British postgraduate training in pathology

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SUMMARY There is growing pressure for a review of postgraduate training in pathology. The establishment of monodisciplinary practice, the rapid advancement of subspecialties with their attendant problems of recruitment, and the decline of research activity by those in training identifies the need for an early change in the pattern of training.

One of the most important contributions made by the Royal College of Pathologists in the past 25 years has been the setting of standards for formal training and assessment of pathologists. The history of this development is, to a large extent, also the history of the College.1

The older Royal Colleges of Physicians and Surgeons, with their well established membership and fellowship examinations after the Second World War were in a position effectively to ensure that all those appointed to consultant posts in medicine and surgery had obtained one or other of these qualifications. Thus they were able to ensure a minimum standard of training before entry into more senior appointments. Membership and fellowship courses flourished, “staff rounds” became established in many hospitals, and there was an urgency by trainees to learn. Furthermore, the intense competition for consultant posts by those who had served in the armed forces ensured continued education and training beyond the granting of these diplomas. Many were stimulated to develop further specialist interests, to undertake research, and to publish scientific papers. These were very much the “publish or perish” days for budding physicians and surgeons. Their enthusiasm to improve their curricula vitae by research activity and the achievement of higher degrees camouflaged the lack of initiative by the universities to assume a teaching role in postgraduate medical education. It fell more and more to the Royal Colleges to assume this role. An air of complacency existed within the universities that sufficient young men and women would come forward to provide for the needs of the universities. They did not see themselves fulfilling a role in postgraduate education to provide for senior appointments within the National Health Service, similar to that which they provided in undergraduate education for medical practice. Thus the universities missed an opportunity which has been difficult to correct.

During this time pathologists often found themselves in an inferior position compared with physicians and surgeons who had formerly held honorary appointments in the hospital. This was a legacy from the days before the establishment of the NHS. This inferior status was also shown by the lack of a higher qualification for pathologists which was considered to be comparable with membership of the Royal College of Physicians (MRCP) or fellowship of the Royal College of Surgeons (FRCS). Many pathologists sat the diploma in clinical pathology (DPath) or the diploma in bacteriology (DipBact) examinations, but these were never considered to be the equivalent of the established qualifications of the Royal Colleges. Not even the diploma of pathology examination of the conjoint board, which was set up by the Royal College of Physicians, became accepted as the appropriate qualification for NHS consultant pathology appointments in spite of the longer training demanded for this than for the MRCP diploma. In part, this lack of acceptance of the DPath may have been due to the failure of those who passed the examination to be considered for election to FRCP on the basis of this qualification. A few pathologists elected to sit the Edinburgh MRCP, which provided an opportunity to be examined in pathology as well as in medicine, but more were encouraged to develop research interests and to take a higher degree in medicine. Thus an MD or PhD became widely accepted as the most appropriate qualification for a consultant pathologist appointment. Nevertheless, it did not form an assessment of training for general hospital pathology practice, and more commonly, directed training into a narrow specialised field. It was against this background that the College of Pathologists was founded. It is little wonder that one of the first tasks which fell to the newly founded college was to start an assessment examination in pathology that would form the basis of a qualification suitable for consultant practice within the NHS.
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At the outset two important decisions had to be taken. The first was whether to continue with multidisciplinary practice in two or more branches of pathology or to adopt a policy of unidisciplinary practice. The second decision was whether to have an assessment for membership taken early in training or whether to have an assessment towards the end of training.

Unidisciplinary practice

By the time of foundation of the college unidisciplinary practice was already becoming established. University departments of pathology had generally become synonymous with morbid anatomy and histopathology. Bacteriology departments had been separate for many years, and virology was beginning to develop as a separate speciality. Some universities had developed academic departments of haematology and chemical pathology, but in others the latter remained as clinical pathology departments in the associated teaching hospitals. The move to unidisciplinary practice was also seen in those larger general hospitals where the number of pathologists permitted specialisation, but in smaller hospitals the general pathologist practising in two or more branches of pathology continued for some years.

Members of the Association of Clinical Pathologists who were on the Academic Affairs Committee of the newly founded College argued for an examination which encouraged multidisciplinary practice, with the four major branches of pathology being assessed in the primary examination and two subjects assessed in the final examination.1 It was regarded as detrimental, however, to academic development for trainees to be required to undergo such broad training, and of limited value to those trainees already committed to unispeciality practice as, for example, in the Public Health Laboratory Service. A compromise was reached which required candidates in the primary examination to take two subjects but only one was required for the final examination. Nevertheless, broad multidisciplinary training was required before the primary examination.

There can be little doubt that the rapid development of pathology in the past quarter of a century has been facilitated by this increased specialisation and unidisciplinary practice. In this respect the College gave a lead in pathology in the United Kingdom, which other countries have followed, but not all have developed this policy to the same degree. For the small hospital it has caused serious difficulties, especially for those in rural areas, where the size of the local population, and hence of the hospital, is not sufficient to justify a consultant in each branch of pathology. In many instances the failure of the College to provide for multidisciplinary practice has resulted in some branches of pathology being covered by non-medical scientists.

Unispeciality practice has also caused difficulty in some of the hospitals of the armed services and in those overseas hospitals staffed by pathologists who have been trained in the United Kingdom. Few, however, would now argue that a higher level of competence in each branch of pathology is not achieved by unidisciplinary practice, and there seems little prospect of a return to any other pattern of practice.

Early or late assessment of training

Whether to take a membership examination after two or three years of general professional training, or to assess competence for consultant practice towards the end of higher specialist training, was debated in the College early in its life and continues to the present day.2 The College of Pathologists departed from the practice of the Colleges of Physicians and Surgeons in opting for a late examination taken towards the end of training. The argument for this departure depended on the extent of knowledge at the start of postgraduate training. Medical students were shown the practice of medicine and surgery during their undergraduate clinical studies. They were expected to be competent in taking a history, the examination of a patient, and in simple technical procedures carried out at the bedside. The transition from being an undergraduate student to a pre-registration houseman was relatively small. During the pre-registration year, clinical training was further developed so that by the time formal post-registration training started, the young physician or surgeon already had several years of experience. How different was the situation in pathology. Although the pattern of undergraduate teaching of pathology varied from one medical school to another, the exposure of students to the practice of pathology was negligible in most until after full registration. Comparatively few medical students had the opportunity to study for a BSc degree in pathology and there was little opportunity for them to undertake project work. Few medical schools encouraged students to perform necropsies or to participate in the interpretation of surgical specimens. Teaching of bacteriology often concentrated on the structure and metabolic activity of micro-organisms rather than on the laboratory investigation and management of infections.

Because of the lack of practical experience in pathology at the start of postgraduate training, it was thought desirable that there should be an additional two years of training in pathology to bring the trainee to a level of experience in pathology equivalent to that of his or her colleagues in medicine and surgery.
Although the MRCPath examination was conceived as the final assessment of training, it was always assumed that trainees would spend one or two years in further specialist training before being appointed to a career grade. This basic assumption has become obscured with the passage of time, largely because the relatively low level of competition for consultant appointments enabled those who had recently passed the final MRCPath examination to compete with a reasonable chance of success. Many trainees now start looking for a consultant appointment immediately after obtaining their MRCPath and the period of further specialist training has been lost. This important feature must not be forgotten in any change of the training regulations that may be introduced.

Current training

Before embarking on training in pathology, further experience in another relevant branch of medicine is recommended. Junior pathologists are advised to gain a post-registration appointment in medicine or surgery before commencing pathology but this is not always possible with the current manpower structure. For haematologists, the combination of clinical management of patients together with laboratory practice has resulted in this further clinical experience being essential. Advisory appointments committees for consultant haematologist posts are unlikely to recommend a candidate without the MRCP, and to gain this qualification requires a period of post-registration clinical training involving the care of acute medical admissions. Microbiologists encourage trainees to gain experience in infectious diseases and chemical pathologists in endocrinology and metabolic medicine, but in neither of these branches of pathology is further postgraduate clinical experience a requirement for the trainee’s progress in the speciality.

This additional clinical training is often undertaken at the expense of laboratory training in branches of pathology, other than that chosen for career specialisation. The objective of the founders of the College that trainees should have broad experience in all branches of pathology has become eroded. Many trainees now have a clear idea of the branch of pathology they wish to practise at the outset of their training and regard the general pathology rotation as a burden with which they would happily dispense if it were not for the multidisciplinary nature of the question paper in the primary examination. Although the College recommends experience in several branches of pathology it does not insist on it. Indeed, its minimum requirement is that candidates for the primary examination should have worked in a laboratory where the four major branches of pathology are recognised, but it does not demand that the candidate has worked in each branch. If the laboratory is not recognised in one or more branches of pathology, however, then the trainee must supplement training by moving to another laboratory which is so recognised. The principle behind this ruling may be admirable, but without a requirement to work in each branch of pathology for a defined period the purpose of this supplementary rotation may be questioned.

It may be asked what purpose this multidisciplinary training serves. For those who are undecided which branch of pathology they wish to choose as a speciality, the opportunity to see each subject practised is of great value. Some trainees change their minds about their career intentions during this period, but this applies to relatively few. In spite of the divergence of the various branches of pathology there is still much in common; multidisciplinary general training enables the junior trainee to appreciate the interdependence of one branch on another. Few would argue that a knowledge of haematology is not essential in the interpretation of the histology of bone marrow, the chemical pathology of iron metabolism in the practice of haematology, or the microbiology of the gut in the biochemical investigation of malabsorption. Yet it may be questioned what relevance knowledge of the instrumentation used in these subjects, and hence of practical laboratory training, has to any other than those who choose it for their career speciality: but this is an aspect of training which is often assessed in the primary multiple choice question paper.

Lack of knowledge of other pathology specialities is now common in those who teach medical students. It is a sad reflection of modern medicine, possibly resulting from this very early specialisation, that undergraduate pathology teachers are reluctant to encroach on other branches of pathology in their teaching and restrict questioning in examinations to their own speciality. Some seem to have lost contact even with the basic level of knowledge of other branches of pathology required by medical students. Little wonder that newly qualified doctors see these subjects as widely separate. On the other hand, there is danger in a little knowledge gained from a short period of training at this stage. How many pathologists feel qualified to practise in subjects other than their major speciality at times of staff shortage or in private practice? How many haematologists, microbiologists, and chemical pathologists feel qualified to perform necropsies at the request of Her Majesty’s Coroners? If the demands of the service require this multidisciplinary practice then training must be made adequate for its provision. It is clearly unsatisfactory...
to accept training in those subjects which may have been limited to a few weeks or months as a junior rotating pathologist many years before. The period of general pathology training is recommended to last for 18 months to two years and is followed by completion of the primary MRCPATH examination.

Higher specialist training for a minimum of three years is orientated to the career choice of speciality, but here too difficulties have arisen. The training of pathologists in major branches of pathology, where the number of anticipated consultant vacancies is large, provides a balance between training grades and career grades. Some distortion of this balance has arisen in specialities such as haematology where training grades have been used as “pairs of hands” without due regard to career prospects by ensuring an appropriate ratio of training grades to career grades. More often the excessive numbers of trainees is justified by the hopeful anticipation that consultant expansion will increase at a rate capable of absorbing the excessive numbers, but trainees are often unable to obtain a consultant post. The difficulty has been compounded by the rigidity of training now found in every branch of medicine, which limits lateral movement of more senior training grades between specialities. It also presents serious difficulties for highly specialised branches of pathology where the number of consultant vacancies is small and variable from year to year. In these specialities, most commonly branches of histopathology such as ocular, paediatric, forensic, and even neuropathology, it is impossible to provide a large choice of candidates for each consultant vacancy as it arises, yet at the same time, ensure there is not a surfeit of trainees at times of consultant stability.

To these criticisms must be added the growing concern, especially among academic pathologists, that the lengthy training leading to the MRCPATH examination inhibits research. Many, if not most trainees, set their sights on the membership examination to the exclusion of research. The college has attempted to reduce this major examination hurdle concentrated at the end of training by permitting the theoretical part to be taken up to two years earlier, hopefully allowing research to be combined with practice for the remaining time. Unfortunately, many have interpreted the theoretical part of the examination taken earlier in higher specialist training as an additional hurdle that further inhibits research.

Although the formal training leading to MRCPATH may inhibit research it cannot be denied that competition for career posts also has a major influence on the attitudes of trainees towards their training and experience. When competition for career posts is comparatively easy trainees are likely to obtain appointments without supplementing training by a period in research. University assessors on advisory appointments committees have found themselves unable to promote a candidate with a good background of research and scientific publications, for it is common to find that such candidates are not forthcoming for appointment. The situation in general medicine and surgery is very different. Here, the surfeit of senior registrars for consultant posts, and even registrars for senior registrar posts, has led to many trainees electing for additional years of research fellowship training and the acquisition of a higher degree to raise themselves above other competitors. A solution lies somewhere between these two—sufficient candidates to stimulate competition yet not so many as to frustrate promotion.

These, then, are the criticisms and concerns which have led the College to review its training and examination structure. In spite of these criticisms there is a widely held view that the present day pathologist is better trained and more experienced on appointment than were his or her predecessors before the foundation of the College. The raising of standards is jealously guarded by those who fought hard to achieve them, and it is little wonder that opinion is divided over the desirability of changing the existing training and examination regulations.

Training in the United States

The American Board of Pathology (Regulations, ABP, 1984) offers, by examination, primary (basic) certification in anatomic pathology, clinical pathology, and combined anatomic and clinical pathology. In addition, it offers special qualification (competence) certificates in blood banking, chemical pathology, forensic pathology, haematology, immunopathology, medical microbiology, neuropathology, radioisotope pathology and, in conjunction with the American Board of Dermatology, in dermatopathology. These special qualification certificates are awarded after the candidate has achieved a primary certificate of the Board of Pathology or of another board of the American Board of Medical Specialties. Candidates entering for the primary certificates in anatomic or clinical pathology must have completed four years of approved training, of which one must have been in clinical training, experience or research. For those entering for the combined anatomic and clinical pathology certificate, or for combined primary pathology and special qualification certificates, the period of approved training is five years, of which one year is in clinical training, experience, or research. Training programmes are evaluated for quality and duration by the Accreditation Council for Graduate Medical Education. In this respect, they are similar to the Royal College of Pathologists'
approval of programmes for higher specialist training with on site surveys.

Training in Australia

The Royal College of Pathologists of Australasia offers graduates of medicine admission as a fellow (FRCPA) after five years' training in an approved pathology laboratory and satisfactory completion of its examinations. Research and project work are encouraged, and up to one year in relevant work may be approved within the total training period. The candidate may take either the general examination in four of the major branches of pathology, having completed at least 12 months training in each subject, or a special examination in one subject at a higher level. This latter examination is taken in two parts in much the same way as that for membership of the British College. In haematology and in immunology there is the opportunity to train for joint fellowship of the Royal Colleges of Pathologists and of Physicians of Australasia.

From the above it is apparent that there is similarity in the length of the training in pathology in the United Kingdom and in these other countries. Several of the countries of the Commonwealth and former dominions have training programmes which are so similar to the British one that reciprocity of training recognition is commonly granted on an individual basis to candidates from these countries. Furthermore, in many of the Commonwealth countries, exemption from the primary examination for membership is granted to those who have achieved an approved overseas qualification in pathology. Because of the difficulty of reviewing training programmes overseas it is clear that approval must be given individually so that the programme may be assessed for each applicant.

The future

The pressure to introduce an earlier examination, possibly after three years of training, is considerable. Before doing so there are several important questions which have to be answered:

1. How are standards to be monitored if assessment of training is taken earlier, before completion of training?
2. How is specialisation to be further advanced so that the clinical demands are met, and indeed advanced, by pathological expertise?
3. How is training for a career post within the National Health Service to be modified to encourage research and the advancement of academic pathology?

4. What changes in the practice of pathology may be predicted and what modifications of training will be required to meet these changes?

Staffing within the NHS is undergoing a major review. It is essential that pathology has sufficient people in the training grades to ensure adequate recruitment, both in quality and quantity, to the career grades. Recruitment to pathology has now greatly improved and no longer presents the difficulties of a decade ago. In spite of this improvement there is still an imbalance between the different training grades and between these and consultant grades. There remains a difficulty in recruitment to career grades in some parts of the United Kingdom and in some more specialised aspects of pathology. In particular, recruitment to academic posts in pathology is less than satisfactory, but it is not always clear whether this is due to financial disadvantage or other reasons. Whatever the cause of these shortages, it is essential that they are corrected so that there are sufficient high quality trainees to compete for consultant vacancies and to provide for expansion of the consultant grade. No adjustment of training programmes will improve the quality of pathology practice if there are insufficient recruits to fill consultant posts.

Standards in pathology

It has been claimed that training in pathology has become subservient to the MRCPath examinations. If this is so it must be corrected, for the major emphasis should be quality of training rather than the examinations. All examinations have defects and even the complex primary and final examinations cannot fully assess all aspects of five years' training. The College has rightly given emphasis to recognition of training programmes, which are approved for individual appointments for higher specialist training, rather than blanket recognition of training laboratories. This provides for greater assurance that training is comprehensive. In spite of this standards may vary because individuals also may vary in their application to training, some gaining greater benefit and some less. If training is to get greater emphasis and the examinations less, then an improved mechanism for supervision of training must be devised.

Review of training programmes on appointment to a post for higher specialist training and quinquennial on site inspection of training facilities may not allow sufficient supervision of training to introduce modifications before the programme is completed. It may be that increased control by greater numbers of regional advisers in postgraduate education, each responsible for supervision in one branch of pathology, combined with a log of training completed by the
trainee would suffice. Reliance on certification by training supervisors within the same laboratory must be treated with caution. It is clear from the variability of candidates recommended by supervisors as suitable for entry to the examinations that some supervisors are persuaded to sign up candidates who are inadequately prepared. If less emphasis is to be placed on the examination then safeguards must be written in to training to ensure that it is adequate. Greater emphasis on external monitoring will have resource implications and it is for the College and health authorities to decide the level of monitoring which can be afforded. Until such time as the quality and quantity of candidates for consultant appointments in pathology increases, it will be difficult to control training adequately with an earlier examination unless there is close external monitoring.

**Specialisation**

It is essential that pathologists are trained to provide a service in the subspecialties of the major branches of pathology. At the same time it must be ensured that trainees are not encouraged to enter these subspecialties in such numbers that their subsequent progress is blocked by lack of career grade vacancies. This apparent conflict can be overcome in one of two ways: firstly, to make proleptic appointments and provide subspeciality training after appointment. This is costly for employing authorities who need to maintain and to pay for the existing service at the same time as training the successor. If, during this period, the trainee is found to be unsuited to the subspecialty or elects to withdraw from the scheme then not only is it expensive but also costly in time, which it may not be possible to make up before retirement of the previous post holder.

The second way is to start training in a major speciality for some years but then, while continuing to practise this major speciality, at the same time to train for a subspeciality either in a rotational scheme or by joint appointments between major speciality and subspeciality laboratories. If a suitable subspeciality career grade vacancy arises then the candidate will be appropriately qualified, but if no such vacancy occurs then the broader based general subject will still be available. This, perhaps, is one of the strongest arguments for an earlier examination to assess broad based training, but it leaves open the assessment of subspeciality training. Even if an examination was introduced for the subspecialities the numbers in each may be so small that it is arguable whether comparability of standards could be achieved from one examination to another.

**Research**

The College already gives recognition to research achievement by granting membership to those who have made a considerable contribution to medical knowledge, or exemption from the primary examination to those with a lesser contribution, including a higher university degree. Furthermore, approval of training in a research appointment may be credited for one year of the total training period. In spite of this recognition there is clearly dissatisfaction that insufficient encouragement is given to trainees to undertake research. Not all trainees are inclined to research, and if compulsory research training is imposed then this may be counterproductive to training and disruptive of the work of academic departments. It would be possible, however, to provide an option within training—to undertake a research project or to prepare a dissertation related to cases studied or technical procedures evaluated. Such a dissertation based on speciality practice has already been introduced in chemical pathology, clinical cytogenetics, and forensic pathology. It provides a valuable means of assessing experience which is not easily assessed in the course of a practical examination such as the current final MRCPath.

If greater emphasis were given by full recognition of a defined period in research in addition to a period of general training then this would be an added incentive to those with the ability and motivation to follow this course.

**Changes in practice**

During the past 25 years there have been major changes in the practice of haematology. The combination of clinical and laboratory practice is now generally accepted and welcomed. The balance still requires careful monitoring for it is easy to weight training to one or other aspects of the subject. It remains to be seen how further developments will evolve, but if this is at the expense of laboratory training it may leave a vacuum which could only be filled by non-medical scientists.

Clinical practice in chemical pathology seems to be increasing. In the past the respective roles of the non-medical biochemist and the chemical pathologist have at times been unclear to those outside the speciality. This has been emphasised in hospitals in which a chemical pathologist has been replaced by a principal or top grade biochemist. Although the medical and non-medical posts are complementary, there is overlap in some of the duties and responsibilities that is reflected in the training and examinations. More recently, in some larger hospitals, chemical pathologists have assumed responsibility for metabolic medi-
icine, and this places greater emphasis on the need for more clinical training, especially where the chemical pathologist has direct patient care. It is important that these changes are carefully monitored and training modified to provide for the changing requirements of the service. Similarly, it is important that the changing demands of microbiology and immunology are kept under review.

In histopathology changes in practice seem to be coming from clinicians specialising in a branch of pathology related to their clinical speciality. This is seen to the greatest extent in dermatopathology where dermatologists have developed skills in diagnostic histopathological interpretation which they can combine with their clinical interpretative skills. Although the histopathologist may be expert in the microscopic diagnosis of skin diseases, he or she may lack the clinical knowledge to make a clinicopathological correlation. The histopathologist, however, is more likely to see dermatological pathology in the context of systemic pathology and here he or she can apply general histopathological knowledge. The way forward may be to follow the model of the joint American Boards of Pathology and Dermatology and to plan for joint clinical and histopathological training. Similar moves have been seen in nephrology and hepatology, but here the pressures are less and the need for joint clinical and laboratory training is not so obvious. The lack of recruits to oculiar pathology may require recruitment of ophthalmologists to undertake this work unless pathologists are forthcoming. This involvement of clinicians in pathology will demand training appropriate to the service they provide. It is of great importance that these changes are identified and the appropriate training provided in the best interest of patient care.

Conclusion

Postgraduate training in pathology is at an important stage in its evolution. It is clear that changes are necessary to ensure that an adequate specialist service is provided and that there is continuing research for future development of the subject. There is such a strong body of opinion for change that it would be unwise not to make provision for the perceived shortcomings of current training. The Working Party on Training and Examinations of the College has offered four options, varying from retention of the existing system to an examination after three years’ training, followed by a further three years approved training and experience for specialist accreditation, but without reference to any further assessment. The weakness of the latter option has been indicated above. Unless there is greater competition for senior appointments and closer external supervision of training, standards for this specialist training may very well decline.

Each branch of pathology presents different requirements for training, but each of these should be capable of being provided within a six to seven year period from senior house officer to senior registrar. For those branches of pathology such as haematology, which require substantial clinical training leading to MRCP, two years of this period would be in clinical training, which would normally be taken before commencing formal haematology training. In other branches of pathology there may be direct entry to laboratory training. Each branch of pathology should have a similar period of laboratory training to qualify its trainees for entry to the MRCPPath examination. From the options put forward it may be appropriate for this period to be three years within the chosen speciality. The remainder of the training period, one to two years for haematologists and others with clinical and laboratory experience who have taken the MRCP, and three to four years for the rest, could be devoted to research and subspeciality training. Assessment of this further period of training could be achieved by the submission of a thesis for a higher degree in a subject directly related to the speciality, or by a dissertation covering the work of the subspeciality training, including case reports and commentary. Only those who have satisfactorily completed this training should be eligible for specialist accreditation.

The loss of multidisciplinary training leading to the primary examination for membership would be compensated by the benefit of further specialisation and advancement of knowledge within the field of career choice. The move to undisciplinary practice is now so complete that the benefits of this greater specialisation outweigh the disadvantages of the loss of short periods of training in other branches of pathology.

For those who gain MRCPPath by published works, specialist accreditation should be given only after completion of the approved period of training. It may be necessary for a form of assessment to be introduced for this group if they choose to work in a hospital diagnostic department to ensure a satisfactory standard to practise.

It is essential that there should be an ongoing review of training programmes so that they can adapt as needs change. This also applies to the recognition of overseas training programmes, and for this purpose a register of those who visit other centres and can report on the facilities is essential.

This paper has been orientated to training of medical graduates because the problems of training seem to be more severe for them than for non-medical graduates. Nevertheless, the proposals outlined above for laboratory based training would be equally appli-
British postgraduate training in pathology

cable to non-medical graduates.

It must also be appreciated that training does not stop on appointment to a career grade, and every encouragement must be given for further training. Likewise, it is essential that there should be some form of assessment of standards throughout professional life, even if this is self assessment by participation in an external quality assessment scheme. There is a reluctance on the part of some to participate even on a voluntary basis in any form of assessment, but times are changing and it is likely that in future the public will want to be reassured that those who are responsible for their care not only have had satisfactory training but continue to update their knowledge and experience.

References

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