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Quality control of laboratories—or of pathologists

Britain has a long tradition of a high standard of pathology services from hospital laboratories. One method of helping to assess and maintain this standard is external quality control. Samples from an outside source are sent to each laboratory for analysis by its routine procedures, and the laboratory returns its results to the sender, who then circulates a list of the results. No laboratory's results can be identified by anyone except the source, but individual laboratories can see themselves where their results are poor and may be sent a comment to draw their attention to unsatisfactory performance.

For several years the DHSS has supported three major schemes that are primarily directed at the analytical rather than the interpretative function of pathology laboratories. Queen Elizabeth Hospital, Birmingham (clinical chemistry), serves more than 450 laboratories, Hammersmith Hospital (haematology) 400 laboratories, and the Public Health Laboratory Service at Neasden (microbiology) 300 laboratories. Some laboratories abroad subscribe to these schemes.

A few laboratories in these schemes are unsatisfactory performers to an extent that could be detrimental to patient care—but it is not known how many laboratories do not take part. The reasons for poor performances are many, but commonly it is due to an increase in work beyond the capabilities of the laboratory in terms of staff, space, and equipment. A limited advisory service for poor performers has been available informally via the organisers of these national schemes.

A more broadly based and independent advisory service has long been seen to be needed. Many pathologists want that assessment and advice to be available within the profession but organised nationally and not from local sources. Agreement has been reached between the responsible professional bodies and with the organisers of the schemes, and expert advisory panels have been set up. All have a representative from the Association of Clinical Pathologists, the Institute of Medical Laboratory Sciences, and the Royal College of Pathologists, with additional representatives from the British Society of Haematology (haematology), the Association of Clinical Biochemists (chemical pathology), and the Pathological Society (microbiology). As yet there is no scheme or panel for histopathology or for immunology. The panels are responsible through a co-ordinating committee to the professional bodies.

All laboratories who participate in the national quality control schemes have been sent a letter by the organisers telling them of these advisory panels and pointing out that continuation in the scheme will now imply identification of persistently poor performers to the appropriate panel in confidence. The panel will then offer to visit and do all it can to help these few very inaccurate laboratories—for example, by advice on procedure and methods or by support of applications for equipment and staff. This plan should not prove expensive to operate, and it should improve the contribution of pathology services to patient care. The American College of Pathologists produces a set of voluntary self-assessment schemes on theory and interpretation which are widely used in the USA: similar schemes are being examined for possible introduction here.

On the surface these plans seem comprehensive and reasonable, but several questions remain unanswered. How many laboratories take no part in the national quality control schemes, and are these good or poor performers? How many laboratories will drop out of the revised scheme because the panels have been set up? Are these existing poor performers the laboratories who do not want anyone to know, or are these the fiercely independent units which regard any such proposals as an interference with a consultant's traditional clinical freedom to manage his department as he sees fit? Will there be laboratories who are content to learn from the schemes that they are poor performers but refuse to receive advice from the panels or to act on it when given? What should be done about them?

A panel may support the pathologist in his view that his laboratory's poor performance is due to lack of long-required facilities already demanded from the health authorities but without the money being granted. Or the pathologist may have wished to make badly needed changes in the local organisation of the laboratory (such as replacement of unsatisfactory staff) but not been allowed to do so. Should this be publicised? What further action could be taken? The panel may consider that the pathologist is at fault—and this is likely to have been recognised, but not acted on (for what powers have they?) by the rest of the staff. The pathologist's inadequacy may be due to illness, or golf, or alcohol, or failure to keep up-to-date, or lack of supervision of junior staff. What should be done?

Many of these questions are applicable to branches of medicine other than pathology. They raise important issues on the responsibility of the profession for those few who do not realise their full responsibilities to their patients and to the NHS. There is still time for the profession to do something about it—and to be seen by the public to do something about it. The report of the Committee on Competence to Practise[1] [2] recommended that it was for the colleges and other professional bodies to provide continuing education and self-assessment methods for consultants. Certainly, quality control schemes provide objective measures of performance, and they offer a good opportunity for the profession to explore the difficult new territory of professional self-scrutiny.

[1] *Competence to Practise*, the report of the committee of inquiry (Mr E J Alment chairman) set up for the medical profession in the United Kingdom. London, Committee of Enquiry into Competence to Practise, 1976.
[2] *British Medical Journal*, 1976, **2**, 1218.