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Round Table Discussion

The discussion was chaired by Carl-Henric de Verdier
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Ragnar Strömberg (Industry): Instruments that should be simple and rapid to use are not simple and rapid to invent. The demands from the users will also be different, since they may have little experience of laboratory work. The industry therefore has to build in a large amount of security and caluclating ability into the instruments. The methods have to be robust. The industry also has to equip the methods with some kind of quality assurance system.

Three levels of decentralization can be recognized:

1. within the hospitals, to satellite laboratories
2. to the primary health care, general practitioners etc
3. to the patients themselves

In the development of instruments and methods a close collaboration between the clinical chemists and the industry is necessary. This meeting is a good example of such a collaboration.

Ulf Nicolauson (National Board of Health and Welfare): The Board has several assignments. One is to print different types of Regulations, Rules, Advice and Information. Another assignment is to provide the Hospital and Health Service Administrations of the counties with planning documentation.

In the Mid-seventies the Board put out its document "Public health and sick care at the eighties" (HS 80). Three different functions were described, viz. primary medical care, county organized medical care and regional care. HS 80 provides the following rules: The primary medical care should obtain its laboratory service from the laboratory of the near by county hospital. Simple tests demanding quick answers may be performed by the personnel of the primary care unit, but the metho-

dology ought to be described by the laboratory staff.

These types of advice are still valid although the Board also has produced its next document "Public health and sick care at the nineties" (HS 90). This document is less detailed in its structure. It states that the expansion of laboratory service according to HS 80 has been realized. The need for new technics and for capital investments is supposed to increase. It is, however, difficult to foresee the consequences of increasing preventive actions within primary medical care.

Questions about liability go back to the security of the patients, but it also includes the security of the personnel working with the analytical systems near the patient. There must be long term systems for assessing analytical quality and for controlling the function of the equipment and the reagents used. The personnel should also have adequate instructions and training in the proper use of the systems for analysis and control.

There are different models for organization in different areas and counties. The administrative and the medical responsibility of the laboratory work performed in the primary care may be given to the director of the laboratory organization or of the near by laboratory. According to another model the administrative responsibility may be given to the head of the primary care unit. A clinical chemist may then be consultant with a medical responsibility for the analytical systems. The administrative organization of the county should provide schemes in order to clarify these responsibilities. During the last years no case has been brought up to the Board about liability within the area of clinical chemistry. So the trial of such cases can not give us any guidance.

Sven Lindstedt (Clinical chemistry, Göteborg): Who is responsible for the analyses performed in the decentralized situation? We have witnessed several commersial laboratories growe up during the last years. If such laboratories produce values on which a wrong diagnosis is made, who has then the responsibility? One way to handle such a matter is to create laws, send out quality control samples, make an authorization

of laboratories etc. In order to take questions like that under consideration a small group has been formed within the Swedish Society for Clinical Chemistry. One way of arguing within the group has been to state that we already have a profession: clinical chemistry. Why not use that, to give the clinical chemist an authorization. With those thoughts in mind the group has taken contact with the National Board of Health and Welfare.

Mogens Horder (Clinical chemistry, Odense, Denmark): Certainly the speciality clinical chemistry exists. There has never, however, been stated that the subject should work only as a centralized subject. It is necessary that the clinical chemists know the demands put forward by the primary care. In Denmark the primary care doctor is responsible for the laboratory activity. There is a discussion going on how much the clinical chemist form the near by laboratory shall be involved and responsible.

Göran Sjönell (General medicine, Stockholm): The young doctor hides himself behind a lot of laboratory tests. It is necessary to learn him, how to work without all these tests or at least with a limited amount of tests. - It is important for the industry to take part directly in what is going on in the primary care. - It is also important that the clinical chemists and the primary care doctors start a conversation with the patients on the various analyses performed. Most people are very interested in those matters. It is not surprising at all that some people send their hair to England for analyses of trace metals.

Ulf Nicolausen: It is also important for the clinical chemists to get a broader view on the situation for the patient, to put the results together with the anamnesis. - The quality of the health and sick care organisation shall be the same on all levels. We shall not discuss in terms of low and high technology on different levels in the health care system. Simple tests giving a rapid answers demand a very high tech-

nological development. Above all, the activity shall not be ruled by the development, but by the demands.

Sven Lindstedt: We ought to know if the decentralisation process is beneficial for the patient. There were no differences in measurable parameters like urinary albumin and ophtalmiatric status in a follow up study on diabetic patients handled with home testing or laboratory testing.

Nils Tryding (Clinical chemistry, Kristianstad): We must know that the indications for the analysis are correct and that the results are interpreted correctly. If the receiver of a laboratory result does not know the physiological and biochemical mechanisms behind the turnover of a substance, then the analysis is of little value. I think that we shall devote ourselves to what we are educated for, viz. helping our clinical collegues to make clinical chemistry data available.

Mogens Horder: We shall develop clinical chemistry in order to answer the questions put in the primary care. The development has to be done in various regions. There are too big differences between e g clinical chemistry in the various countries in Scandinavia. It is important that we put the patient in the center, research within primary care has to get higher priority.

Agneta Häggmark (Clinical chemistry, Stockholm): Education of the medical students is also important. We are trying hard to teach them to request analyses only when needed. If there is an overconsumption of analyses, there must be imperfections in the education given by other specialities.

Göran Sjönell: I agree. The main responsibility is on the clinically working collegues and not on the subject clinical chemistry. - By the way, there is a revolution going on within general medicine. Earlier we were given two whole days of the 6.5 year long study to educate the student. This has now been expanded to two weeks. There are countries where the main

part of the education is located outside the hospitals.

Olof Hygstedt (Clinical chemistry, Borås): The analysis close to the patient is - as I see it - from a non-fasting specimen. It is very difficult to talk in terms of decentralisation, if we do not have reasonable good reference intervals for non-fasting, healthy individuals.

Nils Tryding: According to my view there is no use of reference intervals, except if you want to perform a screening investigation on a population. For a diseased state other intervals can be used. Decision limits are not the same as reference limits.

Ulf Nicolausen: In the ending of this discussion I want to give you some words to take with you home. I should like you to get into closer contact with the primary care and start collaboration and cooperation. It is important that we get rid of the old way of thinking, that the clincial chemists mainly are working for the wards of the hospitals and mainly with sophisticated analyses. We must also work in the direction to raise the quality of the service to primary care and to give support to the people in the developmental work for primary care.

Carl-Henric de Verdier: Before ending the discussion I like to express the interest from clinical chemistry to collaborate with general medicine. We already have committees working within this area and I also see this meeting and today's discussion as a good example of this kind of collaboration.