on repetitive routine sectioning of, for example, uterine fibroids.

The system works well for both laboratory staff and service users. In these days of accountability for use of public resources and analyses of skill mix, managers would also commend the considerable diminution in expensive medical staff time that is required.

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

May have medicolegal implications

EDITOR,—In giving a personal view of the future of histopathology T G Ashworth opines that the bulk of histopathology can safely be reported by non-medically qualified medical laboratory scientific officers and then draws comparison with opticians and paramedical ambulance crews.[1] Ashworth seems to have lost sight of the fact that, although histopathology largely entails the recognition of patterns, this skill takes many years of practice to master and is not to be delegated lightly.

The histopathological diagnosis is regarded as the gold standard for definitive treatment; it should be the responsibility of every histopathologist to ensure that every section is examined with the same degree of depth by someone who is suitably qualified for this task. There is no such thing as an easy histological section; the diagnosis is obvious only after the slide has been looked at. All histopathologists have specimens submitted to them by doctors who believe that the lesion is clinically innocuous; some prove to be otherwise but require great skill to diagnose. Presumably in Ashworth's view these specimens could safely be reported by a medical laboratory scientific officer —a view that I find untenable.

The medicolegal atmosphere in Britain has undergone a shift in the past few years, with histopathologists being increasingly in the front line of medicolegal litigation; the concept of non-medically qualified people reporting diagnostic material ignores this fact. The arrangements in Ashworth's laboratory seem to be idiosyncratic in that the medical laboratory scientific officers do all of the tissue dissection and selection for embedding and microscopy. No laboratory in which I have worked has operated a similar practice, and I find Ashworth's espousal of this practice reprehensible and against the ideals of proper patient care. I agree that medical laboratory scientific officers should be given intellectual stimulation, but I disagree strongly that this should be done by delegating diagnostic histopathology to them.

I do not support protectionism, but in the present NHS it is important that standards are maintained in the face of decreasing budgets; I believe that Ashworth's ideas are retrograde and misguided.

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

MLSOs play a minor part

EDITOR,—We agree with T G Ashworth that skill mix is relevant to medical practice.[1] Ashworth's conclusions relating to histopathology are, however, inappropriate. A modern histopathology service must be cost effective, rapid, and, above all, diagnostically accurate. Furthermore, accuracy must not be compromised by current financial and market forces. The ability to perform necropsies to the standard expected of a member of the Royal College of Pathologists, and the diagnostic skills needed, requires at least five years' training. This is because of educational necessity, not protectionism. It is also why the specialty remains dependent on career grade doctors.

Some histopathology reports are, admittedly, confirmation of clinical diagnoses. Not infrequently, however, histological examination results in unexpected and clinically important findings. These findings often rely on subtle observations, which are unlikely to be made by a medical laboratory scientific officer trained to the limited level of empirical confirmation. Ashworth draws a comparison with cytological screening but fails to appreciate that its inherent false negative rate is unacceptable in histopathological practice.

Medical laboratory scientific officers may have a role in the selection of tissue for microscopy. We consider, however, that this is minor and restricted to specimens not requiring dissection and naked eye clinicopathological correlation. Ashworth's statement that selection of tissue can be done better by a medical laboratory scientific officer is, we believe, unrepresentative. Ashworth is not aware of one case in which this practice has led to a diagnostic error. This, however, is not surprising as tissue indicating the correct diagnosis will have been discarded.

Enhancement of job satisfaction is always to be encouraged. Ashworth's proposals, however, are unrealistic and comparable to a suggestion that theatre sisters should undertake cholecystectomies for intellectual stimulus. Laboratory contracts should now contain service specifications that incorporate agreed national standards. Ashworth's suggestions are unlikely to be acceptable to the accreditation agency Clinical Pathology Accreditation (UK) Ltd, and the department may lose contracts.

Unlike Ashworth, we are proud protectionists of our traditional practice and its ensured quality standards. Prudence in our department results in marginal consultant staffing, hard work, and long hours. We believe that our contracted price for a skin biopsy (£10.40) is competitive.

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

Accreditation refused

EDITOR,—I am the clinical director responsible for the laboratory in which T G Ashworth works as a consultant histopathologist. Readers of his article[1] (with which I concur) may be interested in the outcome of a visit to our laboratory by Clinical Pathology Accreditation (UK) Ltd earlier this year, after the article had been submitted to the journal.

Accreditation of histopathology was refused on the grounds that technical staff took part in the cutting up and trimming of surgical specimens. When we asked why this was considered to be unsound we were informed that it contravened the code of practice of the Royal College of Pathologists.[2] Thus the inspectors seem to have been more concerned with perpetuating the restrictive practices of a professional organisation than with properly evaluating technical quality in our laboratory. In our view this discredits the accreditation of histopathology, especially as we are aware that the "forbidden practices" in our laboratory are duplicated in many others.

Faced with the inspectors' refusal to accredit our laboratory, which we believe maintains high standards, we considered our response. Should we change our current arrangements and debar medical laboratory scientific officers from undertaking the work? This would gain accreditation for the department but at considerable cost. Another consultant would be required, and it would be difficult to justify the appointment of a consultant primarily to undertake a task now being satisfactorily performed by someone earning half a consultant's salary. We would also lose the skill of someone with over 25 years' experience of cutting up surgical specimens and replace him with a junior consultant with perhaps a third of the experience.

So what will we do? We have produced a standard operating policy for cutting up and trimming surgical specimens, which will be ratified as trust policy by our trust board. We will continue with our current working practices, which we believe are of a high standard. We would, however, welcome some form of peer review, which we consider the present system has denied us. We will pursue formal accreditation only when the organisations concerned remove their heads from the sand and see more clearly the changing world of pathology in the 1990s.

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1 Ashworth TG. The future for histopathology: protectionism or prudence? *BMJ* 1994;309:417. (6 August.)
2 Royal College of Pathologists. *Code of practice for histopathology departments.* London: RCP, 1987.

Similar problem with radiographers

EDITOR,—Departments of clinical radiology are under similar pressures to those felt by departments of histopathology.[1] The Royal College of Radiologists has shown that although the number of radiologists has doubled since 1968, the workload has trebled.[2] Most radiologists are aware not only of that increase in workload but also of the increased pressure to deliver services expeditiously and to indulge in other activities including audit and management.

The additional 823 radiologists that the college estimates are required to address this increase in workload seem unlikely to be appointed, and alternative solutions must be sought. Alterations in working practices may help, with increased delegation to radiographers. It is now not uncommon for radiographers to administer contrast media both at urography and during computed tomography.

In many departments general abdominal ultrasonography is undertaken by experienced ultrasonographers, and in some departments radiographers undertake contrast studies, principally barium enemas.[3] I have shown that radiographers with supplementary training can significantly improve their ability to report radiographs from the casualty department.[4]

Film multiviewers to speed up reporting of mammograms in the breast screening programme are almost universally used but seem strangely absent from general departments, where a "reporting pile" is still routine. Their introduction—with film mounting and unloading by clerical staff—could have an appreciable impact on the time spent on the workload generated by plain radiography.

If radiologists are to grasp the opportunities to improve patients' care offered by the newer imaging modalities such as magnetic resonance imaging and the therapeutic potential of interventional radiology then these and all other possible alternatives must be examined. If radiology departments introduced some of these