day. Data processing by a computer-based reporting and record store is essential if such a system is to work. The possible effects of such centralization are disturbing; impersonal service, complex administration, rethinking on technician and graduate training, effect on staff morale, and the role of satellite laboratories are all problems to be faced. Patient care will require concentration of those requiring special investigation in the hospital containing the central laboratory and the laboratory itself should be sited centrally in the parent hospital. Clinical fashions and administrative barriers will have to be broken.

The effect of such centralization and automation will tend to cause a profound revolution in our pattern of working, but should release the medically qualified personnel from much that is mundane and routine and allow them to carry out the task they are best qualified to do, namely, research and development, and to play a greater role either directly or indirectly in patient care.

The Effect of Centralization on Laboratory Procedure in Histopathology

H. K. WEINBREN (University of Nottingham)

With the development of newer techniques, reorganization of hospital groupings and the possibly reduced numbers of histopathology technicians qualifying from training schools, new methods have to be devised for increasing the service load and at the same time relieving technicians of the chore of routine cutting and staining.

Of the possible modifications to existing systems, the main changes envisaged in some new developments involve automatic linkage stations between existing mechanical procedures. Selection of blocks is to be made after macroscopic details are recorded with the help of a suitably programmed two-way computer, the data are stored, and individual print-out notes accompany each specimen.

Tissue processing and vacuum embedding is effected by means of a linear system involving features found in commercially available apparatus and an electronically controlled linkage is being developed between paraffin block production and orientation in a mechanical microtome, in which some knife renewal system is incorporated.

The linkage between section cutting and mounting is provided by temperature-controlled water flow for floating sections and a vertical belt carrying slides to which the sections adhere. Mounted slides are delivered to a staining machine and cover slips may be replaced by a mechanized transparent spray.

Effects of Centralization on Laboratory Services

M. T. PARKER (Central Public Health Laboratory, Colindale)

The main activity in clinical microbiology is identifying medically important micro-organisms in specimens from patients. Centralization would create problems if it removed this work from the point at which clinical and epidemiological decisions have to be taken. Fortunately, present techniques in diagnostic bacteriology are so primitive and so dependent on personal judgment that there is little to be gained from centralizing them further than to the area served by a group laboratory.

The other activities in clinical bacteriology are secondary identification processes, e.g. typing and the identification of rare or 'difficult' organisms, and the detection of antibodies in patients' sera. Here, centralization is sometimes inevitable, but must be justified in each case and usually by one of the following considerations. (a) In a few specialized fields it may be necessary to centralize 'on a person', i.e. the national expert. (b) When a technique is difficult to perform a special laboratory may have to be set up to carry it out. But most examples of centralization 'on a technique' are in fact examples of centralization 'on a reagent'. Here, the main obstruction to decentralization is the reluctance of the special laboratory to become merely a producer of reagents. This can usually be overcome by cautious devolution to selected regional centres. (c) Centralization to achieve an optimal workload often leads to increased efficiency and may often give a quicker service. Virology is a special case, because a credible virological service can seldom be provided except in a relatively large laboratory unit.

The Grouping of Staphylococci and Micrococci

A. C. BAIRD-PARKER (Unilever Research Laboratory Colworth, Welwyn, Colworth House, Sharnbrook, Bedford, England)

The Gram- and catalase-positive, cluster forming coccii belonging to the genera Staphylococcus and Micrococcus cannot be separated by the ability of numbers of the former genus to grow in the absence of air and under these conditions to ferment glucose. Staphylococci can be grouped into two quite distinct species, Staphylococcus aureus (the type species) and S. epidermidis; the latter organism is much more infrequent, although incorrectly, refered to as S. albus in the medical literature.

They are distinguished in the laboratory by such characters as cell wall structure, growth requirements, and metabolic activities such as the production of enzymes clotting animal plasmas (coagulases) by S. aureus. Staphylococcus aureus can be subdivided into several ecotypes based on differences in biochemical properties, serology and phage sensitivity of strains isolated from human and animal sources. Staphylococcus epidermidis can be divided into a number of biotypes corresponding to Baird-Parker's Staphylococcus subgroups II, III, IV, and VI, (subgroup V was subsequently shown to be indistinguishable from II) and into a number of phage types. There is some correlation between phage type and biotype, but this is far from clear cut. Five species are at present recognized in the genus Micrococcus. These are: Micrococcus luteus (the type species), M. lactic, M. morrhuae, M. saprophyticus and M. roseus. If