From the President’s Desk: Speaking of optics, 6/17

June 2017—We typically define “normal” or “true” from the perspective of our local communities and social circles. This reliance on the familiar can compromise communication effectiveness when we don’t appropriately consider the audience. And as the exchange of information continues to accelerate, the impact on what constitutes an authoritative assessment evolves similarly. Sometimes we don’t stop to think.

Richard C. Friedberg, MD, PhD

Recently, we discussed ways to help patients understand that their diagnoses are not a simple product of mechanical algorithms but rather a personalized and focused assessment by a highly trained physician. Let’s continue that discussion on the validity of popular notions about medicine and perhaps shed light on the modern-day snake-oil forces at work.

In business, one of the biggest barriers to efficient communication is a failure to recognize information asymmetry—the reality that even those with similar training do not share an identical knowledge base. Some of us know more than others about some things, and communication on a particular topic works best when we agree on who is most qualified to address it. In medicine, most agree that pathologists are the best experts on the medical implications of test results and biopsies. However, in the public health context, patient and family perspectives introduce significant information asymmetry that complicates communication. The rapid deployment of misinformation from vested interests only adds to the confusion.

A May 8, 2015 article in Science by Michael Mina, et al., detailed an investigation into the connection between long-term measles-driven immunosuppression and overall infectious disease mortality in children. Data on post-measles infections from industrialized nations before and after widespread introduction of vaccination showed markedly greater mortality from other infectious diseases among nonimmunized children. The increased death rate appeared to be driven by an immune memory loss lasting for two to three years after an outbreak, contributing to as much as half of all childhood deaths from infectious disease in industrialized countries. In contrast to the disease, the measles vaccine does not reduce lymphocyte activity and thereby actually protects polymicrobial herd immunity.

Nevertheless, a significant number of well-meaning parents continue to believe that the risks of getting the

vaccination outweigh the risks of avoiding it. Much of the concern about measles vaccines traces back to a thoroughly debunked publication alleging a causal connection with autism. A dangerous and fundamentally antiscience political movement persists.

In an article published May 5 in PLOS One, John Cook, et al., describe a successful effort to "neutralize misinformation through inoculation." Dissecting a flawed argument or highlighting scientific consensus before presenting it, they found, neutralizes the impact, lending support to what the authors call "preemptive inoculation messages." Many of us have access to the databases that can inform educational campaigns and counter misinformation. Perhaps public health programming based on these methods will be effective.

We need to define our niche because we are evolving at least as fast as everyone else. So few in medicine know what we do; many may not know they need us. We know we regularly employ, pursue, and integrate the underlying science into the practice of medicine. Yet we too often fail to communicate to clinical partners outside the laboratory—nurses, physician assistants, administrators, community providers—in terms they readily understand. How do we encourage them to involve us when our words may seem intentionally inscrutable to them?

We are not the only ones whose jargon can confuse. For example, how do you define "patient-centric care"? If "patient-centric" is mistakenly taken to mean that the patient has a knowledge base equivalent to that of his or her doctor, then that physician-patient relationship is in serious trouble. So much trouble that we may someday find ourselves in the unthinkable position of explaining why so many children are dying.

Information asymmetry can work for or against us, so why not play to our strengths? If today's patients and families are getting more information digitally, then why not reach out to other leaders in our hospitals and communities to talk about developing online material? Not everyone in the laboratory will volunteer for public education on the value of vaccines. But someone in every laboratory is suited to the task, just as someone in every laboratory is best suited to read biopsies, manage the blood bank, or handle patient complaints. The best teams are those that make the most of their members. Optics do matter and science is our sandbox. Let's show what we can do.

The Oxford Dictionaries word of the year in 2015 was not a word at all; it was an emoji. The word of the year in 2016 was "post-truth." If those were really the most impactful two terms over the past two years, we need to get to work. We can push back on misinformation. We can discuss the data to empower and enable our patients to recognize the antiscience movement for the dangerous trend it is. We can educate.

We can do a lot together, which is a good way to introduce my second topic, CAP17. From Oct. 8 to 11, we will convene in National Harbor, Md., just outside Washington, DC. Participants have their choice of more than 70 CME courses, including new offerings and courses brought back by popular demand. More than 90 exhibitors will join us as well. It will be a quick four days.

Wayne W. Grody, MD, PhD, will moderate our opening plenary on Sunday morning, where experts will address gene editing using CRISPR/Cas9. Fundamentals of the technology and its potential uses in genetic and oncology research will be covered, along with ethical issues and potential roles for pathologists. It promises to be mesmerizing.

Abraham Verghese, MD, our Sunday evening Spotlight Event speaker, is a professor of medicine at Stanford whose memoir of a time treating AIDS patients in rural Tennessee was a National Book Critics Circle award finalist. His best-selling novel, Cutting for Stone, should be on your summer reading list. Dr. Verghese is a seasoned Ted Talk expert; expect a thought-provoking time away from the day-to-day.

Our Residents Forum and House of Delegates meet on Saturday; they'll break midday to share lunch. CAP17 will host a career fair on Monday evening, and the fellowship fair will return to its Sunday morning slot.

Our advocacy team has grown its footprint at the meeting. Experts in payment policy will address Medicare's new

quality payment program and physician fee schedule. Our Pathologists Quality Registry will formally launch, making our lives easier by facilitating compliance with Medicare's new payment system (MIPS). The Sunday night PathPAC reception and Monday evening CAP Policy and Advocacy Town Hall are not to be missed.

New for this year is the Inspiration Stage on Tuesday evening. There, three individuals will discuss personal and passionate stories about innovation, survival, and engagement. Each is an original thinker and intrepid champion of change.

You'll be hearing more about the meeting as we get closer, but if you have not registered for courses, I'd suggest making that a priority. There are wonderful opportunities to learn from these world-class instructors. See you there.
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Dr. Friedberg welcomes communication from CAP members. Write to him at president@cap.org.