From training to first jobs, can the transition be made easier?

Valerie Neff Newitt

March 2024—Pathology trainees and training programs vary, as do first jobs, but the first year in pathology practice is generally said to be a tough one, largely because of the transition to fully independent case sign-out.

While still a resident, Levon Katsakhyan, MD, now a gynecologic pathologist with Carolinas Pathology Group in Charlotte, NC, and coauthors surveyed 12 anatomic pathology fellows from four institutions near the end of their final training year and six and 12 months into their first jobs, and their findings were published in January (Katsakhyan L, et al. *Arch Pathol Lab Med*. Published online Jan. 5, 2024. doi:10.5858/arpa.2023-0378-EP).

In general, he says, the results show a steady incremental increase in confidence and comfort level with all aspects of independent practice measured in the survey. “This is a first step and a starting point in trying to understand how we can support new-in-practice pathologists through this challenging transition,” Dr. Katsakhyan said in an interview. The response to all three surveys was 100 percent (12 of 12).

The anticipated and actual support from senior colleagues for their new-in-practice colleagues was reported to be strong. It was “one of the highest scores of the questions we asked,” he says. “This is encouraging, but we need larger studies to determine what specific areas of support are most helpful.”

See also: The new-in-practice pathologist

The confidence level in initiating conversations with clinicians showed only minimal incremental increases at six and 12 months. “In training,” Dr. Katsakhyan says, “we’re so focused on refining our diagnostic skills, but at the end of the day our communications skills and relationships with treating physicians are paramount. Developing those relationships early during that first year is important, and it would be good to stress it more in training in different ways.”

Once in practice, he suggests, it would be of help if the senior colleagues introduced the new-in-practice colleague to the surgeons and other physicians, whether in a multidisciplinary conference or elsewhere. This way, he says, “they can have their voices heard early and get involved early in communications with clinicians, so they can begin to develop mutual trust.”

Dr. Varshney

The main challenges the new-in-practice pathologists reported at six months were a high caseload, signing out cases in areas outside their subspecialty, time management, balancing teaching while signing out, laboratory issues, and developing relationships with clinicians. At one year the challenges were similar but for some of them diminished.

Dr. Katsakhyan and his coauthors say many of the challenges are in part rooted in a new-in-practice pathologist having to release reports and take full responsibility for them for the first time. Trainees in pathology programs accredited by the Accreditation Council for Graduate Medical Education cannot bill for final pathology reports, which means a supervising physician must perform the final case sign-out.

“It’s really challenging,” says Neha Varshney, MD, director of surgical pathology and section head of the GI and liver pathology service at the University of Mississippi Medical Center and assistant professor of pathology, University of Mississippi School of Medicine. Dr. Varshney was not involved in the survey of fellows but is a member of the CAP New In Practice Committee. “The biggest issue,” she says, “is the confidence to sign out a case. In training, you always have somebody to do the sign-out, and even if you make a mistake, somebody’s looking after you. Someone else’s name is on there. Then suddenly, overnight, your safety net is gone. That can be terrifying. That’s the biggest issue with transition.”

Graduated responsibility is discussed “from year one to year four in residency,” Dr. Varshney says, “then again in fellowship.” Programs gradually give trainees more autonomy, and “they must be given the accountability and responsibility to own their cases. There have to be benchmarks and milestones to make sure they’re ready to do that.”

Dr. Katsakhyan acknowledges that writing a final surgical pathology report fully and releasing it, within the confines of ACGME-accredited programs, may never be possible, but he suggests activities that would be of value: reporting rapid onsite evaluations for cytology, reporting preliminary diagnoses, or conversing with surgeons. “It will take effort and creativity on the part of the training programs, but there is opportunity for improvement in that area,” he says.

Mayo Clinic in Rochester, Minn., got creative in recent years with its pilot and adoption of a process in which surgical pathology fellows independently manage a subset of cases and release preliminary reports.

The aim was to increase autonomy for trainees in Mayo’s ACGME-accredited surgical pathology fellowship while maintaining safety and supervision, the authors of a recently published article write (Boland JM, et al. *Arch Pathol Lab Med*. 2023;147[11]:1320–1326).

A change in Mayo’s laboratory information system allowed for the release of preliminary reports into the electronic health record, they say, and it was “hypothesized that preliminary report release by trainees might be a meaningful way to provide progressive responsibility and graded supervision.” For the pilot study in 2020, four board-certified surgical pathology fellows in the final two months of their fellowship were permitted to independently manage cases sent from outside institutions for confirmatory review before additional treatment was provided at Mayo. These fellows decided whether to release a preliminary report, to share with a subspecialty pathologist in consultation and then release, or not to release a report and show the case directly to a general surgical pathology attending physician. They were instructed not to release a report on cases where they had concern about the accuracy of the outside diagnosis or the need for additional workup.

The preliminary report released to the LIS was visible in the EHR only to the patient care team; it was not sent to the patient portal until a surgical pathology attending issued the final report. A comment on the preliminary report explained it was generated by a fellow and would be converted to a final report upon review by a pathology attending. The goal for finalizing the report was two days, and fellows were instructed not to sign out a preliminary report for patients who had an appointment within two days of slide review. Any changes deemed potentially clinically significant or major pathologic diagnostic changes, or both, were communicated orally or electronically to the clinical team by the fellow or attending and documented in the LIS.

The fellows released 59 preliminary reports out of 101 cases reviewed and showed the remainder to an attending pathologist without releasing a preliminary report. They shared cases with a subspecialty pathologist before releasing the preliminary report in 20 of 59 preliminary cases (34 percent), which the authors say compares with a share rate of about 20 percent for general surgical pathology attendings on the same service.

The process as of 2021 became a permanent one, based on pilot data and the endorsement and approval of practice leadership. Of 182 preliminary reports released in the pilot and in the first six months after implementation, there was only one case in which the difference in diagnosis between the preliminary and final

reports was deemed potentially significant, but the authors say it did not adversely affect patient care.

Dr. Boland

Feedback from Mayo's trainees on their evaluations and postgraduate surveys about their desire for more independence and autonomy is what led to the pilot, coauthor Jennifer Boland, MD, consultant in Mayo's Division of Anatomic Pathology and professor of laboratory medicine and pathology, Mayo Clinic College of Medicine and Science, tells CAP TODAY.

"We recognize that giving our trainees more independence will ease their transition to practice, so it was something we wanted to find a way to accomplish," Dr. Boland said by email. "Having the confidence and decisiveness to make routine case management decisions is undoubtedly one of the largest challenges trainees face when entering practice. It certainly was for me."

She says the fellows chosen for the pilot had to be board certified, complete at least one surgical pathology rotation before releasing preliminary reports, and be approved by the clinical competency committee.

The main lesson learned since the process became standard practice in 2021: "Some fellows need more encouragement and support to release preliminary reports. So monitoring practice habits, setting reasonable and clear expectations, and checking in with the trainees during the preliminary report experience has been important to ensure trainees take full advantage of this opportunity and feel they are doing so within a safe environment," Dr. Boland says.

The Mayo Clinic approach is not meant to be one-size-fits-all, she says, but she hopes it "will inspire programs to think about a plan that works for them." For those who might wish to create a similar program, the authors advise carefully considering the types of cases for which preliminary reports can be released "and what implication that might have for the clinical teams and patients."

Dr. Varshney of the University of Mississippi would like to see more programs do something similar, and she says the survey of the 12 fellows Dr. Katsakhyan and coauthors conducted is "a very good start" to something larger.

The CAP New In Practice Committee is working on a more expansive survey, she says, to help uncover more problems and barriers so it can help solve them. The committee is now tackling what it can by way of podcasts, blogs, roundtables, and other resources (www.cap.org/member-resources/new-in-practice). In addition, "We just received the green light to create a boot camp for new-in-practice people to teach both soft and hard pathology skills to help them transition and help them build their confidence."

Her advice for job seekers: "Find a job where you can feel safe asking even the stupid questions. Go where there is good mentorship and a supportive environment, where you can showcase your gradual overall improvement." A designated mentor to whom the new-in-practice pathologist is assigned for three to six months would be helpful, she adds.

For those transitioning to practice, she advises: "Don't stress out, and ask for help when you need to. Don't feel ashamed of asking for help."

And for those who bring in new group members out of residency and fellowship, she urges giving them time and support because the transition can be difficult, professionally and personally. “Give them graduated responsibility as well and whatever help you can, whether assigning a mentor or a senior resident in the initial months,” someone who can help them navigate all that’s new.

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