Histopathology and medical laboratory scientific officers

Pathologists are responsible for diagnosis

EDITOR,—T G Ashworth was correct when he predicted that his views would incur the displeasure of some of his peers.[1] In the interest of job satisfaction and economy he advocates that medical laboratory scientific officers should undertake the gross examination of surgical specimens and the microscopical examination of some unspecified tissues. He states that, for 50 years, his laboratory has entrusted the selection of tissue for embedding and microscopy to medical laboratory scientific officers and he knows of no instance in which this practice has led to diagnostic error. Without the aid of external audit what is this statement worth?

Undoubtedly, medical laboratory scientific officers could be trained to describe and dissect many surgical specimens and to select appropriate tissues for histological examination, but they do not have the appropriate background for this. Is it cost effective to train staff for jobs for which they have inadequate background experience and education? While the medical laboratory scientific officers are undertaking these tasks who does the skilled work for which they have been trained?

If a medical laboratory scientific officer misses an early neoplasm in a specimen (for example, an adenocarcinoma in a distorted fibrotic sigmoid colon resected for diverticulosis) who will be responsible? Finally, this separation of gross from microscopical examination increases the chances of diagnostic error. Gross examination is an integral part of diagnostic histopathology, and the findings on gross examination not infrequently modify the interpretation of the microscopical appearances.

With respect to the reporting of microscopical examinations, I am not sure what Ashworth means when he says, "All histopathologists know the lesions to which I am referring, those that require simple, objective answers and which can be easily verified." Does he mean appendixes and gall bladders, when the debate often revolves around whether they should be sent to the pathology laboratory or thrown in the waste bin? If so, does he think that a medical laboratory scientific officer is the best person to identify inflammatory bowel disease, goblet cell carcinoids, or other unusual lesions that are occasionally seen in these specimens? I dispute Ashworth's contention that histopathology largely entails the recognition of patterns and that interpretation is necessary in only a minority of cases. Histopathology entails the interpretation of patterns in the light of all other available data, including clinical information.

Finally, Ashworth suggests that the Royal College of Pathologists' guidelines on workload are becoming increasingly irrelevant in the face of financial and market forces. I hope that accreditation of laboratories will prevent this from happening. If not, a few hefty court settlements in favour of patients whose conditions have been misdiagnosed and who have consequently been mismanaged should do the trick.

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1 Ashworth TG. The future for histopathology: protectionism or prudence? *BMJ* 1994;309:417. (6 August.)

MLSOs are not doctors

EDITOR,—T G Ashworth is right to suggest that histopathologists should review their practices to improve efficiency, but I believe that the remedies implied will be detrimental to patients.[1] Reporting of a specimen depends on the assessment of clinical features, macroscopic appearances, and findings on microscopy. This balance differs from case to case, but a long period of training is necessary to allow correct assessment. As Ashworth points out, many specimens that we report are mundane, but this is evident only after examination by somebody sufficiently broadly experienced to recognise that no difficulties of differential diagnosis are present. The histopathologist should attempt to understand the processes lying behind diagnostic labels, and this requires continuing exposure to the entities in their various guises. The science of histopathology will not advance by our devolving some of our responsibilities to staff who have little understanding of disease processes.

My colleagues who are medical laboratory scientific officers are skilled, patient, dedicated, and enthusiastic. Like histopathologists, they face increasing workloads. Why should we pathologists seek to ease some of our burden by transferring it to technical staff? My colleagues and I try to maintain the morale and develop the skills and intellectual satisfaction of our medical laboratory scientific officers in various ways, but it is not their job to select tissue for microscopy, teach medical trainees dissection, or make histopathological diagnoses. It seems extraordinary for Ashworth to suggest that senior medical laboratory scientific officers might carry out some of these duties better than Ashworth could; should that not be a stimulus for self improvement or retirement?

Selection of blocks for microscopy is crucial for correct diagnosis and prognosis; failure of this element of reporting may lead to errors, with serious implications for patients. Training of doctors in anatomical and histopathological assessment is, likewise, the responsibility of consultant pathologists, not medical laboratory scientific officers.

The increasing workload of histopathologists and the reduced resources available to support it are of great concern. Some extra work can be assimilated, but there are limits; the profession must insist that its first duty, to its patients, demands the highest standard of diagnosis. While it is appropriate for us to assess our work practices and, if necessary, to change them, I believe that Ashworth's prescription is the wrong one. Attempting to make medical laboratory scientific officers into something that they are not is a potential recipe for disaster.

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1 Ashworth TG. The future for histopathology: protectionism or prudence? *BMJ* 1994;309:417. (6 August.)

MLSOs are efficient and save money

EDITOR,—Since 1954, Belfast City Hospital's histopathology laboratory, like that of T G Ashworth.[1] has involved experienced medical laboratory scientific officers in the dissection of a wide range of biopsy specimens, including the selection of suitable blocks. The laboratory used to provide a biopsy service to most of the hospitals in Northern Ireland; the annual number of specimens peaked at 29 000 in 1984. Since then phased decentralisation has occurred and has reduced our annual workload to 17 500 specimens.

We have just received conditional accreditation from Clinical Pathology Accreditation (UK) Ltd. The inspectors commented favourably on the efficiency of the laboratory but pointed out that our use of medical laboratory scientific officers as dissectors breached the code of practice of the Royal College of Pathologists. The inspectors recognised, however, the enhanced job satisfaction of the medical laboratory scientific officers, who greatly appreciate the confidence that we, as pathologists, have in them. Their dissection is careful and closely supervised by consultant staff.

For 40 years this system has worked satisfactorily, with rapid, comprehensive reporting appreciated by all clinical users. In our view, there are essential prerequisites to ensure that the system works safely.

Firstly, senior medical laboratory scientific officers must initially receive intense training from consultant pathologists in the art of dissecting common surgical specimens; this should be supplemented by the creation of detailed bench dissection manuals. Interest is stimulated by the transfer of knowledge of the diseases encountered.

Secondly, a stable, intelligent workforce of medical laboratory scientific officers is needed. (Most of ours have been employed for 15 years or more, possibly partly because of job satisfaction).

Thirdly, a consultant should be available to provide immediate advice when a medical laboratory scientific officer encounters an unusual or difficult specimen.

Fourthly, dissected specimens should be inspected by the duty consultant in conjunction with the medical laboratory scientific officer. The consultant ensures that descriptions are accurate and appropriate blocks have been taken.

Fifthly, consultants' offices should be close to the biopsy dissection laboratory.

Finally, junior medical trainee staff must also become fully knowledgeable about and competent in dissection. They should work side by side with the medical laboratory scientific officers as they acquire the necessary skills. Ultimately, however, a busy pathologist's time can be better spent than

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