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Analytical Goals Revisited in the 1990'ies

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The last decade has brought much new knowledge in the field of quality control in clinical chemistry. Terms have been changed, theories have been developed.

It is my personal view that the decade has been only partly successful. The average clinician has no more knowledge about quality specifications than he had in the 1970'ies. The clinician does not require any particular quality from the side of the laboratory. The clinical chemist has not widened the concept of quality control and assurance from the limited part of our service that encompasses the analytical process.

I find it of highest priority for laboratory medicine to redefine the **concepts** of quality specifications within the frame of the clinical setting; i.e. the analytical process is important but only a part of the whole process.

I would like to see the **concept** of quality specifications include:

- the appropriateness of a certain test for a particular patient at a particular time;
- where (by whom) the tests are made;
- their technical quality;
- determining the costs;
- the interpretation of test results; and
- the clinical action taken and the outcome.

So far, the technical aspects have received most attention. Methods of quality control and assessment are widely used in laboratories. Other aspects, however, have received very little study. Data on rates of use are lacking, for example, and laboratories rarely have any information on outcome. Closer coopera-

tion between laboratory directors and physicians is needed to develop methods for evaluating these aspects of quality and to formulate agreed standards.

This does not mean that the professionals of the discipline should stop developing theories and procedures for quality specifications. But a changing priority is necessary: Simple methods for implementation of the concepts in the dialogue and daily practice between laboratory and the clinic is probably the highest priority for the 1990'ies.

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