

Comments on the Carter Report with respect to Cellular Pathology and Cytopathology in particular.

Background

The Carter Report ¹ is being widely used as a justification for centralisation of pathology services. Many Trusts are faced with a need to collaborate with commercial companies for the provision of pathology services and some are considering “out-sourcing” some of the bulk analytical services, which is very much in line with the current environment of regional centralisation as recommended in the report. However, it is difficult to see how cellular pathology would be funded in this environment when many of its clinical functions require almost the antithesis of centralisation.

Centralisation and commercialisation of pathology as a whole could succeed if the special requirements of cellular pathology were adequately considered in the context of their clinical and pathological connections – especially with respect to National Cancer Networks. In many instances cellular pathology could, if properly funded, represent “loss leaders” in a commercial laboratory setting, attracting high-volume analytical work to centres with high quality clinical pathology services.

The Carter Report admits [Summary, context, para 3, page 5] that “differences between the different specialities....can vary considerably.” Referring to the same paragraph, it has sought to “identify those issues which apply across pathology as a whole, rather than attempting the more complex task of formulating recommendations specific to each speciality.” The report recognises that “Further work is therefore likely to be needed in this area.” Since “this area” covers the whole of cellular pathology, which is largely non-automated and would be unlikely to be financially viable in the absence of “pathology as a whole”, it is essential for anyone looking seriously at centralisation or commercialisation of pathology services to go considerably further than following the recommendations of the Carter Report.

Lack of consideration of cellular pathology in the Carter Report is further demonstrated by the comment that “over 13 million histopathology slides and 4 million cytology slides are examined” [Summary, context, para 1, page 5]. Slides are not the basic parameter for either speciality – and those figures suggest that non-gynaecological diagnostic cytopathology may not have been considered at all.

Specific areas of specialist multi-disciplinary pathology practice

The following specific areas of clinico-pathological specialities need to be incorporated into any commercialised or centralised service and are classic examples of procedures that need to be costed as “end-to-end patient pathways” [Summary, context, para 7, page 6] rather than through isolated “sump” pathology budgets. Many of these services are currently inadequately

funded and / or provided by pathology because clinical teams were unaware (or not prepared to consider the additional costs) of the impact on pathology and the need for their co-operation. The Carter Report recognises “among commissioners, the lack of understanding about the tests available” but could valuably have extended that comment to a lack of understanding among the very clinical teams with whom pathology engages.

Cancer diagnosis and multi-disciplinary teams

- All the cancer teams require review and presentation of histology and cytology along with radiology and clinical findings – for all cases initially diagnosed locally or referred from elsewhere in the network.

Haematology / Oncology diagnosis

- Histological and cytological diagnosis of biopsies (fine needle aspiration (FNA) and excisional) require correlation of morphology with flow cytometry and molecular biology before a final diagnosis can be achieved in a MDT setting.

Ultrasound-guided and endoscopic ultrasound-guided FNA

- These procedures are being introduced with expensive equipment and input from senior clinical staff without consideration of the impact on pathology. Numerous publications in the medical literature show that these procedures are far more clinically effective, and therefore cost-effective, if cytologists (non-medical and / or medical) assess adequacy of the specimens at the time of the procedure and select appropriate material for ancillary tests (microbiology, flow cytometry, immunocytochemistry and molecular analysis).

One-stop breast, head and neck, and thyroid FNA clinics

- All these clinics benefit from the attendance of cytologists to assess adequacy of aspirates and make decisions as above for ancillary tests.

Cervical screening cytology

The current and emerging technologies of liquid based cytology; automation of specimen evaluation; human papillomavirus (HPV) testing for triage of low grade cytological abnormality and test of cure; primary screening by HPV testing; and HPV vaccination will result in centralisation of specimen processing and, possibly, reporting. However, any such re-configuration must not compromise the involvement of medical and non-medical cytologists in multi-disciplinary practice as described above.

Summary

The Carter Report, if it is to be used successfully as a basis for modernising pathology, must address the need for pathology to be “delivered closer to the home”, ...”streamlined around people” and “embracing competitiveness and plurality of provision” [Key drivers of change, para 12, page 8] and must plan



and account for “unexpected, unplanned and unresourced demands” [Barriers to change, para 13, bullet point 6].

Essentially, modernisation teams in Strategic Health Authorities or Trusts must make sure that they themselves cannot be criticised for “a lack of local investment” that is “sometimes a reflection of the level of understanding of pathology and the lack of engagement of its managers and laboratory directors in planning processes” [Barriers to change, para 13, bullet point 10].

A truly modernised service could succeed if the multi-disciplinary procedures mentioned above (and other clinically orientated disciplines elsewhere in pathology) were properly planned and accounted for as “end-to-end patient pathways” by teams involving specialist pathologists, biomedical scientists and the relevant clinicians. If that were done, efficiency savings of centralisation of bulk services could be set against cost-effective patient-oriented procedures such as abound in cytopathology. The Carter Report admits that it has not “attempted the more complex task of formulating recommendations specific to each speciality” which must be recognised by managers who might otherwise “contract out” potentially lucrative services while leaving an inadequate income stream for services such as ours.

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1. Lord Carter of Coles. *Report of the Review of NHS Pathology Services in England*. Department of Health. 2006