The Bulletin

of the Royal College of Pathologists

Number 142 April 2008

The Royal College of Pathologists
Pathology: the science behind the cure

In this issue

www.rcpath.org/bulletin

Subscribe to the *Bulletin* of The Royal College of Pathologists

The College's quarterly membership journal, the Bulletin, is the main means of communications between the College and its members, and between the members themselves. It features topical articles on the latest development in pathology, news from the College, as well as key events and information related to pathology.

The Bulletin is delivered free of charge to all active College Members, retired Members who choose to receive mailings and Registered Trainees, and is published four times a year, in January, April, July and October.

It is also available for our members to download on the College website at www.rcpath.org/bulletin

The subscription rate for libraries and non-members is only £90 per annum. To subscribe, contact the Publications Department on 020 7451 6730 or publications@rcpath.org

Sign up today and keep up to date on what goes on in the world of pathology!

The Royal College of Pathologists
2 Carlton House Terrace, London SW1Y 5AF

telephone 020 7451 6700
email info@rcpath.org
website www.rcpath.org

The Royal College of Pathologists
Pathology: the science behind the cure

The Royal College of Pathologists
Pathology: the science behind the cure

CONTENTS

April 2008

Number 142

You may notice that we have changed the way the pages are numbered in this issue of the *Bulletin*. From now on pages will be numbered consecutively throughout the year, from January to October.

On the cover: Consultant histopathologist, Dr Jackie Elder, is pictured with a patient in the Endocrine Outpatient Clinic at the Countess of Chester Hospital. Photograph by Jenni Collins, Medical Photography and Illustration, Countess of Chester Hospital NHS Foundation Trust. See page 136 for further details.

Photo credits: Jenni Collins, Andrew Walker, Richard Spence, Margaret Cooper, George Brooks, Bill Osment, Photos.com, The Royal College of Pathologists.

EDITORIAL

Professor John Croall
Bulletin Editor

Our changing climate

By the time you read this, spring will have sprung and all will be lush and green. As I type this in February, however, it's still cold and grey. I mention this because the UK Department of Health and the Health Protection Agency have just published *Health Effects of Climate Change in the UK 2008: An update of the Department of Health Report 2001/2002*.[1]

I've been interested in climate change ever since I worked in the Antarctic in 1990–1992, frying under the ozone hole during the summer and watching glaciers melt. So this report caught my eye. To give you a flavour of it: "Key areas for the NHS in adapting to climate change include: ... development of local 'Heatwave', 'Gale' and 'Flood' plans". But there's more, much more, and plenty with direct application to pathology.

Histopathologists will be interested to hear that a large increase in skin cancer and melanoma is predicted, due to more UV exposure and the increase in outdoor activities in the sunny weather. Haematologists and microbiologists may be intrigued to learn that there's a small chance of malaria returning to the UK. It was once common in the southeast of England and even in parts of Yorkshire. There are predictive maps which show that even Inverness could be at risk. It is no coincidence then that our stand at this year's **Chelsea Flower Show** (20–24 May) is a joint effort with the Health Protection Agency and the theme is climate change and the return of malaria to Britain. With the warmer weather, there is an increasing chance of more effective insect vectors joining us from mainland Europe. More ticks too – which means more Lyme disease. And longer warmer summers mean (oh no!) more midges in the Highlands. On the plus side, with warmer winters there will be far fewer winter-related deaths and thus less pneumonias. But warmer summers bring the risk of heatwaves and heat-related deaths. And up to 14000 more cases of food-poisoning each year. If you have time, have a look: it's an interesting and thought-provoking report.

Some of these climate effects are already apparent and some will take a while to manifest themselves. Much more imminent is **National Pathology Week** (3–9 November). In our new 'Public Engagement' section, we have included articles that may give you some ideas as to how you and your hospital can get involved.

Also heading our way is the new form of **revalidation and relicensure** for doctors in the UK. The medical Royal Colleges will be playing a large part. Lance Sandle tells us all about what's coming in his article (p.139). This is essential reading for our UK medical consultant membership.

For a complete change, have a look at John Cooper's report of a seminar on **veterinary pathology** held in East Africa (p.129). I can also recommend the article on **sudden cardiac death in the young** (p.99) by Mary Sheppard, which particularly moved me.

There's plenty of other good content in this issue. And even some **controversy on the Letters page** over clinical attire: bare forearms and wrist as an attempt to prevent infection by improving hand hygiene and removing unnecessary dangly bits of never-laundered germ-infested cloth, aka. the tie. As you can see from my mug shot above, I have abandoned the tie at work myself. And that's a short sleeve shirt, trust me.

Finally I'd like to ask for your help. I am thinking of putting **photographs of laboratories** on future covers. Outside views of the 'front door' or the building would be welcome. Modern and sleek, broken down and semi-derelict, I don't mind. People in the picture would be great. Be artistic if you like. Who works in the oldest building? Or the oldest original laboratory space? What's the worst view out of a member's office window – assuming you still have one? What's the best view? Find the lab camera or use your own and get snapping.

Send your pictures or comments to me at publications@rcpath.org, where they will be very gratefully received.

Professor John Croall
Editor
publications@rcpath.org

Reference

1. Department of Health and Health Protection Agency. *Health effects of climate change in the UK 2008: An update of the Department of Health report 2001/2002*, 2008. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080702 (accessed 14 February 2008).

Professor Adrian Newland
College President

A time of important decisions for medicine and pathology

As I come to write my Presidential report for the *Bulletin* I realise how quickly three months comes around and the slow, and often frustrating, pace of change. I don't therefore apologise for revisiting the well trodden themes of recent *Bulletins*, as these are important times for pathology as well as the rest of medicine and decisions made now will have implications for us for years to come.

We expect Lord Carter's report to be presented to the Secretary of State in March and its contents will be known by the time you read this if, as we hope, it is published at the same time. While we don't know what the report will contain, it is clear from the comments that Lord Carter has made both in our own *Bulletin* and in the public arena that he is very much looking towards an emphasis on the quality of the service, economies of scale and the development of networking. The opportunities for any significant financial saving seem to be fairly remote as the efficiencies of the service become apparent. The problems the report will face reflect the nature of how the NHS has developed and the ability of Foundation Trusts to follow their own path. We wait to see what inducements can be used to encourage reform in the way that many of us feel important.

The logical way forward is through the Commissioners, but for them pathology remains a low priority. The College will continue to strive to educate them and involve them in the pathology diagnostic process. As part of our drive to influence the development of the service, we had a very successful and important meeting in January looking at the introduction of new tests, with a view to working with the Department of Health and the National Institute for Health and Clinical Excellence to develop the equivalent of a national formulary for tests that will aid the planned introduction of the new techniques' investigations, rather than duplicate the hurried and *ad hoc* introduction that we saw with HER-2 testing.

There is also currently a flurry of interest in the development of IT, which was of course one of Lord Carter's themes, with a realisation through Connecting for Health that pathology IT is a potential area for quick wins. This can only be something with which we concur and support, and I would hope that sometime in the early summer we can look at a stakeholder meeting for computerisation along the same lines as the meeting organised for testing.

Pathology under-represented in *Our NHS Our Future* review

The review, *Our NHS Our Future*, continues with meetings for NHS staff, patients and members of the public across England putting forward their views as to how the local NHS will deliver health services in the future. These views will be channelled into each Strategic Health Authority's vision for locally delivered health care which will be published in the spring, and will be part of the larger *Next Stage Review* that Lord Darzi is undertaking.

We continue to feel that pathology has not had the attention it deserves in the review, and I have encouraged our Regional Councils to explore locally what their SHAs are doing. The College's vision is on our website and will provide a coherent and consistent approach to put forward. This is being developed by the Specialty Committees and very much parallels the vision of Lord Carter and his team in the development of networking and the collaborative delivery of services.

Part of the vision is extending diagnostics from secondary and tertiary care to primary care out in the community, and we are co-operating with the Department of Health and The Royal College of General Practitioners in benchmarking primary care pathology. The point that we will continue to reiterate is the importance of quality and standards in the provision of diagnostics, wherever they are situated.

Don't forget the workforce database

Of course we are all aware that we cannot provide a service without an adequate workforce, and the College is striving hard under its new Director of Workforce Planning, Tim Stephenson, to develop the electronic workforce database launched by his predecessor, Chris Foster, in the autumn. As of January, only 2% of medically qualified College

Report of the Review of NHS Pathology Services in England, chaired by Lord Carter of Coles

members have logged on and updated their details, and I ask you all to do that. I apologise for any indigestion caused over the cornflakes by my picture on the back of the January *Bulletin*, and can guarantee if sufficient members log in we won't repeat the exercise!

Leadership and professionalism

As Lord Carter said in his interview in January, pathology often punches below its weight in terms of its importance to the NHS, its use of resources, and its impact on healthcare. This, in part, reflects what often seems like a lack of willingness to engage locally to put our message across. Provision of a high quality service is important but so is engagement in the future modelling of the service. I had the good fortune to attend a meeting in January on 'Frontiers in Laboratory Medicine', co-sponsored by the Association of Clinical Biochemists, where I spoke about leadership, management and professionalism in pathology, and made the point that although pathologists are excellent managers in resource utilisation and service provision, it is important to take the next step and become involved in clinical leadership and in the development and evolution of the service.

I have been very impressed, however, with the number of members who have taken on roles as medical and clinical directors and would certainly encourage this as a way forward. Both Sir Liam Donaldson, the Chief Medical Officer, and David Nicholson, the Chief Executive of the NHS, have recently spoken out in encouraging medical involvement in clinical leadership, and I can only reiterate and reinforce that point.

The Tooke Report and NHS:MEE

On 8 January, Professor Sir John Tooke published his final report on the Enquiry into Modernising Medical Careers. In addition to his initial recommendations, his final report included the recommendation to create a new body called the NHS: MEE (NHS Medical Education England). This body would relate to a greatly strengthened medical workforce advisory machinery and would hold the overall budget for postgraduate medical education, which would be ring-fenced and would act as a professional interface between policy development and implementation for postgraduate medical education and training. This would help promote national cohesion in England and would work with equivalent bodies in the devolved administrations to facilitate UK-wide collaboration.

We have written to the Secretary of State strongly supporting this move. While we accept this is a major development while the Health Committee continues to deliberate on the MMC programme, and Lord Darzi's *Next Stage Review* has not yet reported, we believe that this would provide the necessary foundations for Lord Darzi's vision of delivery outcomes for patients that would be amongst the best and safest in the world.

I also believe, with regard to training, that Ministers should look closely at the implementation of the European Working Time Directive for doctors in training, recognising the effects the reduction in working hours has had on both training and patient care, and believe they should begin to look at the separation of training and service commitment and their relative contribution to the Working Time Directive. This seems to be the only way that many specialties can get adequate clinical exposure through service provision, while at the same time undertaking parallel but separate training.

Healthcare-associated infection

Following the recent reports on 'Clean Safe Care' and 'Hospital Organisation, Specialty Mix in MRSA', we are pleased to see that the whole area of healthcare-associated infection is being taken seriously. We now have the three committees through the Department of Health, The Social Partnership Forum and the House of Lords, which has a select committee to look at controlling the spread of communicable disease, and the College has been asked to become involved in all three areas. I hope that where appropriate we can also involve the relevant specialist societies.

There is much going on and I hope that we can move on from the rather feeble debate aimed at doctors' ties, cuffs and watches that we saw in the autumn and start concentrating on wider issues.

Clinical Excellence Awards

The list of national Clinical Excellence Awards was published at the end of October and College Members did well. It is always a difficult and rushed time of year but the College has now completed the process of recommendations and citations for next year's awards. I am grateful for the considerable efforts put in by the Regional Councils' Awards Advisory Committees and their respective Chairs. We try to make the process as open and transparent as possible, and encourage self-nomination through the Regional Councils.

It is always difficult, as the process starts before the previous year's awards are announced, and many members who fail to achieve an award often feel dispirited and do not resubmit subsequently.

This is the wrong approach and I would certainly encourage anyone in this position to reconsider next year. It is clear that awards are often not gained at the first time of asking and may require submission on more than one occasion to be successful. We start the process in July, when the Regional Councils constitute their local committees and inform members of the timetable for the local process. While we encourage self-nomination, I think it also important to identify those who we wish to encourage to put their names forward. I am still surprised by the modesty of some of our very active members!

I would also encourage those who are not yet eligible for national awards to apply for local awards as it is this initial step that puts you on the pathway to the national process, and does give local recognition for the major efforts that many of our members put into the service.

National Pathology Week

I can't, of course, have a Presidential *Bulletin* column without mentioning National Pathology Week, for which progress is coming on apace. I am very impressed by the efforts that members are putting in and by the enthusiasm with which our specialist societies and allied groups are offering ideas and commitment. You will get regular mailings from Ruth Semple, our Exhibition and Outreach Project Manager, on this and I exhort you to think about what you can do locally and contact Ruth so that she can explain what the College can provide by way of support. As part of this process, we are looking at a logo for the College that can be used with the crest and will help brand National Pathology Week. This is part of our development of the visual identity of the College, of which you will hear much more.

Members become Fellows

At the AGM in November, various changes to the College's Charter were approved. One major step was the abolition of the 'Member' category of the College. As from 1 January 2008 all Members became Fellows and should now use the appropriate post-nominals. This is the culmination of the debate that we have had over the last 18 months and over the next few months those to whom it applies will receive new certificates and we will agree the formal process of its recognition. The changes also recognised Associates of the College, which will formalise membership of the College for those passing Part 1, and Affiliates. These latter will generally be members of the professions allied to medicine who work with College members, but are unable to attain Fellowship of the College by any of the current routes. Many of these Affiliates will benefit by a closer relationship with the College, for CPD and so on, and conversely many have much to offer from which the College can also benefit. This is a major development and step forward for the College.

Professor Adrian Newland
President
president@rcpath.org

College House dinner: invitation

Wednesday 18 June 2008 at 6.45pm for 7.15pm

Painters Hall, 9 Little Trinity Lane, London EC4V 2AD

This is the only College dinner open to all College fellows and members. Guests will be invited from the pathology community, including past College Presidents and representatives from other societies. Please fill out the application form enclosed with this mailing to secure your place or email **michelle.merrett@rcpath.org** for a form.

Professor Phil Dyer

Dr Paul Sinnott

Organs for Transplants: A report from the Organ Donation Taskforce

Professor Phil Dyer and Dr Paul Sinnott summarise a recent report from the Department of Health's Organ Donation Taskforce, outlining the effectiveness and importance of organ donation and transplantation.

In the UK, organ transplantation commenced in the mid 1960s, since which time many important innovations have been contributed by clinical and research workers to the worldwide achievements in this important field. Heart, lung and liver transplantation are life-saving procedures and, along with kidney and pancreas transplantation, are some of the most effective treatments that significantly enhance a patient's quality of life. They are also highly cost-effective. In addition, there are developments underway which should see routine transplantation of bowel, facial skin and composite tissue such as partial limbs in place within the next ten years.

UK Transplant (www.uktransplant.org.uk) is a division of the recently constituted NHS Blood and Transplant (NHS BT), with responsibility for organ allocation and activity and outcome audit. Organ transplant activity for 2006–2007 is shown in Table 1.

The indications for organ transplantation are diverse and entry of patients to transplant lists is an increasing activity as transplantation is established as the most effective, and sometimes the only, treatment option. For example, paediatric, older and more complex patients, such as multi-organ transplants, are more likely to be considered for transplantation now than just five years ago. The numbers on the transplant list at the end of March 2007 are shown in Table 2.

The data in Tables 1 and 2 reveal the striking contrast between the supply of organs and the number of patients needing a transplant. During 2006–2007, more than 1000 patients died because an organ was not found for them. Many more patients who could benefit from a transplant do not get referred for consideration for transplantation because of the known shortage of organs available.

At the end of 2006, the Minister for Health convened an 'Organ Donation Taskforce', chaired by Elizabeth Buggins from the West Midlands Strategic Health Authority. Members included transplant coordinators, surgeons, physicians, patient representatives, an ethicist, a donor family, intensivists and a journalist. The report was published on 16 January 2008 and is available at www.dh.gov.uk.

Organs for Transplants clearly identifies that previous initiatives have failed to have any impact on donation rates in this country, that transplantation is highly effective in both saving lives and reducing costs, and that it is timely to introduce radical changes in the way that the donation service functions.

In the summer of 2007, the Chief Medical Officer indicated his support for changing the UK system of organ donation from an 'opt-in' to an 'opt-out' process. Currently anyone wishing to donate their organs after their death needs to inform their close relatives of their wishes and may register online (www.mylifemygift.org), by phone (0845 60 60 4000) or may carry a donor card. The most important of these is to let close relatives and friends know, since it will be they who are approached after a death.

Several European countries operate an opt-out system, in which organs may legally be taken without seeking permission other than to ensure that the dead person had not registered their wishes

TABLE 1
Organs transplanted in the UK April 2006 to March 2007 (Source: *Transplant Activity in the UK*, UK Transplant)

* 17% increase from 2005–2006

	Kidney	Pancreas	Heart	Heart with lung	Lung	Liver
Organs transplanted from deceased donors	1440	198	156	6	130	647
Organs transplanted from living donors	690*	0	0	0	0	12

TABLE 2
Number of patients eligible for transplantation at 31 March 2006 and 2007. (Source: *Transplant Activity in the UK*, UK Transplant)

	Kidney	Kidney with pancreas	Pancreas	Heart	Heart with lung	Lung	Liver
2006	5773	90	55	110	41	264	365
2007	6333	147	60	88	26	265	315

against donation on a national register. In practice, Belgium, Spain, Hungary and Austria have a 'soft' opt-out, since relatives are always approached to ensure there is no objection to donation. Spain has the highest deceased donation rate in the world, in excess of 30 per million population (pmp) (the UK struggles to reach 13 pmp) and supports intensive care staff with on-site, medically qualified organ donation coordinators who are able to approach relatives knowing that, legally, donation can proceed. An interesting study of a small number of UK citizens who died while resident in Spain showed that they *all* donated their organs after their death.

The Organ Donation Taskforce has now been asked to considering whether an opt-out system should be introduced in the UK and the Prime Minister personally announced that a national debate on this issue would be welcomed. Recent correspondence in the national press and on radio has shown that a diverse range of views exists. Unfortunately, apparently related issues such as the diagnosis of death (which is not part of this report) have become embroiled and the debate is at risk of losing focus.

Organs for Transplants
A report from the Organ Donation Taskforce

Organs for Transplants highlighted that:

- The number of people waiting for transplants is rising by 8% each year
- patients are increasingly **unlikely** to be referred for transplantation
- Asian or Afro-Caribbean patients make up 23% of the kidney list, 8% of the general population but only 3% of deceased donors
- living donations increased by 93% since 2000
- donation after cardiac death increased by 284% since 2006
- the annual rate of donation after brain death has fallen by 15%
- the organ donor register comprises nearly 25% of the population
- surveys of the public reveal that 90% favour organ donation
- 40% of relatives refuse consent to donation
- "it is the system within which both the public and professionals exist that lets everyone down".

There are three categories identified that constitute the donation process: donor identification and referral, coordination and organ retrieval. For each of these three categories, five concerns are highlighted:

- legal and ethical issues
- the role of the NHS
- organisation of coordination and retrieval
- training
- public recognition and public promotion of donation.

The Taskforce synthesised these points as 'Organ donation – a UK-wide service' and stated that:

- a UK-wide integrated service is essential; this goes against the general NHS policy for service provision
- whilst NHS Blood and Transplant (BT) is the logical home for these services, it is currently not in the form envisaged by the Taskforce.

The recommendations of the Taskforce, which have been accepted by the Minister and are to be fully funded, can be summarised as follows.

- Clarification of legal and ethical concerns and the establishment of a single formal body to advise clinical staff.
- Donation should become **usual** rather than unusual.
- Every Trust should appoint a clinical champion for donation, supported by a non-clinical champion such as a patient, and they chair a donation committee accountable to the Trust Board.
- Every Trust Chief Executive and Medical Director is to be accountable for their Trust's performance in supporting donation.
- A national protocol for notification of organ donors will be introduced.
- Any financial disincentives should be removed; the financial cost of donation can be considerable.
- Donor coordinators will be doubled in number and their task will be shared as family liaison, data collection and retrieval components.
- Donor coordinators will be integrated into critical care groups.
- There will be nine regional organ retrieval teams comprising anaesthetic, theatre, surgical

and coordinator roles; none of these staff will have other elective commitments.
- Appropriate public recognition of organ donors and their families.
- Effective promotion of donation, especially among Asian and Afro-Caribbean groups.
- Clearer national guidelines for Coroners.
- Provision of adequate infrastructure to support more transplants, including support services such as histocompatibility and immunogenetics (H&I) laboratories, and a national basis for commissioning.

These recommendations are recognised to be radical, wide-ranging and essential. They aim to increase transplantation in the UK by 50% within five years.

Histocompatibility testing services based in transplantation laboratories throughout the UK are located in Acute Trusts or in the National Blood Service. They are led by consultant clinical scientists and provide a wide range of services in support of organ, tissue and stem cell transplantation and human leukocyte antigen (HLA)-associated disease and drug sensitivity testing. Recently, all UK H&I laboratories formed the UK H&I Network to move forward under the recommendations of the Carter Report.

The reader of this report must be encouraged by its bold and strongly positive approach. Transplantation is well established as an effective procedure and what is needed is more of it.

Professor Phil Dyer
Professor of Transplantation Science and Consultant Clinical Scientist
Transplantation Laboratory
Manchester Royal Infirmary

Dr Paul Sinnott
Consultant Clinical Scientist, Chairperson-Elect, British Society for Histocompatibility & Immunogenetics, Lead UK H&I Network, Transplantation Laboratory
Barts and the London NHS Trust

You can choose to register as an organ donor at: www.mylifemygift.org, where you can download an organ donor card, or you can telephone the organ donor line: 0845 60 60 400
It's time to make your decision and let your loved ones know what you want to happen at the time of our death. **DO IT NOW!**

The changing epidemiology of Legionnaires' disease

Ms Kate Ricketts

Dr Carol Joseph

This time of year marks the beginning of the annual rise in *Legionella* infections. Increased awareness is key to control of this significant infection and here Kate Ricketts and Carol Joseph from the Health Protection Agency provide a timely refresher on the killer disease caused by *Legionella* spp.

Increasing Legionnaires' disease cases

The epidemiology of Legionnaires' disease has undergone significant change in recent years as the result of a complex interaction between the environment and human behaviour. Legionnaires' disease is a pneumonic illness caused by the *Legionella* bacteria. These bacteria normally live in water but can become infective to humans when aerosolised. Cooling towers, whirlpool spas and water systems can all generate aerosols and so must be well maintained in order to prevent a risk to public health.[1]

The Health Protection Agency's National Surveillance Scheme for Legionnaires' disease in residents of England and Wales has been collecting data since 1980. Between 1980 and 2001, there were 150–250 cases reported to the scheme each year. From 2002 onwards, that number has climbed, with over 550 cases in 2006.[2]

Raised awareness

The profile of Legionnaires' disease has increased in recent years, contributing to an increase in the number of cases diagnosed. In 2002, the largest outbreak of Legionnaires' disease recorded in England and Wales occurred in Barrow-in-Furness, Cumbria. This involved 146 cases of Legionnaires' disease and 35 of Pontiac Fever (a milder, flu-like illness that also results from infection with the *Legionella* bacteria) and resulted in seven deaths. Fol-

lowing investigation, the source was found to be a council-operated cooling tower.[3,4]

This outbreak was covered extensively by the news media and was followed in 2003 by two further large outbreaks, which added to the rising awareness of the disease among both clinicians and members of the public. Legionnaires' disease suffers from a high degree of under-diagnosis, and there is therefore the potential for increased awareness to lead to an increase in the actual number of cases diagnosed. Hospital Episode Statistics for 2005–2006 showed that over 300 000 cases of community-acquired pneumonia (CAP) were admitted to hospital in England. Of these, over 293 000 were never specified further; studies demonstrate that a significant proportion of these can probably be attributed Legionnaires' disease.[5]

A study conducted by the British Thoracic Society in 1983 showed that 2% of all CAPs were actually Legionnaires' disease.[6] This means that there should have been around 6000 cases diagnosed in 2005–2006. The Nottingham study in 1998–1999 determined that 3% of CAPs were attributable to Legionnaires' disease,[7] therefore approximately 9000 cases should have been diagnosed. This under-diagnosis mostly occurs because it is cheaper to treat the infection than it is to conduct tests to determine the type of pneumonia.

Testing policies

The introduction of the urinary antigen test has led to an increase in case numbers experienced by many countries across Europe over recent years.[8] The test is quick and easy to use, and may have encouraged more clinicians in England and Wales to attempt a proper diagnosis, especially in milder cases. This is especially noticeable during outbreak situations when the case fatality rate is often lower than for sporadic cases, presumably because the diagnosis of Legionnaires' disease is considered earlier and therefore treatment can be started more rapidly than for equivalent cases in a non-outbreak setting.

Seasonal trends

The unusually high case numbers in 2006 occurred predominantly over the summer months. Cases exhibit a seasonal trend, with peaks occurring between August and October each year. *Legionella* bacteria thrive in the warmer waters of summer; human behaviours change according to the season so that aerosol-generating devices such as showers and fountains are used more frequently, and cooling towers and air conditioning units come online, with their potential to act as sources. This seasonal increase is seen every year, but was particularly pronounced in 2006. The unexpected speed of the increase in case numbers between July and August 2006, from 43 cases to 119, suggests that increased awareness alone was not responsible for last year's rise in case numbers.[9]

In addition to this seasonal variation, Legionnaires' disease figures can also show a seasonal increase as a result of a strong association with travel. Public accommodation sites face unique challenges in the control of *Legionella* spp. Their rooms frequently come in and out of occupancy and as a result the water systems are not always routinely flushed. It can also be difficult to ensure that temperatures are maintained along the sometimes extensive water systems that provide for all of the rooms. Surveillance schemes therefore regularly record an increase in the number of cases of Legionnaires' disease occurring over the summer months, when the majority of people take their holidays. Additionally, with data from the Office for National Statistics showing that the number of travellers is increasing,[10] it is likely that this is further adding to the number of cases of Legionnaires' disease reported to the scheme.

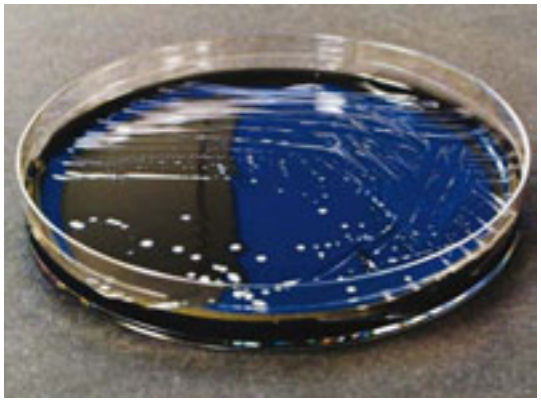
Meteorological influences

The Health Protection Agency conducted numerous investigations into possible clusters of cases of Legionnaires' disease across the country in 2006, in an attempt to ensure that no environmental sources had been overlooked that may have been responsible for this sudden increase in cases. Very few of the investigations identified a source that tested positive for the bacteria. As a result, it was determined that the observed increase in case numbers mainly occurred amongst sporadic cases, distributed across the country.

One factor that may explain the 2006 rise is the weather. Hypothetically, the meteorological conditions may have played a role in optimising the environment for the growth and release of the bacteria. There was a period of very hot weather followed by intense rainfall in the first half of the year, and studies are being conducted to determine whether these meteorological variables can be linked to case numbers.[11]

The data for 2007 has to date mirrored that for 2006 over the first half of the year, but was much lower from August to December. It will be interesting to test the hypotheses generated by the weather study against the 2007 data.

Legionella



Aging populations

A further factor that is likely to be exerting pressure on case numbers is our aging population. The age group containing the highest absolute number of cases is 50–55 years. However, when denominator populations are taken into account, the rate of Legionnaires' disease can be seen to increase with age.[12] This obviously has implications for future levels of this disease and for the resources required to care for increasing numbers of cases as the population in England and Wales becomes more elderly.

Conclusions

The increasing number of cases of Legionnaires' disease in England and Wales has more than one explanatory cause. Changes in human behaviour, such as increased travel and longer life spans, are interacting with environmental factors, such as the weather, in a way that is becoming increasingly optimal for the spread of *Legionella* bacteria.

We can hope that the increasing awareness of Legionnaires' disease and the need for good control and prevention measures may, in time, lead to a decrease in case numbers. However, as this article has discussed, the pressure on increasing case numbers is complex. It is likely that case levels will continue to rise for a good number of years before they begin to show any signs of a decrease.

Ms Kate Ricketts
Legionella Scientist (Epidemiology)

Dr Carol Joseph
Consultant Clinical Scientist (Epidemiology) and Legionella Section Head

Respiratory Diseases Department, Health Protection Agency Centre for Infections

References

1. HSE L8. *Legionnaires' disease: The control of Legionella bacteria in water systems.* Approved Code of Practice (ACoP) and Guidance, Part 3.
2. HPA. Legionnaires' disease in Residents of England and Wales: 2006. *Health Protection Report.* Vol 2, No 5.
3. Telford D, Partridge S, Cumming I, Smith A, Calvert N. The legionnaires' outbreak in Barrow-in-Furness, Summer 2002. J *Epidemiol Community Health* 2006;60:464–466.
4. Joseph CA. New outbreak of Legionnaires' disease in the United Kingdom. *BMJ* 2002;325:347–348.
5. Hospital Episode Statistics. www.statistics.gov.uk/StatBase/Product.asp?vlnk=9420&Pos=&ColRank=1&Rank=422 (accessed 18 October 2007).
6. British Thoracic Society. Community-acquired pneumonia in adults in British hospitals in 1982–1983: a survey of aetiology, mortality, prognostic factors and outcome. The British Thoracic Society and the Public Health Laboratory Service. *Q J Med* 1987;62:195–220.
7. Lim WS, Macfarlane JT, Boswell TC, Harrison TG, Rose D, Leinonen M, Saikku P. Study of community acquired pneumonia aetiology (SCAPA) in adults admitted to hospital: implications for management guidelines. *Thorax* 2001;56:296–301.
8. Joseph CA. Legionnaires' disease in Europe 2000–2002. *Epidemiol Infect* 2004;132:417–424.
9. Anon. *National increase in cases of Legionnaires' disease – update. CDR* Vol. 16, No. 46.
10. Health Protection Agency. *Foreign travel-associated illness in England, Wales, and Northern Ireland: 2007 report.* London: Health Protection Agency; 2007.
11. Ricketts K, Gelb D, Lane C, Charlett A, Lee J, Harrison T, Joseph C. *Meteorological study of Legionnaires' disease cases in England and Wales.* 22nd meeting of the European Working Group for Legionella Infections. Stockholm, Sweden (June 2007).
12. Joseph C. *Epidemiology of Legionnaires' disease in Europe – 2006.* 22nd meeting of the European Working Group for Legionella Infections. Stockholm, Sweden (June 2007).

Dr Mary N Sheppard

Sudden cardiac death in the young and helping bereaved families

Dr Mary Sheppard has been working as a specialist cardiac pathologist for the past 12 years at the Royal Brompton Hospital. Many people think cardiac pathology is boring, lacking the diagnostic challenges of surgical pathology. Even colleagues have been known to state it is "easy", based upon ischaemic heart disease where coronary arteries and diseased muscle is all that is needed to be looked at with the naked eye. However, there is also a very personal and moving aspect to the job, which Dr Sheppard shares with us here.

I initially thought that the cardiac side of my work would not take up a lot of my time in a busy cardiothoracic centre where pulmonary surgical cases predominated. How wrong I was. My mentor and teacher was Michael J Davies, who sadly died two years ago. He had a special interest in sudden cardiac death and published extensively on this topic. Working very much as his junior colleague for over four years on two British Heart Foundation (BHF) research projects into sudden cardiac death, with an emphasis on young people where non ischaemic cardiac causes predominate, gave me invaluable experience in cardiac pathology. Through his gift for teaching, he awakened in me what is now my lifetime interest in this topic, which has happily coincided with public and national interest. We published what are now seminal papers on this topic in the UK[1,2] and established the entity of sudden arrhythmic death syndrome (SADS).[3] Our studies also emphasised that many causes of sudden cardiac death in young people are due to cardiomyopathies or channelopathies which are inherited diseases and thereby evolved the concept of expert cardiological family screening to prevent further deaths.[4]

As a result of my work, I came into contact with families who had suffered a traumatic and totally unexpected death of a child or young partner. The effect on the family, as you can imagine, is total and utter desolation followed by bewilderment and all the stages of bereavement from depression through anger but rarely to resolution.

"Why did my healthy partner/child die?" was a question often put to me by a person, who even by their tone of voice on the phone in the first few stumbling words, I knew was a bereaved human being. These families had to negotiate the bewildering and often slow and archaic coronial system in this country with variable results from the autopsy and subsequent inquest, waiting from months (if they were lucky) to years. From examining post-mortem reports in our initial study,[1] I became aware of the variable quality of autopsies and in particular the way the cardiovascular system was examined. This variable quality in coronial autopsies has since been reiterated by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study, which emphasised that sudden cardiac death cases are poorly investigated, especially when the question of cardiomyopathy or cardiac hypertrophy arises.[5] This is despite published College guidelines and reviews for pathologists investigating sudden death. [6,7]

The discovery by families that death was "unascertained" or that there was a lack of detail in the autopsy, with little or no tissue being taken, was in many cases utterly devastating. This became a recurring theme with many of the families who contacted me through the BHF research work we published. They usually discovered my name while surfing the internet for answers to their many unanswered questions. Pathologists throughout the UK, as a result of the research, began sending me cases and I had by then built up a database of 700 cases over the past decade which enabled me to develop specific expertise in the diagnosis of the causes of sudden young deaths. Through this work we now know that many of the causes of death in young people are due to inherited conditions such as the cardiomyopathies and channelopathies.

Because of my work I was invited onto the government implementation group responsible for formulating the National Service Framework Chapter 8 document on cardiac arrhythmias and sudden death which we published in 2005.[8] The coroner on the group, Michael Burgess, and I provided an addendum on the approach to the autopsy which was published on the Department of Health (DH) website. At the working group I became aware that pathology was considered a minor part of the proceedings by the clinicians and managers within the DH who, during discussions, concentrated on family screening and the establishment of inherited cardiac disease and arrhythmia clinics throughout the country. Yet clinicians admit they need a specific diagnosis when somebody dies suddenly, in order to put the family along a specific screening programme and possible genetic investigations.

Working for this group I first met the family groups who had spearheaded this initiative, usually motivated by personal tragedy. SADS (UK) (www.sadsuk.org), The Cardiomyopathy Association (www.cardiomyopathy.org) and Cardiac Risk in the Young (CRY) (www.c-r-y.org.uk/index.htm) were the family groups represented within the implementation group. I met Alison Cox, the chairperson of CRY, who recognised from personal experience with bereaved families the importance of autopsy and pathology. Alison had heard of me through the bereaved families and asked me to talk at their bereavement meetings held annually. Here I was asked to explain my role and emphasise the importance of retention of the heart and tissue in order to come to a specific diagnosis. With careful, sensitive and subtle explanation of exactly what we do in the autopsy, the families can understand the need for retention and what histology, blocks and slides are. I had to overcome many people's perception of histopathologists as necrophilic, psychopathic, homophobic, desiccated academics surrounded by grisly bits within our own enclosed world (in other words mad, bad and dangerous to know!). Meeting the families and explaining my role to them has opened my eyes to the importance of communication within pathology and with the public. We need to go out there and emphasise the vital role we play in the investigation of sudden cardiac death and other health issues. The bereaved families are looking for answers and need to know more about the conditions that led to the death of their beloved. This role is an important one for us, working in association with the cardiologists who screen the families.

The work I was doing was not funded and carried out by me on a purely voluntary basis. Since then I have obtained funding from CRY to establish a cardiac pathology unit dealing specifically with sudden young cardiac death which will officially open on 7 March 2008. In addition a national network of histopathologists dealing with cases is being developed which has been already highlighted in the *Bulletin* and there is now funding for a national database to be established. These are exciting new developments which will help families enormously in coming to terms with such a traumatic event in their lives. I wish to thank both Royal Brompton and Harefield NHS Trust management and The National Heart and Lung Institute, Imperial College, London for their support.

Dr Mary N Sheppard
Department of Pathology
Royal Brompton and Harefield NHS Trust

References

1. Bowker TJ, Wood DA, Davies MJ, Sheppard MN, Cary NR, Burton JD *et al.* Sudden, unexpected cardiac or unexplained death in England: a national survey. *QJM* 2003; 96(4):269–279.
2. Fabre A, Sheppard MN. Sudden adult death syndrome and other non-ischaemic causes of sudden cardiac death. *Heart* 2006; 92(3):316–320.
3. Behr ER, Sheppard MN, Wright M, Bowker TJ, Davies MJ, McKenna WJ *et al.* Sudden Arrhythmic Death Syndrome (SADS) – a national survey of sudden unexplained cardiac death. *Heart* 2007.
4. Behr E, Wood DA, Wright M, Syrris P, Sheppard MN, Casey A *et al.* Cardiological assessment of first-degree relatives in sudden arrhythmic death syndrome. *Lancet* 2003; 362(9394):1457–1459.
5. Ranson D. Coroners' autopsies: quality concerns in the United Kingdom. *J Law Med* 2007; 14(3):315–318.
6. Sheppard MN. Sudden adult death and the heart. Kirkham NSN, editor. *Progress in Pathology.* [6], 185–202. 2003. London, Greenwich Medical Media.
7. Lucas S, Burnett RCCLSMJ, Moore ISR. The Royal College of Pathologists' Working Party on the autopsy. *Guidelines on autopsy practice – Scenario 1:Sudden death with likely cardiac disease.* 2005. London, Royal College of Pathologists.
8. DH Coronary Heart Disease Team. *National Service Framework for Coronary Heart Disease.* Chapter 8. Arrhythmias and Sudden Death. National Service Framework for Coronary Disease[Chapter 8], 1–20. 1-3-2005. London UK., Department of Health.

Welcome to our new Council members

In the January issue of the *Bulletin* we introduced ten of the Fellows who took up appointments on the College Council, following the College Annual General Meeting on 21 November 2007. We introduce some more Council Members here. Professor Stewart Fleming and Dr Andrew Stacey will feature in future issues.

Dr Ian Bailey

Dr Ian Bailey
IT Advisor

It gives me great pleasure to follow Jem Rashbass as the College's IT Advisor. My earliest vision of NHS IT in action was attempts at capturing data from a Technicon Hemalog 8 back in1977, before university. I maintained an interest in IT but did not get more fully involved until after becoming a Member of the College. However, I did have early experience of pulling clinical detail codes from the laboratory computer at St James in Leeds and 'emailing' them to a bulletin board for a colleague to use for an IT project, all whilst sitting at my home computer in 1988.

I was part of a working group for Chemical Pathology Read Codes in 1991 and Chair of the iSoft Apex user group from 1996 to 2000. More recently, IT representational experience has been for the British Medical Association (BMA), representing either the BMA or CCSC (the BMA consultants' craft committee) on various Connecting for Health committees, including 'Choose and Book' and 'Role-Based Access Control', as well as attending the National Advisory Group. I have highlighted the 'non-core' status of pathology IT on numerous occasions, including directly with Richard Granger, Director General of IT for the National Health Service. I also gave evidence for the BMA to the Carter Review.

IT should help us do our jobs, not hinder. The National Programme for IT is showing itself in many parts of the country and the IT work generated is expanding. It will be an interesting time.

I have been Consultant Chemical Pathologist in Bromley since December 1991 and run a lipid clinic from our Orpington site. I live near West Malling, Kent, and my wife works as an Associate Director of Human Resources in our local Mental Health Trust.

Dr Ian Frayling

Dr Ian Frayling
Wales Regional Chair

I am the only genetic pathologist in NHS employment, as Wales currently has the only post, as Laboratory Director of the All-Wales Medical Genetics Service. There are a few others also qualified in clinical molecular and cytogenetics but they are either in academic or clinical geneticist posts. What does a genetic pathologist do? Well, consider what a clinical immunologist, haematologist or biochemist does, substitute DNA for whatever analyte/s they specialise in, and I hope you have some idea.

I read Medical Sciences at Cambridge, including the Part 2 in Biochemistry, and then I went to the new clinical school at Addenbrooke's, qualifying in 1982. As a senior house officer (SHO) in pathology, I actually found it very useful to be rotated around the specialties, because, although I had included the clinical biochemistry module in my Part 2, I wasn't sure just which branch of pathology I might wish to specialise in. Being Lance Sandle's SHO for a time when he was an senior registrar at Manchester Royal Infirmary didn't put me off! While a registrar in chemical pathology at the children's hospital at Pendlebury, I was enthused by a talk given by Professor Rodney Harris on the burgeoning need for people who could carry out genetic testing. Having done some DNA work as an undergraduate, I therefore sought out somewhere I could do a PhD on it. I found the CRC Chemical Carcinogenesis Laboratory at the Paterson Institute, and did my thesis there on oxidative DNA damage repair in transgenic mice.

At the end of this, the Institute's Director, Professor David Harnden, gave me an excellent bit of direction, by suggesting I get involved in the new fangled cancer genetics, so I spent a year in the molecular genetics laboratory at St Mary's finding mutations in the adenomatous polyposis gene, and some work on pre-implantation genetic diagnosis in a mouse model. I then became an Imperial Cancer Research Fund Clinical Fellow at St Mark's in London in the family cancer clinic, testing the APC gene, and later the DNA mismatch repair genes involved in Lynch Syndrome (HNPCC).

It was then back to Cambridge as a specialist registrar in genetic pathology, where I worked in molecular, clinical and cytogenetics and with molecular histopathology. I moved to my current post in 2003. I regard my early broad training as

having been extremely useful, as the wide experience I gained enables me to understand the various branches of pathology, and to bring that experience to perhaps the newest of pathology specialties, laboratory genetics. It is becoming increasingly clear that a multidisciplinary approach is needed to provide the data necessary to interpret mutations, especially as the introduction of technology enables mutations to be found ever more easily. There is also a great need to give advice to those who request genetic tests, and help them with the interpretation. Hence, I have got involved in immunohistochemistry for MMR proteins, and carrying out somatic genetic tests on tumours such as for microsatellite instability. Currently this helps diagnose hereditary conditions, but soon such techniques will, of course, enable much more detailed diagnosis of all tumours, and prediction of response to treatment.

I have been involved in developing a national strategy for biomarker testing in colorectal cancer, with the help of the Public Health Genetics Unit in Cambridge, and now contribute to the new NEQAS ICC scheme for mismatch repair proteins. With the introduction of high-throughput and array technologies, testing is becoming less of a problem, and interpretation all. Having studied xenobiotics and their metabolism in my PhD, I can appreciate how important pharmacogenetics is going to become in individualising treatment, just as much as somatic genetic analysis is going to revolutionise cancer therapy. This will bring considerable challenges as laboratory genetics moves into the sort of throughput and turnaround times seen in clinical biochemistry.

I represent Wales on a number of national (i.e. Welsh) and UK committees, including the UK Genetic Testing Network (UKGTN) steering group, and this way of bringing together such specialised services is perhaps one model of how molecular pathology in general might one day operate in the UK. The Pathology Modernisation Programme in Wales is gathering pace, including a major subprogramme in molecular pathology, and it is an exciting time to be considering the potential that a single Laboratory Information Management System for the whole of pathology in Wales would bring, and by having completely web-based test requesting, as part of Test Requests Results and Reporting, that advice could be given up front to clinicians on testing strategy before they request anything: and potentially no more scrawled request forms! Having been co-opted onto the SAC in Histopathology, I hope very much to be able to contribute to the training and education of histopathologists in matters molecular. Being 'it' for a specialty means one is much in demand for so many committees and steering groups, but being able to contribute is very satisfying, and I hope I can follow in the successful footsteps of my predecessor and colleague, Professor Geraint Williams. Now, National Pathology Week – do you mean Wales or the UK?

Professor James Lowe

Professor James Lowe
Trent Regional Chair

I am an Honorary Consultant in neuropathology based in Nottingham at the Nottingham University Hospitals NHS Trust and also Professor of Neuropathology in the Nottingham University Medical School. My position on the College Council is to represent the Trent Regional Council which I joined in 2007, taking over as its Chair from Tim Stephenson in January 2008.

I have served on Council in the past and provided assistance in managing issues related to human tissues as the College and pathologists in general were subject to public scrutiny. During my last tour of duty, I was a member of the Specialty Advisory Committee on Histopathology and chaired the Neuropathology Sub-committee. I am an examiner in neuropathology and recently helped establish a national centre for assessment of the autopsy for the neuropathology candidates, under the direction of Paul Ince.

Between 2003 and 2007 I was a clinical head of service for cellular pathology in Nottingham. Recent experience includes involvement in workforce changes following a major Trust merger, witnessing the significant issues that face all laboratory services as they are confronted with the reality of continued delivery of services in the face of ever increasing cost pressures. NHS reorganisation is generally a complex business where the law of unintended consequences operates to maximal efficiency(http://en.wikipedia.org/wiki/Unintended_consequence). To paraphrase Wilde, there is a danger that we will see the emergence of providers of pathology services who know the price of everything but the value of nothing.

Working in a university environment I see great importance in the initiatives being supported by the College to prevent the erosion of academic pathology. There is a long way to go before a career in academic pathology is again aspired to by a significant proportion of trainees, as it was in the past. I am very interested in both undergraduate and postgraduate medical education, and still greatly enjoying delivering my own teaching activities. Provided that it will be adequately resourced, I am a supporter of the new directions to professionalise medical teaching and raise its stature.

I am looking forward to working with my colleagues on the Trent Regional Council, as well as the main team on 'big Council'.

Dr Deborah Mortiboy

Dr Deborah Mortiboy
West Midlands Regional Chair

I graduated from the University of Birmingham in 1986 and, following a period of training in general medicine, embarked on a career in medical microbiology, training on the West Midlands regional rotation. My first consultant post at Good Hope Hospital in Sutton Coldfield was a steep learning curve, becoming Head of Department, infection control doctor and consultant all in one fell swoop, by virtue of being single handed for the first couple of years. I remain grateful for the support of my colleagues in neighbouring Trusts during that time, since I always felt I could pick up the phone to discuss difficult cases or other problems. I think it is important that we should not lose sight of how valuable those informal links can be in maintaining the quality (or is it sanity?) of our work. Thereafter I was joined by a colleague, and became Clinical Director of Pathology, which broadened my horizons further and reinforced my belief that we should view pathology as a whole service, rather than individual disciplines.

I moved to my present post at University Hospital Birmingham almost six years ago and continue to enjoy the role of leading the microbiology service in an environment with a wealth of interesting clinical challenges. I've had an active role in training specialist registrars in the department, and working with fellow members of the regional training committee in appointing and assessing trainees on the regional microbiology rotation. I've recently been involved in reviews of pathology provision within the Strategic Health Authority and as a pilot site for the Lord Carter's review.

I therefore hope these varied experiences will help me to understand and effectively represent the views of my colleagues, in all grades and in all disciplines, in pathology within the West Midlands and to participate effectively in the work of the College through my membership of Council and the Specialty Advisory Committee.

On the home front I have two lively young sons and a better half, who have learned to share my enjoyment of fresh air, country walks and historic houses. They also actively participate in my other interest, namely cookery, mainly by eating the end result but on occasions are hands on (and in!).

Dr Archie Prentice

Council in the East: from Whitehall to Whitechapel (and back again)

Dr Archie Prentice travels to Whitechapel to report on the 227th Council meeting held on 8 November 2007.

Mistaken assumptions

The then-Editor asked me to write this personal view describing a meeting of Council because he was going to miss part of it having to interview Lord Carter. He said I should do this in 1000 to 1500 words and I wondered how on earth I could find that many to describe such a prosaic occasion, envious that Tim Stephenson had the more interesting task. Minutes have such an acrid whiff of generations of collegiate academic dust that I feared I could not muster much interest from one meeting.

I was wrong on two counts. First, we met in the Old Library at the Royal London. Whitechapel's stimulating cultural broth should be seen by all prejudiced Englishmen, whether believing that immigration should have been controlled more carefully or knowing that England would have sunk in the Channel long ago without it. The market that greets you on emerging from Whitechapel tube station is certainly a shock at first encounter. Then there are the tired, emotional, unkempt white men (not the consultant staff) who surround and litter the hospital grounds. Whitechapel has been a port of entry over centuries for the waves of incomers who have changed Britain, but clearly not all succeed and some flotsam gets left behind. In the midst of massive reconstruction sits the Old Library, an example of the superiority of 19th century public buildings. Therein I found the soporific, waspish buzz of Council already underway, but curiously no books (hopefully they are safe in the New Library).

My second mistake was to envy Tim's date with Lord Carter. Under 'Matters arising' we discussed

Lord Carter's review of pathology, which he had touched on briefly during his speech at the College's Annual Dinner the night before. I enjoyed this dinner for the crack I had with Patrick Sarsfield, a most civilised man from the south-west, not because of anything Lord Carter said. He was very complimentary about our efforts (his Lordship that is), as any polite dinner guest would be, but at the end of his speech I was no clearer about our future than ever.

Death and taxes...

Every time I listen to a politician these days, it occurs to me that the only tax they have failed to increase is syntax. The tax revenue has doubled in the past 10 years, so where is it? Why has the NHS suffered reduced spending this year and, if we are as effective and efficient as Lord Carter believes, how will the private sector improve delivery of pathology services? No such awkward questions are ever answered in Council or even at meetings of the Executive, but I have to say I do admire the polite but limpet-like tenacity of recent Presidents (particularly this one) in pursuing Government. It is surprising and irritating to see and hear how often Members and Fellows do not appreciate this. At another recent College dinner (sorry, but the Executive does have to eat with and listen to a lot of important people) with Professor Sir Graeme Catto, he reminded us of the extent to which Government denigrates our worth and the work of Colleges.

Our President tried to cheer us in Council by reminding us of the frequent fate of unwelcome reports to Ministers from well-meaning advisors, but I'm not sure how to interpret that. If Lord Carter is 'on our side', then his report may be shelved and the good parts (e.g. the non-threatening aspects of networking and the insistence on the same standards for private and NHS labs) will be forgotten. If he recommends difficult change, then how will that be transmitted rationally and evenly from a Government intent on distancing itself increasingly from the sharp end of our systems of health care? It is impossible to exclude politics from Council's discussions, such is the level of Government interference with matters concerning health and illness.

Input to legislation

As often happens, the President's report contained some of the more interesting parts of the agenda. For example, multi-professional input appears to have killed off the Regulatory Authority for Tissue and Embryos (RATE), the Government's proposed regulatory body for the implementation of the Human Tissues Act, and there will be favourable amendments to the Act with reduced fees and a review of the code of practice. The new Coroner's legislation is likely to be delayed, allegedly because two Government departments are arguing about legislation which they are afraid to get wrong and which neither understands. I think they need multidisciplinary team meetings to sort out their angst.

Point-of-care testing

As evidence of their need and of the need to be sure of the reasons for sudden, unexpected or unexplained death, witness the apparent enthusiasm of the Department of Health (DH) for evermore 'point-of care-testing' (POCT) on the high street. I know a haematological Clinical Director of Pathology who once told his Primary Care Trust (PCT) that their first investment, when their general practitioners were considering running their own lab, should be to build a new mortuary because his wouldn't big enough; stark but brave, professional and effective advice. The PCT is still using his labs to its entire satisfaction. I also know an eminent barrister who says that anyone foolish enough to be tested by a lab not run by someone who is suitably qualified deserves to pay well over the odds and can hardly complain of the disastrous consequences of misleading results. He is a lawyer though, and your College tries to explain the folly of this 'policy' in more considered tones. Council agreed that there is a need for all pathologists to push the POCT issue into the public eye with careful but effective criticism and I wonder whether College needs to advise Fellows, through this organ, on how that can be done.

Training

We discussed Sir John Tooke's report on training, which had struck me as a fairly predictable turn of the wheel of history, but maybe I'm wrong and maybe the underlying political intrigue is interesting. If you believe in joining up dots, maybe he was encouraged to encourage the disappearance of Postgraduate Medical Education and Training Board (PMETB) into the General Medical Council (GMC) two years earlier than apparently planned. Sir John exhorted us to speak to Government with one voice about training and the Academy of Medical Royal Colleges (AMRC) is producing a business plan for how this might be handled. It will be interesting to see how AMRC, the Academy of Medical Education, the Academy of Medical Sciences and the Joint Medical Consultative Committee interact with unity and clarity, a word bastardised into meaninglessness in recent years. It was encouraging to learn from AMRC that the Chief Executives of the Strategic Health Authorities have said unanimously that consultants must be allowed time off in their job plans to undertake NHS-related work for Colleges, in the interests of the 'greater good'. College needs to know of any colleagues who are hindered in this respect.

Laboratory accreditation

I do not recall a meeting of Council at which laboratory accreditation was not discussed. College also needs to know of any Trust employing a 'profes-

sional' manager of a lab (i.e. one unqualified in our terms or as expressed in CPA's ISO standard B1), as has happened in Northern Ireland. The relevance of ISO has been challenged recently in a DH letter. Lord Carter agrees that there should be a level playing field for NHS and private labs, including the demonstration of compliance with standards of quality. The College has always insisted that CPA accreditation is an essential criterion of a satisfactory laboratory, but defending that may prove difficult. One could be suspicious of a system which allowed 100% accreditation at first inspection, but a devil's advocate could challenge a system which concludes that 45% of participants cannot be fully accredited and none are closed.

Payment by results

College has responded recently to the DH's call for views on the reimbursement scheme known as 'Payment by Results'. Disregarding the misnomer (it's 'payment by activity' and results don't come into it), College saw as less risky the option of inclusion (bundling) of lab costs in the overall tariffs for Healthcare Resource Groups as opposed to their exclusion (unbundling). There are arguments both ways, but Council was given some scary, recent examples of physicians and surgeons working in a healthcare system of another country where unbundling allowed them to inflate their rewards and to exclude labs from appropriate reimbursement.

The cost of revalidation

It is now clear that revalidation and relicensure will involve a huge amount of work for Colleges on behalf of the GMC. Council agreed the establishment of a task force of chairs of Specialty Advisory Committees to work out a five-year continuous, formative cycle specific to each sub-specialty but within a generic College framework. Preliminary discussions with the GMC indicate that this will need evidence on personal workload, output, audit, interpretive EQA and multi-system feedback. Work has begun already to define the process. A first shot at financial figures suggests a set-up cost of £0.5 million and an annual running cost of £250 000 for this College alone. That's about £140 per Fellow per annum, not to mention all the extra time and effort needed from all colleagues and the necessary willingness of SHAs, PCTs and Trusts to make this work.

Looking on the bright side...

It's difficult to end this personal view on a high note after that little bombshell. About all I can muster is the grim satisfaction that we are still in control of the process of proving we are fit for purpose, despite all assaults on our professionalism. The minor gods of irony and paradox may still be on our side, remembering of course that they would first make us proud, etc.

Dr Archie Prentice
Elected member of Council
Member of the College Executive

Speak up: give your view on College consultations

All members should get involved in College's consultations on the guidance and documents that are relevant to their specialty.

Your opinion is vital in helping us ensure that all the documents we produce are reliable and workable in practice – and what you say, counts. You can also claim up to 2 CPD credits for this work. All college documents are put for consultation on the website, you just need to login and visit www.rcpath.org/index.asp?PageID=90

Here you will find all the documents open for consultation and information on the status of documents in the process of being revised before final publication. When a new document is posted, we send out an email to the relevant members advising them of the open consultation.

If you've forgotten your login details for the website, please contact webmaster@rcpath.org

Dr Alison Holmes

An organisational approach to infection prevention

Infection control is everybody's business. However getting everybody to buy into this sentiment is not easy. In this thoughtful article, Alison Holmes shows how it should be done and how her own Trust, the Hammersmith Hospitals NHS Trust in London, is getting on with the process.

Introduction

To deliver infection prevention within NHS acute care we should consider the framework of the organisations in which we work. We should consider if organisations have developed that do not readily support, reinforce or sustain infection prevention and control. Reducing healthcare-associated infection (HCAI) involves an enormous amount of diverse work in ensuring that there is best practice in all the multiple aspects of clinical and hospital management that have an impact on infection control. To truly address this, whole-scale change is required across the organisation, so that infection prevention is systematically embedded in all aspects of managing a hospital and in every aspect of care. The best clinical care should be provided within hospitals that should provide the safest possible environment in which to deliver that care, and infection prevention is a core aspect of that safety. Achieving safety within an organisation requires more than "individual carefulness", it is a "corporate responsibility"[1] and cannot therefore be delivered through an individual or a team, no matter how highly committed and enthusiastic, nor be the responsibility of a separate service. An organisational approach is required.

An organisational approach addresses key problems and barriers to effective infection prevention programmes. It addresses the issue of having a huge amount of available expertise that is not used effectively or with adequate influence. This approach would also deal with the situation of small infection control teams in huge Trusts, providing a 'firefighting' service but without any major strategic input, and where the local expertise is not closely linked to the management framework. It would ensure that a systems-based approach was developed, as sustainability is unlikely if it is dependent on an individual or a set of individuals. The approach could integrate infection prevention and control into corporate governance, making it an essential component of patient safety and creating an environment of organisational learning, continual improvement and reinforcement. Tackling infection control from an organisational perspective would work across all the historical, institutional and cultural barriers and some of the silo working arrangements, which can block action and progress. It could be piggybacked on to existing organisational leadership and be used to change the culture and behaviour of the whole organisation.

Conditions for organisational change

In the industrial and financial world it is well known that organisational change is complex and challenging, and requires conditions that are well established to be demonstrably linked to success.[2] These are:

- a belief in a shared purpose
- reinforcement systems
- skills required for change
- consistent role models.

These conditions provide a useful framework to explore how we could apply these principles to the task of embedding infection prevention and control within acute Trusts. However, applied research on healthcare models is clearly needed to investigate what best delivers effective infection prevention in NHS acute care.[3]

A belief in a shared purpose

The whole organisation must be committed to the belief in the overall purpose of the change. It must be a shared vision and an explicit goal: preventing infection in our patients. All staff must understand their role; widespread multidisciplinary engagement is needed and a clear message that everyone in the organisation matters and everyone is responsible. This shared goal importantly bridges managers and clinicians to a common purpose,[4] and works across multiple parallel hierarchies; not just the professional ones, but those that also exist within specialities, directorates, etc. Above all, the shared purpose must have clear backing and leadership from the Chief Executive.[5]

Sharing the goal is facilitated by ensuring that patient care – not some central edict, political pri-

ority or target – is the driver and by ensuring that data used for monitoring is credible and appropriately analysed. Individual relationships and rapport with senior leaders is critical; however, for large organisations the internal communications team can support multiple methods for communication and awareness. A belief in a shared purpose and vision is greatly enhanced if strong organisational engagement[6] already exists in the Trust, with commitment to the Trust itself rather than to professional and specialist peer groups alone, and if there is a track record of collaborative practice.

There has been much in the media regarding the dangers of managers not prioritising patient safety in infection control (e.g. Healthcare Commission reports on Stoke Mandeville and Maidstone). A gap and lack of understanding of managerial and clinical goals creates a dangerous gulf. There is a clear need for improved dialogue and a common agenda in running health care,[7–9] and the building of close relationships between clinicians and managers has a particular impact on infection prevention. Infection experts without influence, combined with managers without adequate knowledge of risk and who may have competing priorities they perceive to be greater than infection prevention, seriously compromises patients' safety.

Reinforcement systems

Internal reinforcement

These systems must be consistent with the behaviours to be embraced by the organisation, i.e. reflecting the commitment to preventing HCAI. Therefore all internal systems for measuring performance and setting targets, reporting structures, management and operational processes must include and address the commitment to infection prevention, as must any internal reward-granting systems.

Leadership posts with high clinical and high management profiles provide strong internal reinforcement and in 2003 Directors in Infection Prevention and Control (DIPC) had to be appointed in all English Trusts. For the first time ever, a clear leadership post was created, although implementation varied from Trust to Trust.

Internal reinforcement also depends on lines of accountability. A key component of the Hammersmith Organisational Model for Infection Prevention (HOMIP)[10] was establishing directorate accountability. This was critical, as it aligned infection prevention and control with existing decision-making and most financial management structures. General managers and clinical directors were made accountable for infection prevention and control within their directorates, and clinical leads identified. This reinforces ownership, facilitates local surveillance and targets training, specific actions and adoption of best practice. The accountability and quality improvement, however, requires good data and continual feedback to the directorates and appropriate groups so there must be an infrastructure to provide this.

Rather than creating more groups, committees, structures and so on, existing systems, networks and meetings can be used – not just for efficiency, but to avoid duplication and ensure decision making takes place in the right forum. At my Trust we were keen not to introduce any more committees. However, as momentum grew, each directorate decided that they wanted specific directorate-based groups to focus on infection prevention and control. Infection control teams also need to carefully consider whether or not a separate operational infection control service undermines rather than reinforces an organisational responsibility for HCAI prevention. The historical models that many of us are used to may not be the most effective and the type of service that can be provided, particularly by infection control nurses, may need to be more strategic and aligned with how the whole organisation addresses HCAI prevention.

Internal reinforcement can be further supported in appraisals and job descriptions. These provide a clear corporate message and address individual accountability.

Any complacency regarding HCAIs can be addressed by the local reinforcement that this is unacceptable, with selected HCAIs being investigated as clinical incidents. At the same time, Trusts must ensure they fully support and reinforce best practice at the bedside, at the point of care, not just by ensuring consistent best practice through the use of care bundles, etc. but also by the provision of material and equipment to ensure that best practice can be easily delivered, such as alcohol-based hand gel at the point of care and appropriately equipped packs for procedures (e.g. central line packs, peripheral line packs, etc). Research and audit opportunities also provide further internal reinforcement, particularly if the institute is a teaching or academic one.

Lastly, infection prevention and control must be integrated into performance monitoring within the organisation. The balanced scorecard is a framework to measure performance beyond finances that was developed in private industries. It aligns performance measures with strategic and mission goals, so it can measure performance and the factors driving performance.[11] However, please note: you get what you measure. It skews activity and it needs regular refreshing and updating. In 2003 at the Hammersmith, an integrated balanced scorecard was developed which embedded infection prevention and control related outcomes and processes into the directorate scorecards. These went live in 2004. A 'traffic light' system was used, so it was immediately in a familiar format for managers. Core outcomes and measurements were agreed that were also pragmatic and deliverable. These included MRSA and *C. difficile* cases, hand-hygiene

compliance, antibiotic-prescribing compliance and more recently bed management and ward moves. These are now well established with the clinical directorates. Ward level compliance with care bundles (the high impact interventions of the DH 'Saving lives' campaign to reduce HCAIs) has been developed. Frameworks for non-clinical directorates are also being developed. One for Estates and Facilities has recently gone live, however there is a clear need for one in IT and Information, HR, etc. Within specific high-risk specialties and units there are supplemental specialty-specific measures and processes, e.g. compliance with surgical site infection surveillance, etc. Reports can be generated at a Trust level, directorate level and ward level. The underlying database can be accessed to find information on risk, individual patients, etc. The scorecard generated is discussed at monthly performance management meetings with individual general managers of directorates. It is a standing agenda item on the clinical governance committee (now the clinical quality and patient safety committee) and a summary copy goes to the Trust board monthly. Individual directorates have the opportunity to look at further detail, see their own data and package it the way it suits them best. Reporting on their performance in infection prevention and control is a mandatory component of their internal annual reports and they use the data for this and also for local individual reports and meetings.

External reinforcement

External reinforcement is also critical. It is unfortunately currently believed that safety cannot become an institutional priority "without more sustained and powerful pressure" and "that must come from outside the health industry".[12] In the US, this pressure is predominantly supplied by the threat of litigation. This threat can be viewed as a force for patient safety improvement in the US.[13] In the UK, it is the statutory monitoring, government targets, Department of Health and the Healthcare Commission that provide a more significant sustained external pressure, rather than litigation being a primary driver. Significant external reinforcements in the UK are provided by the extensive media interest, public interest and data on HCAIs that are targeted in the public domain. Knowledge about infection rates and Trust standards in delivering infection prevention and control could influence the patient choice that has been introduced in England. It may also provide further external reinforcement to Trust boards. However, perhaps the most rigorous external reinforcement method occurred when the Health Act 2006 Code of Practice for the prevention and control of healthcare associated infections, came into force on 1 October 2006. From June 2007, the Healthcare Commission began a rolling programme of spot checks of Trusts against the Code of Practice.

External reinforcement regarding roles and influence of position is also important. Historically the professional status of public health leadership and infection control within acute care was not high. It was not a highly sought position nor something to aspire to enthusiastically, with little peer recognition or obvious external reward, whether through merit systems, College specialty recognition or from professional networks. For those working in a predominantly academic environment, research and teaching in this area must be recognised and supported in the Research Assessment Exercise, and funding for applied[3] and translational research in the field expanded.

Skills acquired for change

Change cannot be delivered nor behaviours embraced without the knowledge and skills required for change. These must be provided by the organisation and integrated with existing knowledge and practice. Individual and team training should be delivered to all, not excepting managers. Hammersmith Hospitals NHS Trust's infection prevention is integrated into leadership and management training. Nationally, we must consider skill mix of infection specialists, whether they be microbiologists, infection control nurses or infectious diseases consultants. If they are to be DIPCs, not only must they have sound expert knowledge but also the skills to influence and lead the organisation. Colleges and professional bodies need to consider how best to deliver better integrated training so that leaders can be produced. Experts either need to acquire new skills or work alongside skilled senior manager colleagues and *vice versa*. The NHS needs to consider new professional development requirements for a changing healthcare environment.[14,15] It is critical that we work across specialisms and professional silos and acknowledge the role of non-medical leads, e.g. Directors of Public Health and other healthcare workers who may not have primary medical qualifications. Those involved in training programmes need to consider whether the programmes are ready to realise this potential and deliver.

Consistent role models

Role models are required at every level to change behaviour consistently throughout an organisation. Multiple leaders are therefore needed, whose leadership roles are confirmed and supported by their groups, as it is vital that the changes required have meaning to key groups, and leaders must have credibility within these groups. DIPCs must not only have competencies, but have the respect of other clinical and manager leaders. Within the clinical world, this is particularly difficult unless a clinical profile is maintained and there is a track record of clinical engagement and consultation. Senior management role models have to demonstrate that this is not simply an add-on to their management port-

folio, but integral to patient safety and that they as individuals are taking personal responsibility for its delivery. Chief executives must demonstrate their individual personal commitment, involvement and leadership in driving improvement in infection prevention and ensuring it is a core aspect of patient safety in their Trusts.

Dr Alison Holmes
Director of Infection Prevention and Control
Imperial College Healthcare NHS Trust

Reader in Infection Control and Hospital Epidemiology
Department of Infectious Diseases and The Centre for Patient Safety and Service Quality
Imperial College, London
www.cpssq.org/

Acknowledgements
Dr Nick Kambitsis and Eleanor Murray (organisational development) and Martina Dinneen (management).

References

1. Leape L, Epstein AM, Hamel MB. A series on patient safety. *N Engl J Med* 2002;347:1272–1274.
2. Lawson E, Price C. The Psychology of Change Management. *McKinsey Quarterly* No 2, 2003, pp. 30–36.
3. McDonnell A, Wilson R, Goodacre S. Evaluating and implementing new services. *BMJ* 2006; 332(7533):109–112.
4. Silversin J, Kornacki M. *Leading Physicians through Change.* Tampa: American College of Physician Executives, 2000
5. Kohn L, Corrigan J, Donaldson M (eds). *To Err is Human.* Washington, DC: Committee on Quality of Health Care in America, Institute of Medicine. National Academy Press; 2000.
6. Shouksmith G. *Variables related to organizational commitment in health professionals.* Psychological Reports 1994, 74. ISSN 0033-2941 1994, vol. 74 (1), no3, pp. 707-711 (11 ref.)
7. Shortell SM, Waters TM, Clarke KW, Budetti PP. Physicians as double agents: maintaining trust in an era of multiple accountabilities. *JAMA* 1998;280(12):1102–1108.
8. Edwards N. Doctors and managers: Building a new relationship. *Clin Med* 2000;5(6):577–579. The Royal College of Physicians.
9. Edwards N, Kornacki M, Silversin J. Unhappy doctors: what are the causes and what can be done? *BMJ* 2002;324:835–838.
10. Holmes A, Murray E, Dinneen M. Creating a new culture. *Public Services Review* 2006;8. www.publicservice.co.uk/pdf/health/issue8/H8 Dr Alison Holmes ATL.pdf (accessed 16 January 2008).
11. Kaplan RS, Norton DP. *The Balanced Scorecard: Translating strategy into action.* Harvard Business School Press: Boston, MA,1996.
12. Leape LL, Berwick DM. Five years after 'To Err Is Human': what have we learned? *JAMA* 2005;293(19):2384–2390.
13. Annas GJ. The patient's right to safety improving the quality of care through litigation against hospitals. *N Engl J Med* 2006;354:2063–2066.
14. Maude R. Medical management for the uninitiated clinician. *BMJ Career Focus* 2005;331: 207–209.
15. Eaton L. Doctors' career structure to include management training. *BMJ* 2006;332(7550):1114.

A summary of this article appeared in 'Can Organisational Change reduce Hospital Acquired Infections' (*J Hosp Infect* 2007;65 Suppl 2:191–192) and is based on the work described in Holmes A, Murray E, Dinneen M. Creating a new culture. *Public Services Review* 2006;8. www.publicservice.co.uk/pdf/health/issue8/H8 Dr Alison Holmes ATL.pdf (accessed 16 January 2008).

Ian Barlow

Hayley Jackson

Steve Sharp

Accuracy of computer requisition order entry: a Six Sigma process evaluation

Mr Barlow, Ms Jackson and Mr Sharp revisit their Six Sigma evaluation in a blood sciences sample reception area and illustrate the importance of collectively reviewing processes and identifying ways to make improvements.

Introduction

Six Sigma is a rigorous, focused and highly effective procedure, involving proven quality principles and techniques that utilise five key stages during application.

1. **Define** the goals of the improvement activity.
2. **Measure** the existing system. Establish valid and reliable data to help monitor progress towards the goal(s) defined at the previous step by determining the current baseline.
3. **Analyse** the system to identify ways to eliminate the gap between the current performance of the system or process and the desired goal(s).
4. **Improve** the system. Be creative in finding new ways to do things better, cheaper, or faster.
5. **Control** the new system.

Six Sigma process evaluation, originally conceived by Motorola, has been used with tremendous success in industry as a quality-measuring tool and can also be applied in healthcare environments as a means of improving process.

In a previous issue of this journal[1], we described how we used Six Sigma as a process assessment tool in our blood sciences specimen reception area to evaluate our sample rejection rates. Since this study, we have also used Six Sigma to evaluate accuracy of our computer data-inputting processes across two blood sciences specimen reception areas within our PathLinks organisation. This paper summarises the findings.

It is vital that correct patient demographics are entered into laboratory computer systems when blood tests are requested, as errors in this process can lead to results being generated for the wrong patient or requested tests not being carried out. Such errors will cause wastage of resources and unnecessary expense and inevitably lead to delays in result generation, which can ultimately cause harm to patients by delaying diagnosis and/or treatment.

Pathology departments that do not utilise or have access to order communications systems rely solely on their clerical or support staff for accurate data inputting in laboratory computer systems.

The ideal standard is that the patient demographic entry is accurate 100% of the time and that tests are accurately requested 100% of the time. This would be perfection of process and would better the Six Sigma statistic (i.e. process is reliable > 99.9997% of the time or fewer than 3.4 defects per million operations [DPMO]).

Methods

The aim of the study was to assess the accuracy and quality of blood sciences data-entry and test-requesting processes in the laboratory iLAB computer system at two of our PathLinks sites: Scunthorpe General Hospital and Goole and District Hospital, and then calculate the Sigma level of our process.

A total of 197 Scunthorpe requests and 82 Goole requests were randomly selected over a three-day period (1–3 May 2007) and the patient demographics and tests requested by the clinician on the request form were compared to those entered on the iLAB computer system. The difference in numbers of requests selected was chosen as this approximates the ratio of workload difference between the two sites. Any identified errors were recorded and investigated.

Results

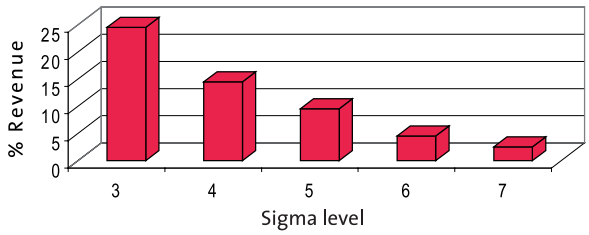
A total of eight errors (4.06%) were identified in the 197 specimens selected from the Scunthorpe site. This error rate equates to Sigma level 3.24 (www.isixsigma.com/sixsigma/six_sigma_calculator.asp).

Of these eight errors, three errors were associated with inaccuracies in patient demographic entry (1.52%) and five errors were associated with tests being requested inaccurately (2.54%). Of the five errors associated with inaccurately requested tests, four were simply missed by the inputting staff and the fifth test was incorrectly requested in place of another, i.e. LDH was requested rather than lipids.

Of the three errors associated with inaccurate patient demographic entry, one patient surname was noted to have been incorrectly entered on the computer, one patient's date of birth was incorrectly entered and one discrepancy occurred with the identity of twins, i.e. the sample and request form were labelled Twin 1 but the sample was booked into the computer as Twin 2.

A total of four errors (4.87%) were identified in the 82 specimens selected from Goole Blood Sciences Sample Reception and all four were all associated with inaccurate entry of requested tests.

FIGURE 1
Cost of poor quality (percentage of revenues)



Adapted from www.qualityamerica.com/knowledgecente/articles/PYZDEKSixSigRev.htm

Two requests had tests missed off the request and two had additional tests requested that were not on the original request form. This error rate equates to Sigma level 3.16.

Discussion

Although this was only a small study, the results clearly show that mistakes do occur during patient demographic and test-requesting processes and at a surprisingly high rate. This is even despite the fact that a secondary data entry check occurs post primary inputting in our sample reception area.

A relatively recent College of American Pathologists Q-probes study of requisition order entry accuracy of outpatient requests in 660 institutions showed that input errors occur with 5% of requests received.[2] This is equivalent to 3.14 level Sigma or 50 000 DPMO. Our blood science receptions at Scunthorpe and Goole are currently at Sigma level 3.24 (40 600 DPMO) and level 3.16 (48 800 DPMO) respectively, which is slightly better than the Q-probes study.

Sigma is a unique tool in that it allows a comparison with industry and business. For example, it has been suggested that many 'ordinary' companies actually operate at between two and three Sigma performance. This equates to between approximately 308 500 and 66 800 DPMO (which incidentally is also generally considered to be an unsustainable level of customer satisfaction, i.e. the business is likely to be in decline, or about to head that way).

A level four Sigma equates to approximately 6200 DPMO, or around 99.4% perfection. Whereas (arguably) this might be an acceptable level of quality in certain types of business, for example a roadside cafe, a 99.4% success rate is obviously an unacceptable level of quality in other types of business, for example passenger aircraft maintenance.

Our results are between 3 and 4 Sigma, which clearly illustrates that there is a significant room for improvement.

Six Sigma focuses on improving quality (i.e. reducing waste) by helping organisations produce products and services better, faster and cheaper. In more traditional terms, Six Sigma focuses on defect prevention, cycle-time reduction, and cost savings. Unlike mindless cost-cutting programmes, which reduce value and quality, Six Sigma identifies and eliminates costs, which provide no value to customers: i.e. waste costs.

For non-Six Sigma companies, these costs are often extremely high. Companies operating at three or four sigma typically spend 25–40% of their revenues fixing problems. This is known as the cost of quality, or more accurately the cost of poor quality. Companies operating at Six Sigma typically spend less than 5% of their revenues fixing problems (Figure 1).[3] The dollar cost of this gap can be huge. General Electric estimates that the gap between three or four sigma and Six Sigma was costing them between $8 billion and $12 billion per year.

Extrapolating these observations to our own institution therefore suggests that we are spending about 20% of our resources fixing problems. Whilst this statistic may be a little off the mark, as no self-respecting pathology department would concede this, the Sigma analysis shows that we are currently running at approximately 44 650 DPMO! This is a huge and unacceptable error rate in what we in pathology would all consider to be a vital and important 'industry', where patients' welfare is at risk. It is therefore vital that we all collectively review our processes and improve.

As stated earlier, Six Sigma has five key stages:

1. define
2. measure
3. analyse
4. improve
5. control.

This article has discussed stages 1 and 2. The next challenge is to now to analyse, improve, and control. We therefore intend to conduct a much larger study, similar to this one, and then modify our processes so that we can improve and control. Watch this space!

Hayley Jackson, Ian Barlow and Steve Sharp
PathLinks Pathology Department
Scunthorpe General Hospital
ian.barlow@nlg.nhs.uk

References

1. Barlow IM, Brothwell L, Schmidt S, Sharp S. Six Sigma process evaluation in a blood sciences specimen reception area. *RCPath Bulletin* 2007;140:39–40.
2. Valenstein P, Meier F. Outpatient Order Accuracy. A College of American Pathologists Q-Probes study of requisition order entry accuracy in 660 institutions. *Arch Pathol Lab Med* 1999;123;1145–1150.
3. Quality America. www.qualityamerica.com (accessed 23 January 2008).

Dr Alec Howat

Improving quality assurance

In this article, the Histopathology and Cytopathology National Quality Assurance Advisory Panel gives details of subtle changes in the management of substandard performance in relevant External Quality Assessment (EQA) schemes, together with details of consequences of non-participation.

1. The Panel has recently dealt with two EQA participants who reached the second action point due to non-participation after reaching the first action point (see below). This matter has previously been discussed in the October 2003 *Bulletin*, but is worth reiterating.
   a. The minimum acceptable level of participation in the EQA scheme is two out of three consecutive rounds of the scheme, calculated on a rolling basis.
   b. Non-participation for reasons of illness, prolonged annual leave or sabbatical leave is an acceptable reason. Non-participation due to workload commitments is not acceptable.
   c. Satisfactory participation will generate a certificate of participation, which should be checked at annual appraisal and at CPA (UK) Ltd laboratory assessment.
   d. Non-participation after triggering the first action point equates to substandard performance and will be scored as such.

2. When laboratories are reported to the Panel for persistent poor performance in technical EQA, the names of the laboratory will be submitted and will therefore no longer be anonymous. This decision has been taken by the Joint Working Group (to whom all Panels report) and applies to all laboratories in all pathology sub-specialties. However, individual participants who are reported to the Panel for reaching the second action point will not be identified (see below).

3. The Panel has updated the management of persistent substandard performance in EQA schemes. Organisers of all histology and cytology interpretive schemes should update the standard operating procedures (SOPs) on substandard performance in interpretive EQA schemes accordingly.

Scoring and first action point

In each round, all participants are scored after discussion of cases at the participants' meeting. Only those cases reaching at least 80% consensus for diagnosis are accepted for scoring. One scoring system is for the code number of any participant scoring within the bottom 2.5% to be noted; any participant can make the occasional erroneous diagnosis, so the first action point is defined when a participant scores within the bottom 2.5% in two out of three successive circulations. Several schemes use other scoring systems to identify substandard performance; however, these must be agreed by the participants and then submitted to NQAAP for approval.

Reaching the first action point results in a 'Dear Colleague' letter being sent anonymously to the participant, clearly pointing out the position, inviting explanations and offering assistance. The next steps are also clearly defined, namely that should the participant's score fall within the bottom 2.5% in two out of three successive EQA rounds (or similar using other scoring systems), he/she will be reported to the Chairman of NQAAP. Non-participation after the first action point will lead to a score within the bottom 2.5% (or similar using other scoring systems).

Second action point

When the second action point is reached, the scheme organiser will inform the Chairman of the Histopathology and Cytopathology NQAAP, who will initiate an appropriate investigation. The organiser will provide details of the EQA responses which have resulted in this referral to the Panel Chairman and to the participant. This can again be done anonymously through the EQA secretary who holds the key to the participant's confidential code. For cervical cytology schemes, Regional QA Directors are better placed to investigate substandard performance by biomedical scientists and cytoscreener staff, with a joint approach for consultants.

The Chairman of the Panel will then correspond with the participant. The task of the investigation is to determine whether the low EQA scores reflect standards of routine practice that may put patient care at risk. The investigation will therefore seek all possible explanations of the low scores (including a review of the nature of the EQA scheme) and concentrate on the participant's routine practice, including conditions of work. The emphasis will be on identifying problems and implementing remedial measures, rather than punitive action.

The dialogue between the Chairman and the participant will be directed at reassurance that the

participant is providing a high-quality service and is not a danger to patients. Documentation of participation in other EQA schemes, internal quality control including sharing of cases and obtaining second opinions, evidence of appraisals and audits, an assessment of workload, health, family matters, problems with colleagues and senior Trust management etc will be sought.

Outcomes of second action point

The Chairman of the Panel will discuss the findings of his/her investigation with all members of the Panel in such a way that will not reveal to the other members the identity of the pathologist under review. These steps should be completed with reasonable speed; a few weeks at most. If the Panel is happy that a high-quality service is being provided and that patient safety is not being jeopardised, a return to the scheme with careful observation of performance is appropriate. In certain circumstances, a change in routine work may result from the procedure, or it may be deemed that continued participation in the EQA scheme (usually a specialist scheme) is not appropriate. If the Chairman has still not been satisfied by a reasonable explanation, or if any lack of cooperation appears to be slowing the evaluation process, the Chairman of the Joint Working Group on Quality Assurance will be informed, and will pass the matter to the appropriate professional bodies. In the case of histopathologists and cytopathologists, that body will be The Royal College of Pathologists' Professional Performance Panel and the Trust's Medical Director. The Medical Director may then ask the College for advice and help, as outlined in the College's *Concerns about performance in pathology: guidance for healthcare organisations and pathologists* (February 2006, see www.rcpath.org/publications).

The latter procedures will be activated only in exceptional circumstances, and should cause no more concern to EQA participants than the current possibility of being reported to a professional body by a colleague for incompetence. The main purpose of Histopathology and Cytopathology EQA schemes remains educational. We anticipate that EQA schemes will continue to be valued by pathologists for this reason.

Dr Alec Howat (Chairman)
Dr Katie Boyd
Mr Allan Brown
Professor Peter Hall
Dr Lynn Hirschowitz

Dr Ian Bailey

FAQs from Dr Ian Bailey, College IT Advisor

In the first of an occasional series of frequently asked questions, Dr Ian Bailey, the College's new IT Advisor enlightens us about the world of NHS mail.

Can I use email for correspondence about patients?

Yes, if you use an nhs.net email address and are sending to someone else who has an nhs.net email address. If you are not using, or the recipient does not have, an nhs.net email address then you should not use any identifier that would help someone else identify the patient. Whilst the email is in transit, it could be intercepted whereas email using nhs.net email addresses is encrypted. However, even if you use nhs.net email, otherwise called NHSmail, you must still ensure good computer security, logging out when leaving and, if using Outlook, ensure that when starting the computer you use at least one password to get access to Outlook.

How do I get an nhs.net email address?

You can get an nhs.net email address by going to www.nhs.net and clicking the 'Register' button. If you cannot find yourself in the directory, you will have to ask your IT Department to put you manually in the directory. Some IT Departments may be reluctant to do this, but it can be done. There are plans to use nhs.net more and individual Trusts may have a project to move everyone to nhs.net, so they may wish you to delay to fit within their timetable.

Dr Ian Bailey
IT Advisor

Dr Jem Rashbass

Online learning resources: the changing face of pathology training

The College is working in partnership with the Department of Health to develop online learning resources to support non-medical scientists and clinical trainees. Jem Rashbass, Chair of the e-learning Steering Group explains the challenges and opportunities of this major initiative.

Introduction

Training high quality pathologists, whether in the biomedical sciences or in the medical pathology disciplines, is a major challenge. In the distant past – when this author trained – training was purely experiential. There was no syllabus, little or no formalised teaching and the breadth of knowledge was simply defined – all you needed to know was enough to be a safe senior pathologist. It was an apprenticeship served alongside more senior colleagues who imparted the 'dark arts' of the subject in an informal way over a period of five or more years.

The world has changed and training is now much more formalised. There are now curricula in most of the pathology disciplines and the scope of what a trainee is expected to know, be able to do, and to what standard at each stage of training are well defined. In histopathology, the training schools have created a more structured learning environment where trainees learn as a cohort with all the benefits that peer-to-peer interaction brings. Pathology schools are also emerging, ensuring a closer relationship between the College and Deaneries.

In parallel with the way we teach them, the way that trainees expect to learn has also changed. While textbooks and journals still remain core resources, it is the use of online learning material that is now a major feature. Online resources certainly add convenience. There is no longer the need to wander over to a library to read a journal article – flicking through *Index Medicus* or standing over photocopiers copying articles from bound volumes are activities of a bygone age. Online versions of textbooks allow the user to search the text rapidly, provide links to up-to-date material or copies of images and diagrams that can be used in personal teaching material. But online teaching brings with it new ways of learning, new ways of searching for information and new types of interactions between trainers and trainees. The challenge is to find those areas where online teaching can be transformational – delivering the knowledge or information in a format or way that the learner needs. In many cases it will not improve on traditional teaching methods, which rely on techniques that have been developed and refined over several millennia, but in some cases it will. Different learners have different learning styles and preferences and so one size will not fit all.

e-learning at RCPath

It is in this context that College has embarked upon an ambitious project to develop a wide range of e-learning resources to support training across all the major pathology specialties. The project is a partnership with the Department of Health as part of a much wider initiative supporting similar activities at the other Royal Colleges. We do not plan to replace traditional teaching methods but to identify and develop online learning material that adds value where best it can across the curricula.

Following wide discussion and a questionnaire to the whole College membership, the approach being taken by the RCPath is slightly different from that adopted by the other Royal Colleges. The majority of the other Colleges have chosen to develop online material that fully covers the entire early years of their training curricula. While this is appropriate for a College that has a relatively uniform membership with a single core basic training programme, our College membership covers many different specialties and includes non-medical scientists and vets. Although there is obviously an overlap between all these groups, the core knowledge and basic curricula of each are very different. Furthermore, many of the specialties have relatively few members; virology, immunology, genetics, andrology and embryology combined account for fewer than 10% of all trainees. To cover everything to the same depth would be a huge undertaking – while to select only the one or two specialties and ignore the rest would disadvantage the smaller specialties.

Given these challenges, the aim of the RCPath e-learning initiative is to develop added value material over the next three years to support medical and healthcare science trainees in seven main specialties: histopathology, haematology, microbiology, chemical pathology, virology, immunology and genetics.

The focus will be on:

- areas that are best covered using online teaching
- specific 'stand alone' topics with discrete learning objectives rather than extensive, integrated online courses
- topics that are not already well addressed by other teaching material, for example in a text book or review articles.

The RCPath e-learning Steering Group has worked closely with the Department of Health e-Learning for Health (e-LfH) team. Together we have decided to develop three separate but overlapping types of educational resource to address the needs of the pathology trainees across all specialties: mini modules, online cases and the 'Pathopedia.'

Mini modules

There are some areas of pathology training that are currently not well covered by text books or where the combination of text, video and images is best presented online as an educational package. Educational mini modules will consist of one or more learning sessions covering discrete components of the curriculum. Each session will have a set of learning objectives that will be covered by the material and these will be linked to questions to provide the learner with the opportunity for formative assessment. A learning session would probably take around 30 minutes to complete. Examples of topics that covered in a learning session might be: good laboratory practice, laboratory safety, the use of a microscope or individual cut-up techniques within surgical pathology.

Clinical cases

These are problem-based learning cases developed around one or more clinical diagnoses. Each case follows a standard format with the history, examination and investigation of a patient, but given the nature of pathology the emphasis will be on the laboratory investigation and interpretation. The cases are structured so that the learner explores the differential diagnoses and works through further laboratory investigations to tease out an underlying clinical diagnosis. There is to be a very close overlap between these laboratory-based cases and the 'case-based scenarios' which are being created to teach clinical diagnosis and management by clinical specialties at other Colleges. The case-based system will be extensive, covering a wide range of clinical diagnoses and investigations across all specialties. Each clinical case will have learning objectives associated with it and these will be tailored to emphasise the specific investigations for an individual pathology discipline.

Pathopedia

This is the most ambitious component of the RCPath learning project. The aim is to create an authoritative encyclopedia-like resource that can be used by both trainees and trainers. It will have breadth covering a wide range of subjects from all specialties rather than long, in-depth, widely referenced review articles. Although the name 'Pathopedia' has some resonance with the online Wikipedia, all the content will in the Pathopedia be quality assured and overseen by an expert editorial board and the RCPath. There will be cross links from the Pathopedia both to the mini modules and to case-based material, image atlases and discussion groups.

The way ahead

Having decided on the types of e-learning material we want to develop, the next step is to identify the first range of topics that need to be covered. The e-learning Steering Group has been looking at the curricula for each subject and sifting out those areas that would best addressed by a mini module, a case or a page in the Pathopedia. A dedicated Pathopedia Editorial Board is working with e-LfH to build the Pathopedia and the case-based system is currently undergoing tests. Of course the content and knowledge that forms the bulk of this material is still to come, but by the time you read this article many of you will have been tapped on the shoulder and asked if you would like to contribute.

There is no doubt that this project is a huge undertaking. The response to the online questionnaire at the end of last year indicated that the majority felt that it was worthwhile – and we are grateful for the many offers of help. The Steering Group recognises that there is a great deal of work to be done and that it will involve a large proportion of the College membership. We all look forward to working with you over the next few years.

All in a name

Projects like this need a name! So we are holding a competition. Details of the prize (a choice of beverage or non-beverage), and how to enter are on the College website – under 'Training and Education'. Select the entry for e-learning and tell us what you think would be a good name for this initiative.

Dr Jem Rashbass
Director and Consultant Histopathologist
Eastern Cancer Registry
Cambridge

Dr Patrick Sarsfield

The ideal histopathology training post: a Peninsula perspective

Paul Malcolm, Mark Smith, Patrick Sarsfield and Joseph Mathew present their recipe for growing the perfect histopathologist. A department that follows these sensible ideas will have trainees clamouring at the door.

This document is based around a survey of opinions expressed by trainee histopathologists within the Peninsula Deanery when requested to describe the features of the 'ideal histopathology training post'. It is by no means exhaustive and some of the points raised clearly lie within the realm of the 'ideal' rather than the eminently practical. However, it does serve to highlight the broad range of considerations felt to be important by this group.

The departmental ethos

The first and in many ways the most fundamental point is that the training department or institution has to desire the presence of trainees for the altruistic purpose of providing high quality training to future histopathology consultants. This carries with it a significant commitment by the department in its entirety (consultants, biomedical scientists and clerical/secretarial staff) in terms of an investment of time, patience, space and – to some extent – finances. Trainees need to feel wanted and valued rather than merely being a spare set of hands to do the cut up, teach medical students and cover meetings for absent consultants. Clearly, training posts carry with them a certain commitment to NHS service provision, but this should not be allowed to overwhelm the trainee to such an extent that insufficient time is available for the careful study of the more difficult, educationally valuable cases. Consideration also needs to be given to the fact that the number and experience level of the trainees within a particular department may vary from time to time; flexibility is therefore required when determining the level of service provision being incorporated into the trainees' workload. It is accepted that within training departments there may be individual consultants who do not wish to be involved with the educational development of trainees. In such circumstances, the trainees should not be expected to undertake the routine tasks and service provision duties on behalf of these individuals.

Departments should have facilities in place for the pastoral care of their trainees. The designated educational supervisor should be a consultant with a firm medical education interest, who has volunteered for the role rather than been pressured into it. They should be the first point of contact for trainees to discuss either direct educational issues or other issues impinging upon the trainees' ability to perform. In addition, some form of mentoring with an extra-departmental consultant may be appropriate for those trainees who feel the need for an impartial sounding board with no direct links to the department within which they are currently working. At the commencement of training, each trainee should be provided with a clearly defined pathway for dealing with serious training issues, for those rare circumstances where the relationships within the department are so poor that reassignment to a different institution might be appropriate. This process should be achievable with minimal recriminations on either side.

As with all members of staff, trainees sign a contract outlining conditions of work upon arrival within a new department. There should be no attempt to alter these conditions without prior discussion with and the consent of the trainees who will be affected.

The training environment

Optimal efficiency requires a comfortable workspace within which all of the necessary tools are available to facilitate the work being undertaken. The following specific points have been raised.

1) There should be a permanent designated work space for the *exclusive* use of trainees, which should:
   - be watertight
   - have natural daylight
   - be well ventilated
   - be in good basic decorative order
   - have independent temperature control
   - be peaceful, facilitating concentration and application to work.

It is inadequate to consider trainees as relatively short-term employees who can be shoehorned into the least desirable space within the department or to use the trainees' office for other departmental activities.

2) Within the work space, each individual should have:
   - adequate space to comfortably complete their work

- a desk of sufficient size to house all basic equipment
- space for personal textbooks, individual file trays and other stationery
- a lockable personal storage area (e.g. a small set of drawers, small locker etc.)
- a dedicated adjustable chair for personal use during the duration of placement
- an individual ergonomic assessment at the commencement of the post in order to ensure that any specific alterations required to the work station can be achieved at an early stage.

3) Each work station should include:
   - a modern, high-quality microscope capable of performing all routine tasks requested of the trainee, e.g. polarisation, x60 lens for cytology, etc.
   - an individual computer station with access to hospital-based results (radiology, clinical chemistry, haematology), computer-based clinical records, local intranet services and the internet.

4) Within the trainees' office there should be a multi-header unit (possibly as simple as a single-arm extension attached to one microscope) to facilitate discussion and teaching within the trainee group.

5) The training department should also have access to:
   - library facilities:

   (i) intradepartmental, including subscriptions to several of the major clinical pathology journals and an adequate range of books. The latter implies current copies of the major histopathology and cytopathology textbooks with a smaller subset of general clinical books covering surgery, medicine, obstetrics and gynaecology, etc. This may also include a range of other teaching and educational materials, such as cytology slide training sets, a CD-ROM library of departmental lectures, complete sets of external quality assurance slides, etc.

   (ii) hospital/institutional library for more general reading, access to a wider range of journals and the ability to order journal articles from remote sources. Trainees should not be expected to pay for journal articles ordered for educational purposes
   - multi-header facilities, to permit group discussion and education
   - regular group training sessions involving both trainees and consultants, which could take the form of multi-header sessions of interesting cases and/or the traditional dreaded 'black box'.

The training post

The fundamental requirements of the specialist training programme in general histopathology are outlined by the College, which have published guidelines with regard to the range of subject areas to be covered and minimal numbers of cases in each broad field to be seen on an annual basis.[1] This section does not intend to reiterate these figures, other than to emphasise that they represent a *minimum* exposure and clearly numbers alone are a crude measure, breadth of exposure being at least as important. What constitutes 'appropriate breadth' is difficult to define. However the consensus view is that this represents a sufficient case mix and exposure, such that upon completion of training the fledgling consultant is competent in the assessment of the broad range of lesions coming in to a district general hospital histopathology department. Implicit within this is an awareness of one's own limitations, with the maturity and self-confidence to obtain specialist advice if and when required.

A number of areas of recurrent difficulties have been identified.

1) Adequate exposure to post mortems: there are significant variations in the provision of training in post-mortem examination between training institutions, often based on differing interpretations of the Coroner's Rules coupled to the marked decline in hospital post-mortem examinations being undertaken. Even in those hospitals where trainees are provided with the opportunity to undertake regular coronial post-mortem examinations, there is often limited exposure to the histological examination of the tissues observed macroscopically.
2) Adequate exposure to frozen sections and rapid turnaround time specimens (breast cores, etc).
3) Adequate cytology exposure: this is an area which may become increasingly difficult with the moves towards more centralised specialist services being offered. From an educational viewpoint, seeing smaller quantities of material regularly is often more useful than large quantities of material being seen occasionally.
4) Sub-specialist areas, notably paediatric pathology, where it can be difficult to obtain adequate exposure. In many areas, the paediatric services are stretched to the point where there is insufficient time for the teaching of general histopathology trainees.

Whilst some of the above are essentially local issues, which can be addressed by careful planning of the juniors rota, there are others – notably the post mortem and sub-specialty exposure – which are more complex and hence of greater concern due to the difficulty in devising obvious solutions.

Teaching

The teaching commitment for individual trainees varies enormously between different institutions. Trainees should be given adequate notice prior to being requested to undertake a teaching session for the first time. At least five working days is considered reasonable. In cases where this minimum notice cannot be given, the session should be rescheduled; applying pressure to trainees to undertake a 'simple lecture' at short notice is unacceptable. There should be access to all of the required teaching materials that may already exist for the topic, with some indication as to the audience, the breadth of coverage required and the nature of the session (lecture, tutorial, etc). The time and location of the session, as well as the presentation formats available (PowerPoint, wall chart, chalk and slate, etc), for the session should be supplied. Finally, there should be some means of obtaining genuine, constructive feedback. Where feasible, for those with high teaching commitments (e.g. those in academic lecturer posts), formal instruction in medical education theory may be appropriate.

Multidisciplinary team (MDT) meetings

There are broad differences in expectation and practice between departments with regard to trainees running MDT meetings. Communication with our 'front-line' colleagues is paramount to our role and requires a certain amount of finesse, which for most trainees is a skill that is developed through bitter experience, rather than being an innate gift. There are a variety of perspectives on the best way to achieve this, ranging from the 'in at the deep end' approach – with trainees overwhelmed and unsupported in the early stages of their career, to the overly protective – where there is little or no exposure, in some cases even after the MRCPath is completed! Clearly the right approach lies between these two extremes and will vary with individual trainees according to personality, confidence and competence. In all cases, there needs to be progressive, staged exposure at a rate with which both parties are comfortable. The consultant for whom cover is being provided (or a nominated deputy) should be available to discuss any problem cases with the trainee prior to the meeting. Furthermore, the case list and slides should be available to the trainee at least 24 hours prior to the meeting, to permit sufficient time for the cases to be adequately reviewed and discussed. Some consultants may feel that it is acceptable to review the cases immediately prior to or even during the meeting itself, however this is inappropriate for trainees. There should be an explicit departmental policy document outlining the timeframe for the formulation of the MDT meeting case list and it should be at the discretion of the trainee whether or not to permit the addition of the inevitable last minute 'essential' cases to the meeting list.

Research

All medical doctors, irrespective of specialty, should have sufficient experience of research methodology to be able to judge the quality of published work, especially in this age of evidence-based practice. This is particularly the case in specialties such as histopathology, with its more academic backbone rooted strongly in the scientific discipline of medicine. Trainees should have adequate time to undertake research to a level appropriate to their individual needs and desires, within the limits of the type of training post that they have accepted. For a minority, this will involve formal enrolment for a higher degree by research, whilst for those with a primary interest in the clinical diagnostic work adequate exposure may be limited to the publication of interesting novel observations (case reports/series, correspondence). Either way, the work is of value on a number of levels and should be encouraged with adequate resources, especially time. It should also be acknowledged that high-intensity, time-consuming research is impractical for most trainees during their normal working week within a district general hospital. Furthermore, the tendency to 'pounce' on new arrivals with an overwhelming mass of 'golden research opportunities and case reports' should be discouraged. New trainees have a natural reluctance to decline these kind offers, yet rarely is it feasible to complete this work during the placement. In all cases, there should be encouragement to present research at local, regional, national and international conferences.

External educational activities

The attendance of trainees at conferences is also considered to be of importance, not only to present research but also from the perspective of continued medical education. Study leave budgets have been dramatically reduced in recent years (for example, from £1000 to £550 per junior per year within the Peninsula Deanery in the last 12 months), to a level that is insufficient to cover the costs of attendance at a single external scientific meeting or training course. Not only are such activities core to the intellectual progression of trainees, they also provide the opportunity to explore areas of potential future specialisation or to address specific deficiencies arising from the regional nature of the training. The pressure placed on study leave budgets is compounded in many regions by the compulsory attendance at regular MRCPath training days. In those regions covering large geographic areas, this can result in significant costs – indeed greater than the current study leave budget! Trainees in such regions who decide to attend external courses or meetings are often funding them out of their own pocket. This is unacceptable and the possibility of training departments having a contingency fund to enable each of its trainees to be fully funded for attendance at one external course or scientific meeting per training year should be considered.

Independent reporting

There is wide variation in departmental approaches to trainee independent reporting, despite the fact that most trainees feel that, with appropriate safeguards, it is to be actively encouraged. It is a nonsense that a final year specialist registrar in histopathology may not independently be permitted to authorise a report on an acutely inflamed appendix, which has been removed by a junior surgeon from a patient who has been anaesthetised by a junior anaesthetist, both of whom have been acting independently! The best approach, and that which seems to be encouraged by the College, is that of graded exposure, with trainees being individually 'signed off' as competent to report specific specimen types as and when appropriate. It seems that applying arbitrary time points to this process fails to take account of individual competence and the simple fact that it may be more appropriate to have a thorough knowledge of your own limitations rather than having passed a specific examination. There should be strong approval by the consultant body within the department prior to permitting any trainee to report independently.

Training placements

The recent move to 'run-through training' with a more centralised selection system has brought about standardisation in recruitment, the merits of which can be argued at length. However, a number of specific observations have been made by recent Specialist Training Year 1 (ST1) trainees within the Peninsula region. There is a preference for trainees at this stage to be appointed in pairs within the same establishment, for the purposes of mutual support and enhanced learning. Some ST1 posts have been split into six-month blocks, with trainees rotating between two different establishments. Whilst this undoubtedly provides a wider exposure, it is felt that at this early stage in training it may be more important to focus on a limited number of approaches to a given task. Furthermore, it means that trainees have to settle into a new department at a time when they are preparing for the ST1 competency examinations. Breadth of exposure may be more appropriate at a later stage and some trainees involved in such split-site training schemes have expressed a preference for undertaking the whole of the ST1 year in a single department. It is also important for many trainees that they are able to establish a stable base during the ST2–ST5 stage of training. Therefore, in regions covering an extensive geographic area, placements should be organised to permit a central base to be established.

Management

Whilst enthusiasm for management training is often limited amongst trainees, there is an acceptance of the need to have a basic grounding in management issues and their impact at a departmental, hospital, trust, regional and national level. Some exposure can be obtained by the attendance of trainees at the departmental consultants meetings or specialty-specific medical management courses (study leave budgets permitting!). There is also the opportunity for involvement with local managerial tasks (e.g. organising the trainees rota, organising teaching programmes, etc.) and application as a local, regional or national trainee representative on one of the numerous organising bodies or committees that meet to discuss and plan the future development of pathology (of this College, the Association of Clinical Pathologists, etc.). The opportunities are out there for those with the inclination and involvement at an appropriate level for the individual is to be encouraged and supported by the training department.

Conclusion

Overall, histopathology trainees are a relatively well motivated group who, given the appropriate environment, make a significant contribution to the work and life of a histopathology department. The areas detailed above are in no way wildly unrealistic and, whilst the financial impact of some of these 'basics' may be viewed with scepticism in the current climate of the NHS, they are no more or less than would be expected by young professionals in other fields.

Dr Paul Malcolm
Specialist Registrar, Peninsula Deanery

Dr Mark Smith
Consultant Histopathologist
Derriford Hospital, Plymouth

Dr Patrick Sarsfield
Consultant Histopathologist
Royal Devon and Exeter Hospital, Exeter

Dr Joseph Mathew
Consultant Histopathologist
Royal Cornwall Hospital, Truro

Reference

1. The Joint Committee on Higher Pathology Training. *Curriculum for specialist training in histopathology and related subspecialties.* The Royal College of Pathologists, September 2005. www.pmetb.org.uk/fileadmin/user/QA/Curricula/Approved_curricula/Pathologists/HistopathologyCurriculumRunthruMay07FINAL_01.pdf

Ruth Semple

Welcome to the new 'Public engagement' section

As you will read over the next few pages pathologists are already involved in some fantastic public engagement activities. All of the pathologists concerned view their science communication as a fun and fulfilling aspect of their work that makes a difference. It promotes a positive image of pathology and raises interest in the subject.

Public engagement work develops skills in communication, project management and teamwork. It also has the potential to enhance how you feel about being a pathologist, as by sharing your enthusiasm with others, you can rediscover the reasons why you specialised in your chosen discipline in the first place.

Although this sounds terrific, we all know how challenging it is to do your 'day job', never mind anything extra. There are many obstacles in your way: publication pressure, lack of time, support, training and resources, as well as negative attitudes from others, be it your peers or supervisors. However, the College is now committed to public engagement, and we would like to try and help remove some of the barriers to involvement by offering coordination, support, training and recognition.

A MORI report in 2002 asked the public who they trusted to tell the truth. The government and the media came in last at 19% and 13% respectively, while scientists scored quite high at 64%.[1] In 2005, a MORI report, which examined public attitudes to science and scientists, found that over 80% of adults think science makes a good contribution to society and that science will make our lives easier.[2] However, only 40% of people feel informed about science.[3] Clearly, there is a need for scientists to engage more with the public, especially since the public indirectly fund a great deal of research.

In February, as part of the Outreach Project, four focus groups were carried out with two sets of student groups, aged 16-18; A-level science teachers and members of the public. The first part of the session was to determine what they already believe about pathology and pathologists, and where they get their information from, as well as to understand their personal stake in health matters and what role pathology and pathologists are perceived to play. Words such as: autopsies, dead bodies, corpses, maggots, organs, CSI, morgue, rotting flesh, bad smell and lonely came up a great deal. However, after participants were exposed to a colourful overview of pathology in practice today, some of their opinions changed, eliciting comments such as: "Is it even about dead people?; Wow, they help save living people; Medicine wouldn't be like it is today without pathology". This demonstrates that there is an urgent need for pathologists to engage with the public to help dispel the misconceptions and inform society about the true nature of pathology.

So how do you go about doing this? The next four articles will focus on some of the work already being done to change perceptions of pathology. There are many other ways in which you can get involved. For example, you could develop resources and activities, create a podcast, write an article, and much more. Remember, any of these activities could form part of an event or resource for National Pathology Week.

If you would like to become involved with outreach, please do get in touch. You may have an idea you would like to discuss, or may wish to help organise an outreach session, or maybe you would just like to contribute but you're not sure how.

I would love to hear from you!

Ruth Semple
Exhibition and Outreach Project Manager
ruth.semple@rcpath.org
020 7953 0390

References (all accessed 19 February 2008)

1. www.ipsos-mori.com/polls/2002/bma.shtml
2. www.ipsos-mori.com/polls/2004/ost.shtml
3. www.ipsos-mori.com/polls/2004/ost.shtml

Dr Maesha Deheragoda

Moulding perceptions: educating young people about the benefits of pathology

Education is all it takes to make a difference to peoples' perceptions. With the right approach, a positive impact can be made even on those students who wouldn't otherwise consider learning about medicine or a career in medicine.

Perceptions, education and sociology

Prior to training in histopathology, I trained for several years as a paediatrician. The experience taught me that fears hindering recovery from illness and compliance with medical care can be dispelled with education about the illness, tailored to the age of the child and the educational abilities of their parents.

Over the last three years I have been a medical careers advisor for a careers company. This has involved talking about life as a doctor to students aged 15–17 years, at schools ranging from independent boarding schools to Government funded schools in the most socially deprived areas of London. This experience has exposed me to perceptions that pupils from different cultural, ethnic and socio-economic backgrounds have about doctors, which in turn informs their decision whether or not to choose a medical career.

The potential impact of the Education Centre at the College

The development of an education centre that will educate people about the role of pathologists is to be welcomed. Not many of the students I teach are familiar with pathology as a specialty. Indeed, some don't realise that a medical degree is necessary to become a pathologist – so far removed is the popular image of forensic pathologists solving murders from the healthcare needs of the population, that some students don't equate being a pathologist with being a doctor. The Education Centre at the College will hopefully educate people about the role of pathologists in modern healthcare. Through this venture, communities will appreciate the valuable contribution pathologists make to the health of the society and talented students may be encouraged to consider pathology as a worthwhile future career. This article will explore some of the perceptions young people have towards medicine and pathologists in particular. Awareness of these perceptions will contribute towards the development of an Education Centre that is accessible and interesting to all.

A young person's perception of the medical profession

What informs the public about doctors? Each time I meet a new group of pupils, I run a brainstorming session in which I ask for their views on doctors and what informs their perception of life as a doctor. (I have excluded the responses of doctors' children from the following discussion, as the majority of pupils I teach have no exposure to medicine other than through visits to their GP.) The most common reason students give for wanting to study medicine is "to help people", closely followed by the desire to apply the science they learn at school.

Without exception, across the range of different groups I have taught, doctors are perceived to be respectable, intelligent, trustworthy people of high standing within society. However, this perception actually dissuades some young people who are socially disadvantaged from considering a career in medicine as they see being a doctor as something that is attainable by those from a privileged or wealthy social background rather than those with educational ability and motivation for the profession. Pupils from these backgrounds tend to perceive medicine to be a far less desirable career choice than a career in finance, law or management, which are seen as being more achievable by individuals from their local community.

The reasons behind the lower uptake of medicine as a career choice amongst young people in poorer areas are complex and manifold, but I feel that they include a lack of exposure to doctors within their communities who can act as mentors and role models and lack of access to facilities that educate about medicine. I feel that this group would particularly benefit from the facilities that will be available at the Education Centre.

The media portrayal of medicine is the main source of information most children have about doctors and life as a doctor. Television dramas such as *Scrubs*, *Holby City*, *ER* and *Casualty* are favourites amongst school pupils. These dramas glamorise certain medical specialties such as surgery (the

most common ambition quoted by young males considering medical careers) and portray medicine as being a high-pressure, emergency-orientated profession. Activities that pathologists are commonly involved in – diagnosis, research and education – are not usually featured on TV, with the consequence that school pupils are unaware of their relevance to patient care.

What is a pathologist?

The most common answer from the students I have taught is "I don't know". Others, who watch *CSI* on television, tell me that as a pathologist I "cut up dead bodies and solve murders" for a living. However, even the work of forensic pathologists as depicted on television is not seen as a particularly glamorous field of medicine compared with surgery or paediatrics. I'm not sure of the reasons behind this, but they may include fear and a lack of knowledge about why autopsies are performed. Most pupils wanting to be doctors want to "help people" – dealing with dead patients is not seen as helping people. There is clearly a need for education relating to the 'positive' role of the autopsy as an educational tool in future patient management.

Given that the majority of pupils get their impression of life as a doctor from the television, it is perhaps not surprising that they don't know what pathologists do. It is rare that pathologists other than forensic pathologists are even portrayed. Even if a pupil has been an in-patient, they are unlikely to have encountered pathologists.

Exposure to pathology can inspire the next generation

How do we go about developing an Education Centre that is accessible and interesting for young people?

Two of the main challenges of educating school groups at the Education Centre and through the outreach programme are:

1. to demonstrate that pathologists "help people" through their diagnostic, research and educational activities
2. to encourage school students to see pathology as an interesting and challenging specialty and perhaps consider a career in pathology.

In my experience, young people will enjoy and remember a learning experience more if it is relevant to their own lives and communities, for example, by seeing how pathologists aid the diagnosis and management of infective diseases or cancer, which they may have experienced at first hand or through a relative. When it comes to pathology as a career, many pupils are exited by the prospect of making a beneficial contribution to other peoples' lives and society in general, and seeing examples of how the work of pathologists historically and in the present day have made an impact on society could help in this regard.

Pupils want careers that will challenge them. Enabling pupils to experience the diagnostic challenges we face as pathologists in a practical setting will go some way towards enthusing them about pathology as a career.

The next steps

To challenge perceptions of pathology and raise awareness of the role of pathologists in healthcare, there is a need for education about the contribution of pathologists to the diagnosis and management of patients, and on the role of pathology research in making medical advances that benefit the health of our society. By educating young people, you indirectly educate their families and communities, and also have the opportunity to attract talented individuals into pathology. How best to re-create the challenges and excitement of our careers in a way that can be experienced practically will be the subject of discussion over the coming year for those involved in developing the Education Centre.

Dr Maesha Deheragoda
Cancer Research UK Clinical Research Fellow
Histopathology Unit
CRUK London Research Institute

Honorary Specialist Registrar in Histopathology
University College Hospital, London

Professor Paola Domizio

I want to see my colon!

Well it looks like people ARE interested in pathology, at least when it's personal. Professor Paola Domizio explains...

During my brief dalliance with clinical medicine many years ago, talking to patients was the part of the job I enjoyed the most. Not surprisingly, it was the element I missed the most when I became a histopathologist. It was about 15 years ago when a professor of paediatric gastroenterology first mentioned to me that a 10-year-old boy who had just had a colectomy for ulcerative colitis would really like to see his excised colon. Education and public engagement had always been in my blood, so I jumped at the chance. He came to the laboratory with his parents and I spent about half an hour showing them his diseased colon, comparing it to a normal colon, and explaining to them in lay terms the pathology of ulcerative colitis. All of us – the child, his parents and I – found the experience positive and highly valuable. Consequently, I decided to extend the opportunity to all children who had had bowel resections for inflammatory bowel disease.

Nowadays, those children who accept the invitation – about 90% of those offered – attend the pathology laboratory together with their parents, once they have recovered from surgery and feel up to seeing their bowel. This is sometimes several weeks after leaving hospital, when they return for an outpatient visit. On arrival, I give them a mini-tour of the laboratory to orientate them and explain the processes involved in examining a specimen histologically. I show them their own specimen, so that they can see how badly diseased their bowel was, and encourage them to handle the bowel. Many of them also take photographs. Recently, a teenage girl told me that she wanted to use a photograph of her and her family next to her excised bowel as a Christmas card. If the child is old enough, I then show them a representative histological slide and explain to them the pathology of their particular disease. I offer those who are doing biology at school a slide to take away with them and show their friends on the school microscope.

This has been a very successful initiative and all the children who have attended the laboratory have been more than satisfied with the outcome. The ages of the children I have seen range from 6 to 16 and nearly all of them get something out of it. The most frequent comment from the children is "I now realise why I was getting so much abdominal pain" and "I feel much better now the disease is out of my body".

Similar initiatives are taking place across the UK. 'What colour is my cancer?' is a service set up at St James' Hospital in Leeds to show teenagers with leukaemia their tumour cells under the microscope (see page 127). This service was awarded a prize for innovation at last year's Medical Futures Innovation Awards. The citation for the award reports how one child, George, described his cancer as "black" and "evil" and withdrew from social interaction after diagnosis. Within months of attending the Leeds programme, he described his cancer as "a beautiful planet" and his social problems improved dramatically.

There is no doubt that this type of initiative is highly valuable. Children find the approach cathartic and the experience of seeing the diseased organ out of their body helps their psychological healing. I have also tried showing adults their excised organs, but they react differently from children. Adults tend to be squeamish, whereas children are fascinated and curious. I really enjoy this part of my job and just wish I had time to offer the service more widely.

A teenage girl, and her family, happy to see her colon on the cut-up bench

Professor Paola Domizio
College Registrar and Professor of Pathology Education
Barts and the London School of Medicine

Professor Kevin Kerr

Harriet Dow

Don't be scared of going back to school

Professor Kevin Kerr likes nothing more than getting out of his lab and going back to school. In this article Professor Kerr and Harriet Dow explain how rewarding and easy it is to get the young (and old) interested in pathology.

Don't believe the hype

Already questions are being asked about how well Britain is likely to perform in the 2012 Olympics, but if hand wringing about the state of national institutions were to be elevated to an Olympic event, then there would be no doubt that the UK would enjoy a clean sweep in every event, setting some spectacular world records along the way. Remember British Rail and the endless re-telling of stories of leaves on the line, the wrong kind of snow and the curled-up sandwiches in the station buffet? What about the NHS ? Superbugs breeding in every nook and cranny of your local hospital, GPs who'll bump off Gran with a hefty dose of diamorphine as soon as your back is turned and not-to-be-trusted pathologists pickling all sorts of bits and pieces in jars and stashing them away in their garden sheds. And of course, the State education system: A-levels dished out just for writing your name at the top of the paper, full body armour needed for playing conkers in the playground, overcrowded classrooms in inner city schools where the kids can insult their teachers in any one of 36 languages and the flogging-off of playing fields meaning the only physical activity that some children now get is exercising their thumbs 'txting m8s' during lessons.

Even if only a tiny percentage of this were even remotely true, then surely pathologists should think twice before dipping their toes in the allegedly turbulent waters of the UK education system and giving thought to getting involved with their local school? Well, all I can say is "Come on in, the water's lovely!"

What does a microbe sound like?

I started working with a local primary school over three years ago following a successful bid for a Royal Society Partnership Grant[1] and have been involved in collaborations with schools in the area ever since. My only regret is that I didn't get involved sooner. Working with students and their teachers can be a hugely enjoyable and tremendously rewarding experience. I never fail to be impressed by the interest, fertile imaginations and enquiring minds of the pupils. The enthusiasm of the younger children, in particular, is remarkable. At the end of a presentation in a primary school classroom, when an invitation to ask questions is made, a forest of hands will shoot up and you will find yourself dealing with a fusillade of queries such as: "Can microbes make sounds?; Do microbes eat other microbes?" and "What happens to the microbes in your body when you die?" The ability of students of all ages to soak up information in a seemingly effortless way is also impressive and is reflected in the material they produce: drawings and diagrams, written work, PowerPoint presentations and even 'thank you' letters.

Forming partnerships with schools yields a number of benefits for pathologists individually, as well as for the NHS in general. Firstly, there is the opportunity to work with someone who is not only scientifically trained but who also applies scientific knowledge in their day-to-day working life. Hopefully this will bring the sciences which underpin pathology off the two-dimensional page of the text book and make these topics more real and relevant. Secondly, there is the chance to inform older students of career opportunities in pathology (there is also an ideal opportunity to dispel commonly held views that pathology is really only about cutting up corpses). Finally, activities of this type can help Trusts, especially Foundation Trusts, fulfil public involvement responsibilities.

Home or away?

Although it is easier for a pathologist to visit a school, there are limits on the amount and type of kit that one can take into school, especially for primary schools where it is not possible to take any microbial cultures – even of unequivocal non-pathogens – into the classroom. Secondary schools differ in this respect and it is permissible to do experiments which include culturing bacteria and fungi in the science labs. Activities in school needn't be restricted to the setting of the science lab. PowerPoint presentations along the lines of 'A day in the life of a medical microbiologist' can be given. These are well received by secondary pupils, especially if (not too graphic) clinical images can be shown. Children of all ages are fascinated by the 'pee, poo and puke' aspect of medicine and a session that seems to work well is 'The Life that Lives on You' where some of the more unsavoury activities of the normal human microflora such as bad breath, smelly feet and post-baked bean

flatulence are discussed. Young children also revel in the gorier side of microbiology and are always keen to take part in 'The Guinness Book of Microbial Records' (adapted from material available at the American Society of Microbiology's *Microbe World*[2]) where they vote for their contender for the deadliest microbe in history.

Now wash your hands

Nevertheless, only so much can be achieved working within the limitations of a PowerPoint presentation and there is no doubt that 'hands on' activities are by far the most popular with students. These include the 'Glow and Show' box for learning about hand hygiene and the 'Calamity Kitchen' to illustrate the importance of hygiene in the kitchen in preventing food-borne infection.[3] Impressions of hands on bacteriological agar before and after handwashing can be taken. Because of the prohibition on live cultures, A4 sized pictures of the results can be shown on a return trip to school. More sophisticated experiments can be undertaken in secondary schools. For example a Royal Society Partnership grant allowed us to look at bioremediation and the use of bacteria to clean up oil spillages. In addition to work with entire classes, one-to-one work can also be undertaken, such as helping students with A-level coursework assignments.

Visits by students to the hospital are logistically more difficult to arrange but students seem to really appreciate the opportunity to see inside the pathology labs. Younger pupils don lab coats and latex gloves with a mixture of enthusiasm and solemnity; older pupils seem keen on finding about career options; teachers are interested in new technology such as PCR and *everyone* asks lots of questions.

Engagement with young people need not be confined to the setting of formal education. Hospital open days present excellent opportunities in this respect. Laboratory and mortuary tours are always popular at our Trust open events. Health and safety as well as biosecurity issues preclude visits to the Microbiology Department, but for those who are interested we offer a virtual tour of the lab in the form of a looped PowerPoint presentation. Other activities such as interactive quizzes can also be offered. For one Trust open event, we asked young people to test their knowledge of superbugs with an interactive quiz adapted from earlier work we had done with the BBC/Open University *Learning Zone*.[4] Freebies, such a small bottles of alcohol hand-rub, pens and blocks of 'post-it' notes blagged shamelessly from company reps in the preceding weeks are carried away by young (and not so young) people as precious trophies and help to attract interest to the stand, as does the opportunity to win a 'Cuddly Bug'[5] for taking part in a quiz or 'The Handwash Challenge' with the 'Glow and Show' box.

How do I get involved?

If our experiences have piqued your interest in working with young people there are a variety of ways in which you can get involved. We can confidently say that schools would be delighted to have you on board! Links between education and business are an increasingly important factor in the delivery of qualifications that are becoming more occupationally focussed. There are a number of people and organisations that can help you start to work with education... we guarantee you will enjoy it!

At Harrogate and District NHS Foundation Trust (HDFT), a new role for an Education Liaison Officer (EDLO) has been created specifically to build links with local schools; its primary aims are the facilitation of high quality interventions at secondary level involving staff from HDFT and students, that contribute to the delivery of the Science and Health and Social Care curricula, and also to raise awareness of the vast range of careers available throughout the NHS.

Students from Fountains School take turns to view slides

This role has been piloted for nine months with a number of schools and has been extremely successful, with schools responding in a very positive way. The possibilities for partnership working between HDFT and our schools continue to grow, and we are looking to extend the EDLO post in the next six months to work with all secondary schools in our area. In future, we hope our remit will extend to further work with primary schools.

Education Liaison Teams also exist at some larger Hospital Trusts throughout the country, so check

Students from Fountains School visiting the lab

with your Trust – they may be able to help you get involved.

In addition, Education Business Partnerships will be pleased to work with you. EBPs are countrywide organisations that have a specific remit to help schools and colleges enrich the curriculum, and businesses engage actively in the development of their future workforce. For details of your local EBP, go to www.nebpn.org

What resources are available to help me put teaching material together?

Working with schools can be done using very little resource other than your time. For example, going into a classroom to talk about how you use science in your day-to-day job may take an hour out of your day, but little else. If you don't have time to develop material from scratch, there are a wealth of off-the-shelf options available, for example, from the American Society of Microbiology.

Of course, having financial backing can allow you to be more ambitious; it can assist with the purchase of equipment that will enable students to have more of a 'hands on' approach, encourage partnership projects with teachers, for example the joint production of teaching resources that can then be delivered to full year groups of students, and it can also contribute towards the cost of your administrative time. There are a number of potential funding sources including the Wellcome Trust (www.wellcome.ac.uk). We recently submitted an application for a project 'Clogs and Civet Cats', which looks at the response of doctors, scientists, the media, government and society as a whole to new epidemics by comparing the York cholera epidemic of 1832 and with those of SARS and the threat posed by avian 'flu. If successful, this will be a project delivered in partnership by the Trust, the University of Bradford and SETPOINT North Yorkshire.

SETPOINTs are funded by STEMNET (www.stemnet.org.uk). STEMNET works with a range of partner organisations to ensure that the UK is underpinned by a strong supply of people with a range of science, technology, engineering and mathematics (STEM) qualifications, working across a range of occupational areas. STEMNET supports SETPOINTs financially by distributing core funding raised from government. Not only can SETPOINTS be source of potential funding, they are also invaluable sources of expertise and teaching resources. They also organise many events in which you could potentially get involved.

Finally, it is worth noting that Ruth Semple, the Exhibition and Outreach Project Manager at the College, will be able to help with liaison with educational establishments.

Professor Kevin G Kerr
Consultant Microbiologist
Department of Microbiology
Harrogate District Hospital

Harriet Dow
Education Liaison Officer
Harrogate and District NHS Foundation Trust

References (all accessed 27 January 2008)

1. www.royalsociety.org/page.asp?id=1948
2. www.microbeworld.org/know/deadliest.aspx
3. www.foodlink.org.uk/testyourself.asp#
4. www.open2.net/healthliving/body_mind/superbugs_quiz.html
5. www.giantmicrobes.com

Dr Jens Stahlschmidt

Histopathology meets the teenage cancer patient

What Colour is my Cancer is a novel way of engaging teenagers and young adults with their disease. This project won a Medical Innovations Award in 2007 and was mentioned in Private Eye![1]

Traditionally histopathologists serve to make morphological diagnoses for clinicians who have submitted biopsies or resection specimens from their patients. It is the nature of a laboratory- based workplace that patient contact almost never occurs. Of course there are exceptions and, particularly after a sudden death, when no clinician has been involved initially, a meeting of the pathologist and the patient's relatives or parents may take place.

The 2005 NICE document, *Improving Outcomes Guidance for Children and Young People with Cancer*,[2] highlighted the importance of "open communication between professionals, children/young adults and the families". The Teenage and Young Adult (TYA) service in Leeds is well established and aims to provide TYAs with age appropriate treatment, support and information.

'What Colour is my Cancer' is a project which started in Leeds St James's University Hospital in 2006 and brings histopathology outside the laboratory. It is a novel service for TYA cancer, offering patients and their relatives the opportunity to view their diagnostic samples under the microscope with a histopathologist, a haematologist and/or the principal cytogeneticist depending which key diagnostic material was involved and to discuss 'the features' with them. This developing service was the brainchild of Sue Morgan MBE, the lead Macmillan nurse for TYA cancer. She was once asked by a patient "what colour is my cancer?". After establishing whether there was a potential interest among the TYA patients to view and understand their cancer samples, several meetings followed with the healthcare professionals involved. After Ethics Committee approval for a smallscale exploratory study, I agreed to do the histopathology part.

Approximately two thirds of the cases were solid tumours (excluding CNS tumours), a third were leukaemias and another third had karyotype preparations available. We had good support from our laboratory manager and were able to utilize an old, but no longer used, extremely robust Leitz SM Lux microscope with a Y-type discussion head, including a digital camera to take photographs directly through the ocular. Having had my last direct patient contact about ten years ago I felt nervous. How would the patient cope with the setting, how would I cope and would we be able to share our different realities to make this session satisfying for all involved? The diagnosticians had clear rules: not to discuss treatment, prognosis or general management. It was vital that Sue Morgan joined

Jens Stahlschmidt showing a young patient slides

in the meetings as she knew the patients and families well and could support both the patient and their relatives in what could be a very emotional experience. All sessions took place on the teenage cancer ward and took between 40 to 70 minutes. Family members were present with the TYA in the majority of sessions and, occasionally, friends were present too.

At the beginning of each session the patient's knowledge and understanding about basic cell biology was explored. This varied greatly depending on educational background and personal interest. To ensure a common knowledge base the range of 'normal' cells was explained using illustrations. A photo collage was used to show the multiple steps from receiving, cutting up and processing of a histopathological sample up until the typing of a report. A paraffin block and an unstained section were also used to illustrate the work of the histopathology laboratory. This took about three to five minutes, depending on the degree of curiosity, but this stage was enlightening for the TYA. The vast majority of patients or relatives had no idea or did not disclose any prior knowledge about histopathology. This is in keeping with other published data.[3]

After ensuring appropriate setting of the microscope for the patient, the session started with the normal/benign area and then lead into the lesion and the differences were explored. Usually the patients were amazed by histology, particularly once they could identify different structures and could have some control over the microscope. The depth of explanation depended on, and was lead by, the patient. The actual appearance of the tumour usually did not bear any resemblance to the young person's imagination prior to the session. Patients described previously held images of "black", "evil", "spiky shapes with teeth", etc. and after the session replaced them with "tiny sausages" or "jellybeans" or "dead lumps of bone."

Conclusion

Every single patient enjoyed the session and none regretted seeing their samples. What impact these sessions had on their cancer journey remains unclear. Is it beneficial and worth the time/resources? Currently we plan to evaluate 'quality of life' measures in this patient group as part of a follow-on project. What does it mean for the histopathologist? There is a significant time commitment but for the pathologist it is a great opportunity to meet the young people and to gain further insight into the clinical aspects of these cancers. For the profession of histopathology, I hope we have contributed to a new, more accessible image, particularly in paediatric practice when histopathology has recently had a negative reputation.

Dr Jens Stahlschmidt
Consultant Paediatric Histopathologist
Department of Histopathology
St James's University Hospital, Leeds

References

1. *Private Eye: Histology Therapy.* 2007; 1190: 10.
2. *Improving Outcomes in Children and Young people with Cancer. An Assessment of Need for Cancer Services for Children and Young People in England and Wales.* NICE Clinical Guidelines (2005). www.nice.org.uk.
3. Laposata M. What many of us are doing or should be doing in clinical pathology: a list of the activities of the pathologist in the clinical laboratory. *Am J Clin Path* 1996; 106 (5): 571–573.

Dr Suzy Lishman

Update on National Pathology Week

I am pleased to report that we are making good progress with plans for National Pathology Week (NPW). Thank you to everyone who has already pledged to run an event. We already have 60 nationwide events planned. This is a fantastic number but we want the first NPW to be a great success so those of you who are still deciding on what to do and need some advice, please get in touch with Caroline Shaw, Press and Communications Manager caroline.shaw@rcpath.org or Ruth Semple, Exhibition and Outreach Project Manager, ruth.semple@rcpath.org.

Dr Suzy Lishman
Assistant Registrar
National Pathology Week Project Lead

Professor John E Cooper

Veterinary pathology training in East Africa

Now this is different. John Cooper takes us on a visit to Kenya and tells us about the challenges veterinary pathology faces in that part of the world. His description of the five-day workshop he ran certainly made me envious – "open-air lunch in a forest setting" – wow! Now read on...

The importance of veterinary pathology

Veterinary pathology remains the key to diagnosis and control of animal disease in East Africa (Kenya, Tanzania and Uganda). It is vital to the surveillance of disease in domestic livestock, to the inspection of meat, fish and other animal products and to the detection of infections that may be transmissible to humans. Most routine post-mortem investigation of animals in East Africa is carried out in the field by government or private veterinary surgeons, few of whom have had advanced tuition in pathology. They therefore rely on their undergraduate training in order to interpret changes, select samples for laboratory investigation and make a diagnosis.

Veterinary pathology skills are, however, increasingly needed in East Africa. Concern about food safety and zoonoses is growing, in part because so many people in the region are immunocompromised on account of malnutrition, HIV/AIDS, malaria or other infectious diseases. The need to monitor animals for emerging human infections, many of which originate from wildlife, means that veterinarians are expected to be proficient in the investigation of morbidity and mortality in species as diverse as apes and amphibians.

Wildlife pathology is also important in its own right. The decline of endangered or threatened animals, such as the world-famous flamingos of the Kenyan and Tanzanian Rift Valley or the celebrated mountain gorillas of the Virunga Mountains of South West Uganda, requires an input by veterinarians who have knowledge of comparative medicine.

Dr Daniel Chai (left) demonstrates the post-mortem examination of a baboon

Restricted training opportunities

Despite such importance of animal pathology in East Africa, the number of nationals who are specifically trained in the discipline remains small – essentially only a handful who have undergone postgraduate studies at one of the region's three veterinary schools or who have studied overseas – and opportunities for further training in pathology are very restricted. There are few in-country courses and those that exist tend to emphasise domesticated species rather than wildlife. The specialist pathologists in the region have only limited access to literature because veterinary school and institute libraries are poorly funded and maintained. For veterinary officers in the field, the situation is often particularly difficult because many work in isolated areas where electronic communications are compromised or totally lacking.

Nairobi workshop

It was against this background that a workshop took place in Nairobi on 27 June –1 July 2007, generously supported by a grant from the Pathological Society of Great Britain and Ireland, under its Open Scheme. Hosts for the workshop were the Faculty of Veterinary Medicine (FVM), University of Nairobi and the Institute of Primate Research (IPR), National Museums of Kenya (NMK). Both provided facilities and much appreciated logistical support. The coordinators were Professor John Cooper and Mrs Margaret Cooper, a veterinary pathologist/lawyer husband-and-wife team, currently based at The University of the West Indies in Trinidad and To-

bago, with several years experience of life and work in East and Central Africa.

There were 30 official registrants, comprising staff from the host institutions, two from the Kenya Wildlife Services (KWS), ten selected final-year students from the Faculty of Veterinary Medicine, Nairobi, postgraduate students from Makerere University, Uganda, and experienced veterinary investigation officers and a senior laboratory technician from Tanzania. A few extra places were made available for additional day-delegates, observers and other interested persons. Handouts included literature from the College.

The theme of the workshop was comparative pathology – that is, the study of the mechanisms of disease in different species. Throughout the five days the term 'pathology' would be defined and discussed in its broadest sense, with theoretical and practical sessions on topics as diverse as the physiology of reptiles and amphibians, necropsy of monkeys, wildlife and zoonotic diseases and the legal and ethical considerations of examining animals and taking, transporting and processing diagnostic samples.

The sessions started with a theoretical interactive discussion of post-mortem techniques and the interpretation of gross lesions. Professor Cooper highlighted the value in comparative pathology studies of establishing and using reference collections and museums, especially when dealing with endangered species or unusual diseases. The afternoon was devoted to practical work, a format that was to be followed on the succeeding two days. On Day 1 the emphasis was on gross necropsy and on refreshing registrants' knowledge of the pathology of domesticated animals. In supervised groups, the participants performed post-mortem examination of dogs and sheep and were thus able to compare the normal anatomy of monogastric and ruminant animals, as well as observing pathological lesions and a range of autolytic and other artefactual changes.

Day 2 took place in the Institute of Primate Research (IPR), part of the National Museums of Kenya, situated in attractive natural woodland at Karen, on the outskirts of Nairobi. The forerunner of the Institute was a non-human primate breeding centre on the other side of Nairobi, established by the late Dr Louis SB Leakey, the famous Kenyan palaeontologist. Now, 30 years later, IPR was a WHO–Collaborating Centre, with a dual mission both to carry out important biomedical research and to promote the conservation and welfare of non-human primates. IPR is involved in studies on tropical diseases including schistosomiasis, malaria and leishmaniasis, and research on other, often neglected, conditions such as endometriosis, which affects women throughout much of the world. Mrs Margaret Cooper, a lawyer with particular experience of animals and veterinary matters, gave the first lecture, focussing on health and safety risk assessment in pathology and precautions that should be taken to protect staff and others during necropsies and laboratory investigations. A presentation by Professor Cooper on correct, safe and consistent techniques for taking diagnostic samples emphasised the value of cytological examination in comparative pathology work. Cytology provided a rapid and inexpensive way of making a diagnosis, especially in cases of infectious or neoplastic disease, and was a technique not only ideally suited to fieldwork but also to day-to-day investigation, especially in poorer countries. In the afternoon the participants dissected the carcasses of dead baboons and compared the organs and tissues of these with those from the domesticated species that had been examined on Day 1. The primate material also permitted everyone to rehearse the making of cytological 'touch preparations' from an array of organs and tissues.

The venue for Day 3 was the preclinical department of the Faculty of Veterinary Medicine at Chiromo. Lectures were presented on the particular features (and challenges!) of work with non-domesticated animals, including wildlife. Professor Cooper, assisted by Mrs Damaris Rotich (National Museums of Kenya) described how ectothermic vertebrates (reptiles, amphibians and fish) differ from endothermic species (mammals and birds) in terms of physiological and pathological responses. The metabolic rate and thus all other mechanisms,

Registrants and co-ordinators with their course certificates

including inflammatory reactions, antibody production and wound-healing, are all temperature-dependent. This led to a discussion of veterinary work, especially pathological investigation, of free-living wildlife. Emphasis was laid on the importance of using minimally-invasive diagnostic and health-monitoring techniques, for welfare and safety as well as scientific reasons. This was where many pathological methods came into their own – for instance, the laboratory investigation of faeces, regurgitated material (including bird pellets), dropped feathers and shed skins of snakes. The speakers stressed that an interdisciplinary approach was often needed, especially when investigating mass mortality incidents ('die-offs') in wildlife, as exemplified by on-going studies on lesser flamingos (*Phoeniconaias minor*) in the Kenyan Rift Valley. Finally, the growing field of forensic veterinary pathology was described, with particular reference to the methods that are used to investigate poaching and other aspects of 'wildlife crime'.

The afternoon was devoted to the investigation of birds and reptiles, including a clinical session during which participants handled and examined live tortoises and snakes. A post-graduate veterinary research worker assisted in this session and showed participants his department's collection of hinge-backed tortoises (*Kinixys belliana*), which were being kept to study aspects of reptile physiology. Using these and other live specimens, delegates were shown how to take samples for laboratory examination from the buccal cavity, skin and cloaca. This was followed by post-mortem examination of dead snakes and of a selection of wild birds, including an African kite (*Milvus migrans parasitus*), provided by the National Museums of Kenya.

The focus of Day 4 was practical work – the investigation and correct description of skeletal and dental pathological lesions, using skulls, jaws and bones of gorillas (*Gorilla* species), and the differentiation of histological changes in mammals and birds. The latter was greatly enhanced by an impromptu presentation on the taking and processing of animal tissues by one of the Tanzanian delegates, a highly experienced laboratory technologist. Participants enjoyed an East African open-air lunch in a forest setting, with large swallowtail butterflies floating past and Sykes monkeys (*Cercopithecus mitis*) attentively watching over the proceedings.

The final day of the workshop consisted of fieldwork in the Ololua Forest adjacent to IPR, in which an exercise was staged. The participants were told that a suspected outbreak of avian influenza affecting wild birds ('free-living eagles') needed to be investigated. The 'sick' birds (in fact, two very healthy local chickens) had to be located in the forest, the area cordoned off and full clinical examination and sampling, including swabbing and making of blood smears, performed. Later, following the 'death' of the birds, necropsies were performed and further specimens taken for laboratory investigation. All of these activities were to be carried out using field equipment (no more than one person could carry), selected by the participants from a collection of items shown to them at the beginning of the exercise. Initiative had to be used to find water for making up formalin and other purposes, probably from the waterfall or one of the small streams in the forest. Finally, the area had to be cleared and cleaned and all 'potentially infective' material removed. The session clearly proved both educational and enjoyable, many participants saying that they were gaining experience of such fieldwork for the first time.

The workshop concluded with another picnic lunch in the forest, the presentation of certificates and thanks to the coordinators from the participants, delivered in traditional East African style.

Evaluation

This workshop, aimed particularly at students, young pathologists and fieldworkers from three different countries, covering the pathology of both domesticated and wildlife species, and incorporating a strong practical component, was probably the first of its kind to be held in East Africa. It appears to have been a great success. It is neither easy nor proper for coordinators to assess the value of their own workshop, but the following comments provide some insight into participants' perspectives:

- "It will help me in teaching general and comparative pathology better to the students".
- "I am now, after this training, in a better position to handle disease problems in wildlife".
- "It will make me a better diagnostician and I will be able to handle tissues and samples well".
- "Fun workshop and educative".
- "It will improve my diagnostic skills"
- "It is a stepping stone in my development as a comparative pathologist".
- "Wildlife sampling was completely new to me. The workshop has enlightened my skills/confidence in this field".
- "The invaluable knowledge I have acquired will enable me to build on to my vet pathology knowledge and improve my teaching skills at the university".
- "The workshop was a great success. We were greatly enriched by the vast experience of the Coopers in diagnostic, forensic and comparative pathology. It has opened our eyes to new possibilities and made pathology more alive than ever".

Professor John E Cooper
School of Veterinary Medicine
The University of the West Indies, Trinidad

Daniel Ross
Chief Executive

Amendments to the Royal Charter, Ordinances and By-laws 2007

Daniel Ross, the College's Chief Executive, and his deputy, Elspeth Evans, outline the background to the recent changes made to the Royal Charter and explain how they affect all of us.

History

The College of Pathologists was founded in 1962 when its first provisional Council was appointed. The College of Pathologists became The Royal College of Pathologists by Royal Charter signed by Her Majesty the Queen on 28 February 1970. The affairs of the College are currently regulated by the Royal Charter and the Ordinances, as approved by Her Majesty's Privy Council and by the By-laws, as approved by the College Council.

Constitution

The Charter sets out the objects of the College and provides for the categories of members, fundamental rights of the members and the powers of the Council. The Ordinances set out in more detail the procedures for admission of members and appointment of Council. The By-laws contain general administrative provisions relating to payment of subscription fees and election procedures.

Making changes to the constitution

The constitutional documents have been amended piecemeal over the years and, as a result, the location of the various insertions and amendments has not always been consistent.

Early in 2007, Council approved the recommendations of the Working Group on Fellowship, Good Standing and CPD, chaired by Dr Peter Cowling, which resulted from consultation with the membership. This required changes to the constitution and provided the opportunity to review it as a whole, with the aim of making it more streamlined. The Royal Charter, Ordinances and By-laws were revised accordingly, approved by the AGM on 21 November 2007 and approved by the Privy Council in December 2007. One of the aims in the College's Forward Plan 2008–2010 is to implement the changes in membership categories within 12 months of receipt of Privy Council approval of the revised constitution.

Key amendments

Certain specific amendments to the constitution have now been made.

1. All references to "good standing" have been removed, as the term is considered superfluous.
2. The category of "Member", with the entitlement to use the post nominal of MRCPath, has been abolished and all those holding this category of membership have been redesignated as Fellows, with effect from 1 January 2008. Subject to their continued membership of the College, they are entitled to use the FRCPath post nominals. Over the next 12 months, the Membership Department will be issuing revised certificates to all those affected. All persons having passed the Part 2 examination or who have been successful at an application for membership by submission of published works shall in future be admitted directly as a Fellow. There is no increase in subscription resultant from this change.
3. A new membership category of "Affiliate" has been introduced. This category is intended for anyone working in a pathology-related field. Affiliates will be able to register with the College for an annual subscription. They will receive a copy of the College *Bulletin* and, if UK based, be able to participate in the College's Continuing Professional Development scheme. The intention is to make the College's facilities available in an inclusive manner to all persons who practise in pathology-related fields. There will be no entitlement to use any post nominals with this category of membership. Exact details of the Affiliate scheme will be published in due course.
4. Associate membership will be offered to candidates on passing the Part 1 examination. This category carries no right to use any post nominals. Those currently holding the Diplomate grade of membership via the route of having passed the Part 1 will have their membership category transferred to Associateship over the next 12 months. Diplomate membership of the College is now only open to those persons who have passed the College's diploma examinations.
5. The quorum requirement for General Meetings has been reduced from 40 members to 20 members, as a more realistic number.

6. Aside from the Registrar, whose term of office was due to expire at the 2010 Annual General Meeting, all the Honorary Officers' terms of office expire at the 2008 Annual General Meeting. However, in the interests of continuity, it is expedient to stagger such retirements. Therefore, the revised constitution defers the retirement of the Treasurer and Assistant Registrar to the Annual General Meeting in 2009, together with the Registrar who has agreed to retire one year early. At the Annual General Meeting in 2009, and at subsequent Annual General Meetings when a vacancy arises, the Treasurer and Registrar will be appointed for three-year terms, not five as before. This ensures that the retirements of the President and the Vice-Presidents (upon serving full terms) will not coincide with the retirements of the Registrar, Assistant Registrar and Treasurer. It will be possible for future Treasurers to serve up to a maximum of two consecutive three-year terms of office. All other Honorary Officers may only serve one three-year term.

The full version of the revised Charter Ordinances and by-laws is available on the College website at www.rcpath.org/index.asp?PageID=1360

Daniel Ross
Chief Executive

Elspeth Evans
Deputy Chief Executive

Vacancies on Council

Vacancies on College Council

There will be eight vacancies on (national) College Council to serve from 19 November 2008 to November 2011. Any Fellow is eligible to be nominated.

This is an opportunity to contribute to the development of pathology services and influence what happens in the various specialties represented in the College.

Nomination forms and a job description are available in the Fellows and Members area of the website (log in first, then go to www.rcpath.org/index.asp?PageID=502.) Applications must be returned to the Registrar at the College by 13 June 2008. There are usually several nominations for each place and a postal ballot will be held in July/August.

Vacancies on Regional Councils

There are vacancies on some Regional Councils to serve from 19 November 2008 to November 2011. Any Fellow or Member in the relevant region is eligible to be nominated.

This is an opportunity to participate in College activities at a local level and influence what happens in the various pathology specialties at a national level. Please put your name forward.

Nomination forms are available in the Fellows and Members area of the website (log in first, then go to www.rcpath.org/index.asp?PageID=109). Applications must be returned to Charlotte Balazs at the College by 13 June 2008. If necessary, a postal ballot will be held in July/August.

Meeting of Council in 2007

A new College visual identity

Since the article in the January *Bulletin* the Visual Identity Project Team have been working hard, along with Designers Collective, to develop the College's new identity. We are delighted to launch it here.

The new logo, elegant and simple

The Royal College of Pathologists
Pathology: the science behind the cure

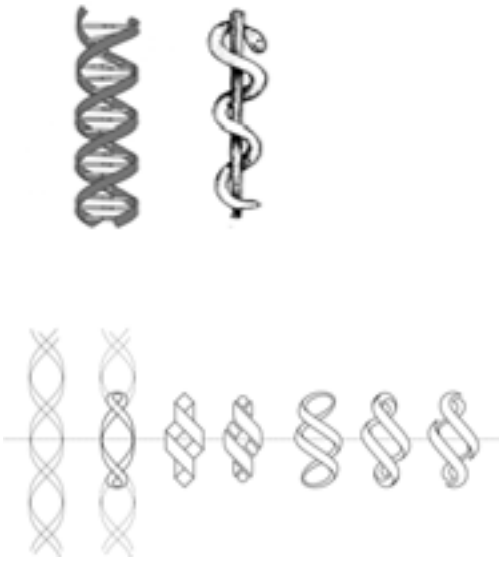
The designer's perspective

When designing a new identity for an organisation such as the College it is well to remember the words of Linus Pauling, twice winner of the Nobel Peace Prize and the Father of Molecular Biology: 'The way to get good ideas is to get lots of ideas, and throw the bad ones away'.

The brief was for a modern identity, relevant to the 21st century, that reflects the positive and dynamic nature of the College, whilst still representing a sense of authority within the field of pathology. Not an easy task, but as we are designers with a history of working for other Royal Colleges, science-based publishers and societies we felt well placed to deliver the brief.

We started generating ideas, and through focus groups we did as Linus advised and threw away the bad (we prefer to say less relevant!) ideas, leaving us with two very recognisable images: the DNA double helix and The Staff of Aesculapius, which represents medicine and appears on the College crest. When combined, we found that these symbols created a beautifully simple and elegant design. A design which we feel reflects the College's role within pathology in the 21st century.

The thinking behind the final design



Designers Collective

The fundamental principle behind introducing a new identity is to develop a strong, consistent image which will enhance the College's reputation for professionalism and high standards.

The new identity will help to fulfil the College's strategic priority of furthering public education in the field of pathology as it will be pivotal in the launch of the Education Centre and for National Pathology Week. It will also appeal to a more diverse audience which the College hopes to attract in these ventures.

The idea from the start of this project was never to lose the College crest. We are hoping to appeal to a wider audience and needed to develop a more modern logo that can work in harmony with and compliment the crest.

The crest is an important part of the College's history and something we are proud to retain. This heraldic symbol conveys a sense of gravitas and is a mark of authority to the outside world, highlighting the importance of the work of the College.

We sought feedback from other organisations that have re-branded and also from our design agency who have worked with other Colleges, on how we achieve this balance and get the best results. The advice was that the crest should be retained on materials such as fellowship certificates, and letterheads. We will be producing brand guidelines that will explain how the crest and logo work together and individually.

We held a focus group in December 2007 which included representatives from Executive, Lay Advisory Committee, trainees, senior users and College

Daniel Ross, Chief Executive, at one of the employee feedback sessions

employees where various initial designs were reviewed and feedback collated.

Following the focus group, the designs were modified and we held employee feedback sessions to discuss the practical implications of the new design on College documents, and the designs were developed further.

The developed design was presented to Council and Council selected the final colour for the main version, which will be used on the majority of College material. We will shortly be rolling out new stationery and templates for you to use for your College documents and correspondence, together with guidelines. Please ensure you and your staff use the new College logo as required. Many thanks for your cooperation. We hope you agree it's a wonderful development.

Ruth Bacon
Business Process Manager

Chelsea Flower Show 2008

Professor Peter Furness at the Chelsea Flower Show last year

The College has been successful in securing a place at the Royal Horticultural Society's Chelsea Flower Show, 20–24 May 2008. This year the College and the Health Protection Agency will host a joint exhibition exploring the possibility that climate change may increase the risk of malaria returning to the UK.

The exhibition will focus on: the evidence for global warming in the UK; which species of mosquito are capable of transmitting malaria; the life cycle and biology of the parasites that cause malaria; symptoms associated with malaria and how pathologists diagnose and treat the disease. There will also be a display of plants that are used in the prevention and treatment of malaria, some practical advice on how to keep mosquitoes out of the garden and general advice on reducing the risk of acquiring malaria abroad.

For further information or details on how to become involved, please contact Caroline Shaw, Press & Communications Manager on Tel: 020 7451 6752, Mobile: 07970 790902 or email: caroline.shaw@rcpath.org

Research Fellowship and Pilot Awards

The Royal College of Pathologists and The Jean Shanks Foundation are pleased to invite applications for a research fellowship in a pathology discipline or related field of 3 years duration to commence in Autumn 2008.

Applications are also invited for 2 pilot awards, one for pathology health service research (systems and processes) and one for more general pathology research.

Further information and application forms are available on the College's website at www.rcpath.org/index.asp?PageID=127

The closing date for receipt of applications is Friday 30 May 2008.

Interviews will be held on Wednesday 25 June 2008.

The late Dr Jean Shanks

Media award

To improve understanding of human pathology and the role of pathologists and as part of the celebrations during National Pathology Week, the College is sponsoring an award to a journalist, who in the opinion of our panel of judges, has written or broadcast an item about pathology which promotes the public understanding of the specialty over the last year.

The award is open to all journalists in medical, national, radio, television and online media and journalists can self nominate. The article or broadcast item must have been published between January 2006 and 1 July 2008 (closing date for nominations).

Nominations can be made via the website, by email or by post to the Director of Communications, Professor Carrock Sewell. Members and Fellows must support nominations with a copy of (or access to) the article/recording for the panel of judges and must be received by 5.00pm on the closing date: 1 July 2008. The award will be presented during National Pathology Week, 3–9 November 2008.

For further information please visit the website: www.rcpath.org or contact Caroline Shaw, Press & Communications Manager, on Tel: 020 7451 6752,
email: caroline.shaw@rcpath.org

Undergraduate medical student essay prize

The College is concerned that there is poor general understanding of human pathology and the role of pathologists within the medical profession. The College is keen to change this by establishing an annual Undergraduate Essay Prize to raise the profile of pathology in the minds of undergraduates and to stimulate an interest in following a career in pathology.

The Prize will open to all medical students and entrants can enter the competition by filling in an application form on the College website. A certificate of originality must be submitted with the entry. Essays will be judged by the Publications and Media Committee and the award of £1000 will be announced during National Pathology Week, 3–9 November 2008.

This years topic is: **A knowledge of pathology is not essential for modern medical practice. Discuss.**

For further information please visit the website: www.rcpath.org or contact Caroline Shaw, Press & Communications Manager on Tel: 020 7451 6752,
email: caroline.shaw@rcpath.org

On the cover

Consultant histopathologist, Dr Jackie Elder, is pictured with a patient in the Endocrine Outpatient Clinic at the Countess of Chester Hospital. This 43 year old hypothyroid gentleman presented with a 4cm right-sided isthmic thyroid swelling, shown to be solid on ultrasound scan in a background of multinodular goitre. A fine needle aspiration (FNA) was performed by Dr Elder and directly spread on to glass slides. Dr Elder is showing the patient the slide and explaining what will happen next. The slides were taken back to the laboratory and reported shortly afterwards. Cytological features suggested Hashimoto's thyroiditis. The FNA is a quick, relatively easy technique that is acceptable to patients and can give rapid results. Photograph by Jenni Collins, Medical Photography and Illustration, Countess of Chester Hospital NHS Foundation Trust.

Education Centre construction update

Daniel Ross
Chief Executive

Construction work continues at 2 Carlton House Terrace. There are now 20–30 builders present on a daily basis. Entrances to the new rooms have been created, and other areas have been bricked up to create the perimeters to the rooms. It was quite a feat of engineering, since several supporting walls had to be propped up before the demolition could take place. The steel lintels were brought on site, sprayed with fire-resisting paints and then put into place. They are being left exposed and will be painted with a suitable finish in due course.

The brick work in the lower ground floor is of varying age and quality. Many alterations were made to the property since it was built in 1828

Construction work continues at 2 Carlton House Terrace

and, having stripped the plaster off the walls, the multitude of different styles of brick used in the last 180 years has been revealed. This will give the lower ground floor quite a bit of character. A number of replacement bricks were needed where the quality was too low, and they were sourced from architectural salvage so as to ensure as close a match as possible to the various originals. The whole area has to be sandblasted to remove any remaining plaster. It was envisaged that this phase would be done earlier but, as is the nature with these projects, it was decided once work had begun to put this part of the project back to allow other things to be completed first.

Squeezing all the necessary plant and equipment into the very small areas reserved for such items will be quite a job. The plant rooms have now been set up to take the equipment which necessitated building various mezzanine levels. This work was very noisy and we must apologise to our neighbours on the Terrace for any inconvenience caused.

Meanwhile the design team has been busy finalising the specification for the audio-visual facilities that will be installed. These facilities will allow the multiple rooms to be used together for one conference and also to be able to have video-conferencing at the College.

The planning of the move back into Carlton House Terrace from our temporary location is well under way. An exact date has not yet been indentified, but the move back will happen some time in June. There is some work to the upper floors of the College that has to be completed before we move back too: fire doors around the main staircase need upgrading to the current standard, to be automatically closeable in the event of a fire, some additional intruder detection is required, and the internal areas need painting as part of our lease obligations.

The project is currently running two to three weeks behind the original schedule, but is still on track to be completed by the end of September as planned.

Daniel Ross
Chief Executive

New Honorary Fellow: Dr Julia Moore

Dr Julia Moore was admitted to Honorary Fellowship of the College at the Fellows' Admission Ceremony at the Royal Overseas League on 21 February 2008. The President gave the following citation.

The President, Professor Adrian Newland, presenting the award of Honorary Fellow to Dr Julia Moore

The Royal College of Pathologists is delighted to honour Dr Julia Kay Moore with the award of Honorary Fellow.

Dr Moore has been very active nationally in her role as Senior Medical Officer (SMU) with the Department of Health and has made major contributions toward teaching and training in the UK, while continuing to fulfil her post as a consultant anaesthetist. It is in her role as SMO that she has been enormously helpful to the College and I would like to acknowledge the vital contribution that she has made in workforce and training in pathology. As SMO she was instrumental in the development of the Intensive Training and Assessment School for overseas trainees that has helped facilitate the introduction of many experienced overseas recruits. This has made a major contribution to easing the workforce crisis that this specialty was facing.

In addition to the development of the SHO schools, she was one of the pioneers in the development of run-through training in histopathology. This helped standardise and shorten training, and again these two initiatives have helped considerably improve workforce recruitment into this hard-pressed specialty. She was able to obtain the funding to allow these developments to happen and it is clear that without her drive and enthusiasm neither project would have succeeded. The run-through training model has been adapted for use in other specialties and will be important for these in the post-Sir John Tooke development of Modernising Medical Careers.

While working with us in histopathology she was also instrumental in developing an e-learning project in radiology that has led to international praise and recognition, and through the Academy of Medical Royal Colleges has worked on its development on a much wider scale. I would like to acknowledge the support that she has given our College in developing the e-learning project in pathology, which is acknowledged as a model for training a multi-disciplinary and multi-professional workforce such as we have in our specialty. I see this also as a basis eventually for the development of re-certification. This, with the work that she has put in with a number of other Royal Colleges, has given the UK a tremendous lead in this innovative area.

Her energy and enthusiasm are impressive, it is clear that she puts in many more hours than she should and the service has benefited accordingly. For this extra effort and the benefits that it has borne, particularly for our own College, she deserves suitable recognition and I am pleased to present her with Honorary Fellowship of the College.

Professor Adrian Newland
President

Dr Lance Sandle

Professional standards: the new agenda

Our new Director of Professional Standards, Dr Lance Sandle, reveals the big changes in revalidation of UK doctors that are imminent. These include, for the first time, a big role for the College. Unless you are retiring soon there will be no escape. So please read, mark and inwardly digest these pages to find out exactly what's about to hit us.

Professional standards: the new agenda

Even the most casual political observer will have noticed that successive governments of whatever flavour have over the last 25 years sought to decrease the perceived autonomy of professions. Unfortunately, the actions of a minority of doctors have only served to increase this resolve in respect of the medical profession. The media have been only too happy to sell newspapers or increase viewing figures by reporting details of the latest medical mishap, misbehaviour or worse. In these times of "no blame" culture, there's still plenty of room to blame doctors - and the other healthcare professions are not far behind.

Revalidation

The endgame of this sequence of events begins with the publication of the White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*, (2007) covering the regulation of healthcare and associated professions. When I attended the Revalidation Steering Group of the Academy of Medical Royal Colleges in December 2007 I reminded them of our considerable non-medical membership who will have their own future revalidation requirements. However, initially, the focus will be on the regulation of medical doctors.

It clear that the Royal Colleges will be responsible for recertification through setting standards, arranging comprehensive assessment of doctors against those standards and issuing statements of assurance to the General Medical Council (GMC). It is suggested that recertification should occur on a 5-year cycle.

The two components of revalidation are relicensure and recertification. Both will be a positive affirmation of the doctor's entitlement to practise and confirmation from the College to the GMC that a doctor has met appropriate standards. The common elements in the process will hopefully enable the implementation of one process with two outcomes.

The College has convened a short-life task force to prepare for these changes, which had its first meeting on 6 March 2008. It is accountable and will report to, in the first instance, the Professional Performance Panel (PPP), and secondly, College Council.

The brief of the task force includes the development of fair and transparent standards and processes for revalidation that meet the needs of pathology specialties and the GMC. The task force will also commission tools that are developmental and supportive and assist doctors in recertification by solving problems early on. It will ensure consistency and share good practice across pathology specialties, and identify and develop appropriate systems for the delivery of revalidation.

The membership comprises the Director of Professional Standards, the chairs of the relevant Specialty Advisory Committees (SACs) and the Chair of the Lay Advisory Committee. Professional Standards Unit (PSU) staff will be in attendance and provide administration. It is also hoped to have a representative from the GMC.

The work streams are:

(a) standard setting
(b) assessment methodologies
- multi source feedback (MSF)
- continuing professional development (CPD) scheme development
- clinical audit
- external quality assurance (EQA)

(c) e-portfolio.

Thus the brief includes all the elements of the work of the PSU, and determines our development programme for the foreseeable future. During my time as Director I intend to report to these headings, which will hopefully give us a framework we can all relate to.

Standard setting

The GMC has reviewed the headings of *Good Medical Practice* (GMP). Four domains for revalidation are now proposed by the GMC:

- knowledge, skills and performance
- safety and quality
- communication, partnership and team work
- maintaining trust.

Assessment methodologies

Multi source feedback (MSF)

The College plans to develop a universal pathology-focused MSF tool to be completed by colleagues. The tool should be able to satisfy a range of competing requirements for pathology trainees and consultant pathologists (members and non members). The overarching aim is that any pathologist or trainee pathologist only needs to use a single MSF tool. The work of the College will conform to the principles set by the Academy.

Continuing professional development

CPD portfolios will be an important part of the revalidation process. This is recognised by the Academy which, with the GMC, has commissioned a study to investigate the effectiveness of CPD across all medical specialties.

We need to ensure appropriate governance so that the conduct of the scheme is transparent and the contents of portfolio reliable. As a result the PSU will no longer be able to grant retrospective approval for CPD credits for meetings.

The PSU has reviewed the credit allocation guidelines for the 2008–2009 CPD portfolio and will map the categories of CPD to the credit allocation guidelines so that those preparing personal development plans can be clearer about where their needs lie in the coming year. This will help to ensure an appropriate spread of credits between categories.

Clinical audit

The White Paper, *Trust Assurance and Safety –the regulation of Health Professionals in the 21st Century*, stresses the role of clinical audit as a driver for continuous improvement and as evidence to be used in revalidation. It is thus timely for members and trainees to be encouraged to submit high quality clinical audits for evaluation and certification at www.rcpath.org/index.asp?PageID=152

There are two different types of audits that can be submitted:

1. First-time audit i.e. for which no re-audit has yet been performed (we will send your audit for evaluation of quality).
2. Re-audit. Submission must contain full details of re-audit and first time audit.

The purpose of submitting first-time audits for evaluation is to validate the audit process so that re-audit is of value. Feedback may be provided by the evaluators which will be developmental. Re-audits successfully evaluated by the second route will be awarded a Certificate of Quality of Clinical Audit and 5 CPD credits.

High quality clinical audits that have been awarded a certificate may be published on the College website with the consent of the author at www.rcpath.org/index.asp?PageID=1453 *[Or even in The Bulletin. Editor.]*

We are always happy to enrol new audit evaluators and those interested in becoming involved should contact Maria Marrero in the PSU at Maria.Marrero-Feo@rcpath.org.

Interpretative external quality assurance

EQA is a good example of a continuous assessment process and enables the early identification of concerns about performance. It is intended to build on the success of these schemes by extending them to as many specialties as we can via the SACs.

e-portfolio

The development of e-portfolios for medical professionals is a key topic at present and one that is very relevant to the College.

There are number of portfolio options already available:

1. CPD portfolio (RCPath)
2. Training portfolio (RCPath)
3. Workplace based assessment (proposed)
4. Revalidation portfolio (proposed)
5. Foundation trainee portfolio
6. Other portfolios or logbooks-undergraduate
7. Existing paper portfolios (many).

The development of (3) and (4) above would represent a large financial commitment on the part of the College. This requires careful planning, including anticipation about future development of current College portfolios.

Throughout national discussions there is an assumption that all of the above will be electronic/web-based and that paper systems will not be maintained or developed in the future. This is especially true for revalidation. The implications of this need further discussion within the College.

Funding issues

Funds have been made available to the Academy from the GMC and the Department of Health (DH).

The GMC has been funding the Academy to carry out work on revalidation for the last two years. In March 2007 DH made a grant to the Academy of £1.5 million to enable the development of standards for specialist re-certification by the medical Royal Colleges and faculties. This grant is intended by DH to support the development projects, pilot studies, consultation events, administrative, project and IT support, communications strategy and the production of regular reports.

In November 2007 we submitted a business plan for revalidation to the Academy of Medical Royal Colleges for consideration by the Academy along with other Colleges' bids against the £1.5 million grant. Unsurprisingly, the total bids exceeded the sum available and they are at the time of writing undergoing analysis.

Anyone who has read the White Paper can do back-of-envelope calculations as to how much

their College and/or GMC subscription might rise, but none of the stakeholder bodies has grasped this nettle – yet.

Other issues

1. Consultation on plans for revalidation. The PSU recognises the need to engage the membership and will initiate an extensive communication exercise in the near future.
2. National Clinical Assessment Service (NCAS) and the work of the Professional Performance Panel. We have provided NCAS with names of two histopathology nominees to sit on a short working group (maximum two meetings) on the assessment of histopathologists. This links into the work being done by the SAC in Histopathology on error, drawn together from various documented opinions on the issue. This work will result in a discussion document for wider consultation.

Stella Macaskill and I have also met with NCAS to discuss the working protocol with regard to shared cases.

The effect of the revalidation proposals on the work of the Professional Performance Panel (in particular the workload for College professional performance reviews) cannot be judged at present but needs to be kept under surveillance.

My own take on this is that the College and the GMC are still deciding on what revalidation will look like as a process. Once this is clarified I suspect things will move much more quickly. I'll keep you posted.

Dr Lance Sandle
Director of Professional Standards

Maria Marrero

Certification of high quality clinical audit

The Royal College of Pathologists encourages you to submit your completed clinical audit to the certification scheme for peer evaluation, to demonstrate audit of high quality which meets the College's criteria and standards. Evidence of the quality audit activity will be an important component of revalidation. The submission process is straightforward and takes only a few minutes to do. To make a submission, please visit www.rcpath.org/index.asp?PageID=152

There are two different types of audits that can be submitted for evaluation.

1. First-time audit, i.e. one for which no re-audit has yet been performed. The purpose of submitting first time audits is to validate the audit process so that re-audit is of value. The evaluators may provide feedback, which will be developmental.

2. Re-audit. Submission must contain full details of the first time audit and the re-audit. Re-audit successfully evaluated by this second route will be awarded a 'Certificate of Quality of Clinical Audit' and 5 CPD credits.

If your audit application is not satisfactory, you will have the opportunity to resubmit your audit in order for it to be re-evaluated. You can do this by adding to your original application via a personal resubmission link sent by email. To make a resubmission, you must satisfy the points raised by the evaluators and address all the deficiencies in your original audit.

The evaluation process

A preliminary check is undertaken by College staff before the submission is sent to two evaluators in that specialty, who will review the audit blindly and independently of each other, in line with the criteria and standards set out by the College (see www.rcpath.org/index.asp?PageID=1069).

High quality clinical audits that have been awarded a certificate may be published on the College website at www.rcpath.org/index.asp?PageID=1453 and in the *Bulletin*, with the consent of the author.

For more information on how to submit an audit, please contact me.

Maria Marrero
Audit and Quality Coordinator
Professional Standards Unit
Email: audit@rcpath.org
Tel: 020 7451 6737

Roy Palmer

Coroners' post-mortem examinations: passion and practicality

Roy Palmer, doctor, barrister and coroner, takes issue with an article by Peter Furness that appeared in the October 2007 *Bulletin*. In this lively article he uses his experience and skills to challenge us to think again about Coroners' post-mortems.

I am responding to the item in the October issue of the *Bulletin* (*RCPath Bulletin* 2007;140:60–64) from Professor Peter Furness, with a few thoughts from one London Coroner.

The reason for a coroner's post-mortem

First, government or society must decide, as Peter Furness says, what the coroner's post-mortem examination is for.

When I was a medical student, just about everyone who died in hospital underwent a 'hospital' (i.e. 'consented' – although I do wonder how informed the consents were!) post-mortem examination. They were conducted by the teaching hospital pathologist, who took as long as they needed.

Today, we have very few hospital (consented) post-mortem examinations. The last time I asked one of my district general hospitals, I was told that in the previous year 600 post-mortem examinations had been undertaken, 595 of them for me and only 5 as consented.

So, why the demise in the consented post-mortem examination? Does it matter? If so, what should be done? Are doctors fearful of approaching relatives for consent? Are relatives more reluctant to give consent? Are the Human Tissue Act provisions impeding things? What is the problem and can it be fixed?

Applying guidelines

Second, are the College's guidelines for autopsies to apply to all post-mortem examinations? Or only to consented post-mortem examinations? If, as Peter Furness says, there should be only one standard, how realistic is that, given the statutory provisions? As a medic, I rather agree that there should be one standard. But if I try to apply the law as written, there are difficulties.

Schedule 2 of the Coroners Rules 1984 (as amended) require the pathologist to provide to the coroner: *"In my opinion the cause of death was ....."* and the law requires answers on the balance of probability only. You do not have to be certain, and not even to be satisfied so that you are sure (the criminal law standard). This sits with the GP's duty to issue a Medical Certificate of Cause of Death giving his opinion as to the cause of death. As Peter Furness says, is it essential to (for example) open the skull in every case, e.g. where there is a massive bleed from say a ruptured abdominal aortic aneurysm?

Timings and costings

Third, has any work been done to put a price on a post-mortem examination done to the College's 'gold standard'? If not, it is about time someone did the work. How long will a College standard post-mortem examination take to perform? At the appropriate salary for an NHS consultant pathologist, to what fee does that amount?

Conversely, has anyone worked out how much of an NHS consultant pathologist's time my local authority can expect to purchase for the statutory post-mortem examination fee of £93?

Looking for answers

Fourth, increasingly, clinicians, epidemiologists and the Chief Medical Officer (*pace* research on prions) look to the coroner's post-mortem examinations to provide answers that used to come from consented post-mortem examinations. However, laws have been passed that make for problems (the amended Coroners Rules and Human Tissue legislation). They are asking for something that the coroner's post-mortem examination was never intended to deliver. If the information is wanted, there should be a return to the consented post-mortem examination with a publicity drive to explain the necessity.

If the intention behind the post-mortem examination is something other than to assist the coroner with (a) identification of the deceased or (b) the means by which the deceased came by his death, then it is beyond the scope of the coroner's autopsy and consents are required.

Because the coroners' post-mortem examinations are outwith the NHS, there is none of the usual audit and quality control that would apply to NHS work. Most coroners are lawyers, not doctors. Those few of us that are doctors are not pathologists. It will not be the coroner that oversees the quality of the post-mortem examination – and the matter will be worse if and when a new Coroners Act is passed if (as planned) all coroners in future will be lawyers.

So, if there is to be quality control it must be provided for in statute and there must be an agreed standard for the task and a fee that reflects the extent and quality of the work done.

Histology

If histology is performed in every case, as per the College's guidelines, it will more than double the cost of the coroners' post-mortem examinations – a burden on the public purse. For example, in my jurisdiction, my annual routine post-mortem examinations cost around £200 000. If histology is to be done on five blocks in every case, that will add about £125 per case to the £93 already payable – and the local citizens will have to bear that cost. So will their dustbins be emptied less often? Will the schools budget, or social services budget, be reduced? Where will the money come from?

If the object is to satisfy medical needs and curiosity, ought not the burden to fall on the NHS rather than, as now, the local authority?

Options

Option 2 in Peter Furness' article related to cutting down on numbers of coroners' post-mortem examinations. How would this be done? General practitioners are already not required to work at night. Deputising doctors will not know patients well enough to issue Medical Certificates of Causes of Deaths. The 'Shipman effect' means that referrals to coroners have gone up from about 33% to 48% of all deaths in the last 5 years. Try as we do, we often cannot persuade general practitioners and hospital doctors to issue a Medical Certificate of Cause of Death. If they cannot or will not sign up a death there is little option but for us to arrange a coroner's post-mortem examination. Unless there is a marked change in attitude and practice among doctors and relatives, we are not easily going to be able to reduce the numbers of post-mortem examinations.

I do think that Option 1, regarding proper costings (the first point made in my commentary above), is in need of further work. If the work is necessary and the rate for the job is correct, we may solve most of the problems. But there will be squeals (if not loud yells) of protest from budget holders and HM Treasury!

Option 3, reducing the standard of investigation, also requires debate. What is the coroner's post-mortem examination for and should it be expected to replace or fulfil the scope of the consented post-mortem examination? If the College gold standard is to be right for every case (but should it be?) then the work must be properly resourced and funded. *If* the purpose of a coroner's post-mortem examination is to replace the GP's or hospital doctor's best guess as to cause of death in cases where a doctor cannot issue an Medical Certificate of Cause of Death, then I do suggest that the College gold standard is excessive – which takes us back to the question of the purpose of a coroner's post-mortem examination! I do think that pathologists (as well as coroners and legislators) should give further thought to the standard for a post-mortem examination.

Option 5 related to taking the coroners' post-mortem examination outside the NHS altogether. Yes, that is a theoretical option – as it was an option 40 years or so ago when there were fewer coroners' post-mortem examinations and many were done by the accredited forensic pathologists of yesteryear. But there are now insufficient forensic pathologists even for the 'suspicious deaths'. So going down that route, whilst theoretically worthy of exploration raises, many other issues – not only about numbers of pathologists but also about quality, audit, mortuary provision, etc. (There are ever fewer public mortuaries).

Getting legislators and civil servants to comprehend at least some of the issues raised is, in itself, a major obstacle and hurdle!

I hope that this contribution to Peter Furness's paper is helpful.

Roy Palmer
HM Coroner, Greater London (Southern District)
Deputy Coroner, City of London

Emeritus Professor Kevin McCarthy

Appreciations

Emeritus Professor Kevin McCarthy 1921–2007

The death of Kevin McCarthy in August 2007 breaks an important link with the 'golden age' of virology, when major results could be obtained with little more than imagination and green fingers for cell culture.

Liverpool-born, 'KMcC' (as he was known) graduated from Liverpool Medical School in 1944 and, after a year as Demonstrator in Anatomy, was poached by Allan Downie to join what was probably the world's leading poxvirus laboratory. Apart from the short break mentioned below, he spent his entire career in Liverpool. His prize-winning MD was awarded for work on smallpox, and his studies on the antibody response to smallpox and vaccination were quoted as authoritative 30 years later in the WHO account of smallpox and its eradication. He did important laboratory work on smallpox outbreaks in Britain in the 1950s and provided a regional diagnostic service into the 1970s. He was a member of the tribunal that investigated the 1973 smallpox outbreak in London and a key defence witness in the Health and Safety Executive's unsuccessful prosecution of Birmingham University for the 1978 laboratory-associated outbreak. However, his main focus switched to other viral exanthems.

The stimulus was a period in Boston during 1954–1955 with John Enders, soon after the latter had isolated measles virus in cell culture. KMcC contributed to important early papers on measles and established that giant-cell pneumonia was an unusual manifestation of the infection. He returned to Liverpool to continue work on measles and was eager to teach the new cell culture techniques. However, he also turned to rubella and, with Carl Taylor-Robinson, was the first outside the USA to isolate rubella virus and the first to detect reliable, rapid cytopathic effect and plaque production. These were important contributions and visitors from many European laboratories came to learn these techniques.

Successively Assistant Lecturer, Lecturer and Senior Lecturer in Bacteriology, he succeeded Allan Downie in 1966, changing the department's name to Medical Microbiology. Although disliking administration, he followed Downie's example and protected his staff from it as much as possible. He encouraged them to pursue their own research interests and important work was done on influenza, *Chlamydia*, varicella-zoster, zoonotic poxviruses and antibiotic resistance. His time at the bench was limited but he supervised measles and rubella vaccine trials and led groups that investigated herpesvirus latency and reactivation in rabbits, and human ocular herpes. After retirement in 1986, he continued as a Research Fellow, advising on herpes projects and working on HIV and on the growth of cancer cells *in vitro*.

Perhaps his greatest burden was the long-delayed move into the 'new' Royal Liverpool Hospital. Apart from protracted building problems, this involved the merger of the University Department with the labs of the Royal. He delighted in pointing out that the 'three-cogwheel' motif adopted by the steering committee would jam if they tried to rotate it! His department also provided diagnostic services for four other hospitals. Although this was supervised by consultant senior lecturers, the ultimate responsibility was KMcC's. He was a Founder Member of the College and, enjoying teaching, was one of the first to host virology practical examinations.

Throughout his career he had the support of his wife and family and an absorbing hobby; his 'garage' was a workshop. Here, he made toys for his children and grandchildren, mended broken toys for staff children and devised and built numerous items of equipment from Meccano and army surplus; shakers, stirrers, rockers, mixers. The McCarthy phase contrast adaptor was marketed by Baker and the 'Liverpool egg punch' was made to order for Liverpool graduates and honorary members of the department.

He married Mary Aylward in 1946 and they enjoyed the close company and successes of their family: Judith (the source of the 'Judith' strain of rubella virus) and Gabrielle, both teachers; Hugh and Ruth, both dentists, and Catharine, a botanist. We enjoyed their visits to the lab and also wine tastings at the McCarthy home. The photograph, by which his family want him to be remembered, ideally catches his impish sense of humour. He will be remembered fondly by all the staff and students who passed through the department during his whole time there.

Derrick Baxby

Professor David Mason

Professor David Mason 1941–2008

Professor David York Mason, who died on 2 February 2008 from post-operative complications, was an internationally renowned authority on the diagnosis and pathology of human lymphoma and leukaemia. Professor Mason had an influence far beyond his own laboratory. His work on techniques and reagents has spread to virtually every hospital in the world. He can truly be said to have changed radically the practice of pathology as it relates to haematological malignancy.

David Mason was born on 30 November 1941 and educated at Tonbridge School, St John's College University of Oxford and St Thomas' Hospital, qualifying in 1966. He came from a medical family but was brought up with a life long passion for the arts. He combined these two enthusiasms at University, occasionally veering more to the arts than his tutors would have preferred. This led to a highly successful and satisfying role in the early development of television satire. He was a scriptwriter for some of the early pre-Monty Python satirical shows especially "That Was The Week That Was" for which he was still delighted to be receiving some royalties right up until his untimely death.

After qualifying in medicine he turned his back on a literary career and concentrated the rest of his life on the study of human lymphomas, a cancerous tumour of the lymph glands and other tissues that presented considerable problems in diagnosis and classification to clinical haematologists. He was one of the first, with Clive Taylor, to show that antibodies, then studied mainly in test tubes by scientists, could be applied to clinical samples from patients. He immediately realised that the discovery of monoclonal antibodies in 1977 was a great opportunity for this to be developed. In spite of considerable scepticism from many colleagues he persevered with the production of these antibodies, specifically developing them for human applications. To enable this he developed and improved many technical methods including the alkaline phosphatase-anti-alkaline phosphatase (APAAP) technique whose description has become a citation classic. Today his reagents and methods are applied daily in the routine practice of pathology worldwide. He was very enthusiastic about international collaboration. Visitors flocked to his laboratory from around the world to study these new reagents and learn their applications. He rarely turned anyone away if there was space and cared not if they were famous or just starting out. An enthusiasm to learn and co-operate was all he desired. Today the leaders in lymphoma pathology and research include many clinicians and scientists who spent time with him in Oxford.

He was promoted to Reader (1994) and then in 1997 to Professor of Cellular Pathology at Oxford. The Leukaemia Research Fund was his main source of funding throughout his career and with which he developed a close personal relationship. He founded and was the first director of the Leukaemia Research Fund Immunodiagnostics Unit, which has recently been expanded into a national antibody resource for the charity's research workers. Within this Unit he built up an incredibly loyal and helpful team that stood by him for over 20 years. The key players are Jackie Cordell, Margaret Jones, Karen Pulford and Bridget Watson.

He was a founding member in 1991 of the International Lymphoma Study Group that brought together pathologists and clinicians from around the world to discuss and agree on lymphoma diagnosis and research. At that time there was a great divide between the United States and Europe, with many rival and highly complex classification schemes. David, alongside Peter Isaacson, Harald Stein, Elaine Jaffe, Nancy Harris and several others, brought all of these disparate opinions together and formulated a new, clear, highly practical scheme for clinical use. Today this is encapsulated as the WHO classification of lymphomas and leukaemias. A tribute to the enormity of this achievement comes from the fact that present-day diagnostic pathologists utilising this scheme wonder what the arguments can have been about. Another measure of his success is that over nearly 30 years he was regularly the top cited scientist in Oxford and always in the leader table of UK scientists.

Until his death David continued to investigate avenues to improve classification and diagnosis with new reagents and techniques. A recent promising approach has been the development of methods of highlighting underlying genetic lesions directly on a patient's lymphoma samples. Latterly he achieved this in a very successful collaboration with his wife, Teresa Marafioti, who is an experienced haematopathologist in her own right.

The Nuffield Department of Clinical Laboratory Sciences, University of Oxford

Examinations results: Spring 2007

Several members have pointed out that we omitted to publish the Spring 2007 examination results in previous issues of the *Bulletin*. We apologise for this error and any inconvenience caused, and publish the results here. We congratulate all successful candidates.

Successful candidates for the Diploma examination

The following candidate has passed all components of the relevant Diploma examination.

Dermatopathology
Dr Rokiahmah B M Ali MRCPath

Successful candidates for Part 1 examination

The following candidates have passed all components of the relevant Part 1 examination.

Clinical Biochemistry
Miss Katie Bainbridge
Dr Ophelia Blake
Mr Steffan Evans
Dr Virginia Lee
Dr Taruna Likhari
Dr Sadie Marsh
Dr Leslie Perry
Dr David Preiss

Successful candidates for the Part 2 examination

The following candidates have passed all components of the relevant Part 2 examination:

Clinical Biochemistry
Dr Stephanie Barber
Dr David J Cartwright
Dr Maria Fitzgibbon
Dr Loretta Ford
Dr Heather Holmes
Dr Fiona M Ivison
Dr Derek McKillop
Ms Paula O'Shea

Clinical Cytogenetics
Mrs Adele Calvert
Dr Kalliroi Stergianou

Haematology
Dr Jayanthi Alamelu
Dr Muhanna Al-Muslahi
Dr Karthikeyan Arumugam Ramasamy
Dr Reuben Benjamin
Dr Muhammed Ceesay
Dr Mhairi Copland
Dr Josephine Crowe
Dr Claire Davies
Dr Rachel Elliott
Dr Simon J Harrison
Dr Victoria E J Hervey
Dr Claire Hutchinson
Dr Kamaraj Karunanithi
Dr Geothy Kochethu
Dr Suchitra Krishnamurthy
Dr Maxine Lissack
Dr Hamish Lyall
Dr Simon Lyons
Dr Peter Maclean
Dr Scott Marshall
Dr Vickie McDonald
Dr Carolyn M Millar
Dr John Moppett
Dr Edward S Morris
Dr Jayashree Motwani
Dr Annette Nicolle
Dr Bassam Odeh
Dr Sarah Oram
Dr Nahla Osman
Dr Jiri Pavlu
Dr Martin Pule
Dr John Quinn
Dr Amrana Qureshi
Dr Kavita Raj
Dr Beverley J Robertson
Dr Susan Robinson
Dr Jacqueline Ruell
Dr Oonagh Sheehy
Dr Anthony Todd
Dr Sara Trompeter
Dr Salaheddin Tueger
Dr Rachel Wells
Dr Deborah Yallop
Dr Ghada Zakout

Histopathology
Dr Huyam Abdelsalam
Dr Khorrum E Abdulla
Dr Kwame Adu-Poku
Dr Monica Agarwal
Dr Tanya S Alan
Dr Zainab Ali
Dr Salim Anjarwalla
Dr Gurprit S S Atwal
Dr Manimekalai Balakrishnan
Dr Lisa Barker
Dr Julia Bell
Dr Olaf Biedrzycki
Dr Lesley Christie
Dr Steven Corrigan
Dr Saral Desai
Dr Garrett Fitzgerald
Dr Ehab Husain
Dr Deepa Jacob
Dr Tahir N Khan
Dr Marium Khan
Dr Elaine M MacDuff
Dr Sunita Mane
Dr Michael McKenna
Dr Emma McLean
Dr Magda Mikhail
Dr Andrew O'Hara
Dr Alka Patankar
Dr Lipsita Patnaik
Dr Rajaguru Rajaguru
Dr Catherine Robinson
Dr Patthinihennedige Rodrigo
Dr Brian A Rous
Dr Neil Sahasrabudhe
Dr Vishakha Sovani
Dr Tamala Surendra
Dr Mark R Taylor
Dr Monica Terlizzo
Dr Caroline M H Thaung
Dr Matthew Theodosiou
Dr Rachel Thomas
Dr Mini Varghese
Dr Clare Verrill
Dr Twesha Wahie
Dr Julie A Walker
Dr Annikka Weissferdt
Dr Elizabeth J Wilson
Dr Amgad Youssef

Immunology
Dr Mohamed Abuzakouk
Dr Hana Alachkar
Dr Helen Bourne
Dr Matthew Buckland
Dr Efrem Eren
Dr Anthony Rowbottom

Medical Microbiology
Dr Mohammad Abrishami
Dr Catherine Aldridge
Dr Abhijit Bal
Dr Jeanine Bygott
Dr Helen Chesterfield

Dr John Clark
Dr Sophie E Collier
Dr Miruna D David
Dr Rebecca Davis
Dr Kirsty Dodgson
Dr Soma Gaur
Dr Abdul Ghafur
Dr Margaret Gillham
Dr Sarah Glover
Dr Imad B Ibrahim
Dr Ranganathan Iyer
Dr Sinead McNicholas
Dr Joy Michael
Dr Raigama Mortimer
Dr Tamsin Oswald
Dr Hawabibee Petkar
Dr Natasha Ratnaraja
Dr Mohammed Raza
Dr Kordo Saeed
Mr Siu Tang
Dr Mili Torok
Dr Emma J Watson

Toxicology
Dr Sarah E Campbell

Virology
Dr Sandeep Ramalingam
Dr Samir Dervisevic
Dr Nteimam Jonathan

New Year Honours list

We note the conferment of honours to the following Fellows and warmly congratulate them on their achievements.

Knight Bachelor
Professor Alexander Markham FRCPath
Professor Bruce Ponder FRCPath

Dame Commander of the Order of the British Empire
Professor Kay Davies FRCPath

Officer of the Order of the British Empire
Professor Clair du Boulay FRCPath
Professor Phil Dyer FRCPath
Professor Treen (Curly) Morris FRCPath

Professor Clair du Boulay

Professor Treen Morris

Deaths

The deaths of the following Members and Fellows were announced at the January 2008 Council meeting. We extend our condolences to those who grieve for them.

Richard Finlay ALEXANDER	(Fellow UK)
Brian Ernest Dudley COOKE	(Fellow UK)
Philip Nathan COWEN	(Fellow UK)
Klaus Franz Karl CZERWENKA	(Fellow overseas)
Thomas Bryson Mitchell DURIE	(Fellow UK)
Jack Eric ENNIS	(Fellow UK)
George Smith GRAHAM	(Founder Fellow)
Ruth Marian HASLAM	(Member UK)
Eunice LOCKEY	(Fellow UK)
Kevin McCARTHY	(Fellow UK)
Ellen Catherine MOORHOUSE	(Fellow overseas)
Pauline Marcia POOLE	(Fellow UK)
Alistair John ROBERTSON	(Fellow UK)

Oliver Memorial Lay Award 2007: John Marriott

The Oliver Memorial Award for Services for Blood Donation and Transfusion was presented at the British Blood Transfusion Society (BBTS) Gala Dinner and Awards Ceremony on 15 September 2007, in Glasgow. Mr John Marriott was presented the 2007 award in the 'Lay' category by Professor Frank Boulton, President of the BBTS. John was a very active lay member of our Lay Advisory Committee from 1999 to 2004 and still maintains his links with the College. His nomination, reprinted below, was given by Dr Shubha Allard.

I would like to nominate John Marriott as an exceptionally worthy candidate for this award.

John has been a lay member of the Chief Medical Officer's National Blood Transfusion Committee since 2002, where his active contribution has undoubtedly helped to ensure that patients are placed well and truly at the heart of clinical blood transfusion practice across the NHS. His commitment to this cause is very well demonstrated by his participation in the successful National Patient Transfusion Awareness Campaign, aimed at informing patients about the risks and benefits of transfusion, alternatives to donor blood and the importance of patient identification. He has participated actively in the National Patient Safety Agency's Blood Transfusion Patient Safety Initiative with a view to reducing blood transfusion errors by 50% in 5 years since late 2004. He has also been a member of the NHS Blood and Transplant's Clinical Audit and Effectiveness Steering Group since 2002 and Serious Hazards of Transfusion (SHOT) since 2005.

His contribution to other groups has been truly remarkable. These include membership of The Royal College of Pathologists' Lay Advisory Committee 1999–2004, The Royal College of Physician's Joint Specialist Committee (RCP JSC) for Academic Medicine since 2005, RCP JSC for Gastroenterology and Hepatology since 2004, RCP iLab Project since 2005, Chief Medical Officer's Tuberculosis Action Group and Core Postgraduate Research Grant Awards Committee since 2005. In addition, he has been Chairman of the Devon and Cornwall Region Multiple Sclerosis Society since 2004 and a volunteer for the Epilepsy Information Network since 2003.

John is a retired Royal Navy Commander who has tirelessly supported and pursued the interest of patients within transfusion medicine and many other disciplines within the NHS. Throughout this, he has maintained his good humour and has been a very reliable advocate for patients despite personal medical problems and the several hours of travel required from the West Country to attend various meetings.

Mr John Marriott being presented with the 2007 award in the 'Lay' category by Professor Frank Boulton, President of the BBTS

Dr Shubha Allard
Consultant Haematologist
Barts and the London NHS Trust
NHS Blood and Transplant

Northern Success in Hospital Doctor Awards

The North of England Cancer Network (north part) Thyroid Multidisciplinary Team, led by Dr Ujjal Mallick, consultant clinical oncologist at Newcastle upon Tyne, won the *Hospital Doctor* Oncology Team Award on 22 November 2007.

The awards ceremony was held at the Hilton Hotel, Park Lane, London and was attended by representatives for each of the three shortlisted teams within each category.

This Thyroid Cancer MDT aims to be truly multidisciplinary and is particularly inclusive of its cellular pathology members who include Drs Sarah J Johnson, Debra S Milne and Atuora Okpokam in Newcastle and Sunderland (all also members of the UK Endocrine Pathology Society, [www.ukeps.com]), with additional support from Fergus Young and his colleagues at Carlisle, and other colleagues in Gateshead, North and South Tyneside. There is a weekly joint thyroid clinic for thyroid cancer patients and the team meets twice a month to discuss cases, videolinking between Newcastle, Sunderland, Carlisle and Wansbeck.

The team includes in its achievements the publication in 2000 of the first ever guidelines for the treatment of thyroid cancer in the UK and one of the first in the world. This formed the basis of the British Thyroid Association / Royal College of Physicians Guideline for the management of thyroid cancer published in 2002 and revised in 2007 (www.british-thyroid-association.org/guidelines.htm), which was partly edited by members of the team. Additionally the team has designed the first multicentre randomised controlled trial for thyroid cancer, the HiLo trial, which is now underway and is one of the largest in the world. Another innovation in the team is a patient representative, Kate Farnell, who works alongside the healthcare professionals in the joint thyroid clinic and set up the first thyroid cancer patient support group in this country, Butterfly North East, now being rolled out nationally (www.butterfly.org.uk).

Only a few members of this large team are shown in the photograph, taken at a joint thyroid clinic in NCCT. From the left they are: Chris Stephenson, nuclear medicine technician; Christine McGreal, specialty manager; Kate Farnell, patient advisor and founder Butterfly North East; Petros Perros, consultant endocrinologist; Amit Chakrabarti, specialist registrar oncology; Margaret Morris, endocrine specialist nurse; Michelle Shield, MDTM coordinator; Ian Driver, consultant physicist; Ujjal Mallick, consultant oncologist and Olive Golightly, staff nurse outpatient department.

Dr Sarah J Johnson
Consultant Pathologist
Department of Pathology
Royal Victoria Infirmary, Newcastle upon Tyne

The Northern Cancer Network Thyroid Cancer Multidisciplinary Team (photograph reproduced with permission from Jim Varney Photography www.jimvarney.co.uk)

Healthcare Scientist of the Year Awards 2007: Dr Christine McCartney

Dr Christine McCartney being presented with the Award by Professor Sir Bruce Keogh, NHS Medical Director, and Professor Sue Hill, Chief Scientific Officer

In 2007 Professor Sir Bruce Keogh and the Chief Scientific Officer (CSO), Professor Sue Hill, presented six awards to healthcare scientists.

These were the 4th Chief Scientific Officer's Awards, started by Professor Hill to highlight the many achievements of healthcare scientists.

Healthcare Scientist of the Year was awarded to Dr Christine McCartney, Director of the Health Protection Agency Regional Microbiology Network and a Fellow of this College. It was awarded for the way in which she has delivered new services and improved existing ones for the benefit of public health and her abilities in communicating so effectively with the public on complex scientific issues, such as *C difficile*, MRSA, and Polonium 210.

Dr McCartney began her scientific career in Glasgow, working at the Western Infirmary and the Royal Infirmary, and progressed there to a consultant equivalent post in medical microbiology. In 1992 Dr McCartney moved to London and joined senior management at what was then the Public Health Laboratory Service. The Health Protection Agency has involved Christine McCartney in many roles including helping establish a group of laboratories capable of responding to bioterrorism. These rapid-response diagnostic capabilities were responsible for identifying several serious infections during the war in Iraq and more recently dealing with the London bombings.

Dr McCartney has also helped to refine the services provided by the Regional Laboratory's Network, ensuring that the needs of both the public and the NHS are met by providing an effective, modernised microbiology laboratory service to back up the HPA frontline in the prevention and control of infectious disease.

Medical consultants: new appointments, offers and retirements

The following appointments have been offered (as at 12 February 2008), which are naturally subject to acceptance by the applicants. The lists are prepared by the College's Workforce Department, on the basis of returns completed by College Assessors on Consultant Advisory Appointment Committees and submitted by the above date. Any forms received after this date will be published in the next issue. If doctors fail to take up their posts, they should inform the Workforce Department, email **medicalworkforce@rcpath.org**. Whenever you move homes or jobs, please remember to inform the College Membership Department and send your new details to **membership@rcpath.org**

Region	NHS Trust/NBS/HPA/HA	Base hospital	Appointee
Chemical pathology			
London	Lewisham	University Hospital Lewisham	Dr Ann H Fleming
London	Lewisham	University Hospital Lewisham	Dr Isabelle Meiers
London	Lewisham	University Hospital Lewisham	Dr Dalibor Stratil
Wales	Bro Morgannwg	Princess of Wales, Bridgend	Dr Adam J Cookson
Haematology			
Eastern	Cambridge University	Addenbrooke's	Dr George A Follows
Eastern	West Suffolk	West Suffolk	Dr Mamatha Karanth
London	Guys and St Thomas	St Thomas	Dr David H Bevan
North West	Stockport	Stepping Hill	Dr Montaser A Haj
Northern & Yorks	Hull and East Yorkshire	Hull Royal Infirmary	Dr Hazem A Sayala
South East	Dartford and Gravesham	Darent Valley	Dr Anil V Kamat
West Midlands	Shrewsbury and Telford	Across sites	Dr Michael L Shields
West Midlands	Walsall	New Cross, Wolverhampton	Dr Vinayak Tandon
Histopathology/cytopathology			
Eastern	Mid Essex Hospital Services	Broomfield	Dr Dia E Kamel
Eastern	Mid Essex Hospital Services	Broomfield	Dr Mahir A Petkar
London	Barts and The London	Across sites	Dr Matthew S Buckland
London	University College London	University College London	Dr Rupali S Arora
Mersey	Southport and Ormskirk	Southport District General	Dr Naga B Musthyala
Northern & Yorks	Calderdale and Huddersfield	Calderdale Royal	Dr Richard C Knights
Northern & Yorks	Leeds Teaching	Leeds	Dr Lisa J Barker
Northern & Yorks	York	York	Dr Nicola J Maughan
North West	Pennine Acute	Across sites	Dr P Ranjani Chakravarthy
North West	Pennine Acute	Across sites	Dr Vinita Charan
North West	Pennine Acute	Across sites	Dr Adegoke U Oyegade
North West	Stockport	Stepping Hill	Dr Nadine A Elgeredly
South East	Ashford and St Peters	St Peters	Dr David J Cartwright
South East	Brighton and Sussex	Royal Sussex County	Dr Mark R Taylor
South East	Oxford Radcliffe	John Radcliffe	Dr Elizabeth J Soilleux
South East	Northampton General	Northampton General	Dr Tahir N Khan
West Midlands	Birmingham Women's	Birmingham Women's	Dr Lynn Hirschowitz
West Midlands	Shrewsbury and Telford	Royal Shrewsbury Hospital	Dr Huyam M Abdel Salam

Region	NHS Trust/NBS/HPA/HA	Base hospital	Appointee
Immunology			
Northern & Yorks/ Trent	Hull and East Yorkshire, and Northern Lincolnshire and Goole (joint Trust post)	Across Trusts	Dr Mohamed M Abuzakouk
MM, CCDC, virology & epidemiology			
Eastern	Basildon and Thurrock	Basildon	Dr Benny P Cherian
Eastern	Cambridge	Addenbrookes	Dr Sani H Aliyu
Eastern	Norfolk and Norwich	Norwich	Dr Samir Dervisevic
North West	Lancashire Teaching	Across sites	Dr Nicholas F Hallam
Wales	Velindre	National Public Health Service	Dr Brendan J Healy
Neuropathology			
London	Kings College	Institute of Psychiatry	Dr Tibor Hortobagyi

RETIREMENTS

Region	NHS Trust/NBS/HPA/HA	Base hospital	Appointee
Histopathology/cytopathology			
North West	Morecambe Bay	Royal Lancaster Infirmary	Dr Vijay M Joglekar
North West	Blackpool, Fylde and Wyre	Victoria Hospital	Dr Kadaba Vasudev
Northern & Yorks	Leeds Teaching	Leeds	Dr Susan M Claydon
Northern & Yorks	York	York	Dr Ian N Reid
Northern Ireland	Belfast Health and Social	Belfast City	Dr Linda M Caughley
West Midlands	Birmingham Women's	Birmingham Women's	Dr Terence P Rollason
West Midlands	Shrewsbury and Telford	Royal Shrewsbury Hospital	Dr Peter W Leedham
MM, CCDC, virology & epidemiology			
Northern & Yorks	The Mid Yorkshire	Across sites	Dr Mallika Mohanraj

CORRECTION

In the previous issue of the *Bulletin* (RCPath *Bulletin* 2008;141:68), the entry for Dr Dhilanthy Arul incorrectly appeared in the 'Retirements' section when it should have been in 'New appointments'. Dr Arul was appointed to the Whittington Hospital NHS Trust, London, in August 2007. We apologise for the error and for any confusion or embarrassment caused.

We welcome your letters. Please mark correspondence for the attention of the Editor of the *Bulletin*, and email to **publications@rcpath.org.** The copy deadline for the July 2008 issue is **1 May 2008.**

Hospital cleanliness

Dear Editor
As consultant medical microbiologists, infection control practitioners and Fellows of the College we were very disappointed to read the views expressed by the President in the *Bulletin* in the paragraph on hospital cleanliness in his report (January 2008; 141:4).

The NHS is in the process of a major cultural change towards a time when avoidable healthcare-associated infections will no longer be regarded as just "an inevitable nuisance" but will instead be considered totally unacceptable. There are many infection control practices for which there is not a good evidence base and these practices should not be dismissed as irrelevant just because the research has not been done. Many of them have a basis in sound common sense – something which is not common enough! We too would like to see high bed occupancy rates reduced and time to clean the bed areas addressed, but we feel strongly that the way the President seems to dismiss the other messages regarding, "arms bare below the elbows" and the dangling tie is regrettable. It is not possible to wash your hands and wrists properly if you have long sleeves, or are wearing a watch/jewellery.

All who work in the NHS aim to provide high quality, clean, safe patient care. Potentially dismissive statements such as "lack of evidence base" for common sense approaches to allow proper handwashing are unhelpful and will undermine the efforts of many College members.

Yours sincerely

Dr Maeve Keaney
Consultant Microbiologist/Infection Control Doctor

Dr Paul Chadwick
Consultant Microbiologist/Clinical Lead

Dr Chinari Subudhi
Consultant Microbiologist

Salford Royal NHS Foundation Trust

Response

Hospital-acquired infection is a major issue in the NHS and is certainly one that undermines the faith of patients in the service. The authors of the letter have, however, misinterpreted the tone of my comment. None of us should ignore common-sense measures that improve cleanliness. However, the point that I was trying to emphasise was that the Departmental directive by only concentrating on the standards of dress of doctors risked trivialising the issue and ignoring the wider aspects that we all accept as relevant in hospital-acquired infection.

You will see from my *Bulletin* comment in this issue that this message has finally got across, with a number of separate initiatives, all of which the College is involved with. I hope they will lead to sensible conclusions that look at all aspects of risk rather than appearing to point the finger at one particular group.

Professor Adrian Newland
President

Careers leaflets and exhibition banners

Is your medical school or local college holding a careers fair? Are you ever approached by science teachers, careers advisors, students or other lay people wishing to know more about pathology? We produce two attractive and easy-to-read pathology information and career leaflets.
Free copies of these leaflets are available by calling Jenny Barber 020 7451 6741 or emailing jenny.barber@rcpath.org

Pathology: the Hidden Science that Saves Lives is written for the general public and school children, explaining what pathology is and highlighting the different specialties

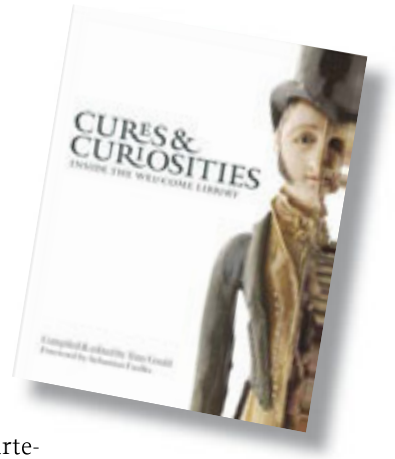
Careers in Pathology is aimed at school leavers exploring careers in pathology as doctors or biomedical, clinical or forensic scientists

We can also lend you our colourful and striking freestanding exhibition banners for display at your careers fairs and other local events.
We have five different banners, highlighting different areas of pathology. To borrow one or more, please call Jenny Barber on 020 7451 6741 or email jenny.barber@rcpath.org

REVIEWS

Cures and Curiosities: Inside the Wellcome Library

Tony Gould (edited)
Profile Books, 2007, £15, 226 pp
ISBN 978 1 8466 8033 5



Sir Henry Wellcome was a wealthy American businessman who spent his life collecting thousands of health-related artefacts from around the world. The books and manuscripts from his collection form the contents of the Wellcome Library on the Euston Road in London and the other items are on permanent loan to the Science Museum. This book was published to coincide with the opening of the refurbished Wellcome Collection in 2007. It is a snapshot of medical curiosities, chosen by over 20 contributors to illustrate the diverse and rich contents of the Collection.

The authors write about their chosen topics with knowledge and enthusiasm, with subjects including 17th century recipe books, lunatic asylums, alchemy, war injuries, alternative medicines, birth control and genealogy. The Collection covers over 3000 years of medicine, from embalming in Ancient Egypt to the sequencing of DNA. Several of the chapters are illustrated with short case studies, including one by Ruth Richardson, which describes the findings of a 17th century post mortem. The author compares the refusal of the family of the deceased to allow retention of a curious cardiac serpent (possibly blood clot) to "the recent hospital scandal over organ retention, parents whose children's bodies had been ransacked for body parts without their knowledge or consent". This rather judgemental interpretation of events illustrates the strength of the Wellcome Collection and helps put it in context – the material demonstrates the whole spectrum of views, from the official to the sensational. This forms a valuable resource for the historian and a fascinating glimpse of medical and social history for the lay person.

A few interesting snippets from the book follow:

- Dr Crippen was only caught because he used slaked lime rather than quick lime to try to dispose of the body of his murdered wife. Instead of destroying the body, it preserved it.
- During the Second World War, a malingerer's guide disguised as a box of matches was produced by the enemy. This told soldiers how to fake illness so that they could fool their doctors and be sent home.
- Apparently the leprosy of the Old Testament was not the disease we know today, but psoriasis or vitiligo.
- One man wrote to Marie Stopes in the 1920s saying that he and his wife hadn't consummated their marriage after three years because they didn't want children yet.
- Bills of mortality showed that in the early 20th century one in ten children didn't reach their first birthday. In one district, a cash payment was made to families for every child that reached the age of one – the mortality rate suddenly dropped.

This book is divided into short, manageable chapters and is well illustrated throughout. In the introduction, Tony Gould states that the aim of the book is "to give the reader a taste of what is available in the Wellcome in the belief that this will act as an incentive for further exploration." I think that it succeeds in this aim. The Collection includes three exhibitions as well as the library, all of which are open to the public. If you can go, this book serves as an interesting souvenir–if you can't make it to the Collection, this book gives a good taster of what's available in an entertaining and informative manner.

Dr Suzy Lishman
Consultant Histopathologist
Peterborough District Hospital and College Assistant Registrar

Pathology of the Urinary Bladder: Major problems in pathology

Christopher S Foster and Jeffrey S Ross (edited)
Saunders Elsevier, 2004, £72.99, 328 pp
ISBN 0 72169 212 5

The most remarkable feature of this book is its scope. There are 23 chapters covering a broad range of issues relevant to urinary bladder pathology, many of which, particularly in 'non-cancer' fields, are often either ignored or poorly presented. This book would grace the shelves of any library, if only for the clarity and detail provided in the chapter covering the complexities of the embryology and anatomy of the urinary bladder, which are key to understanding the diseases that affect this organ and the interpretation of operative specimens. Functional (or dysfunctional) aspects are equally well described and presented, and controversies around diagnoses such as interstitial cystitis are explained and clarified. An entire chapter is devoted to changes seen in the bladder following spinal cord injury, which may at first seems to be relevant to few pathologists, but in fact addresses common problems such as the effects of catheterisation for instance, or the presence of calculi.

Several chapters are written from the surgical perspective, providing a good insight into the issues relating to cystectomy in particular. We are increasingly faced with novel types of resections following advances in surgery and the chapter on urothelial pathology following reconstructive bladder surgery provides a clear exposé of techniques and their consequences.

In their preface, the editors emphasise that all the contributions are from highly informed individuals and that any repetition is a sign of enlightened agreement, whereas differences are indicative of areas of uncertainty with differences in interpretation. In the chapters dealing with molecular markers, for instance, different authors have indeed analysed the same mol-

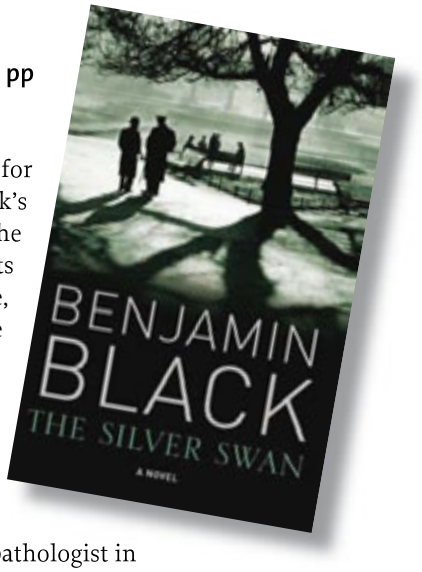
ecules in different ways, which is informative and results in an overall balanced view of their likely significance and application to routine practice. Interestingly, however, the chapters covering more 'conventional' diagnostic and prognostic factors, including bladder tumour classification, do not reflect the controversies that exist in this area, which have been outlined in the College dataset for reporting urinary bladder specimens. The emphasis on the value of the World Health Organization/International Society of Urological Pathology classification of urothelial lesions is probably to be expected since senior authors of the chapters in question were co-signatories of the original publication. There is an assumption that the classification is easy to apply, with little reference to the difficulties that exist in routine practice with significant inter-observer variation. Some discussion of these problems would have been useful.

The authors and editorial team are to be congratulated on the quality of the images that are provided throughout this book. Any pathologist would find it a useful addition to his or her library as a useful reference both for diagnostic conundrums and as a teaching aid.

Dr Patricia Harnden
Consultant Histopathologist
St James's University Hospital, Leeds

The Silver Swan

Benjamin Black
Picador, 2007, £16.99, 345 pp
ISBN 978 0 33045 403 2



The ostensible reason for reviewing Benjamin Black's second crime novel, The Silver Swan, here is that its central character, Quirke, is a pathologist. But there are better reasons for reading it. Benjamin Black is the crime-writing persona of the Irish novelist, John Banville.

Quirke – we are not told his first name – is a pathologist in Dublin who prefers the dead to the living. He is a big, taciturn man, a reformed alcoholic, a widower, lonely and alone. He describes himself as curious...an inadequate explanation for what he gets up to. He is asked by a university acquaintance, whom he can barely recall, not to perform a post-mortem on the acquaintance's recently deceased wife, Deirdre Hunt, a presumed suicide by drowning because Billy Hunt cannot bear the thought of her being cut up. Quirke agrees. But when the body arrives in his laboratory, he notices a puncture mark on the inside of her forearm. His autopsy confirms that the cause of Deirdre's death was not drowning. Characters remind us that Quirke has every reason not to get involved: a reference to Black's first novel. Yet, apparently motivated by nothing other than the sentimental appeal of a barely remembered schoolmate, Quirke decides to lie to the coroner about the cause of death.

Quirke is not the skilful investigator teasing out clues for the reader. When he attempts to explain the mystery, he gets it entirely wrong. He is merely one of the characters in a beautifully orchestrated drama of apparently unconnected lives. As the intersection of these lives is revealed through flashbacks, so too is the cause of Deirdre's death. The drama unfolds unhurriedly at first, because the author wants us to observe. Black does not miss an opportunity to describe, and the descriptions are wonderful:

"The sky was clear, a flat blue plane clamped squarely along its lower edge to the horizon; there was a strong breeze and the salt-laden light over the bay had a bruised cast to it."

"[The leverets] were very young, for their eyes were hardly open, and they seemed not so much to breathe as to throb, faintly and fast, as if they were already exhausted at the very prospect of all the desperate running they would have to do in their lives."

The pace quickens in the second half, when the narrator describes Deirdre's shocking but compelling voyage of self-discovery. Deirdre and her irresistible conniving business partner cause the lives of six characters to intersect. They are all unattractive people caught up in a bleak, seedy tragedy.

As well as the mystery of Deirdre's death, there is the unfolding of a deeper tragedy. Like characters in Greek drama, these characters see themselves as subjected to events. Countless times we are told that the characters don't understand why they act as they do. Events seem fated and inevitable. The purposelessness of the participants suggests an invisible hand moving actors in a drama. Nobody, and especially not Quirke, seems able to escape fate. The bleak story contrasts with the dazzling poetic language. It is, appropriately, a compelling read.

Michael Menlowe
Lay member, Lay Advisory Committee

Evidence-Based Laboratory Medicine: Principles, practice, and outcomes (2nd edition)

Christopher P Price and Robert H Christenson (editors)
AACC Press, 2007, $73 (AACC members) and $91 (non members), 545 pp
ISBN 978 1 59425 071 2

This second edition, written by the same editors, comes out four years after the first. It is a greatly extended and rewritten work, which incorporates the main topics of the first edition but introduces a more detailed breakdown of the original subject areas, together with a complete rewriting of the sections that remain.

Whereas the previous edition might be seen as a 'quick user guide', albeit detailed, this edition covers a wealth of new areas and is both an invaluable practical reference source and a book that is thought-provoking and enjoyable to pick up for the occasional hour of reflective learning.

Due to the diverse way in which tests are used, the evidence-based laboratory medicine cycle is a complex one, with many discrete stages. The book highlights the fact that evidence-based laboratory medicine involves far more than knowing the results of the latest randomised controlled trial. The use of evidence is considered in this book from formulating the clinical question to be answered, through – amongst others – analytical factors,

designing clinical laboratory studies and assessing outcomes, searching and appraising literature, formulating and appraising evidence and guidelines, evidence-based reporting and implementing and teaching evidence-based laboratory medicine.

The new short chapter on (US) evidence-based medicine and regulation could perhaps benefit from a sister section on its European counterpart, but that is a very small omission in a book that successfully synthesises the huge amount of new and older thinking which has come together to drive the way we now go about selecting, assessing and implementing tests and test strategies.

The two books make more of a pair than sequential editions. Starting out afresh on the subject, the reader could be recommended to read the first edition for an overview of the different subject areas and then delve more deeply into the second to look at the topics in more depth.

For those who think they already have a good understanding of the concepts underpinning evidence-based laboratory medicine, this second edition will challenge the reader to go further and highlight some significant knowledge gaps. It is essential reading both for those who develop and deliver routine services and those who are looking to advance their knowledge in the more detailed aspects of evidence-based laboratory medicine. It is an excellent book, and this reviewer has already put aside some time in the coming year to read the individual chapters in more depth.

Dr Stuart Smellie
Consultant Clinical Biochemist
Bishop Auckland Hospital, Bishop Auckland, Co Durham

Mim's Medical Microbiology (4th edition)

Richard V Goering, Hazel M Dockrell, Derek Wakelin, Mark Zuckerman, Peter L Chiodini, Ivan M Roitt, Cedric Mims
Elsevier, 2007, £39.99, 668 pp
ISBN: 978 0 323 04475 2

I had not come across this textbook in any of its previous editions so it was interesting to encounter it for the first time for this review. I found myself wishing that I had been able to access such a textbook during my own training back in the eighties.

Its almost 700 pages are divided into major sections. The first is called "The Adversaries - Microbes". This covers the structure and function of bacteria, viruses, fungi, protozoa and even arthropods. Classic stuff but it also shows it is up to date by including a section on bacterial genomics, discussing PCR and DNA microarrays for example. Next comes "The Adversaries – Host diseases". Enter medical immunology and host defences. Now we reach "The Conflicts" – really a combination of the previous 2 sections looking at the reality of infectious diseases – how they get in, how they spread, how the body reacts, how the parasite survives.

The core of the book is in section 4: "Clinical manifestation and diagnosis of infections by body system". Aha! A systems-based approach. The book works its way around the body looking at infections affecting each part in turn. Finally in part 5 "Diagnosis and control" we get to what to a medical microbiologist is their daily bread and butter: antimicrobials and infection control. At the very end there is the pathogen parade – an alphabetical list of pathogens with short notes on each one. Each has page references to where the germ in question is found throughout the book.

Overall this book is an impressive achievement. It is clearly written, makes great use of full colour diagrams, illustration and pictures. It is up to date and is written by leaders in the field. The contribution of Peter Chiodini to this textbook results in an excellent coverage of modern parasitology which is not at all common at this level. What level? Well, it would be an excellent textbook to accompany an undergraduate medical course in medical microbiology. Do these still exist? Alas, they don't in my part of the UK. It would be suitable for any other course in medical microbiology at an undergraduate level, and would, I suspect, be a good base on which to build for specialist postgraduate training such as the College exams. But knowledge of medical microbiology at a much deeper level than this volume contains would be needed to pass them.

Professor John Croall
Consultant Microbiologist and Clinical Director of Pathology
Countess of Chester Foundation NHS Trust

Hematology/Oncology Clinics of North America – current and emerging system treatment strategies for breast cancer

Andrew D Seidman (editor)
Saunders Elsevier, 2007, £41.99, 240 pp
ISBN 978 1 416 04323 2

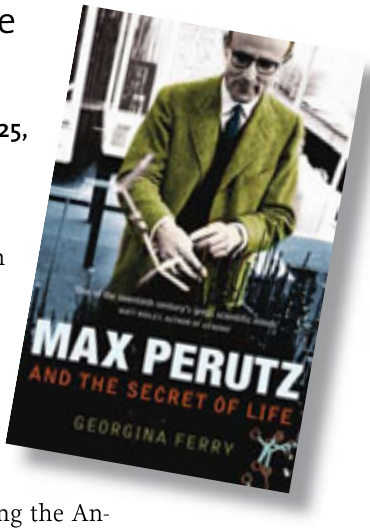
This book provides an authoritative update on modem approaches to systemic treatment strategies in patients with breast carcinoma. The presentation is in the form of a series of monographs dealing with issues such as adjuvant chemotherapy for early stage breast cancer, adjuvant endocrine treatment, Trastuzamab (Herceptin for early stage breast cancer), chemotherapy for metastatic breast cancer etc.

This book is primarily focused towards a medical/clinical oncology readership and as such is in the main too detailed, in my opinion, for pathologists to find a huge amount of interest in every chapter. However, those pathologists dealing with biomarker evaluation and prediction of response to treatment will find this a useful guide to available therapies and including those emerging new targeted treatments and their background molecular pathology.

Professor Ian O Ellis
Professor of Cancer Pathology
City Hospital, Nottingham

Max Perutz and the Secret of Life

Georgina Ferry
Chatto and Windus, 2007, £25, 352 pp
ISBN 978 0 701 1 7895 2



Max Perutz left Vienna in 1936 for Cambridge drawn by the opportunities for young scientists to pursue their own ideas in a more relaxed and friendly way than in the hierarchical system in Austria. His parents soon followed, fleeing the Anschluss and a comfortable middle class existence, so that Max found himself having to support himself and his family. This is the story of all the obstacles he overcame both in his family life and in science. With the outbreak of the second world war, Max was interred first in Britain, then transferred to Canada where he was classified as a prisoner of war. It was during the war that he was spotted by Lord Mountbatten and found himself designing floating airfields made of ice in what was known as the Habbakuk Project. In an earlier project he studied the movement of glaciers, an ideal project as it combined his two great interests outside science: skiing and mountaineering. It is quite clear from the descriptions that had Max not succeeded in science he would have been a first rate mountain guide.

However, the application of X-ray crystallography to the study of haemoglobin was going to occupy him for the next 16 years of his life. It is a fascinating story and before the structure is revealed, the work to the elucidation of myoglobin and DNA are told in contrast to the maverick way Watson and Crick arrived at the structure of DNA without doing any X-ray crystallography themselves with the painstaking and more difficult problem of solving the 3-D structure of haemoglobin. Although it was Crick who suggested introducing a metal atom and then submitting the complex to X-ray crystallography, it was Max's determination and skill which produced his eureka moment and revealed how he could make sense of all the spots and opened up the whole field of protein crystallography. The advent of computing was to be decisive in converting the 40,000 reflections produced into a 3-dimensional structure. At the end of much painstaking work, Max was strangely reluctant to start the computer programme and to use the generated data to make a 3-dimensional model, so it was his research fellow on making the first model, realised that haemoglobin resembled four molecules of myoglobin. It fell to Max to make the first plastic model of haemoglobin and his reward was the Nobel prize.

Another problem Max now faced was the establishment of the Laboratory of Molecular Biology-he was crucial in setting this up and fostering an ethos which allowed four Nobel prize winners and six Fellows of the Royal Society to work without the need for any management meetings. He recognised good ideas in people and allowed them to be creative and so produced good science. How influential he was resulted in him being elected as the first chairman of the European Molecular Biology Organisation.

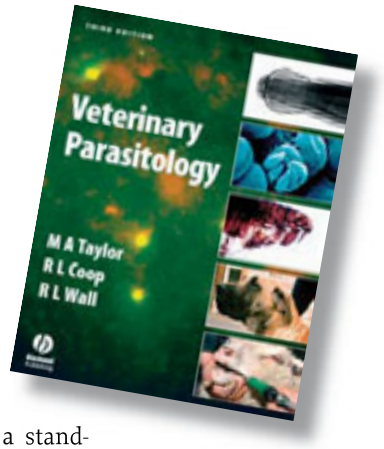
Georgina Ferry has produced a first rate account of his life, as an ex-New Scientist writer the science is explained in a way even Max would understand and applaud, straightforward and without jargon. There is no difficult physics and the story will appeal to anyone who wants to know how science works and how exciting scientific research can be.

Max Perutz was an outstanding scientist and this biography reveals his skills in so many areas and Ferry quotes Crick's opinion of him, "Max wasn't a particularly quick thinker. He was a plodder, but a very persistent plodder, and he had considerable insight as a result of his plodding. It didn't come out in flashes".

Dr Rhys John
Consultant Clinical Biochemist and Honorary Senior Lecturer
University Hospital of Wales

Veterinary Parasitology (3rd edition)

MA Taylor, RL Coop and RL Wall
Blackwell Publishing Ltd, Oxford, 2007, £65, 874 pp
ISBN 978 1 40511 964 1



The first edition of this book, published in 1987 and authored by Urquhart, Armour, Duncan, Dunn and Jennings, soon became a standard text for the teaching of veterinary parasitology in many veterinary schools because at that time most parasitology texts were very heavily biased towards human medicine. Also, the format of the book – as well as its contents – fitted in well with the needs of students in its portability and standardised, almost encyclopaedic, style that student could use in a variety of teaching and learning situations. The second edition in 1996 included a small number of revisions, additional colour plates and a paperback binding. However the current edition, edited by Taylor, Coop and Wall, has undergone a major revision to include a much larger number of parasite species, with a consequential increase in page numbers to 874 over the 286 in the first edition and an additional kilogram in weight.

In this third edition, the information on individual parasites is presented in a similar style to earlier editions dealing with predilection site, morphology, hosts, lifecycle, clinical signs, diagnosis, pathology, epidemiology, treatment and control. As well as increasing the total number of parasites included, the text also takes into account revisions of taxonomy and nomenclature that have taken place since the publication of the first two editions. As in the previous editions, the current edition also includes chapters on epidemiology, antiparasitics and laboratory diagnosis.

The major change that has taken place is that individual parasites are now grouped by systems, i.e. according to host and predilection site rather than taxonomically. The authors justify this change as they consider that the 'systems' approach aligns better with current teaching practice in veterinary schools. While this approach works well with some parasites, there is danger that information on 'multi-system' parasites will be lost or fragmented, leading to misunderstandings and misconceptions with or-

ganisms such as tapeworms. The authors clearly appreciate this potential source of confusion and claim to have addressed this by providing "a comprehensive checklist for each section and extensive cross-referencing" However, the cross-referencing system works at a very basic level, consisting only of cross-references to individual chapters rather than specific pages.

Many of the excellent line drawings included in the original editions have been included in the new edition. However, many of the greyscale illustrations are poorly reproduced, as are many of the in-text colour figures: a high proportion are either too light or too dark to reveal usable information.

Although I have some reservations about accessibility of information in the current edition, this book clearly stands out as a very comprehensive and authoritative reference source on veterinary parasites. However, the weight of the current edition, at nearly 2 kg, potentially restricts its usefulness as a portable student text and much of the content is likely to be redundant for most undergraduate courses. I also fear that the flimsy paperback binding of the current edition, combined with the strain put on that binding by the weight of the book when balanced on knees, cluttered desks, etc. will mean that the new edition may not even survive until the end of the course. The review copy was showing signs of wear after only several weeks' use, with the protective plastic laminate already cracking on the spine.

Dr Tudor Jones
Senior Lecturer in Veterinary Parasitology
University of Edinburgh, Royal (Dick) School of Veterinary Studies

The Foundation Programme for Doctors: Getting in, Getting on and Getting out

Radcliffe Publishing, 2007, £16.95, 110 pp
ISBN 1 84619 116 5

As the title suggests, this book aims to summarise and provide useful advice on the recent changes in medical career structure and training. It is written by current medical students and foundation doctors who have had first-hand experience of the insecurities and uncertainties of Modernising Medical Careers.

The first chapter offers an overview of the fundamentals of Modernising Medical Careers (MMC) and Medical Training Application Service (MTAS), bridging the gap between medical school and specialist/general practice training. Subsequent chapters take the reader through the process of initial job application for final year medical students, the difficulties and challenges of working as an FY1 doctor through to preparing and applying for specialist training. The new style of training is explained regarding training schemes offered, assessment and the changes in post graduate education.

The book is informal, upbeat and easy to read. It combines tables of tips and advice with simple factual guidance. In addition, there are frequently asked questions and worked examples. Included are relevant addresses, further resources and website references to help you find the information you need. The book also touches on issues such as flexible training, having time out and training abroad.

As with many books of its kind, some sections are already out of date. Unfortunately, a few questions remain unanswered as the new system is still very much in its experimental stage.

The College recommends that at least 10% of all FY2 programmes include an element of pathology. This is to encourage junior doctors to understand the role and importance of laboratory medicine in clinical decision making as well as considering a career in pathology. It also encourages efficient and economic use of the laboratory services. It is hoped that trainees leave their pathology placements with increased knowledge and experience to take back to their clinical careers even if they do not pursue a career in pathology.

Having lived through the changing medical career structure myself, I found the book to be very comprehensive. I was a guinea pig in one of the first FY2 pilot programmes in the country. My colleagues and I would have found this book particularly useful during that time.

The book is ideal for final-year medical students, foundation doctors, doctors from overseas and for those teaching, working closely with and mentoring junior doctors. For Bulletin readers the book offers valuable knowledge on the current climate of the Foundation Programme and familiarity with new terminology.

Despite the general bad feelings towards MMC and MTAS and the recent controversy and anxiety caused, the book remains positive yet realistic. Junior doctors are under continuing pressure to get into their chosen specialties. I feel that this book offers some very genuine, practical advice and guidance for all junior doctors during this period of transition.

Dr Golda Shelley-Fraser
ST2 in Histopathology
North Bristol NHS Trust

Expert witness book winners

Congratulations to Dr Mark Farrington, who won a copy of *Expert Witness Fees*, and Dr Louise Teare, who won a copy of *Expert Witness Practice in the Civil Arena*, courtesy of J S Publications (www.jspubs.com) following our book prize in the January *Bulletin*.

Matthew Baillie erratum

Bulletin RCPath January 2008;141:42
The caption should have read 'Matthew Baillie FRS (1761 - 1823) in Thomas Pettigrew's Medical Portrait Gallery 1838. London, Whittaker and co.'
We apologise for this error and any inconvenience caused.

DISCOUNTS ON BOOKS AND JOURNALS

As an added benefit of College membership, we have negotiated the following discounts for members, fellows and registered trainees. For more details, log on to our website,www.rcpath.org/publications and click on Discounts on pathology titles in the left-hand menu.

Blackwell Publishing

Blackwell Publishing offers an exclusive 15% online discount to members. To get your discount visit www.blackwellhematology.com

Choose the book you want, then click on the 'Buy' button and following the steps through to 'Enter payment details'.

Enter the code **RCPFM06** in the discount box and click on 'Check order' to ensure your 15% discount has been applied.

Elsevier Science books

Elsevier Science is offering a 15% discount on all pathology titles. To take advantage of this offer, visit the Pathology homepage on Elseviers website http://intl.elsevierhealth.com/pathologytext/default.cfm?partnerid=45373

Just choose your book and click on the 'Order now' button and your 15% discount should automatically show up on the screen.

You can also contact Elsevier to order by post, phone, email or fax: Elsevier Books Customer Services, Royal College of Pathologists Bookclub, Linacre House, Jordan Hill, OX2 8DP. Email csbspecialsales@elsevier.com, tel 01865 474 150, fax 01865 474 151.

Please include Account Number **M18C36**, your contact details and a delivery address where you want your books posted to.

Hodder Education

Members can save 15% on the complete range of Hodder Arnold titles, visit
www.hoddereducation.com
to browse the website, choose the titles you wish to purchase, then simply enter the code **Wo000163** at the checkout to secure your discount.

Taylor & Francis

Books

Taylor & Francis is proud of its first class-medical, biomedical and pharmaceutical science publishing programme. To receive 15% off their publications, members should write to the following address, citing the code **RCPATH1**: Direct Sales, Taylor & Francis, Thomson Publishing Services, Cheriton House, Northway, Andover, Hants SP10 5BE, or email: cis@thomsonpublishingservices.co.uk

Journal

Taylor & Francis also offer substantially reduced rates on individual subscriptions for their journal:

- **Pathology** (Journal of The Royal College of Pathologists of Australasia. Editor: Professor CS Lee) Volume 10/11 for £150/$281 (full price £267/$438).

To order, please contact Taylor & Francis quoting the College discount price above: Taylor & Francis Group, Customer Services Department, T&F Informa UK Ltd, Sheepen Place, Colchester, Essex, CO3 3LP.

Website www.tandf.co.uk/journals
Email journals.orders@tandf.co.uk

Maney Publishing

Maney Publishing offer substantially reduced rates for their journal *Hematology*, which Maney is publishing from 2008.

Hematology (Editor: Professor Adrian Newland) Volume 13 (2008), published in 6 issues per annum, for £65 / $125 (full price: £157/$298)

To order, members should contact Maney Publishing and quote 'RCPath discounted rate.'

Address: Maney Publishing, Suite 1C, Joseph's Well, Hanover Walk, Leeds LS3 1AB, UK
Tel: +44 (0)113 243 2800
Email: subscriptions@maney.co.uk
Web: www.maney.co.uk/journals/hem

This offer is strictly for private subscriptions, sent to individual College members at their private addresses.

COLLEGE SYMPOSIA

May 2008

16

Training the Assessor: Workplace-based assessment

16 May 2008, Manchester

5 CPD credits
Manchester Conference Centre, Weston Building, Sackville Street, Manchester, M1 3BB

This is the final training session for term time 2007-08. This repeated training event is aimed at consultants, staff grade and associated specialists, senior biomedical scientists, clinical scientists, trainees and other healthcare professionals who may undertake an assessor's role

June 2008

4

Haematology follow-up/chronic disease management meeting A joint meeting between The Royal College of Pathologists and the Cancer Services Collaborative 'Improvement Partnership'

4 June 2008, London

5 CPD credits
Mander Hall, Hamilton House, Mabledon Place, Bloomsbury London, WC1H 9BB

This is a one-day symposium aimed at addressing the current and future context of UK clinical haematology with regard to its sustainability in providing appropriate services for the management and follow up of increasing numbers of patients with chronic haematological conditions, both malignant and non-malignant. The aspirations of the Cancer Reform Strategy and projections for haematology consultant staffing levels for the next 10-15 years are key factors that necessitate different ways of thinking about service provision, instead of the traditional hospital based outpatient clinic model. Data will be presented on alternative approaches already working effectively. The meeting is aimed at clinicians (medical and nursing) in haematology but would also be of value to haematology service managers and improvement leads.

20

Vulval diseases: Integrated gynaecological; dermatological and pathological aspects

20 June 2008, Nottingham

5 CPD credits
The East Midlands Conference Centre, University Park, Nottingham, NG7 2RJ

This exciting one-day meeting deals with very topical subjects and most recent updates from research, diagnostic and treatment aspects. It is aimed at consultants and trainees who share interest in clinico-pathological aspects of vulval diseases but of varied background including gynaecologists, general practitioners, dermatologist, genito-urinary physicians and pathologists.

November 2008

26 and 27

Transfusion medicine today

26 and 27 November 2008, London

11 CPD credits
The Royal College of Pathologists, 2 Carlton House Terrace, London, SW1Y 5AF

Transfusion medicine is an essential component of modern health services, and blood safety is still high on the political agenda. This symposium will address many of the current major issues affecting blood services in the UK, which also have resonance throughout the transfusion world.

To see programmes in full, and get online booking discounts, please see

www.rcpath.org/conferences

Alternatively, fill in the application form on the following page or contact Michelle Merrett, Events Manager, on tel 020 7451 6740 or email michelle.merrett@rcpath.org

Further meetings are being arranged, so please visit our website regularly for details.

Conference application form and proforma invoice

Surname:..... Initials:..... Title:.....

Address:.....

.....

Postcode:..... Specialty:.....

Telephone:.....Fax:.....Email:.....

Place of employment (if different from above):.....

.....

Diet/special requirements:.....

Where did you find out about this event?:.....

REGISTRATION FEES: please tick appropriate registration fee (*early booking is one month prior to event date)

2008 one-day conference fees

Early*/online bookings:	Fellows £160	☐	Concessions £75	☐	Non-members £210	☐
Regular bookings:	Fellows £180	☐	Concessions £120	☐	Non-members £230	☐

Conference title:.....

Training the assessor - 16 May 2008

Fellows/Registered trainees £80 ☐ Non-members £125 ☐

Two-day fees for 'Transfusion medicine today' - 26 and 27 November 2008

Early*/online bookings:	Fellows £300	☐	Concessions £150	☐	Non-members £400	☐
Regular bookings:	Fellows £350	☐	Concessions £230	☐	Non-members £450	☐

Total payment enclosed £.....

Cheques should be made payable to The Royal College of Pathologists – please note that cheques should be in £ sterling drawn on a UK bank. Cancellations are subject to a £20 administration charge. No refunds will be made for cancellations notified within seven days of the event, but substitute delegates will be accepted at any time.
NOTE: If you are forwarding a copy of this application form to your Finance Department for payment, please ensure a copy is faxed to the Conference Department on 020 7451 6701 to reserve your place and that they quote the title of the conference and your full name on all cheques or payment advice slips.

Please copy and return this form to:
Events Manager, The Royal College of Pathologists, 2 Carlton House Terrace, London, SW1Y 5AF

Conference enquiries: tel 020 7451 6740, fax 020 7451 6701,
email meetings@rcpath.org, web www.rcpath.org/conferences

NOTICEBOARD

If you would like to advertise a course or service advertised in this section (free of charge), email the details to publications@rcpath.org by 1 May for publication in the July 2008 issue.

Urologic Surgical Pathology for the Practicing Pathologist
7-10 April 2008, Tucson, Arizona

The Department of Pathology, Massachusetts General Hospital, Harvard Medical School will present a four-day postgraduate course in Urologic Surgical Pathology under the direction of Robert H. Young, MD with faculty. The objective of this course is to provide a comprehensive review of urologic surgical pathology with special attention paid to common diagnostic problems such as prostate biopsy interpretation, recent advances and new entities. Instruction will be primarily by lecture, but will also include frequent discussion periods. Each participant will receive a comprehensive course syllabus. See www.cme.hms.harvard.edu

Glycomics: Recent Advances and Exploitation Opportunities
15 April 2008, BioPark Hertfordshire

Glycomics encompasses the rapidly developing field of large-scale analysis of the 'glycome' – the entire complement of complex sugar structures expressed in cells, tissues or whole organisms. Glycans have incredible structural and functional diversity and are critical players in a huge variety of biological processes, many of which have fundamental roles in disease processes. Prof Jerry Turnbull, University of Liverpool (Meeting Chair). The deadline for early registration is 20 January 2008. Abstract guidelines can be found at www.euroscicon.com/absguidlines.html. Details: www.regonline.co.uk/glycomicso8. General enquiries: enquiries@euroscicon.com or visit www.euroscicon.com. CPD accreditation is being sought from the IBMS.

St Mary's course in histopathology of the bone marrow
16 April 2008, Hammersmith Hospital, London

This course, which includes both lectures and work at individual microscopes, is suitable for consultants and other career grade post holders in haematology and histopathology and is also valuable for trainees in these disciplines. 60 places only. 7 CME credits. The cost is £110 including a light lunch (or £100 if CD not needed). www1.imperial.ac.uk/medicine/about/divisions/is/haemo/courses_haemo/

Improving Immunohistochemistry
25 April 2008, University of Westminster, London

This meeting is dedicated to the technique of immunohistochemistry and in situ hybridisation. Presentations by leaders in the field are focused on the technical aspects of IHC as well as the importance of IHC in the areas of drug discovery and diagnosis. Technical and scientific presentations are interspersed with the latest developments from the leading manufacturers of IHC products. Dr Will Howat, Cambridge Research Institute, Cancer Research UK (Meeting Chair). This is a CPD-accredited meeting organised by EuroSciCon (www.euroscicon.com). Abstracts are welcomed – see website. To book, please visit http://www.regonline.co.uk/ihc2008

Histopathology for SpRs – The Early Years - Part one
28 April–2 May 2008, Leicester Royal Infirmary

This 5 day intensive course is aimed at SpRs to bridge the gap between early training and final preparation for the MRCPath. The course contains nine intensive sessions covering areas such as liver biopsies, renal biopsies, lymphoma, inflammatory skins etc. The entire course is based around glass slide microscopy and multi-headed microscope tutorial sessions. All of the sessions are different to those delivered in the second half of the course which will run in November 2008. Places are limited to nine candidates. Course fee is £420.
Please contact Dr Mark Bamford Mark.Bamford@uhl-tr.nhs.uk 0116 2541414 ext. 2184 or the Course Administrator Judith.Corry@uhl-tr.nhs.uk

Gynaecologic and Obstetric Pathology for the Practicing Pathologist
28 April-1 May 2008, Naples, Florida

The Department of Pathology, Massachusetts General Hospital, Harvard Medical School, will present a four-day postgraduate course in gynaecologic and obstetric surgical pathology under the direction of Robert H. Young, MD and David C. Wilbur, MD, with faculty. The objective of this course is to provide a comprehensive review of gynaecologic and obstetric pathology, focusing on common practical problems in differential diagnosis in these areas, which account for so many specimens in daily practice. Instruction will be primarily by lecture but will also include frequent discussion periods. Each participant will receive a comprehensive course syllabus. For further information go to www.cme.hms.harvard.edu

CEMACH Conference: Why Children Die
30 April 2008, British Library, London

The purpose of the day is to present the findings of a confidential enquiry into child deaths in three regions of England, and in Wales and Northern Ireland during 2006. An overview of all the deaths will be provided, along with an analysis of avoidable factors identified in detailed panel reviews of a sample of the deaths. The study is the first of its kind and will produce recommendations for children, their carers and the institutions that exist to help them be healthy and stay safe. This event launches the first publication of a report entitled 'Why Children Die' and will initiate the dissemination of key recommendations for health professionals involved in this area of care as well as Local Safeguarding Children Boards. Suitable for all health and other professionals involved in the care of children. Details: www.cemach.org.uk; tel: 020 7467 3219; email: conferences@cemach.org.uk

Developments in cell culture technology to enhance cell growth in vitro
2 May 2008, BioPark Hertfordshire

The purpose of this meeting is to review some of the new enabling technologies available to help overcome some of the limitations of cell culture. This includes the development of new products and protocols to improve the technique of growing cells in the tissue culture laboratory. There will be a panel discussion; bring along your

questions on the day. Dr Stefan Przyborski, Reader in Stem Cell Biology, Durham University and Director and Chief Scientific Officer of ReInnervate Limited (Meeting Chair). This is a CPD-accredited meeting organised by EuroSciCon (www.euroscicon.com) and provides a fantastic networking opportunity for scientists. To book, please visit www.regonline.com/cellcultureo8

Coaching for Scientific Managers - A one day workshop
16 May 2008, London

This workshop is aimed at all scientists in a management position. Particularly suited to those moving into lectureship, project management, group leader and lab manager roles. It is also ideally suited for those looking for promotion to a management role. This workshop will be run by Liz Dickson of Yabber Yakka. The deadline for early registration is 20 March 2008. Details: www.regonline.co.uk/coachingo8. General enquiries: enquiries@euroscicon.com or visit www.euroscicon.com. CPD accreditation is being sought from the IBMS.

Infection prevention in hospitals
16 May 2008, BioPark Hertfordshire

In this forum infection prevention, control and research into this within hospitals will be discussed. Dr Raj Pnaiser BSc (Hons) FIBMS PhD (Meeting Chair). This is a CPD-accredited meeting organised by EuroSciCon (www.euroscicon.com) and provides a fantastic networking opportunity for scientists. To book, please visit www.regonline.com/infectiono8

Value of Life – Value of Death
21 May 2008, Sheffield Hallam University

The legal, philosophical, ethical and medical aspects of life and death. Topics for discussion: value of life and death, definitions of life and death, the right to demand treatment or death, practical realities of demanding treatment and who decides? Further information available from www.ethics-network.org.uk or by registering interest at ethics2008@sth.nhs.uk

Prostate needle biopsy course
30 May 2008, Cardiff

Organised by the British Association of Urological Pathologists (limited to 24 participants). See the BAUP website www.uropathology.org and contact Farida.Esufali@cardiffandvale.wales.nhs.uk to reserve a place.

Association of Clinical Pathologists' international scientific meeting
12–13 June 2008, Prague, Czech Republic

Sessions on: Histopathology errors and why we make them; Histopathologists and concealed homicide: will I end up in court?; Lectures on virology, mycology and paediatric microbiology; Haematology including a morphology session, updates on IVIg guidelines, primary thrombocythaemia and myelofibrosis, management of acquired bleeding disorders, classification of hodgkin lymphoma, use of molecular markers in AML management, mantle cell lymphoma, immune evasion in viral infections; Chemical pathology including lectures on obesity, HIV and dyslipidaemia, small dense LDL-C,PCOS and the metabolic syndrome, laboratory IT, cardiac markers, sex - why do we need it?; plenary lectures by Professor BI Duerden, Dr M Buyse and Mr D Ricketts, Presidential address and poster presentations. See the ACP website www.pathologists.org.uk or contact the ACP Central Office on 01273 775 700 or jacqui@pathologists.org.uk

The Intercollegiate Course on Human Nutrition

This unique course has been specifically developed by representatives of the various Medical Royal Colleges and the British Dietetic Association and is aimed at trainees, consultants, general practitioners and other professional groups from across the spectrum of clinical specialties. Two courses will be held in the second half of 2008. See www.icgnutrition.co.uk for more information.

16–20 June, Glenesk Hotel, Edzell, Angus, Scotland

Course organiser: Dr William G Simpson, Clinical Biochemistry, Aberdeen Royal Infirmary, Aberdeen, AB25 2ZD. Tel: 01224 554620. Fax: 01224 694 378. Email: w.g.simpson@abdn.ac.uk

15–19 September, Durham

Course organiser: Professor Carolyn Summerbell, School of Health & Social Care, University of Teeside, Middlesbrough, TS1 3BA. Tel: 01642 384 124. Email: J.Straker@tees.ac.uk

Future Advances in Regenerative Medicine
13 June 2008, BioPark Hertfordshire

This meeting will provide a current overview of regenerative medicine in the UK. Dr Stephen Minger, Kings College, UK (Meeting Chair). The deadline for abstract submissions is 10 February 2008. The deadline for early registration is 20 March 2008. Abstract guidelines can be found at www.euroscicon.com/absguidlines.html. Details: www.regonline.co.uk/adultstemo8. General enquiries: enquiries@euroscicon.com or visit www.euroscicon.com. CPD accreditation is being sought from the IBMS.

Gene therapy - Systems and Applications
24 June 2008, BioPark Hertfordshire

The deadline for early registration is 20 January 2008. Abstract guidelines can be found at www.euroscicon.com/absguidlines.html. Details: www.regonline.co.uk/genetherapyo8. General enquiries: enquiries@euroscicon.com or visit www.euroscicon.com. CPD accreditation is being sought from the IBMS.

ELISPOT technology: Newer tricks
8 July 2008, BioPark, Hertfordshire

The meeting is designed to discuss the advances made in ELISPOT technology including the range of cytokines that can be measured, as well as discussions on assay development and applications to both basic and clinical research. "ELISPOT technology" will cover all aspects of the assay development from initial cell stimulation to analyzing spot formation. Dr Sefina Arif (Meeting Chair). This is a CPD-accredited meeting organised by EuroSciCon (www.euroscicon.com). The deadline for early registration is 20 April 2008. For more information see www.regonline.co.uk/elispoto8

Hands-on Cardiac Morphology
9–11 July 2008, Royal Brompton Hospital and Imperial College London

This course takes registrants from the basics of normal anatomy and simple congenital heart malformations through to the more complex defects and the cardiac conduction system. Live video demonstrations are followed by practical 'hands-on' sessions under the guidance of tutors. Each participant will receive a course handbook with colour diagrams. Places are limited. CPD and EBAC sought. Course organiser: Dr Yen Ho. Details and registration forms: www.rbht.nhs.uk/cardiacMorphology

23rd International Lectin Meeting
11-16 July 2008, Scotland

Interlecs are international, interdisciplinary symposia usually held every two years. Their aim is to bring together researchers specialising in different areas but with a common interest in protein-carbohydrate interactions. Submission of abstracts for oral and poster presentation is welcomed on all aspects of lectin science and glycobiology. Interlec-23 will focus on the role of carbohydrate-binding proteins in human health and disease. The first two days of the meeting will be held in Edinburgh and the remainder at Stirling University. Details: www.interlec23.com

Techniques and applications of molecular biology
14–17 July 2008, University of Warwick, Coventry

A course for those in the medical profession wishing to improve their understanding of the principles and applications of genetic engineering techniques. Optional accreditation leads to a masters level Postgraduate Award. Contact: Dr Charlotte Moonan, Department of Biological Sciences, University of Warwick, Coventry CV4 7AL. Tel 024 7652 3540. Fax: 024 7652 3701. Email: Charlotte.Moonan@warwick.ac.uk Web: www.warwick.ac.uk/go/biosciencesshortcourses

Bionanotechnology and the Foundations of Nanomedicine
15 July 2008, BioPark, Hertfordshire

Bionanotechnology is concerned with the interactions and integration of nanomaterials and devices with biological systems (at the molecular, cellular, organism and population levels) and their exploitation in products and processes. One area of exploitation is in advanced healthcare provision and in this regard it forms the foundations of nanomedicine. In this meeting the applications of nanoscale science to drug discovery, novel therapeutics, diagnostics, regenerative medicine and drug delivery will be presented. Professor Tony Cass, Institute of Biomedical Engineering, Imperial College London. This is a CPD-accredited meeting organised by EuroSciCon (www.euroscicon.com). For details, visit www.regonline.co.uk/nanomedicineo8

Practical Pulmonary Pathology
29 July - 1 August 2008, London

This course is designed to provide histopathology and cytopathology trainees and consultants with an opportunity to study diagnostic lung pathology in a comprehensive manner. It comprises lectures and practical microscopy sessions, the latter making up roughly half the time and consisting of individual study of a unique collection of cases. Further details and application forms are available from Professor B Corrin, Brompton Hospital, London SW3 6NP. Fax +44 20 7 351 8293. E-mail: b.corrin@imperial.ac.uk

22nd ACP Management Course
3–5 September 2008, Hardwick Hall Hotel, Sedgefield, County Durham

This is a wide-ranging, residential course run by pathologists for pathologists, introducing management issues relevant to the running of a modern pathology service. It is intended for specialist registrars and trainees in pathology in their final year of training, clinical scientists and those who have held their first consultant post for less than 2 years. Course organisers: Drs Angela and Mike Galloway. The course will address the following subject areas: the NHS Reforms, funding of the NHS, regulatory requirements, role of PCTs, financial Management, Business Planning, Demand Management, Managing Staff, Appraisal and job planning, Self Management, Future organisation of pathology services. Course fee: £575 (includes pre-course folder, course information handbook, a copy of the 2nd edition of the ACP Guide: Surviving the First 2 years as a Consultant, en suite accommodation, all meals, refreshments and course dinner). Early application is encouraged. Details: Miss Jacqui Rush, Association of Clinical Pathologists, Tel: 01273 775 700. Fax: 01273 77 303. Email: jacqui@pathologists.org.uk. Web: www.pathologists.org.uk

British Society for Clinical Cytology (BSCC) 47th Annual Scientific Meeting
7-10 September 2008, Griffith College, Dublin

The BSCC is delighted to announce its 47th Annual Scientific Meeting to be held at Griffith College in Dublin. The event provides an invaluable opportunity for an update on the latest developments in clinical cytology at the same time as a chance to network with colleagues in a city renowned for its warmth and hospitality. The programme includes symposia on automation, emerging roles of HPV testing and biomarkers in cervical neoplasia. It also discusses a multidisciplinary approach to assessment of thyroid nodules and the use of molecular diagnostics in the cytology of effusions. For further information, please visit the website www.bsccevents.co.uk

Coaching for Scientific Managers
26 September 2008, London

This workshop is aimed at all scientists in a management position. Particularly suited to those moving into lectureship, project management, group leader and lab manager roles. It is also ideally suited for those looking for promotion to a management role. This workshop will be run by Liz Dickson of Yabber Yakka. This is a CPD-accredited meeting organised by EuroSciCon (www.euroscicon.com). For more information see www.regonline.co.uk/coachingo8

PCR Perfection: Insider tricks
3 October 2008, BioPark, Hertfordshire

This is a CPD-accredited meeting organised by EuroSciCon (www.euroscicon.com). The deadline for abstract submissions is 10 July 2008. Abstract guidelines can be found at www.euroscicon.com/absguidlines.html. The deadline for early registration is 20 July 2008. For details visit www.regonline.co.uk/pcro8

Visualising Cellular Function in vivo
24 October 2008, BioPark Hertfordshire

The deadline for abstract submissions is 25 July 2008. The deadline for early registration is 20 July 2008. Abstract guidelines can be found at www.euroscicon.com/absguidlines.html. Details: www.regonline.co.uk/cellfunctiono8. General enquiries: enquiries@euroscicon.com or visit www.euroscicon.com. CPD accreditation is being sought from the IBMS.

Problems with Microarrays (and how to shoot them!)
4 November 2008, BioPark, Hertfordshire

A day filled with technical tips that didn't make it to the manuals yet. This Users Symposia is designed as a small informal meeting for anyone with questions about microarrays. After you register for the event you get the opportunity to submit up to four questions which will be given to the panel of experts on the day of the Symposium. The questions are delivered by the meetings chair and there will be plenty of time for interaction with other delegates and with the panel and to ask further questions. The chair of this panel will be Professor Eric F.P.M. Schoenmakers, University Medical Centre Nijmegen, The Netherlands. This is a CPD-accredited meeting organised by EuroSciCon (www.euroscicon.com). The

deadline for early registration is 20 August 2008. For more information see www.regonline.co.uk/usermicro08

Returning to Science: Is it all Compromise?
7 November 2008, BioPark, Hertfordshire

This meeting will be a comprehensive overview of the issues of returning to work after a career break. The deadline for abstract submissions is July 10th 2008. Abstract guidelines can be found at www.euroscicon.com/absguidlines.html. The deadline for early registration is July 20th 2008. For more information see www.regonline.co.uk/return08.

Recent advances in Flow cytometric techniques and instrumentation
14 November 2008, BioPark, Hertfordshire

Instrumentation has to keep up with the rapidly moving field of science served by flow cytometry. This meeting will bring together the most recent advances in clinical and research flow cytometric techniques and the hardware that has been developed to keep pace with the scientific requirements. Dr Ian Dimmick, University of Newcastle (Meeting Chair). The deadline for abstract submissions is August 10th 2008. Abstract guidelines can be found at www.euroscicon.com/absguidlines.html. The deadline for early registration is August 20th 2008. For more information see www.regonline.co.uk/flow08.

Hands-on Cardiac Morphology
2–4 March 2009, Royal Brompton Hospital and Imperial College London

This course takes registrants from the basics of normal anatomy and simple congenital heart malformations through to the more complex defects and the cardiac conduction system. Live video demonstrations are followed by practical 'hands-on' sessions under the guidance of tutors. Each participant will receive a course handbook with colour diagrams. Places are limited. CPD and EBAC sought. Course organiser: Dr Yen Ho. Details and registration forms: www.rbht.nhs.uk/cardiacMorphology

XXV WASPaLM World Congress of Pathology and Laboratory Medicine: Pathology Update 2009
13–15 March 2009, Sydney, Australia

Details: evep@rcpa.edu.au or visit www.rcpa.edu.au

Diagnostic Surgical Pathology 2009
22-26 June 2009, Riva del Garda, Italy

This refresher course in surgical pathology is co-directed by Drs. Robert H Young and Juan Rosai, and sponsored by the Department of Pathology of Massachussets General Hospital, Harvard Medical School Department of Continuing Education, and Centro Diagnostico Italiano, Milan, Italy. The faculty includes 11 experts in their respective areas. For details, see www.cme.hms.harvard.edu

ACB Management Course 2008
Date: 15–20 June 2008
Venue: University of Surrey
Delegates: Maximum of 28 (specialist registrars/post-registration clinical biochemists and immunologists, and consultants)
Cost: £650 for ACB members, £800 for non-members

The week will build on the well-established and acclaimed Association for Clinical Biochemistry management courses held in 2003, 2004 and 2006.

- Designed for those preparing for MRCPath and senior laboratory management.
- Utilising lectures, workshops, discussions, group projects, debates and presentations.
- Led by senior members of the profession, NHS managers and the Postgraduate Medical School Department of Health Care Management.

The course will look at the NHS, its changing structure, its finance and staff groups. It will provide sessions on the psychology of organisation structures, managing budgets and demand, laboratory organisation, training, job descriptions, employment legislation, ethics, appraisal and people management. It will provide training in evidence-based medicine and devote a day to clinical leadership.

With course places restricted to 28, those interested should apply as soon as possible. For further details, contact Stephen Halloran or 01483 688 553 or s.halloran@nhs.net
Application forms can be obtained from the Association for Clinical Biochemistry office.
Tel: +44 (0)20 7403 8001
Fax: +44 (0)20 7403 8006
Web: www.acb.org.uk

Pathological Society of Great Britain and Ireland

The Pathological Society of Great Britain and Ireland offers several grant schemes, namely:

SCHEME	DEADLINES
Bursaries for undergraduate elective or vacation studies	31 January, 30 April, 31 July, 31 October
Educational Grant Scheme	1 March, 1 June, 1 October & 1 December
Fellowships	1 January & 1 August
Intercalated Degree Grants	1 March each year
Open Scheme	1 March, 1 June, 1 October & 1 December
Pathological Society Meetings Bursaries	1 June & 1 November
PhD Studentship Scheme	1 November each year
Pilot Study Grant Scheme	1 January & 1 August
Travel & Conference Bursaries	Open

Full details are available on our website www.pathsoc.org

Or contact: Miss Julie Johnstone, Deputy Administrator, Pathological Society of Great Britain and Ireland, email julie@pathsoc.org

The Pathological Society of Great Britain and Ireland meetings in 2008

1-4 July 2008, Leeds
Joint Meeting of the Pathological Society and the Dutch Pathological Society (NVvP), incorporating Trainees' Programme

1-4 September 2008, Cambridge
Pathological Society's 2nd Summer School: Molecular pathology for the uninitiated: a conceptual & practical guide

Further information available from:
Ms RA Pitts
Pathological Society of Great Britain and Ireland
Tel +44 (0)20 7976 1260
E-mail admin@pathsoc.org
Website www.pathsoc.org

Legacies

The objectives of the College are to advance the science and practice of pathology, to educate the public in matters relating to pathology and to promote study and research work in pathology and related subjects and publish the result of such study and research. Financially, the College aims to match activities to projected income. The College is funded from subscriptions, examinations and related fees, investment income, grants from outside bodies and charitable donations.

As with other Royal Colleges, bequests or legacies are always gratefully received. Leaving a gift to charity in your will is a very special way of helping to secure the future for organisations such as The Royal College of Pathologists, for which you may have great affection and regard. Legacies to the College have the added benefit of being exempt from inheritance tax and this could reduce or eliminate completely any potential tax, which might otherwise be payable out of your estate. An open legacy may be made toward the general purposes of the College. This is preferred because it allows the College to apply the funds donated where the need is greatest at the time the legacy eventually becomes available. This can be quite different from the perceived need when a will is made. However, you may legally oblige the College to spend the money in a particular area of College work or for a specific purpose by making a restricted legacy.

Additions to your existing will can be made using a 'Form of codicil', printed below. Please note that witnesses should be present when you sign the form, but it should not be witnessed by a College member or the spouse of a College member. As a general point, we always recommend consulting a solicitor or qualified will-writer before making a will; they should give you all the legal and tax advice that you require.

If you are considering including a legacy to the College in your will, we would very much appreciate being informed of your generous act. To inform us of your bequest or for specific advice on legacies to the College, please call Daniel Ross, College Chief Executive, on 020 7451 6789 or email daniel.ross@rcpath.org

Form of codicil

(Please photocopy and complete in block capitals)

I .....(name) of .... (address) declare this to be a Codicil which I make this ..... day of ..... 20..... to my Will which bears the date ..... day of .....(month) .....(year).

I give to The Royal College of Pathologists ('the College'), registered charity number 261035, the sum of £..... (amount in words) ..... free of all taxes whether payable in the United Kingdom or in countries overseas for the general purposes of the College and I declare that the receipt of the Honorary Treasurer for the time being of the College shall be sufficient discharge to my executors.

In all other respects I confirm my said Will. In Witness thereof I have hereunto set my hand the day and year first written above.

Signed by the Testator/rix: ..... (signature) as a Codicil to his/her last Will in our joint presence and by us in his/hers.

FIRST WITNESS: .... (signature of first witness)
Name and address: .....
.....

SECOND WITNESS: ..... (signature of second witness)
Name and address: .....
.....

Legacies for outreach and educational work

As you all know, the College is about to embark upon an extremely exciting phase of its development of the new state-of-the-art Education Centre and we are delighted that our fundraising efforts have been so successful to date.

Construction of the bricks and mortar element of the new Centre is now well underway at Carlton House Terrace – but importantly, the College is now planning for the future by developing the Outreach Programme that will spread the awareness of pathology throughout the UK and abroad.

In addition to the Outreach Programme, we are also in the process of putting together National Pathology Week, which will take place in November and be a landmark initiative in the UK.

No other UK college has committed so much to the future of our profession in terms of time and resources. This will begin to promote the importance of pathology to the grass roots of this country through schools, colleges, hospitals and many other sites where the general public can have access to important healthcare information.

If we are to safeguard the future of our profession in the face of increasing competition from other medical and science career opportunities, it is vital that we commit ourselves to the promotion and awareness of pathology, and continue to train our young professionals to the very highest standards.

The Education Centre and the Outreach Programme, including National Pathology Week, will require financial support from the College for many years to come and we hope very much that we can build upon the tremendous support you have already given and ask if you would consider leaving a legacy.

We have given regular updates on how to add a codicil to your will to assist us in this way, and if you would like additional information on will making, the following websites might be useful:

www.direct.gov.uk
www.bbc.co.uk
www.thewillsite.co.uk

For any further enquiries, please contact me.

Daniel Ross
Chief Executive
020 7451 6700
daniel.ross@rcpath.org

UK members: please check your records are correct on the electronic database!

This multi-professional database is now available at www.canceruk.net/rcpworkforce.htm

UK College members can update their own records using their existing College website username and password. Please note that changes of address should still be notified to the Membership Department. If you need a username and password, please press 'Register' on the College homepage at www.rcpath.org

A helpdesk run by the database's designers is open 9am – 5pm Monday to Friday on 0870 840 8033

Vulval diseases

Integrated gynaecological, dermatological and pathological aspects

Friday 20 June 2008
(Provisional programme – 5 CPD credits)

To be held at
The East Midlands Conference Centre
University Park
Nottingham, NG7 2RJ

This exciting one-day meeting deals with very topical subjects and most recent updates from research, diagnostic and treatment aspects. It is aimed at consultants and trainees who share interest in clinico-pathological aspects of vulval diseases but of varied background including gynaecologists, general practitioners, dermatologists, genito-urinary physicians and pathologists.

Early/online bookings:
(one month prior to the event or online)
RCPath Fellows £160
Concessions £75
Non-members £210

Regular bookings:
RCPath Fellows £180
Concessions £120
Non-members £210

Registration deadline: Friday 13 June 2008

Book online at
www.rcpath.org/conferences
Or contact Michelle Merrett, Events Manager
Tel 020 7451 6740
Email michelle.merrett@rcpath.org

The Royal College of Pathologists
Pathology: the science behind the cure

Provisional programme

At the end of the day the participants will:

- increase and update their current knowledge of HPV, HPV vaccine and its association with vulval and anal diseases
- recognise and treat premalignant and malignant vulval diseases
- understand the underlying aetiology of vulval diseases
- have knowledge to understand and treat common pruritic condition of the vulva at different ages
- understand vulvodynia.

09.30	Registration and coffee
10:00	Evaluating the efficacy of HPV vaccine Andrew Boyle, Sanofi Pasteur MSD
10.25	Effect of HPV vaccine on changing the profile of the National Statistics Professor Simon Herrington, University of St Andrews, Fife
10:50	The future of cervical screening; HPV testing vs. cervical cytology Dr Sanjiv Manek, John Radcliffe Hospital, Oxford
11:10	Coffee
11.30	The visible lesion: is it cancer? Miss Karen Williamson, City Hospital, Nottingham
11:55	Anal intraepithelial neoplasia, HPV and HIV related diseases Professor J Scholefield, Queens Medical Centre, Nottingham
12.20	Lunch
13:20	Vulvodynia Mr David Nunns, City Hospital, Nottingham
13:45	Lichen sclerosus; a diagnostic enigma Miss M Macpherson, Queens Medical Centre, Nottingham
14:10	Lichen sclerosus; a continuing enigma Dr Suha Deen, Queens Medical Centre, Nottingham
14:35	Coffee
14:55	Vulvar pruritus through the life cycle Dr Sheelagh Littlewood, Queens Medical Centre, Nottingham
15:20	Sexually Transmitted diseases; views and experience TBA
15.45	Close

national pathology week

3–9 November 2008

get involved...

hold an open day in your lab

give a talk

organise a display

give a tour

dedicate a grand round

To get involved please contact Caroline Shaw on 020 7451 6752
or email Caroline.Shaw@rcpath.org