage.

You should have considerable experience in clinical biochemistry having completed your basic training and possess an appropriate higher degree. Evidence of progress towards, or possession of, MRCPath (or equivalent), would be advantageous.

For further information/informal visits please contact: Dr Michael Thomas, Top Grade (Consultant) Clinical Biochemist on 0171-830-2991 or Ms Helen Smith, Prinicpal Biochemist on 0171-794-0500 ext 3302.

For an application pack, contact the Human Resources Department, Royal Free Hospital, Pond Street, Hampstead, London NW3 2QG. Tel: 0171-830-2064.

Closing date: 8th February 2000

Ref: OP/CB/818

MID ESSEX HOSPITAL SERVICES NHS TRUST
BROOMFIELD HOSPITAL, CHELMSFORD, ESSEX
DEPARTMENT OF CLINICAL BIOCHEMISTRY

Clinical Biochemist

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