Clinical pathologists—a threatened species?*

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All pathologists, and especially those of you who are of my generation, have been giving increasing thought to the career prospects for young doctors and share, with me, concern with the declining recruitment to our speciality. Like you, I can look back over some twenty or thirty years to the days of numerous applicants for Consultant Pathologist posts, impressive short-lists with candidates of quality and high qualifications, products of our own universities and training laboratories and we often experienced real difficulty in choosing the successful applicant. We certainly never dreamed of the situation that has developed over the last ten years. One can recall sitting on an Advisory Appointment Committee in 1960 with a past President of this Association, where there were 21 applicants, 18 of whom possessed an MD or MRCP or both and one of the distinguished "short-list" candidates was appointed to a small provincial laboratory, the condition of which if found today, would not only attract no applicant but would also necessitate closure on safety grounds.

It is the decline in young doctors in training and particularly the number of applicants for consultant posts in clinical pathology, the emergence of a number of what I will call "threat factors" in our professional environment, and the gloomy prognostications of my contemporaries, that have prompted me to choose the title of my address. I shall attempt to examine the factors that operate in the complex work arena that confronts us all and try, by analysing evolution and trends, to indicate how those who have some ability to affect the destiny of our speciality and in particular this Association, can bring about an improvement in our affairs. My anxieties stem quite simply from my firm belief that the "good laboratory"—that is, one that operates with high quality, efficiency, economy, harmony, and one which encourages new ideas, is one with the right type of medical direction at its head.

Of course as a speciality fundamental to medicine

and considering the changes in diagnostic and therapeutic procedures that we had to assimilate, adaptability and versatility were hallmarks of the clinical pathologist, and indeed were part of the attraction of the speciality. We could look forward to continuous stimuli, interest and variety. What was not anticipated by my generation was an increasing encroachment upon our professional and scientific function by factors extrinsic to this but nevertheless vitally affecting our professional activities and our freedom. Twenty years ago the words "management", "functional budgets" and "union" were absent from the pathologist's work vocabulary and even "responsibility" was a rare word; we all knew who did what and what they were responsible for. It is in this context and out of concern for young doctors entering our speciality and out of hope that we can increase their numbers, that I direct most of what follows to the younger pathologists, those in training and those recently established as consultants.

Past history

Before they can fully appreciate the problems affecting us today, it is I think necessary for them to have some knowledge of the evolution of our speciality, particularly since the establishment of the NHS. Without our younger colleagues having some knowledge of past history affecting clinical pathology, they will be less well equipped to deal with the threats that exist for them today.

The advent of the 1939-45 war, produced new services of major significance, the Emergency Medical Service (EMS), Pathology Service and the Emergency Public Health Laboratory Service (EPHLS). The latter was generated largely out of expectation of microbiological warfare and the former to cope with the dispersal of population out of the major conurbations. Both these services were to a large extent, created by the dispersal of academic pathologists from teaching hospitals and research institutes, and this sudden availability of expertise all over the country gave an immense impetus to clinical pathology which consolidated its position as a speciality in its own right. For the first time, not only

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rural areas but towns and hospitals of considerable size, experienced modern well organised and administered Public Health bacteriology and clinical pathology, with doctors in charge of these laboratories.

With the advent of the war, the pathology services in the armed forces received an enormous transfusion of academic and practical pathology "know how", which of course became essential for the proper prosecution of hostilities especially in medical high risk areas in the Middle and Far East. You will know of many distinguished members of this Association who gained international reputations in these various war situations and in distinguished professorial and other posts they later held.

I hope to convey to you that by the time the NHS was established in 1948, pathologists and clinical pathology were on the ascendency in a big way. Military service experience, coupled with the post war supernumerary trainee scheme, coupled with rapid introduction and expansion of pathology services in the NHS all over the country, appeared to transform clinical pathology into a "boom" speciality. Yet even at that time, a major threat appeared in a move mainly by surgeons and physicians to relegate the clinical pathologist to a sub-consultant status with a grading, and of course remuneration structure, inferior to theirs. Do not forget that it was due to the stand taken by a few members of this Association that this move was defeated, but even so a considerable degree of status threat emerged. The majority of consultant pathologist posts at that time, especially a second or third post in a large laboratory, were advertised as whole-time without a part-time option and not only were the holders debarred from private practice but also payment for domiciliary visits. The first decade or two of the NHS thus saw two types of consultant emerging; the part-timer believing himself to be, and behaving in a manner superior to the whole-timer. The SHMO (Senior Hospital Medical Officer), sub-consultant grade was also frequently applied to pathologists.

You will appreciate therefore that at this time status within the profession was a major pre-occupation of the young consultant pathologist. This was a paradox when you consider that he reigned supreme in his department, especially if he was in sole charge. He and his chief and senior technicians trained the staff; (the Institute of Medical Laboratory Technology was just emerging), and he was appointed and expected to run the laboratory. The whole of the performance and relationships whether in a hospital, public health, or reference laboratory could clearly be seen to reflect the calibre of the consultant head. Problems existed for recruits to laboratories having senior long-established patholo-

gists, especially with a private practice component in "general pathology" role; partly for this reason, but mainly because of the problem of professional freedom being every bit as important to the young pathologist as status tended to choose a whole-time appointment if there was any option.

The young consultant wanted no constraints placed on him by clinical colleagues especially, but also wanted professional freedom vis-à-vis senior pathologist colleagues.

I illustrate this by a case I knew where a young consultant was appointed to a provincial laboratory and found not only that he had to correct misuse of laboratory tests by clinicians of long standing, but also found that those same clinicians were accustomed to take technicians out of the laboratory to collect blood and other specimens during domiciliary or private patient visits.

The young pathologist was able swiftly to correct all these curious arrangements without hesitation because he was whole-time and his contract at Region meant he was free and independent enough to do what he knew was right. He could develop the function, quality, and prestige of his laboratory without interference from the clinically arrogant, and this is exactly what he and countless others in similar circumstances proceeded to do. All this accounts for the predominance of whole-timers in clinical pathology, and also the growing demand from the younger consultants at that time for an independent College of Pathology as opposed to a Faculty of the College of Physicians.

I think it is fair to say that by the mid-50s most of us had got what we wanted, aided by strong Regional and Central Pathology committees and I am inclined to regard this as the Golden Era. The magic "10% per annum" increase in staff and equipment was an accepted "norm" from the Ministry of Health downwards. We were masters of our destiny or almost! Clinical pathology in the late 50s appeared to have rosy prospects for the future. Why has this not fully materialised? What are the factors that have changed the situation for pathologists from one of relative stability and confidence to instability and doubt about the future, even a sense of threat? Why are we now plagued with worries and uncertainty? Why do some of us even question our future as medical specialists?

In no particular order, and picking only what I think are the major factors, I would list the following:

CHANGES IN LABORATORY MEDICINE AND THE ROLE OF THE CONSULTANT PATHOLOGIST

There can be no "putting the clock back" to reduce

the vast amount of now routine diagnostic and preventative technological procedure in our laboratories, which has forced the clinical pathologist over the years to retreat and rely more and more on scientists, technologists and automation, to the extent of becoming almost factory-orientated and -dependent. This has been accompanied by the introduction of non-medical science graduates which has been a major factor in the development of clinical biochemistry for over two decades and has led to the tendency on the part of the clinical pathologist to show a "flight from technology", not only in biochemistry but also in haematology, immunology, and microbiology. There is no doubt that this has threatened and depressed recruitment to biochemistry of potential chemical pathologists, though there are signs that this is not so severe a problem today. Possibly this stems from a clarification of role or the attempts to do so, but there are signs that the total clinical orientation of the laboratory doctor will produce situations of difficulty vis-à-vis the physician in, for example, infectious disease or oncology or endocrinology.

For this and reasons I will give later, I do caution the tendency to flee from technology. At the same time surely, there can be nothing but advantage with the present trend towards using analytical equipment outside the laboratory at the requesting level providing adequate quality control and qualified supervision are retained. This should help reduce the factory input to laboratories with consequent elevation in importance of procedures requiring consultant involvement. Also the requester, if he or she has to process the request, will be more critical of its real necessity.

What one cannot predict is the degree of challenge in the future to medical direction of laboratories. I am uneasy for this reason about the phrase describing non-medically qualified personnel as of "equivalent status" to consultants. Of course other doctors are facing similar challenges especially in psychiatry, geriatrics and radiology; physiotherapists have long since gained independence to advise and treat patients and there are at least 3000 in independent practice in this country.

However, as I have said to some of you before and will say again, I do believe that *recorded* statements and opinions from laboratories relating to the diagnosis or to differential diagnosis or to the treatment of a patient, and statements of a patient's prognosis, should always require the signature of a medically qualified person. They are after all not only important to the patient clinically but would have grave medico-legal consequences.

MANAGEMENT DISPUTES AND THE ADVENT OF TRADE UNIONISM INTO THE HOSPITAL ENVIRONMENT

I am of the opinion that the advent of Trade Unionism, and you know what I mean by this term, to the hospital and laboratory scene has done a great deal of damage to clinical pathology as a career for scientifically motivated doctors. In the past the great majority of us entering clinical pathology, especially on a whole-time basis, did so for the intention of promoting modern high quality patient care; if you like putting the sugar icing on the clinical cake. We also required order and tranquility for the proper execution of research. Strife over management and demarcation of responsibility are anathema to these ideals.

The Zuckerman Report of 1968 and circular HM (71) 47 brought matters to a head by questioning the traditional relationships between professional staff in laboratories, and has been responsible for confrontation and the agonising gestation of circular HSC (IS) 16 and the inadequate response of the Royal Commission.

I am sure that all of you like myself, have heard senior colleagues say that they would be unlikely to consider clinical pathology as a specialist career today because of these factors. Many certainly consider them to be a major cause of poor recruitment but it is necessary to keep a sense of proportion and realise that all hospital doctors, and the country generally, can suffer from irresponsible wielding of Trade Union power; but of course we are involved in direct managerial accountability and are more constantly in touch with possible stresses in this field than are other medical colleagues.

We should never forget that, unlike much of industry, we can invoke great public support and sympathy in a strike situation if, as our colleagues showed recently in affected areas, we can ourselves maintain an essential service. This has a far-reaching effect on public opinion which might not be so concerned with, or take much note of, a comparable situation in an industrial dispute. Experience has shown that far from inflaming the situation, increased respect and understanding has evolved between pathologists and MLSOs. For this reason again, I do urge caution about the tendency for the "flight from technology" and the growing emphasis on the clinical role of the laboratory doctor. I believe the latter is vital, but it should not be at the expense of remaining technically "in touch", not just so as to be able to deal with a shut-down but more importantly to enable understanding and appreciation of the problems of our MLSOs and the great contribution they make.

THE CHANGE IN ATTITUDE TO WORK WITHIN THE PROFESSION

By the changing attitude to work within the profession, I refer to the negotiating stance taken, whereby remuneration is more and more being related to quantifiable professional activity, and at the junior end, introduction of the UMT system is a prime example of this and I know is held by many of you to be a major cause of poor recruitment to our speciality. This and changes in consultant contracts, typify the weak power-base we pathologists have in the negotiating sphere. I do not deny for one moment the splendid work done by comparatively few colleagues on our behalf; it is simply that we of course are heavily outnumbered by clinical as opposed to laboratory orientated specialities.

How can you quantify supervision, maintenance of standards, consultation, administration, management and research in the face of quantifying numbers of patients, operations, treatment procedures etc? It is often difficult to make surgeons or physicians dealing with consultant negotiations, appreciate that the quality of their laboratory service is determined by the quality of consultant pathologist leadership and how do you answer them when they ask for a valuation to be placed on this?

CHANGING ATTITUDES TOWARDS THE MEDICAL PROFESSION

There is now a very noticeable change in the attitude of the public towards the profession and more particularly in the attitude of other health professions; almost weekly we witness the criticism in the media of the doctors role in society, varying from politicians' rantings, to supposedly dispassionate Reith lectures. The doctor's aura of omniscience and infallibility is challenged at many levels. This is not unique to the UK; in the USA the nurses have been making a bid to take over a diagnostic and therapeutic role in hospital medicine.

The antiauthoritarian trend is understandable on two grounds certainly; firstly, infallibility is frequently shown to be a myth, and secondly we in particular know the great and growing contribution in scientific and technological fields made by non-medically qualified personnel. Nevertheless, the abolition of a hierarchical structure in hospital medicine and particularly laboratory medicine, has had a profound effect and pathologists have had to exchange the relatively easy role of "director" for the far more difficult role of "manager"; one relatively free of threat for one that appears to be constantly under threat.

THE FINANCIAL DECLINE OF THE COUNTRY

The declining financial resources of the country have

changed the happy "10% per annum increase" to one of defensive rearguard action further complicating the pathologists' role and involving him in the handling of the so-called "budget". If he is to be seen to be responsible for the total laboratory function, he has to manage the direction of the functional budget—an activity considerably removed from the pleasures of clinical pathology and research.

ALTERATIONS IN CONSULTANT CONTRACTS

Alterations to consultant contracts stem again from negotiations carried out mainly by clinicians with a strong power-base and with motives as I have already referred to; based on quantifiable clinical work but also based on subsidiary sources of remuneration including private practice. Here again, our power-base in these matters is vociferous but in the minority. Many pathologists entered their career to avoid involvement in the day-to-day financial marketing of their services and recent negotiated contract changes have not been to their liking; but to be fair some others are well satisfied.

The foregoing is just a summary of our problems which twenty or more years ago hardly existed. I suggest to you that together they constitute a situation warranting the subject of this Address. Are clinical pathologists a threatened species? I think the answer today is "yes", but perhaps not quite so much as it would appear, and I am now going to look at changes and new factors in our speciality which augur for future well-being.

Factors giving reason for optimism

RECRUITMENT

Firstly, I do not think that we are in a permanent recruitment crisis and I doubt if large scale drastic action is required. It is noteworthy that anaesthetics is now no longer a shortage speciality; the simple publicity of it being a shortage speciality for some years, coupled with the provision of larger numbers of recognised training posts and coupled, I suspect, with growing job competition, seems to have taken care of the problem.

I am sure the growing overcrowding of the junior doctors ranks with genuine unemployment now being forecast, together with the drying-up of overseas opportunities, will lead to plenty of recruits within the next three years at the most. What we are short of is training posts. One reason for this is that many of us in the Regions, after years of erratic availability of trainees of variable quality, many coming from and returning overseas, have opted for another consultant post or a medical assistant to give permanency and to improve our own work output by

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not having to train and check our trainees. The situation now is that with many regional consultants having a personal work load far in excess of the College "norm", they simply do not have the time for proper training of SHOs and registrars; this is very unsatisfactory as regional laboratories are the best training ground at registrar level for future consultants.

With fewer trainers these posts as far as Regions are concerned, will have to be created at relatively few selected laboratories until the consultant establishment is increased.

Encouragement for the young doctor to make a positive decision for pathology early in his career, depends to a large extent upon the impression he gains in his undergraduate and preregistration years of the role of the clinical pathologist and here we have a serious deficiency; what could be called a crisis of identity. I am afraid that in general we do not project a clearly discernible attractive image. Textbook pathology and "clinicopath" conferences and necropsy attendance in the undergraduate years, do little to enlighten the embryo doctor as to the day-to-day work of a clinical pathologist in a regional laboratory.

Our junior members plea for more training and contact with consultant clinical pathologist practice in the undergraduate years is entirely praiseworthy, but will it materialise in the face of fierce competition from every medical faculty for student time in an already lengthy training? One solution to this problem might be the introduction in the pre-registration year of a period of compulsory attachment to a clinical pathology department.

Even as little as a month of this in a busy provincial general hospital laboratory would be invaluable, not only as an eye-opener to the young doctor, but also would repay enormous dividends in correct and economic usage of the department, and tied to the coat-tails of enthusiastic consultant pathologists on rotation through each discipline, would above all show them how to consult with the clinical pathologist who has rightly been referred to as the consultant's consultant.

I also have a feeling that improved recruitment by the juniors making a positive early decision to enter our ranks, rather than to sidestep from a "popular" speciality in which they have failed to progress, will be good for clinical pathology. Also my generation should not forget that pathologists in training today are growing up in the altered environment which we find so hard to accept. They may take management in their stride and adapt more aggressively and progressively to their professional environment.

PRIVATE PRACTICE

Secondly, I would touch briefly on private practice and its recent availability to whole-time consultants. For about 25 years I have been accustomed to give the same service to my part-time colleagues private patients as to their NHS patients and have been nourished by periodic expressions of thanks and goodwill and the occasional pathological rarity. I am sure this is common to all whole-timers.

There has all the same been an uneasiness in this situation in that the honest clinician has to explain to his patient that his pathologist colleague's work is free on the NHS or simply refer to the "lab", leaving out of consideration a consultant opinion reached sometimes with long labour and difficulty and dependent upon years of knowledge and experience. You will all, regardless of speciality, readily evoke clinical situations where your contribution is diagnostically or therapeutically or prognostically critical and the major factor in charting the private patient's course. For this reason I personally see good for our speciality in having the opportunity to price our worth vis-à-vis surgeons and physicians.

I have no time to detail problems but there are two principles that I would mention, one is that you should charge the patient direct so that you as a consultant are identified by name and contribution. If you work as a group of consultants, one name would suffice.

Secondly, I have heard a suggestion that you should have a standard fee for all reports including histology reports, this is in my view unacceptable; clinical management and operations carry a wide variety of fee dependent upon difficulty and experience; so does your work.

I know these changes in contract have met with a mixed reception in our ranks as far as private practice availability goes and I share many of your misgivings, but on balance in the present medical climate in this country I am in favour of the changes. One thing is necessary to clarify, not only with one's clinical colleagues but particularly with your MLSOs with whom you will wish to come to an accommodation, and that is that while you are entitled to expect all NHS work due to you, private work is in the hands of the clinically responsible doctor who is free to choose his source of pathology, radiology etc. Therefore it will be the reputation of the pathologist or pathologists involved which should be a major factor in attracting private work.

Council of this Association meeting informally with Dr Gerard Vaughan, Minister responsible for the health service, expressed anxiety over private pathology laboratory management not being in the hands of qualified pathologists exercising proper quality control and ethical standards. Similarly the

anxieties of our chemical pathologist colleagues over the carrying out of analytical procedures outside recognised clinical pathology laboratories, could have relevance to the private sector.

This is of particular relevance in situations where groups of consultants have tried to set up technician-run private laboratories minus quality control and consultant pathologist opinion and supervision. Neither do we wish to see the emergence of the foreign scene of "business" medicine with the maximising of investigations partly for defensive reasons but also for the maximising of income. I have no doubt that none of us wishes to see clinical pathology in this country follow that course. For this reason, the present Government's encouragement of the rapidly expanding independent practice component, for clearly understandable reasons, requires watching.

Sooner or later you will find that major expansion of private practice will carry with it a demand for controls, restrictions and monitoring of activity. For some time in the USA, the provident institutions, faced with soaring costs, are demanding a "rationing" of clinical pathology; Government faced with patient complaints at the cost of being ill and the readiness to involve doctors in litigation because of high fees, has led to the growth of systems of Professional Audit. Here the development of "Complaints Procedures" starting with the Davis Report and still continuing today, brings me to consider another likely change in your activities, not imminent but in my view not far off.

MEDICAL AUDIT

So-called Medical Audit, as I have hinted, is a process which appears to arise when the profession is under criticism and threat. As the Australian experience in 1972 showed, Government can force its introduction as a matter of policy usually as a consequence of public criticism and concern.

Three years ago when I was a member of the CCHMS, I was invited to chair a working party on "Medical Audit" and to be quite frank my main motive in undertaking this somewhat daunting task was that I knew that clinical pathologists have a major part to play in any kind of what is in effect clinical quality control. It seemed to me that if some kind of audit was introduced then a probable result of this would be a significant, possibly in some instances predominant role, falling on pathologists. It would have a profound effect on the status of pathologists within the profession generally.

I do not have time to detail the report of the working party but in brief it consisted of two parts. The first dealt with Continuing Education which if implemented could have transformed the scene for

our Education Secretary; his courses would all have been oversubscribed! Sabbatical leave on a properly organised basis was an important feature of this section on Continuing Education. The second part analysed current "audit" processes which are already considerable in our hospitals but expanded these into a more formal periodic review primarily informative and educative involving voluntarily, all hospital medical staff in analytical procedures with formal meetings, aimed not primarily at revealing "poor performers" but more at revealing unknown facts, statistics and data which call for remedial and updating action.

Topics such as perinatal mortality; use and abuse of blood transfusion; avoidable postoperative sepsis; coronary care etc etc, it was envisaged would be chosen with the objective of bridging the maximum consultant involvement and obviously in many of these the clinical pathologist would play a major part in providing statistical information and opinion. Because of his wide involvement in many specialities and with many individuals and having a knowledge of so much variety of input and output, one could imagine some topics being largely developed and organised primarily by a pathologist.

An inevitable by-product of this was the question of the clinical "poor performer" and what might happen in the event of an audit process repeatedly revealing a serious personal or speciality deficiency. It was here that the projected scheme foundered; the education component was accepted in principle but because we do not have the same degree of political pressure *yet* in this country as compared with the USA and Australia, the whole report has been shelved. I shed no tears about this except to say that I regret the shelving of the Continuing Education component.

Medical Audit is being developed by GPs, and the Royal College of Physicians is conducting an enquiry into it and I expect in due time, pathologists will be asked to participate. I expect in years hence continued criticism of the alleged immune omniscience of consultants will force some kind of audit into hospital clinical practice. If this is so, I urge all pathologists to be watchful; your involvement can to a large extent put audit on to a scientific and educative basis and help to steer it away from a paranoid and witch-hunting atmosphere of which, rightly, the consultant sector is scared. The working party went out of its way to point out that properly handled audit could be a powerful weapon for achieving proper funding and allocation of resources to the good of the nation's health service.

A NATIONAL PATHOLOGY SERVICE

Some of you, I know, consider that the changes in the

clinical pathology environment are so threatening from professional and service aspects, the situation to be so lacking in progressive thought and policy, and so subject to political interference, as to require complete reorganisation of the clinical pathology services of the country.

The holders of this view suggest a need to chart a new course and policy because of the changed scene with which we are confronted; as examples of political pressures, they point to the "Patients First" restructured health service administration and to the discussion document "The Future Hospital Provision in England". The former is evolving now; the latter could be accepted as future hospital strategy in part or whole.

Both these NHS policy changes have a fundamental effect on pathology services and some pathologists feel that if only their service administration could be separately organised, they could then feel free from constant change in policy, change in financial control, and the involvement with parochial interference.

Small wonder then that pathologists caught up in this web of politically motivated change in the pattern of the NHS provisions ask the question, "What about a National Clinical Pathology Service?"

In considering this, let us suppose that we had a separately funded and administered service, one run by a Clinical Pathology Services Board, perhaps similar to the PHLS Board, appointed by the Secretary of State with similar statutory representation of which about one quarter would be pathologists. Today it would almost certainly involve, directly or indirectly, Trade Union representation and of course all this would require an Act of Parliament to implement such a scheme. The Board would appoint a Director and Deputy or Deputies perhaps representative and responsible for each branch of pathology and an executive to run the service which would include the National Blood Transfusion Service.

Being independent in administration, it would have a grading and pay structure of its own, possibly along the lines of the PHLS. The capital and revenue allocation to the service would come direct from the DHSS.

What advantages can one see in such a scheme?

First the strategy would be based primarily on informed pathology advice and reasoning; the execution of that strategy would be entirely in the hands of pathologists and scientists. It would be less susceptible to local political whims and pressures. The service could be tailored, not to rigid local authority district or regional boundaries but primarily to hospital and locality service requirements with special centres on an area or regional

basis for specialised, or complex, or expensive functions and for the co-ordination of expertise. All this would be centrally planned and co-ordinated by pathologists via the executive. A management structure could be defined nationally. The use of financial resources would be directly controlled. There would be greater staff mobility to deal with crises in laboratory manning. Meetings of laboratory directors would enhance sharing of ideas and sharing in policy making, management, and research co-ordination and in collaborative investigations. Continuing Education and up-dating exercises would be developed; not only would laboratory quality control be maintained but a degree of indirect and informal pathologist professional "audit" would follow.

One can think of other advantages that such autonomy might bring including that of knowing in advance the capital allocation year by year, and also direct access by Directors of Laboratories to the Head of the service.

What are the disadvantages?

First is it likely that more money from Government would be forthcoming to a Pathology Board than is currently spent? Not only is there pressure from the present Government to cut back today on all centrally funded schemes, but a great deal of laboratory expenditure in the NHS coming from two sources Region and District, each with some difference in approach for equipment, staff, consumables, service contracts and structural maintenance etc, is sufficiently variable and obscure as to enable many laboratories to do a lot better than if the whole pathology service expenditure was separated off and laid bare for all to see. The financial aspect is critical.

The sheer size of the undertaking would render impossible on a national basis the advantages that smallness in size gives the PHLS; also in dealing with four or five disciplines, each becoming increasingly independent of the others, would enormously complicate organisation.

On a *national* basis it might only be manageable as a single discipline structure like the PHLS and this would fragment the clinical pathology services.

On a *regional* basis a multidisciplinary service might be feasible; it would be a larger scale of the wartime EMS sector pathology service which based each sector on a teaching hospital. This would extend and separate off the present regional pathology and base it in Regional Health Authority control and not in District Health Authority control. This is totally against present Government policy.

The separation of pathologists as consultants from the same management and administrative environ-

ment as all other consultants would damage their status within the profession, and sooner or later lead to their being regarded as non-clinical doctors of inferior status. This would operate against pathologists aspiring to greater clinical involvement in their work as consultants.

The transition of all pathologists to a separated service from other clinical consultants would greatly weaken our power base. At negotiating level we would tend to be regarded as a separate group of doctors and in seeking support of other hospital doctors and general practitioners over such matters as management disputes, grading and pay disputes, our position I am sure would be greatly weakened.

There would be no guarantee that we would be immune from possible union trouble and we would be in a much weaker position to deal with it without support from our clinical colleagues.

These are only a few of the main points which occur to me and attractive as is the thought of working in a neat, tidy, well administered service, largely run by people who are of our kind and to whom one would have direct access; I have I think advanced good reasons against a national clinical pathology service but I leave you to continue the argument and one question that you have to ask to test the hypothesis is, will young doctors be more likely to become recruits to such a service?

It is of interest to note that an extensive study was carried out in Scotland some years ago by a working party of the Scottish Scientific Services Council. This was concerned with the future of Scientific Services in Scotland and it received a powerful appeal for a separate pathological service from a number of quarters. I was interested to learn that the working party found it could not support the suggestion and advanced many of the reasons I have outlined, and I feel this is very significant when one considers the rather different environment for consultants north of the border, with a long-standing predominance of whole-time appointments. If they rejected the

proposal, I think the rejection would be stronger south of the border.

This is not to say that we should not strive for a continuing reappraisal and restructure of the existing arrangements. The new Districts may prove to be insufficiently large for the trends in technology and in particular the College developments in pathologist training.

In conclusion let us not forget that today, compared with the first decade or two of the NHS, we have a professional organisation in pathology which is growing in strength, particularly resulting from the founding of our Royal College. We now have examinations and a training organisation clearly to be seen to be of first class standard and a pattern of education both for trainees and established consultants which is really all quite young, less than 20 years. We have a direct representation through the College President on the Joint Consultants Committee and thus to the DHSS. In particular this Association's splendid annual programme of post-graduate education and its journal have reached new pinnacles of esteem. Its broadsheets and twice yearly conferences are valuable contributions.

Of prime importance for the future is the clarification and integration of the role of this Association with the College. We cannot afford to compete, we must collaborate and this Association with its splendid record of over 50 years in looking after the interests of the laboratory *doctor* has a great contribution to make to the future. If such integration and strengthening is achieved, I feel confident that our younger colleagues, many of whom will in time reach high office in this Association, will look back on past Presidential Addresses and seeing this one, say "a threatened species, who said so?"

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