TALKING POINT

Pathology laboratories, management, and the future: fact or fantasy? A glimpse into a crystal ball

G W PENNINGTON

Traditionally, the management of pathology laboratories has been in the hands of consultant pathologists or scientists of equivalent standing. During the past decade, however, many challenges have been made to this traditional management structure and there is now evidence that the incidence of such confrontations is increasing.

The management of pathology laboratories has been protected by the guidance issued by the Department of Health and Social Security in 1974.¹ A similar circular was published for Wales (WSC(IS)27).² The circulars recommended that the services should continue to be hospital based and that a departmental structure was appropriate with medical and non-medical staff participating. This is a permanent association, the participants of which are not necessarily all drawn from the same profession—for example, a chemical pathology laboratory may be staffed by pathologists, biochemists, and medical laboratory scientific officers.

The fundamental unit described is the "department" comprising a body of people associated in a single discipline—for example, chemical pathology, microbiology—"managed by a medical consultant or a non-medical scientist of equivalent standing who is head of the department." If there is more than one medical consultant or scientist in a department the health authority is advised to consult the staff concerned in order to designate one to be head, either for a term of years or for an undefined period. An equivalent circular was not issued in Scotland but, because of the number of industrial disputes in Scottish laboratories, the Scottish Home and Health Department has recently issued 1984 (GEN) 4.³ This is currently subject to a legal manoeuvre by the trade unions concerned to attempt to prevent its implementation.

Attempts to undermine pathologists

Over the years pathologists, and to some extent radiologists, have been in the front line of attempts by various professional organisations and trade unions representing medical laboratory scientific officers to undermine the position of the pathologist as head of the department by stating that they do not recognise HSC(IS)16 (or its Scottish or Welsh equivalent), and by suggesting that medicals should undertake "clinical" duties and not be concerned with the day to day running of the laboratories.

In attempting to achieve these ends the scientific officers have, through the Whitley Council B, managed to obtain a post of principal medical laboratory scientific officer with floating duties between the disciplines. This is mainly administrative in nature, though the person appointed is stated to be in overall "technical charge." It is an anachronism that at a time when medical pathologists and Whitley Council A graduate scientists are confining themselves to one discipline a medical laboratory

scientific officer appointment should be made across disciplines when the person has often received training in only one. He is, however, easily accessible to the district administrator, and this may lead to the attempted exclusion of the consultant pathologist in his rightful role as head of department. There have also been attempts by writing it into their job descriptions to make medical laboratory scientific officers directly responsible to either the district administrator or the district medical officer—a further attempt to bypass the control of the consultant pathologist.

In the latter instance pathologists were not helped by the publication in the *BMJ* of specimen job descriptions for district medical officers in which responsibility for laboratory staff was stated to be held by the district medical officer.⁴ This article, from the Central Committee for Community Medicine and Community Health, was published without consultation with other craft committees of the BMA and has since been nullified with respect to laboratory practice and responsibility.

In Fife, in an effort to invalidate consultant control, reports in cytology were sent out by the medical laboratory scientific officers without referral to the consultant. After instructions from the health authority to the contrary there was a sit in at the laboratory. The police had to eject the medical laboratory scientific officers, and court action was brought against those concerned.

It could be argued that some management problems in laboratories would be alleviated by amalgamation of Whitley Council A (graduates) and Whitley Council B (medical laboratory scientific officers) into a single spine structure. Though this is possible, there would undoubtedly be rejection by both groups as to where their precise places in the new structure should be. Others would take the view that before such an amalgamation could take place there would have to be a thorough review of the future needs of National Health Service laboratories.

Though pathology has been in the forefront of management battles, it should not be assumed that all is strife; it is not. There is unrest in only a small number of laboratories throughout the country. In most laboratories a happy and stable relationship exists between the various types of staff, each with a knowledge of their own responsibilities for the good of the patients whom they serve.

Difficulties in other disciplines

Even so, unrest is not confined to pathology. A challenge to medical leadership has arisen in radiology where consultants have had problems with some radiographers seeking to control departments. Psychiatrists are also having problems with some psychologists and social workers, where group decision making has been allowed to override the views of the doctor. The implementation of the new nursing proposals *Towards Standards* threatens to produce problems between the medical and nursing professions at the bedside.⁵ Once the consultant has prescribed nursing the type of nursing care given and implicitly the length of stay in the recuperative period is decided by the nurse. The control of the patient will, therefore, pass to the nurse,

but responsibility will remain with the consultant—an impossible position.

Furthermore, we now have the implementation of the Griffiths report, as outlined in the official circular HC(84)13, and the appointment of general managers at regional, district, and unit level, each with defined responsibility and possibly leading to the determination of new management structures.⁶ Although it may be argued that this need not conflict with HSC(IS)16, previous experience of changes in organisation indicate that there will again be challenges to the medical control of laboratories.

It seems likely that a single person may be appointed in management control of the entire laboratory complex—not as at present on an individual discipline basis but rather like the old days when an appointment was made by the health authority in “administrative charge.”

Unacceptable proposals

Either through neglect or by management incompetence, some management functions may pass into hands other than those of the consultant or non-medical scientist of equivalent standing. Alternatively, some health authorities may now think that they have considerable freedom to determine the most appropriate structure for themselves, and this undoubtedly means that some pathologists will be faced with unacceptable proposals and will have to be prepared to argue their case strongly through the medical advisory machinery to the health authority. The problem for the health authority is that the post of a laboratory manager will be seen as meaning a far greater non-clinical managerial commitment than that of the chairman of a “cogwheel” division. Not all consultant medical staff would wish to take such a post and not all would adjust to a redefined managerial role. There is, however, little doubt that once such a post is taken up the consultant with management aptitude and inclination may well hold it for considerably longer periods of time than is the current practice. However unpalatable this is, it will have to be measured against the possibility of having a principal medical laboratory scientific officer to whom heads of department are managerially accountable.

In the longer term it is also possible that the introduction of management budgets for clinicians may provoke further upheaval in pathology laboratories. It is difficult, at this point, to speculate what effects this will have until the present experiments are analysed. It is possible to visualise (although unlikely) that the cost of laboratory services might be itemised out on a historical basis shared between consultant medical staff and general practitioners according to the extent of their previous demands. Once these consultants held their budgets they would be free to reduce their demand for tests in order to save money; to transfer to other areas of need such as medical equipment.

In theory this is fine, but one of its practical consequences is that the manager of the laboratory and heads of department could find that half way through the year the income from clinical consultants was not even sufficient to pay salaries let alone cover consumables because of the drop in demand. This could lead to the dismissal of staff and, for example, the withdrawal of emergency services.

Renewed Luddism

In its entirety this seems an unlikely scenario, but even if only partially implemented it may well strengthen the resolve of health authorities to put a strong laboratory manager into

the management structure during the changes next year. Added to all these potential problems are the changes taking place in the laboratories themselves. The story of the Luddites is worth retelling as technological advances elsewhere may conspire to decrease the volume of laboratory testing while simultaneously increasing the productivity of those who test.⁷

Luddism refers to the act of irrational and futile machine wrecking by skilled workers whose jobs had been eliminated by automation. The original Luddites were English handloom workers who became unemployed as a result of new technology in the weaving industry, coupled with a decline in demand for woven materials and a move by employers to lower labour costs by replacing skilled weavers with automated looms and child labourers. Although the corollary with the present laboratory position is obvious, it is hoped that such events would never take place in National Health Service laboratories.

The old philosophy that bigger is better is being exchanged for test results at the lowest cost possible. Innovative approaches to accomplish this end will include increased reliance on automation with unskilled “machine minders,” cluster laboratories, bedside pathology, and possibly contracting out of laboratory services. It is rumoured that pathology is on the government’s list for possible contracting out.

As this trend gains momentum—particularly with the advent of general managers and clinical budgets, and as jobs are progressively eliminated (for there is an element of overstaffing at the highest technological levels in some laboratories)—anxiety and rage may well be common reactions. If irrational and futile destruction of laboratory equipment did take place history buffs would not be surprised.

There are, however, lessons to be learnt from outbreaks of Luddism in the past; change should be gradual rather than cataclysmic and, if possible, the elimination of jobs should be through attrition and not lay offs.⁷ Unless a thorough laboratory survey demonstrates the contrary, it may be futile to continue to train skilled laboratory staff—and possibly pathologists—if the demand for their skills rapidly declines.

In the years to come fewer workers will be required to provide laboratory services for inpatients and outpatients and many currently skilled positions will be eliminated as unskilled personnel use automated machinery. It has recently been suggested in America that there will be a reduction of 50-60% in current manpower.⁷ It is hard to believe that this country will be different. If this is substantiated we had better start preparing for the future. But all of this is conjecture based on the changes currently being introduced into our hospitals and laboratories and perhaps other interpretations are possible.

In preparing this article I was helped by Professor Roger Dyson’s paper *Implementing the Griffiths Report—Implications for Pathology Laboratories*, which was sent to all members of the Association of Clinical Pathologists, and by the views of Dr H Soloway, editor of *Pathologist*.

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