From the President's Desk: If you can't find your niche, build it, 4/17

April 2017—Our ubiquitous access to (and increasing reliance on) search engines such as Google, Siri, Cortana, and others has resurfaced much of the intellectual landscape. The historical "Guardians of the Truth" no longer sit comfortably in ivory towers waxing poetic while issuing definitive determinations of "fact." Today, when we want to know something, we reach for our phones. The answers, devoid of context and authoritative citations, seem to be so simple there.

Dr. Richard Friedberg

As we learned long ago, facts may be associated in time without having any causal connection. Just because I caught a "cold" after walking outside last December doesn't prove the weather caused my illness. In medical school, I often heard that two facts can be both true and unrelated and that correlation doesn't imply causation. Statements of fact without proper context can be misleading, a truth itself that is woefully underappreciated. In some cases, such as vaccination, the negative consequences can be significant. We can all be led astray trying too hard to squeeze facts to fit into theory.

We know it is not unusual for patients to demand a medication based on hearsay or advertising. Then again, we also know that a true placebo can seem therapeutic. When a patient with severe knee pain is not a surgical candidate, what clinician will criticize an over-the-counter medication that seems to ease the pain? Physicians care for people, not numbers; if the patient feels better, then that part of the mission is accomplished. Primum non nocere.

I started to think about this after reading an article copublished online by the Atlantic and ProPublica, "When evidence says no, but doctors say yes." The author, David Epstein, posits that patient care is not consistently based on good science. For many of us, that is no surprise, but he does raise concerns about how well patients understand the value of recommended treatments.

Epstein quotes a review published in Mayo Clinic Proceedings of studies that look into the efficacy of current clinical practices. The review covers 363 articles published over a decade in the New England Journal of Medicine. More than 40 percent of those studies proved or strongly suggested that the prevailing practice was either not

beneficial or less helpful than the practice it replaced.

Patient-facing providers may not have time to review the literature on each case. As medicine's scientists we need to highlight questions raised by the findings of laboratory tests. Certainly, there are practical barriers, but many of our clinical partners cannot keep up with the daily deluge of new technologies and scientific knowledge relevant to their work. We are on top of those things.

So we attend to our role and respect that of our partner clinicians. Most often, this comes down to asking the right questions of the right people at the right time. We share the science we know in a language they understand to keep our clinical partners apprised of new alternatives. Always, we remain engaged.

We hope our patients understand that pathologists are physicians who think of them in personal terms and whose work is integral to their health. Nevertheless, many of them believe that their laboratory diagnoses are purely machine-generated, algorithm-driven reports. Patients need to know that there is much more involved in their care. They need to know we are there for them.

There is plenty we can do about that. For many patients, a hospital stay is uncomfortable, dissociative, and intimidating. Those of us who can find time to visit the bedside can communicate personal commitment to their health and safety. When I see a patient, I always ask if he or she has questions and encourage them to ask the uncomfortable. We are their doctors. They should know that.

Twice a year, my institution offers a "mini medical school" to the general public. A self-selected audience of about 100 comes together for eight evenings over two months with a presentation and discussion led by a clinical leader. Cardiology may share images of the heart and what can go wrong. Anesthesiology may discuss pain and pain control. I talk to them about how the pathologists in our anatomic and clinical laboratories make life-altering diagnoses.

Initially for almost all who attend, we are little more than a black box. I personalize the discussion, asking each one to think of a loved one's health journey and what that uncle, aunt, parent, child, or partner had to go through. Many get teary. I'll show an image from a biopsy, knowing that none of them can read the slide but all can appreciate the long-term impact and consequences of a professional interpretation of that image. I want them to realize we see not "a malignancy" but a person. And they recognize how critically relevant our actions are to that patient's future.

After the talk, there is an hour-long tour of the laboratory, to unbox that black box. They love to see the equipment, knowing it's there for their families. And we typically enjoy bragging rights for the highest audience satisfaction scores.

Not everyone will want to organize such a series in their community (although I highly recommend it). And not everyone will want to talk to colleagues about treatment alternatives that come to mind when we review test results. But we can all do something to make our work more visible and more personal to our patients and clinical partners.

Our patients will continue to ask Google or Siri for health information; that's not going to change. We can, however, influence the culture of care in our institutions. We can encourage our staff to give thought to the quality of each patient encounter, to help patients see that those digits, decimals, and descriptions we put in their reports reflect the care and concern of a highly professional team. We talk about finding our niche in the evolving medical environment. If you can't find your niche, build it yourself. It will fit much better. Taking a personal interest in those we care for and those we work with is in our toolbox, too.

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Speaking of getting personal. . . . If the 2017 CAP Practice Characteristics Survey has not yet arrived in your inbox, please check your spam filter. Every response sharpens the aggregate findings, generating key indicators used to set priorities for advocacy and member services. In a perfect world, we would know what every member is thinking

in real time; a robust rate of return will get us close. This iteration is shorter, leaner, and quicker to complete; new software speeds turnaround via computer, tablet, or smartphone. Please return it promptly.

Dr. Friedberg welcomes communication from CAP members. Write to him at president@cap.org.