The Royal College of Pathologists

*Pathology: the hidden science behind the cure*

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# Guidance on histopathology referral practice

## March 2007

| **Unique document number** | G039 |
|---|---|
| **Document name** | Guidance on histopathology referral practice |
| **Version number** | 1 |
| **Produced by** | Professor Mike Wells |
| **Date active** | March 2007 |
| **Date for review** | ~~March 2009~~ This document was archived in Spring 2016. |
| **Comments** | This document was originally produced in October 2004 by Clair du Boulay, former Chair of the Histopathology SAC, as a working document from the SAC but was never officially published. It was reviewed by Professor Peter Furness on 6 October 2006 after consideration at the Histopathology SAC and some minor changes made. It was available on the RCPath website for member consultation and comments from 13 October–10 November 2006 and received 43 responses. The authors have considered the feedback and amended the document accordingly.<br><br>Please email publications@rcpath.org if you wish to see the comments and authors' responses to the feedback.<br><br>**Professor Carrock Sewell**<br>**Director of Publications** |

## 1 INTRODUCTION

This document relates to the referral of histopathological specimens (including cytopathological and post-mortem specimens) for specialist opinions for the benefit of the patient, in the context of the UK National Health Service. It does not cover sending specimens away for other purposes, such as clinical trials, even if there is a potential benefit for the patient from such second opinions.

Histopathological diagnosis is not an exact science and it is normal practice for histopathologists to refer cases for second opinion to their colleagues.

The RCPath through **Good Pathology Practice** recommends that all pathologists should actively participate in some form of referral practice as this is in the best interests of patients, good continuing professional development (CPD) and good practice. A histopathologist who never seeks other views is a potential cause for concern. It is important that pathologists are not discouraged from this practice because of cost implications.

Please also see the College document: *Guidelines on inter-departmental dispatch of samples from patients sent to another hospital or centre for assessment and/or treatment (2nd edition)*, available on the College website (www.rcpath.org)

### 1.1 Examples of referral categories

1. Internally within a department e.g. difficult cases discussed.
2. Informally between colleagues in adjacent hospitals e.g. generalist pathologist seeking advice from a pathologist in sub-specialist practice.
3. Routinely within cancer networks (cancer units to centres).
4. Formally where a second 'primary' diagnostic opinion is required.
5. Sub Specialty tertiary referrals linked to patient pathways.

### 1.2 Funding

a. There is considerable variation as to whether or not charges are levied for referrals. The Department of Health has made it clear that no central funding for referrals will be provided other than through existing networks such as the National Specialist Commissioning Advisory Group for ophthalmic services and bone tumour services.

b. For referrals where a histopathologist wishes to obtain a second diagnostic opinion from outside their own organisation, there is a historic culture of expectation that a service will be provided *gratis* by expert histopathologists on complex cases. However in the context of pathology modernisation, payment by results and tighter commissioning, models of funded referral practice need to be established.

c. The College recommends that referring trusts outside an individual organisation or network should be recharged and such trusts employing the referring pathologist should expect a charge to be made for the service.

d. All pathologists should ensure that there is a local expectation that when material is sent away for a specialist opinion a charge will be made for the service, and that arrangements are in place to ensure that the charge will be paid.

e. Any managerial requests to avoid referral to minimise costs should be countered on the basis of good clinical governance. A pathologist who believes that good patient care demands an expert referral, but is not allowed to make that referral on the grounds of cost, has a duty to make this problem known to

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management and to the clinician responsible for the patient in question. In extreme cases it could be necessary for such a pathologist to refuse to issue a report.

f. For referrals linked to cancer networks, in the first instance the referral should be from cancer unit to cancer centre within a single cancer network. Such referrals should be routine, and systems for charging, if necessary, should be agreed during the process of establishing the network. Only in difficult cases should it go to tertiary or national centres, thereby becoming a supra-network referral. It should be noted that some more recent National Institute for Health and Clinical Excellence guidance contains specific recommendations relating to the commissioning of local and national histopathology referrals.

g. In the case of a referral for a second opinion outside a network, a charge should be levied by the providing Trust to the referring trust. This should include a fee for both technical service and professional clinical opinion.

h. The problems associated with unfunded national referrals (for some an additional workload of up to 1000 cases per year) place a considerable burden on a few, predominantly teaching hospital consultants. These are often clinical academics.

i. Where individuals have large referral practices, whether inside or outside cancer networks, the College recommends that this be recognised in their job plans.

j. This document deliberately does not provide guidance on what is an appropriate fee, but the expectation is that the fee should do no more than cover costs. The Department of Health has signalled its intention to develop a national tariff for this type of work.

k. This document does not cover overseas referrals. It is specifically noted that some UK pathologists provide a referral service to assist medical provision in underdeveloped countries, and it is hoped that such work can continue without charge, as a charitable activity.

### 1.3 Audit

The College recommends that pathologists audit their patterns and frequency of referrals so that they can demonstrate the number of cases being referred over a period of time and costs can be built into pathology business plans. To that end we advise that a record of additional consultations, including the name and location of the colleague consulted should, where practicable, be made in the relevant pathology report.

Primary care trusts and other commissioning groups need to be aware that histopathology referral is good practice and that this should be accounted for in budget allocations.

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