The Association of Clinical Pathologists

Summer 2007

# acp News

## PATHOLOGY IN THE UK: IN-HOUSE OR OUTSOURCE?

Should pathology be taught by pathologists?
Cremation: the burning questions
A loss of confidence
Hi Ho Silver!

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# Contents



Front cover – Photo by the editor

# Editorial

**Minerva**

*Quote me as saying I was mis-quoted*
*Groucho Marx (1895-1977)*

They tell me that unless you have been quoted out of context you haven't made the big time. I was warned when I took over as editor that more people than you would expect, some in high places, read *acp News*, hence the sometimes heavy application of the editorial blue pencil – if you think some of the things you read here are near the knuckle you would be amazed at what some contributors write that doesn't get under the radar! I had also been informed that snippets occasionally get into the *BMJ's* Minerva column – a kind of grown-up version of our Curettings. However, Minerva's reference to my *acp News* editorial (spring 2007) regarding the fee paid by the coroner to pathologists performing coroner's autopsies was misleading to say the least.

*Dr M D Harris is Editor of acp News and a Consultant Histopathologist/Cytopathologist in Peterborough*

In my opinion, and confirmed by others to whom I have spoken, my editorial gave a balanced view of the arguments as to whether the fee is derisory or "a nice little earner"; Minerva chose to quote the latter view. Not only that, but the fact that it was clearly a satirical piece, published in a professional magazine renowned for its tongue-in-cheek approach, was not conveyed to any readers unfamiliar with the *acp News*.

I am told that the Great and the Good (or is it the Good, the Bad and the Ugly?) of the College were bracing themselves for an onslaught of press enquiries about how they could defend their "nice little earner" and were actually hoping to use the opportunity to air some of the aspects of the NCEPOD coroner's autopsy study that were overshadowed last time by the "you're all cr*p" press spin. However, like a teenage girl on a Saturday night, they waited by the phone but no one called. I guess that means either that no one cares, or possibly that no one reads Minerva. I bet that doesn't get quoted!

(I have just been corrected by one of the Great and Good. Strictly speaking I was not quoted (or even mis-quoted) as Minerva didn't use (or mis-use) my exact words. What was I then … shafted perhaps?)

**Informed consent**

The issue of consent is a thorny one and, for those of us who trained some years ago (I qualified in medicine in 1981 and passed the final MRCPath in 1991), it is rather confusing, frontier stuff that seems to have a "make it up as you go along" quality about it. Or at least that is the impression you might have formed if you had followed the successive out-pourings from the "powers that be" post-Alder Hey. Who knows what they might have come up with if their deliberations hadn't been tempered by some very sensible people in our profession? Welcome to the 21st century!

I remember as a clinical medical student in the late 1970s being attached to a surgical firm where the pre-registration house officer, a rather amiable but vague sort of chap, would consent his consultant's patients for operation by saying, "We're going to cut you open. Sign here." Interestingly, they all did and no one complained. I wonder how he would have got on with that approach now. I also wonder whether patients nowadays are really any better informed about their illnesses and operations and, if so, whether they are any happier as a result. I suspect not.

My granny came from a generation who respected and feared their doctors, or if not actually feared them, they would certainly no more have considered it proper to question their judgment than they would have done with a teacher, or the local vicar. They knew their place, particularly the working classes, and they believed (or rather they were told to believe) that everyone had their "station" in life. Doctors of that period were far less able to make a significant difference to the course of a patient's disease, which would either prove to be self-limiting or fatal. In that pre-antibiotic era doctors' skills were largely judged on their ability to predict the outcomes of conditions, and much of the rest entailed a supportive role. Even in surgery outcomes were poor, infections common (*plus ça change*!), and anaesthetics was a very risky business.

Successive waves of social change have seen a change in attitude, not only to the medical profession, but also to other groups previously held in high esteem. Bank managers of the Captain Mainwaring mould have been replaced by friendly chaps who seem more concerned with selling you life insurance than they are about your overdraft. Or take old "Professor" Jimmy Edwards, the star of *Wack-O*! – which surely brings back memories of a bygone age of socially acceptable child abuse in Britain. I believe the film version was even called *Bottoms Up*! Well he is now superseded by trendy young things who are afraid to even raise their voices in case they traumatise the poor little darlings and find themselves suspended pending investigation. I wonder how many of them secretly wish they were back in the days of *Wack-O*! And in medicine, Sir Lancelot Spratt, along with James Robertson Justice who played him, has gone to join that celestial ward round in the sky. Is he sorely missed? Certainly not by New Labour, he isn't. I wonder what he would have made of the new age of "informed consent".

So what does "informed" in this context mean? Sticking with the clinical side (I'll come on to the relatives of the recently deceased in a moment), how does a doctor ensure that patients are both informed and use that information to give their consent to various procedures? Say for example I need an operation which, like all surgery, is not without at least some risks attached. How am I to weigh up those risks against the risk or discomfort of not having the operation? (I am being a coward here and not giving myself something which is immediately life-threatening, where the decision might be a lot more clear-cut.) Without having the same level of insight and experience as the surgeon, surely I can't. Furthermore, how can the surgeon give me the necessary information without introducing a bias from his or her own opinions? The public as a whole are not good on the concept of risk, so a rational choice in medical matters involving greater and lesser risks, that range from the anaesthetist knocking off your dental caps to death itself, is always going to be a difficult call for a lay person to make. Perhaps "informed" here really means choosing whether or not to do what the doctor thinks is best.

And what about the concept of consent; where does that get us? If you have a serious condition that requires surgical intervention, surely you should not be *consenting* to someone actually doing something about it, you should be *requesting* that they do so. Perhaps the need to obtain a signed request for operation, rather than a passive consent, would serve to sharpen the punters' minds here.

Consent from next of kin in relation to a post mortem is yet another can of worms. As I understand it, when a hospital post mortem is requested the hospital has charge over the body and has an obligation to ensure that there are no objections from the next of kin, which is subtly different from obtaining consent. However, part of that permission includes specifying whether material can be used for teaching and research. In a coroner's case the position differs and although issues regarding retention of material have been dealt with extensively (although the outcome is, in my opinion, not fully satisfactory) it is less clear what is permissible in terms of teaching, or where the line should be drawn as to who is covered by the term and who may attend an autopsy. Teaching juniors in histopathology is certainly reasonable; in fact most coroners I have worked for would not even consider that separate permission would be needed, whether the post mortem is

**Mummy … are those frogs fighting?**

actually done by the trainee under supervision or the results shown to them. They may be wrong in this assumption. Likewise, demonstrating the findings to both senior and junior clinicians would be regarded as acceptable by most sensible people, although when junior doctors are involved the dividing line between this and teaching becomes blurred.

So what if those same juniors wish to attend an autopsy on a patient that they haven't treated; is that different? And what about medical students? They are the next generation of doctors; they must be trained. In many ways I would think it outrageous if relatives whose deceased had benefited from current medical expertise were then to refuse the opportunity to support the training of students.

Personally, I would take the same view over attendance at post mortem by nurses, both in training and trained; however, some might disagree. But are nurses of all grades equal in this respect? What about those training in other areas, like radiographers, theatre assistants and paramedics? Where do we stand on attendance by police trainees, other emergency services, or the military? And what about the training of bereavement officers and the like? At what point should the permission of relatives of the deceased be sought before non-essential staff can attend a post mortem for educational purposes alone. I feel we have a minefield here, possibly equal in complexity to the issues surrounding tissue retention. I can't see the press getting much joy out of the headline: "Medical students watched post mortem on my wife"; however, if for medical students you substitute police cadets, bereavement counsellors or firefighters, you just might.

**In this issue**

Is in-house or outsource the future of pathology? Whilst the debate in this issue centres on the world of cellular pathology (histo/cytopathology, or whatever else you want to call it) the issues are just as relevant to other branches of pathology. Remote locum-style groups such as PathLore are certainly becoming more proactive in soliciting work, not only from trusts without a full complement of consultants of their own, but now by approaching trust chief executives with a view to off-site provision of at least some aspects of the service. Is this beyond the pale or just a wake-up call in the UK that this is how much of the rest of the world does business? Well, in the interests of fairness and balance, *acp News* has given Ian Ellis and Hugh Jones the chance to put their opposing sides of the argument. To complete the trilogy Simon Knowles gives his view on the current setting up of pilot sites post-Carter with his appropriately entitled article "Even pilots are no blooming use if you don't know where you want to go"!

Julian Burton kicks of a mini-series of articles on medical teaching by asking the question: "Should pathology be taught by pathologists?" My opinion has long been that all aspects of medicine are best taught by someone who understands how to teach, wants to do so and has enough knowledge of the subject to best pass said knowledge on to their students. That person may or may not be a pathologist, or even necessarily a doctor, but it should not just be a lecturer, or even professor, who happens to have a research interest in that field, regardless of their competence as a teacher. I also believe the same applies to much if not all clinical teaching at an undergraduate level. See if you agree with Julian's views.

I felt it was about time I, too, burst into print again in a full-length article, not just an editorial or various columns and curettings. As I was asked to deliver a talk as a crematorium referee on the newly created MSc course at Staffordshire University, I decided I might as well write a piece for *acp News* at the same time. Much of what I have said is necessarily

**Mummy … why does that moth look like it's two moths?**

my personal view, but I have tried to clear up some misconceptions as well (some of them, bizarrely, are erroneous views held by other referees who clearly have never read the Home Office guidance). It is a bit long, but I hope it is of use to those who complete cremation forms. Please feel free to use the information as you wish and, if there is an interest, I will try to create a condensed version that can be used as a guide.

Magnus Boyd, a solicitor at Carter-Ruck, who are specialists in privacy, defamation and reputation protection (for some reason *Private Eye* never seems able to get their name right), has become something of a regular contributor here. This time Magnus looks at the position of the GMC in the light of recent judicial decisions affecting the confidentiality of medical records.

And last but not least, following his articles on handling meetings and managing time, Bob Mathers, our resident outsider from the training world, takes a look at problem-solving non-Lone Ranger-style. Bob has been a great supporter of *acp News* and is keen to hear from anyone interested in any of his training programmes. He can be contacted at bobmathers@btinternet.com.

What else? Well, perhaps encouraged by her special commendation prize for journalism in pathology (a nice certificate, but no money), everyone's favourite agony aunt (although this time with no problems to solve, so you must all be so very content in your jobs) returns to give the antipodean view on pathology in the UK.

Enjoy.


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## Cover Story

**British bulldog**

Seen by the editor in the seaside town of Hunstanton, this British bulldog seems to epitomise the "kick-ass" attitude in some circles regarding the future of pathology services.

As well as being a familiar Churchillian image, British bulldog can also refer to a children's "tag" game and it is also the name of a wrestling tag team. It was also the name of a now-defunct 70s progressive rock band. Any readers of *acp News* who have got any of their albums (and that includes Minerva), please can the editor borrow them?

## Invitation to Contributors

In addition to the constant flow of material from ACP Council, ACP committees and ACP branches, *acp News* needs new material from you, the members of the ACP.

**Pathology news items (1200-1500 words):** Any items related to the ACP or the College, pathologists in general, or medical and management matters that may have an impact on pathologists.

**Articles (1500-2000 words):** These can be papers, reviews, essays, commentaries, critiques or polemics. Submitted articles are always very welcome, as well as suggestions for articles and/or details of people whom the editor may approach.

**Reports (1000 words):** These may be personal views and reports on interesting meetings, travel or anything else of interest to the readership. Travel reports are specifically for holders of ACP travel fellowships, however, other reports from abroad are welcomed.

**Columns (600 words):** Regular and irregular columnists exercise their thoughts. Please feel free to rant.

**Pathological creative writing:** All literary forms, including short stories, serials, surrealism and even poetry.

**Appreciations (1000-1500 words):** We prefer appreciations on retirement, rather than obituaries. Please discuss these with the editor before submission.

**Photo-journalism:** Favoured subjects include pathologists doing something interesting, or College and ACP officers doing anything at all. Interesting or artistic photographs are welcomed.

**Cartoons:** Suggestions are welcomed.

**Curettings:** Jokes and humorous titbits are always needed.

**Debate:** Letters to the editor are welcomed, but may be shortened for publication, or even converted into articles. Please try to refrain from writing unless you are prepared to be published. All criticisms of organisations or named individuals will entitle the parties to a right of reply. Please bear in mind the UK libel laws!

**Trainees:** Trainees are especially encouraged to submit material in any and all of the above categories. These will normally be placed in the trainees' section. Appointments committees in particular value publications in *acp News*.

**Editorial Policy:** The editor would particularly encourage overseas contributors, material from trainees, material from non-histopathologists, commentary on current affairs in pathology, occasional columnists, innovations in pathology, humorous writing on pathology-related topics, and anything downright cantankerous.

**Format:** The *acp News* style guide was published in the autumn 2005 issue, pages 11-12, and copies can be obtained from the editor. The publication is a magazine, not an academic journal, and long lists of references are generally considered unnecessary. Where given, references should be in the Vancouver style and should be kept to a maximum of around six per article, unless absolutely necessary. Alternatively, authors may prefer to give a recommended reading list, or a list of relevant internet links. The editor prefers these as they take up less space.

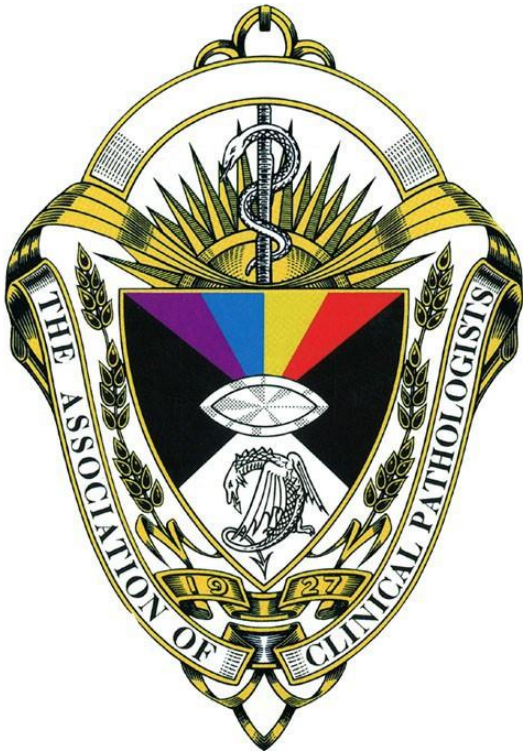
**All suggestions are welcome; however, the editor's decision is final.**

*Acp News* is published quarterly. Regular publication dates are:

| Issue | Publication month | Copy date |
|---|---|---|
| SPRING | February | 5th December |
| SUMMER | May | 5th March |
| AUTUMN | August | 5th June |
| WINTER | November | 5th September |

Copy is best submitted by email, or on disc if the file size is large, in any version of Microsoft Word, although it should be possible to accommodate other formats. Submissions on paper by snail mail will also be accepted. Illustrations can be sent as transparencies or prints, but high-quality digital images (TIFF or JPEG) are preferred.

**Please send email submissions direct to the editor at mdharris@doctors.org.uk.**

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