



SCIENTIA ILLUMINAT MEDICINAM

# THE HONG KONG COLLEGE OF PATHOLOGISTS

## 香港病理學專科學院

The Hong Kong College of Pathologists, Incorporated in Hong Kong with Limited Liability

## President's Message

### INTERNATIONAL LIAISON COMMIT- TEE OF PRESIDENTS MEETING

This newsletter is considerably larger with the inclusion of the complete minutes of the ILCP meeting held in May in London.

The range of subjects covered was far reaching and again reinforced the fact that the challenges and changes occurring in Pathology are universal.

Please take the time to read and consider the range of subjects covered. Your Council would be most pleased to hear your views and comments.

### “SHOULD SURGEONS SEND ALL SURGICAL SPECIMENS TO THE PATHOLOGY LABO- RATORY?”

This article, published in the most recent edition of ANNALS OF COLLEGE OF SURGEONS OF HONG KONG [*Ann. Coll. Surg. H.K.* (2000) 4, 106-109] is recommended reading.

It contains salutary examples justifying the need to submit all but a very few removed organs and tissues for histopathological examination.

This timely article acts to remind us of the absence and the need for

the College to adopt positions on such aspects of our professional practice.

### NEWER LOOK NEWSLETTER !

We hope that all members of the College will agree that the small increase in production costs for the Newsletter is fully justified. We still aim to maintain the costs at a reasonable level.

If you would prefer to receive the newsletter ONLY by e-mail, please indicate by sending your email address to the Registrar on:

[ngwf@ha.org.hk](mailto:ngwf@ha.org.hk)

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### Points of special interest:

- ILCP Report, 2000
- Combined HKCPATH, HKIAP, RCPA Meeting 2001 approaches
- “Operation Whitecoat”

## HKAM - Second International Congress.

*“Medical Advances and Information in the New Millennium”*

Support your Academy!!  
Attend the Congress!  
November 2-5th, 2000.

## Combined Meeting of the HKCPATH, HKIAP, RCPA.

*“Challenges, Opportunities in Pathology”*

Pencil in the dates now!  
October 4-7th, 2001.

## Letters to the Editor:

### PROFESSIONAL INTEGRITY

It is quite possible that members of the College, among other medical professionals, will receive an invitation from an apparently reputable legal firm in HK asking if you would be willing to assist by giving advice in a potential medico-legal case.

You may receive a few details as to the case but be asked if you are willing to attend a discussion at the firm's office. Sometime in the following meeting it will become apparent that the subject of the proceedings are in

fact tobacco-related-matters.

It is strongly suggested that before you accept such invitations you take a little time to "surf the Web" especially searching for items such as 'operation whitecoat'. Action on Smoking and Health (ASH) ([www.ash.org.uk](http://www.ash.org.uk)) is one good site to begin - look under their sidebar for "Industry conduct".

Alternatively you may call Professor Tony Hedley who, in his role as

Chairman of the Council on Smoking and Health (COSH), can provide additional information and advice and would be very pleased to hear from you. (Phone: 2819 9280)

Your professional integrity is worth this time to investigate. Do not believe that you are far away from the epicentre of tobacco related intrigue.

R.J Collins,  
Department of Pathology and Clinical Biochemistry, Queen Mary Hospital.

## Hong Kong Academy of Medicine - Second International Congress.

The Congress will be held on  
2 - 5 November 2000.

Registration Fee:  
- HK\$2,000 after 31/8/2000.

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The theme is "Medical Advances  
and Information in the New  
Millennium"

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The "**Best Young Investigator  
Award**" will be awarded for  
outstanding original work by a  
trainee.

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The Academy needs your help -  
all Fellows and trainees are  
encouraged to register.

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Fellows attending the entire  
Congress will be awarded up to  
15.5 CME credit points.

## INTERNATIONAL LIAISON- COMMITTEE OF PRESIDENTS

**Royal College of Pathologists,  
2 Carlton House Terrace, London  
12-13th May, 2000**

The 2000 meeting of the International Liaison Committee of Presidents at the Royal College of Pathologists (RCP) was hosted by the RCP and the Association of Clinical Pathologists (ACP), United Kingdom. A list of attendees is appended. The meeting on Friday, 12 May, was moderated by Professor John Lilleyman, president of the RCP, and on Saturday, 13 May, by Dr. Mansel Haeney, president of the ACP. While an agenda was published, the report which follows reflects the discussion as it developed with a significant overlap of topics.

### **Pathology Societies--Structure, Membership, Role:**

Opening discussion centered around a letter from Netherlands pathologists sent to the American Society of Clinical Pathologists (ASCP) which highlighted pressures to abolish or decrease the role of clinical pathology in that country, pressures which to some degree were identified in all countries represented. The perception of most governmental agencies is that there is little or no need for medically trained pathologists in such areas as chemistry and microbiology. The benefit of single pathway training is being called into question in many countries.

In Australia, there is a need for generally trained pathologists, particularly in rural areas, but that need is also apparent in some urban areas as well. In Ireland, the chief emphasis is on anatomic pathology, but the need for general pathologists is still great. The pattern in the United States is training in both anatomic and clinical pathology and most pathologists practice in both areas to some degree. Most practice anatomic pathology and then develop expertise in one or more areas of clinical pathology, depending upon the size and composition of the practice group. Specialization is more prevalent in academic institutions. In the US, the American Association for Clinical Chemistry is seeking to expand into haematology and microbiology as well as chemistry.

In the UK, a pathologist is defined as anyone practicing in a medically associated field, e.g. haematology, microbiology, chemistry. The ACP was founded in the 1920s when most pathologists were generalists. All ACP members are medically trained. The number of medically trained clinical chemists is

### **Exam Dates for 2000**

#### **ANATOMICAL PATHOLOGY**

Written Examinations (Membership, Fellowship) - Mon, August 14th

Autopsy Examinations - During the month of September

Slide Practical Examination (Membership, Fellowship) - Tues, October 3rd

Oral Examinations (Membership, Fellowship) - Weds-Thurs, October 4-5th

#### **CHEMICAL PATHOLOGY**

Written Examinations (Membership) Mon, August 14th

Oral, Written Practical, Data Interpretation (Membership) - Week beginning 9th October

#### **HAEMATOLOGY**

(Fellowship) - October Mon-Fri, 2nd- 6th

#### **MICROBIOLOGY**

Viva and Practical (Fellowship) - First half of October

(Details for all exams have been sent directly to the candidates.)

declining in the UK, with other clinical scientists directing the clinical laboratory. Most clinical pathologists carve out specialty niches; e.g. most haematological pathologists are 90% clinically oriented and that specialty is still expanding.

In Australia, most small donor centers have now been closed with blood collection accomplished by larger centers and mobile drawing units. Pathologists deal almost exclusively with recipient issues. Australian laboratories are being acquired by industrial

**The NINTH  
ANNUAL GENERAL MEETING  
of the College will be held on  
November 25th, 2000**

**at**

**MEMBERS STAND  
HONG KONG JOCKEY CLUB  
RACE COURSE  
HAPPY VALLEY**

**Please enter that day in your diary  
and consider bringing along members  
of your family to make this an even  
more memorable evening.**

(ILCP Cont.)  
interests, with net profit overshadowing clinical concerns.

It was stressed that the key to preserving and enhancing the role of the pathologist was establishing good relationships with the medical staff. Even large commercial laboratories are recognizing this essential. Quest now hires over 400 pathologists.

**Societal Membership Requirements:**

At present, the RCP has about 7500 members, of whom approximately 20% are not medically qualified. ACP members must all be medically qualified, and membership now numbers approximately 2000. The College of American Pathologists (CAP) requires certification by the American Board of Pathology (ABP) for Fellowship. Junior members are chiefly those in training. They may remain in this status for only a finite period before they become

board certified and eligible for Fellowship. The ABP had about 400 examinees for the last examination, of which 80% were in combined AP/CP. Subspecialty certification requires examination after further training and previous general board certification.

Ireland follows the qualifications for the RCP and the UK examination. There are about 200 pathologists members of the society.

The ASCP has about 70,000 members, the majority of whom are Associate Members, i.e. medical technologists, cytotechnologists, etc. There is almost total overlap of pathologist membership with the CAP.

Members in the Royal College of Pathologists of Australasia (RCPA) are admitted as Fellows only after examination, and all must be medically qualified with specialty training. New Zealand medical graduates may also be admitted and the New Zealand Society of Pathology has been amalga-

mated with the RCPA with formation of a New Zealand Committee. Affiliates are specialist pathologists recognized as such prior to a definite cut-off date. A Faculty of Oral Pathologists is being established and other member categories are under discussion. All classes other than Honorary are admitted only after examination.

The RCP admits non-medically qualified members after rigorous examination or by published papers. About 20% are non-medically qualified, but are largely invisible in the political activities of the RCP. There is at present an effort to meet with technologists and other clinical scientists. There has been consideration of establishing a Faculty of Clinical Scientists within the RCP for senior technologists.

The US has an excess of PhD training programs with many graduates failing to find positions as the number of positions in research decrease. There is some evidence that the use of PhDs in the laboratory is decreasing and direction returning to pathologists.

The Hong Kong College of Pathologists has about 250 members, almost all of whom are mono-specialty trained. While there is a combined AP/CP program, it is not popular. All members are medically trained. The College is under the umbrella of the Hong Kong Academy of Medicine. Some members of the HK College of Physicians are promoting infectious diseases as a specialty.

In the UK, infectious disease clinicians are active in infection control, with the specialty developing in a manner similar to that in haematology.

**International Pathology Societies:**

Dr. Utz Merten, president of the World Association of Societies of Pathology and Laboratory Medi-

cine (WASPLM) led the discussion by asking "what does WASPLM do for societies?" Constituent societies expect support of their own programs. Language differences confuse perceptions of what each society or person means. Recently, a joint statement by WASPLM and the International Federation of Clinical Chemistry on laboratory accreditation was formulated. A major question is how does one define a laboratory director. Dr. Henry Travers, CAP representative on the WASPLM Bureau, has been given the task of crafting a definition for discussion.

There are 56 societies in 42 countries comprising WASPLM. Only 10 are English speaking.

The CAP is presently reviewing its relationship with WASPLM. Dr. Madden of Ireland stressed the need for global harmonization. The ASCP has concerns about time, travel, and money in regard to the benefits derived from WASPLM.

Australasia has relationships with Singapore and Malaysia, but focuses more regionally. The Forensic Secretariat of WASPLM is supported by the RCPA through Dr. Steven Cordner.

Hong Kong has been very much focused on the UK and Australasia with regard to education, etc. There is no longer a HK Pathology Society which could belong to WASPLM and Hong Kong pathologists are more supportive of the International Academy of Pathology and similar bodies.

The ACP has a history of WASPLM support with Drs. Walter Timperly and Barrie Murphy. It did not send delegates to Sao Paulo, and while still belonging, it does not actively support WASPLM. It believes that a global approach to such things as DNA testing and usage would be beneficial.

The RCP is ambivalent about membership. It would support

WASPLM if there were a change in structure, focus, and operation.

The consensus demonstrated underlying support for a world organization, but there was reservation about costs as related to benefits. There was consensus that the societies had lost control of WASPLM.

### **Laboratory Structure & Management:**

The development of 'core' laboratories is a response to automation and the perception that consolidation of high volume testing could result in cost savings and better turn around times. Personnel management has been a major problem and all of the forecast benefits have not necessarily been achieved. The trend in the UK has been to gather services into a central laboratory, largely based on geographic proximity. Essential emergency services have been left locally. Consolidation has been evaluated on the basis of potential savings with a 2 to 3 year payback. There is still an attempt to have pathology consultation readily available.

Success or failure of such ventures depends upon the trust and interaction medical staff has with the facility and the efficiency of couriers and specimen/data transfer. Consolidation may only shift personnel and not decrease the number of FTEs. Staff reduction does not automatically flow from automation. The skills needed by personnel may change with some technologists finding new niches in consolidated laboratories. In the UK, some entry level personnel now have PhD degrees--training well above the actual need. In the US, technologist training level requirements are tied to the complexity of testing categories mandated by the Clinical Laboratory Improvement Act of 1988 (CLIA88).

In some areas of the UK, a single management structure may con-

trol several laboratories without consolidation of functions or testing--management consolidation rather than testing consolidation.

Core laboratories within an institution can result in efficiencies and cost savings, as well as standardization of testing. While some perceptions of core laboratories are negative, there may be benefits to patients and cost savings. Sometimes, pleasing physician clients overrides the logic of other benefits.

### **Point-of-Care & In-vitro Testing:**

In the UK, a joint working group has developed guidelines for these areas of testing directly under the supervision of the pathology department. With control by the laboratory, testing could be discontinued if it was thought to be faulty. The guidelines spell out needs for quality control, etc.

In the US, the control of such testing depends largely on what entity has the ability to charge. Capture of testing data is a critical issue. POCT is regulated in the US, but much of the testing is in the 'waived' category. While Federal standards may not require regulation of the testing itself, a license to perform testing is mandatory. Both the CAP and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) require the same quality control as does other testing. (Of course, de facto, this makes our requirements more stringent than the governmental regulations.)

### **Role of Non-pathologists in Pathology:**

Errors in cytology evaluation in Kent Hospital in England led to adverse media publicity and a lawsuit by patients harmed. While the patients won their case, the judicial opinion in the appeals court did establish that cytology, by its nature,

is not 100% error free. All positive or questionable smears must be reviewed by a trained cytopathologist. (Cytoscreeners are low-paid, with work reviewed by a trained cytotechnologist. There is an attempt to obtain permission for cytotechnologists to sign out any case in which they feel confident of their diagnosis. Positive or questionable cases would not necessarily require review by a pathologist. The theory is that quality would improve because pathologists are too busy or too poorly trained to render accurate diagnoses.)

The question was raised about the dividing line as to what examinations require the pathologist-- what about normal gall bladders, appendices, etc.? In the UK, haematologists are allowing technologists to sign out abnormal blood smears even with malignant cells if the result is not unexpected. The opinion in the UK is that there would be no increase in false negatives. A 'mis-match conference' would make it obvious if negatives were being over-called.

### **Pathology Assistants:**

In the US, training of pathology assistants has ranged from on-the-job training after high school to formal 4 year academic courses. There is now better definition of required training and a move toward certification. In practice, there must be a description of what the assistant may do, and all of their work must be under the supervision of the pathologist.

In the UK, the training requirement for pathology assistants is the same as for histotechnologists and they are under the same certification standards.

In Australia, the end responsibility for 'cut-up' or 'grossing' is the pathologist's. There is movement toward a sub-set of medical technologists for these functions. Under the Australian system, guide-

lines may be set which have the force of law.

### **Laboratory Accreditation:**

In the US, there is, theoretically, mandatory inspection of all laboratories. In reality, the Health Care Financing Administration (HCFA) registers and licenses laboratories, but many of those perform only waived testing and no inspection is carried out. For laboratories performing moderate or high complexity testing, there are several routes for accreditation. One choice is HCFA inspection, carried out by inspectors in state health departments under contract to HCFA. HCFA also grants 'deemed status' to several organizations whose voluntary programs are considered equivalent to or more stringent than the Federal standards. Organizations granted deemed status include the CAP, JCAHO, the Commission on Office Laboratory Accreditation (COLA), and the American Association of Blood Banks (AABB).

Accreditation is not mandatory in the UK or Australia, but in Australia, most are evaluated by the RCPA. There must be participation in external quality control.

Germany has three separate schemes, with about 25% of laboratories accredited. Accreditation is not mandatory.

None of the systems assess pathologist competency.

### **Professional Competency:**

In the UK, there is increased public scrutiny about missed medical diagnoses. There is building pressure to mandate proof of professional competence. CME is not felt to be pertinent in this regard, while annual appraisal by the employer as well as peer review and examination is being pushed. A mechanism to assess competency is under study but not yet fully devel-

oped.

In the US, licensure is the purview of the individual states. Many have a CME requirement.

Certification of specialists is by national specialty boards. All boards except the American Board of Pathology now have time-limited certificates, leading to a need for recertification. The ABP has a voluntary recertification program. A recent study by the Institute of Medicine which reported between 50,000 and 100,000 annual hospital deaths due to errors has been given much publicity in the US. The report suggested a need for second opinions in surgical pathology as one step in reducing deaths due to errors.

The RCP has input into the training of pathologists and examination is built into the training programs. The major test is administered after completion of the first two years of training.

In Australia, the program of continuing professional development is based on maintenance of a learning diary. In New Zealand, recertification becomes mandatory on July 1, 2000, requiring CME and some form of practice audit. As of now, the audit requirement can be satisfied by practice in an accredited laboratory. A more rigorous system of assessment is being developed in Australia, which would include random assessment of competence as well as targeted assessment where there is question of a pathologist's abilities.

In Hong Kong, CME is mandatory if a pathologist wishes to remain on the Medical Council Specialty Register. The CME is likely to be expanded (as Continuous Professional Development) to include recertification; however, the College feels the latter should not be in the form of an examination. The possibility of direct peer evaluation has been suggested.

### Recruitment of Trainees:

In the past, most UK specialty trainees were required to have a 6 month rotation in pathology. Some of those trainees switched from their original choice of specialty into pathology. There are now problems with unfilled training positions, a situation which is also seen to some degree in Australia. There is also some maldistribution with most positions in Scotland still being filled. Medical school applications in the UK are still relatively high, but other specialties such as general practice are now having problems filling the training slots. Problem-based learning with no basic lectures in pathology results in little or no exposure to pathology, with a negative effect on recruitment of pathology trainees. Medical schools in the UK have been expanded with some slots reserved for applicants with prior degrees. (Most medical students enter directly without an undergraduate degree.) Government policy fails to match anticipated needs with the number of training positions. There is heavier accent on training in clinical medicine prior to pathology training. Those without clinical background tend to gravitate to anatomic pathology.

In the US, there has been bad press about a lack of pathology positions, based largely on erroneous data. Debt load of medical graduates tends to push them into surgical specialties where the opportunity to repay debt is greater than in pathology. Fewer American medical graduates are entering pathology training with about 2/3rds of trainees now being International Medical Graduates, mostly from the Pacific Rim. They have good work ethics, but fundamental clinical training and language training is sub-optimal. There is also a trend for PhDs to enter pathology, again having lesser clinical skills. Many of the trainees are women.

The recent emphasis on primary care is fading.

Recruiting very good trainees is not a problem in Hong Kong, however, there are fewer and fewer training positions available because of budgetary restrictions.

In Germany, many trainees are older women, e.g a 39-year-old female with teenage children.

The worldwide trend to more women in pathology was noted by all. Pathology is perceived as a more flexible way to practice, but the preponderance of women creates staffing problems in many instances.

### Pre-Training Aptitude Testing:

The RCPA is reviewing its arrangements for training and certification for eligibility for admission to Fellowship. It has concerns about the diminished pathology content in many first medical degree courses, the trend to require two years of mandatory general clinical training after the first medical degree, and the concurrent need to reduce the total time required for full specialist training arising from diminished "lifetime workforce participation". There is some evidence of a shortage of pathologists in some rural areas, Forensic Pathology, and in some disciplines. Issues raised include the following:

1. Is it feasible to establish "streaming" for pathologists earlier in the medical education process?
2. Is there a place for an assessment process of aptitude prior to acceptance into specialist training?
3. Is a common education module for all medical specialties feasible?

In the UK higher specialist training in anatomic pathology can commence without any assessment of ability. This is changing so that after 9 months, there will be an aptitude test to determine ability to recognize patterns, and thus identify those with good mental skills but poor or absent pattern recogni-

tion skills. This process is in development and is probably more subjective than objective.

The ILCP attendees expressed major concerns about this approach. Dr. Bachner raised the question of how such a test could realistically be developed and expressed concern that it could establish significant roadblocks to pathologists as practice is changing and evolving in new directions. A final caution was raised about using Kodachromes for pattern recognition.

### Module of Basic Education:

Increasing pressure on time in the undergraduate medical curriculum on the one hand and diminished total workforce lifetime participation on the other are both creating pressures to keep the length of time to proceed from basic medical training to full qualification as a specialist to a minimum. On the other hand uncertainty about availability of both training and career positions requires training for a medical specialty to be sufficiently flexible to accommodate several career choices either initially or after certification, without a need for complete retraining.

In the UK, the RCP has no influence on the content of undergraduate training. Concerns were expressed about pushing people into a specialty too early in their careers. In the final year of medical training, the student has special elective study modules, and must be served in at least 3 areas.

Single discipline pathology training was identified as a hindrance to movement to other specialty areas. The need for cross coverage in practice is becoming more essential. The US model of training in both anatomic and clinical pathology allows much more flexibility for career path changes.

The movement in Europe is toward general training. In Ger-

many, trainees are focused almost exclusively either on anatomic or clinical pathology, with cytology within the purview of each.

There was consensus that clinical training was essential for the pathologist.

### **How Does One Assess Quality?:**

In the UK, there is some assessment of quality in anatomic pathology within the accreditation process. It is chiefly internal quality review, i.e. review by other pathologists or second opinions. In cytology, there is external proficiency testing. There are also regional programs where slides are circulated both in general and specialty pathology areas.

The ACP monitors individual performance in an anonymous manner for such programs. The pathologist monitoring the plan will write a 'dear colleague' letter when poor performance is identified, but the identity of the poor performer is blinded and known only to a secretary. In the typical scheme of 12 slides, 10 cases should be of common or routinely seen diagnoses, while 2 may be inserted for educational purposes. The 'correct' diagnosis is that of the majority of the participants, and may not represent the 'expert' diagnosis. Slides are sent with pertinent data, e.g. what special stains have been done and the results. Consistent poor performance leads to reporting to the professional body, which must take action such as mandating additional training. Salary continues during such remedial training. Grouping in each scheme is voluntary with the participants submitting cases. Each laboratory receives a set of slides. In the scheme described, there are 60 consultants, with 18 labs. The monitor checks the first and last slide to assure diagnostic quality. Scores are cumulative over time and the system identifies about 5%

as poor performers. Similar pilot schemes are in place for chemistry and haematology, attempting to evaluate interpretive competency. The anatomic scheme is oriented towards the general pathologist, with specialist schemes under development, e.g. breast, skin, etc.

### **Benchmarking of Effectiveness of Government-funded Services:**

In the UK, a process is underway to collect data about testing value, staffing levels, etc. Data analysis has not been done. The National Health Service has been asked for funding to collect data from all labs for one year with the goal of identifying guidelines for allocation of resources.

In Australia, the costs of pathology to the government and the taxpayer are clearly identified, but it is not certain that all testing has value to the patient. Quality of testing is assured by a mandatory accreditation process with standards set by the National Pathology Accreditation Advisory Council, into which professional societies have input. There is a database which monitors the ordering profile of every practitioner. The Health Insurance Commission can investigate those who vary markedly from the ordering norm. The system has been effective in reducing expenditures. There is now an attempt to structure fees based on evidence rather than empiric data. There is a Medical Services Advisory Committee which was established as an expert body to examine the efficacy, safety, effectiveness and cost-effectiveness of new medical technology.

In the US, the CAP has moved from a workload unit system of evaluating lab volumes to the present Laboratory Management Index Program (LMIP) which evaluates and gives comparative data within peer groups of resource expenditure for testing. There is presently

a group working on pathologist staffing, but with historic concerns that release of any such data could lead to a ceiling on staffing, rather than a floor.

### **Malpractice & Litigation:**

In the UK, there has been recent publicity about organ retention in autopsy cases. The public scrutiny began with a cardiac surgery competency case where parents discovered that the heart of the patient had been retained. This led to the revelation that numerous hearts had been retained, 90% of which were from forensic cases. Parents claimed that they had not been informed that the hearts of their children would be retained. In other cases, multiple organs have been retained. The case is one example of the increased media attention to medical problems and 'errors'.

Ireland has a parallel problem, and the past practice of pituitary gland harvest for human growth hormone production without informed consent was highlighted. As a result, more strict guidelines for organ and tissue retention have been developed.

While some jurisdictions apparently allow organ and tissue retention without informed consent, discussion focused on the need for more specific autopsy permission forms. This problem also extends to the use of archival materials for research purposes—does one need special informed consent? The proper disposal of removed tissue is also becoming an issue. In the UK, there are now mass burial or cremation ceremonies for products of conception, with families invited on a monthly basis by each hospital.

### **Error Rates:**

Discussion focused on a recent Institute of Medicine report in the US which claimed that 40,000 to

100,000 deaths occur annually due to medical error. Among recommendations in the study is one to establish a national office to receive data from mandatory reporting of deaths and errors. It raises the spectre in the US of forcing mandatory second opinions in surgical pathology, mandatory autopsies, and guarantees of no harm from administration of blood and blood products.

The concept of a 'zero error rate' should be avoided. The public must be educated that there is an irreducible poor outcome result from any medical intervention. This is particularly important in the Pap smear arena. Sometimes, only time determines what is or is not an error. Discrepancy rates or adverse outcome rates may be better terms than error rates. Handling on a risk/benefit basis is necessary.

### **Patenting of the Human Genome:**

The issue of patents surfaced in the US when laboratories were informed they would be charged a royalty for a hemochromatosis test. Most information regarding the human genome crosses both academic and commercial borders. There is fear that patents will interfere with patients' access to care and testing.

One attempt to patent testing in Australia was not successful. Several tests have been patented in Germany.

One could probably use a patented test to compare results with another non-patented test, similar to what presently occurs in pharmaceutical testing.

### **Re-Emergent Infections:**

A major problem is the re-emergence of tuberculosis with drug-resistant strains. The largest problems are in immigrant populations and HIV infected individuals. Many tuberculosis patients enter

with bizarre signs and symptoms versus the traditional cough and abnormal chest film. In Australia, most of the problems come from the Pacific Rim. Hepatitis C has a high prevalence in transplant recipients.

Many medical institutions require testing for Hepatitis B immunity or vaccination for the medical staff. In Germany, all medical personnel must be tested for both Hepatitis A and B. In some locales, there is at least discussion about testing for HIV as well.

### **Bio terrorism:**

The brief discussion centered on the need for all people to be aware of the possibility of bio terrorism. Cited was a recent anthrax hoax in Lexington, Kentucky.

### **The Future Paradigm of Pathology:**

Based upon the discussion during the meeting, the following concepts and developments were identified as shaping the future practice of pathology:

1. Molecular pathology will assume an increasing role.
2. Laser extraction of single cells for DNA analysis will allow more accurate diagnoses.
3. Pathology may have become over-specialized, and there may be movement back to more generalized training.
4. Increasing numbers of women will change staffing patterns within pathology.
5. Information is becoming globalized with use of the World Wide Web--a true pathology web site would be beneficial.
6. Telepathology will be more widely used, raising questions of how pathologists will be paid.
7. Teaching may move to virtual reality systems.
8. Partnership opportunities exist with other specialties, e.g. ra-

diology.

9. Pathologists are well situated for total information management.

10. Clinical pathology will move away from reference ranges into probability predictions.

11. Lay advisory input to medical decisions will become more prevalent. (In the UK, all of the Colleges have lay advisory input. Some lay advisors have some medical background. The RCP has 5 lay members and 3 from the RCP. The group has been found useful in determining the language in informational brochures and in issues of re-validation. The group meets every 2-3 months, and is voluntary.)

### **Future Meetings:**

- 2001 - United States of America (Late October)
  - 2002 - Germany
  - 2003 - Canada (Potential)
  - 2004 - Australia
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