Clinical Topics

Laboratory management in Europe

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During 1969-77 the Institute of Medical Laboratory Sciences (previously the Institute of Medical Laboratory Technology) published several leading articles in their *Gazette*, in which it was claimed that the management of clinical pathology laboratories should be removed from medically qualified pathologists and put into the hands of medical laboratory scientists (formerly technicians). These articles included their evidence to the Royal Commission on the National Health Service in January 1977.[1] The title of medical laboratory scientist is defined in this as applying to all the non-medical staff of medical laboratories, comprising both those previously designated as medical laboratory technicians and those designated as biochemists or other scientific officers. Previously the difference between these laboratory workers had been the acquisition of an honours degree of a university, usually in a scientific discipline.

The following are included in the 10 items of the summary of main points in this publication.[1]

"4: The managerial head of the medical laboratory service in each health district should be a medical laboratory scientist accountable to the district management team for all medical laboratory investigations performed in the district.

7: In order to give the protection of the Professions Supplementary to Medicine Act 1960 to patients on whom medical laboratory investigations are conducted outside hospital and blood transfusion service laboratories, these investigations should come under the control of the medical laboratory service for the health district."

The Clinical Laboratory Service of the NHS has traditionally been the responsibility of medically qualified consultant pathologists or in certain circumstances a scientific officer of equivalent standing, and this was recognised by the DHSS.[2] In 1968 the Committee on Hospital and Technical Services published its report[3] (the Zuckerman Report) and in 1978 a consultative paper entitled "Implementing Organisational Aspects of the Zuckerman Report" was issued by the DHSS under the heading quoted below.[4]

Investigation

As I found the claims of the medical laboratory technicians (now scientists) so surprising and their implication to clinical pathology in particular and clinical practice in general so fundamental, I decided to find out the position in the other countries of the EEC, and if possible in countries of the Warsaw Pact. I therefore arranged to visit consultant pathologists in the EEC countries, but unfortunately I was unable to visit Luxemburg and Eire. I applied to the British Council for help with the Eastern countries, but they could help me only with introductions in Poland.

In Denmark I talked to two pathologists and a biochemist, and in the Federal Republic of Germany I had discussions with two doctors. In the Netherlands I met three pathologists, but in Belgium and Italy I met only one in each. In France I was fortunate to meet seven doctors when I visited two hospitals for discussions about laboratory management. In Poland I had the advantage of meeting three pathologists, and I was introduced to technical staff in almost all the laboratories.

I arranged my interviews under the same headings for each laboratory, and with minor variations I received the same information throughout Europe and in Poland. My report is based only on my own impressions and is not intended to be a verbatim account of replies to my questions. I have not named the pathologists concerned because I thought that anonymity would lead to greater freedom of opinion, and I gave only the barest outlines of the reasons for my inquiry. I made full notes of each interview at the time and have used them in preparing this report. Wherever I went in the EEC countries and Poland I was received with the greatest courtesy and consideration.

Results

(1) *In . . . is there usually a director of the department of pathology and is he medically qualified?*

All the replies were unanimous—that is, in all the countries of the EEC and in Poland the director is medically qualified. In some cases it was further emphasised that this is the law of the country. In Poland and much of Western Europe haematology and clinical chemistry are separated from histopathology, and microbiology may be a different service. Sometimes these subjects may be under the direction of clinicians, but in all cases I was assured that a medically qualified doctor was in charge. Occasionally in Poland a biologist may be appointed.

Most of Western Europe has a flourishing private sector with private laboratories, but these also seem always to be under medical direction and must be licensed. A pathologist remarked that they have learnt from watching the British NHS, and as a result they are determined not to lose their private sector. Sometimes these private laboratories provide services for the state hospitals.

(2) *What is the function of the director (a) in pathology and (b) in administration?*

The answer to (*a*) is that the director in pathology is closely engaged in supervising the technical work as well as issuing reports on specimens. According to his specialty, he often sees patients for investigation and may initiate or supervise treatment. In the case of histopathology he discusses the specimens with the surgeons, just like the common practice in Great Britain. Ease of access for clinicians was emphasised as important.

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In the case of administrative duties (*b*) the director is entirely responsible for running the laboratory. There are of course various committees and discussion groups, but nowhere did I gain the impression that they were statutory; consultation with scientists, technicians, and lay administrators was taken to be an ordinary aspect of good management and my contacts seemed rather surprised when statutory committees were mentioned. In Poland, too, the medical director is completely in charge of his department.

(3) *Does the director delegate his duties, and if so, to whom?*

I had some difficulty in conveying the meaning of this question. Delegation to scientists, technicians, or lay administrators is apparently not possible. In all countries I saw the pathologist personally reading and signing the reports on specimens, and I understood that this is common practice. During holidays the work is covered by a colleague, and sometimes a laboratory may be closed; this applies both to certain hospital and private laboratories.

(4) *What is the director's relation to the hospital administration?*

In no case did I hear of any undue interference in running the laboratory by lay administrators, on the contrary I gained an impression that the administrators were neutral and prepared to be helpful. One pathologist remarked that collecting fees from the insurance companies to pay for inpatient and outpatient costs occupied the administration full time and they were not tempted to interfere with management of the pathology laboratories. In some Western countries, and I understand in Poland as well, there is a part-time medical director of the whole hospital (for instance, the professor of surgery), who presides over the medical executive committee on which the senior administrator sits. He seems to have considerable powers, and I gathered that this was a rotating appointment.

(5) *Who appoints technical and scientific staff and who has the authority to dismiss them?*

Members of these staffs are employed by the administrative officer of the hospital, and other members of the laboratory staff—for example, electronic engineers—are in the same position. Both appointment and dismissal are done by the administrators, but only on the advice of the head of the department. As in the United Kingdom dismissal is rare, and one pathologist wryly remarked that he would expect three weeks' strike, but would be prepared for that before he asked for such action. In the private laboratories (where investigations are largely paid for by insurance) the pathologist himself employs his technical, scientific, and other staff. Almost all the technical staff are women and due regard is given to time off for pregnancy. In Poland there seems to be a shortage of scientific and technical workers and dismissal from one hospital (for example, for unreliable work) would be ineffective since plenty of jobs are available in other hospitals. It was remarked that a male technician was once employed, but never again, as it was a failure. Staff are employed by the hospital authority on the advice of the pathologist in charge.

(6) *How is finance for the laboratory arranged?*

Nobody had heard of functional budgeting, and by and large the ordinary expense of the laboratory is met by the administration out of the statutory item-for-service fees paid by the insurance companies for the tests performed. There were surprisingly few complaints about the book-keeping in the laboratory necessary for recouping these fees, but I reflected that in the UK we have to make returns to the DHSS for apparently no material benefit. The pathologists apply to the administration and the medical director of the hospital for permission to purchase more expensive equipment, and this may be delayed to the next or even the following year, but in one hospital such permission was given as a debit to be met out of subsequent finance. As always, money seemed to be scarce, but the comments on this were rueful rather than aggressive. In the private laboratories such expenses are decided by the pathologist and are based on supply and demand. The best-equipped laboratory that I visited was private and owned by a small group of pathologists and one business manager who was a biochemist. In Poland I gathered an impression that supplies and finance were rather more scarce than in Western Europe.

A further question, which I did not put to all the pathologists at the time but asked them subsequently by letter, concerned postmortem-room technicians. I did not have replies from all of them, but in Western Europe the cadaver is apparently never opened by the technician when the pathologist is absent. The cranium may be removed in his absence, but the brain and meninges are not disturbed. These technicians seemed to have little or no training apart from on-the-job apprenticeship. In Poland I found that these technicians were unqualified and worked part time. They are usually old men who put up with unpleasant work for extra pay. Traditionally, they open the body and remove the organs in the absence of the pathologist, but efforts are being made to stop this practice.

Conclusion

The management of pathology laboratories in the EEC countries and in Poland seems to be much as it was in Great Britain before the Zuckerman Report was published. It seems to be efficient and I discovered no evidence of dispute between the various members of staff, nor did I find any suggestion of claims by technical, scientific, administrative, or other staff to take over management from the medically qualified director. One wonders why Great Britain should be the only country that I visited where this claim is made. Only Poland has a national health service financed by the government, but the insurance schemes in other countries seem to be effective.

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References

[1] *Gazette of the Institute of Medical Laboratory Sciences*, January 1977.
[2] DHSS, *Organisation of Scientific and Technical Services*, HSC (IS) 16. London, DHSS, 1974.
[3] Committee on Hospital Scientific and Technical Services 1967-8, *Report*. London, HMSO, 1968. (Zuckerman Report.)
[4] DHSS, *Scientific and Technical Services in the NHS*, Path 18, 1977-8. London, DHSS, 1978.

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What are the chances of a return to normal function after rupture of the supraspinatus tendon sutured within three weeks of the injury?

Rupture of the supraspinatus is usually associated with previous degenerative changes in the supraspinatus tendon, and the patient is nearly always elderly. The chances of return to normal function after suture, even if this is within three weeks of injury, are very small indeed, and this is probably largely due to the pre-existing degenerative changes. Even if "normal function" does not return the patient will often achieve reasonable use of the shoulder and arm, albeit with limited active and often passive abduction movements of the glenohumeral joint.