Put it on the Board, 6/14

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For trainees, information ‘gaps are closing’

With the dismissal of residents from training programs having led to well-known tragedies, the most recent in pathology just a year ago, attention is being paid to the importance of ensuring residents’ well-being and properly handling remediation, probation, and dismissal.

The Accreditation Council for Graduate Medical Education has strengthened its requirements for what kind of information residency programs must share about residents’ performance. The ACGME’s common program requirements, last revised in June 2013, say “a program director must provide timely verification of residency education and summative performance evaluations for residents who may leave the program prior to completion.”

Dr. Domen

That is an important step, says Ronald E. Domen, MD, a member of the CAP’s Graduate Medical Education Committee and former associate dean for graduate medical education at Penn State Hershey Medical Center and College of Medicine. He is a former residency program director, and he currently directs two fellowship programs at Penn State, one in blood banking and transfusion medicine and the other in clinical informatics and quality.

“The ACGME’s requirements are now much stricter,” Dr. Domen says. “At least there’s some effort to be sure that certain things are being looked at with these applicants. In the past, that wasn’t necessarily true. Somebody could be passed off from a program and have all kinds of issues there and nobody really said anything. The ACGME is trying to ensure there’s plenty of opportunity to document any issues that have come up.

“The gaps are closing,” he adds. “It’s still imperative upon program directors to make sure they do their due diligence on why an applicant is leaving after, say, two years in another program. Are there issues I need to be aware of that someone’s not telling me? It’s a really tough situation,” he says, pointing out that the potential for tragedies like those seen in pathology is always present.

It was on May 12, 2013 that Anthony Garcia allegedly killed a Creighton University pathologist and his wife in their Omaha, Neb., home. Authorities also allege that in 2008 Garcia killed the son and housekeeper of another Creighton pathologist. Prosecutors say Garcia’s actions were retribution for the pathologists’ role in his 2001 dismissal from Creighton’s pathology residency program. A judge last month ruled Garcia competent to stand trial.
Dr. Domen is the author of an article published this month in the American Journal of Clinical Pathology that

outlines what program directors should consider when dealing with residents who require remediation, probation, or dismissal (2014;141:784–790).

According to the article, remediation plans should identify the specific issues involved, define expectations for improvement, detail how progress will be evaluated and assessed, set a timeline for completion, and detail the consequences for failure to satisfy the goals. Each step in the process should be documented thoroughly, and residents should get help in identifying support networks, such as employee health assistance programs or faculty and resident mentors, the article says.

Sometimes residents struggle to become competent in performing their clinical duties, but other times the problem is one of unprofessional behavior. The latter will be the focus of a July 10 session at the Association of Pathology Chairs' annual meeting in Boston. CAP Graduate Medical Education Committee chair Suzanne Zein-Eldin Powell, MD, and former GMEC chair Michael Talbert, MD, will lead a 90-minute discussion for program directors, titled "Remediation of Residents' Unprofessional Behavior: A Hard Nut to Crack." The session will include case studies to help program directors think through the best strategies to use in dealing with these challenges.

The process of screening the men and women who want to be physicians begins with medical school. John E. Prescott, MD, chief academic officer for the Association of American Medical Colleges, says criminal background checks are done for all medical school applicants and notes that the evaluation process looks beyond applicants' raw brain power.

"Every year, we have students who are at the top of their class, with the highest MCAT scores, and yet no medical school picks them up," Dr. Prescott says. "For some reason, there's a feeling they are not a good fit for a particular school, or there is some other issue that identifies them as not being right for medicine."

Academic medical centers have a responsibility to ensure that trainees' well-being is monitored, Dr. Prescott says.

"We owe it to ourselves in the profession to reach out to people who are trained to be physicians to see if there's something we can do to assist them," he says. "With these tragedies, we have to do everything we can to prevent them."

The ACGME's requirements say that sponsoring institutions "must provide residents/fellows with access to confidential counseling and behavioral health services." Some organizations have taken that a step further, with a proactive approach to promoting trainees' well-being.

One of these is the University of Washington, itself the scene of tragedy. In 2000, second-year pathology resident Jian Chen—distraught after his termination from the UW program—shot and killed his pathology professor mentor before turning the gun on himself.

The tragedy sparked a service aimed at helping residents handle the stress, burnout, and depression that often accompany their long hours and demanding duties. It is not enough to offer mental-health counseling, says Mindy Stern, a social worker who runs UW Medicine's Wellness Service.

"There's a mountain of evidence in the literature that mental health declines during the training years," she says. "You need to create a whole culture of wellness."

The program offers social events for residents and a weekly newsletter to let them know about fun, low-cost activities in the Seattle area. Stern says such outreach has helped earn the wellness program an 85 percent rate of self-referrals—as opposed to referrals by program directors or other officials.

"We have completely normalized the process of reaching out when someone's under stress," she says.

—Kevin B. O'Reilly

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A special honor for a vision and the Vanderbilt team's feats

A rousing speech that documented Vanderbilt University Hospital's use of laboratory expertise to improve test ordering and patient care while cutting costs earned Michael Laposata, MD, PhD, a standing ovation unprecedented in the nearly two-decade history of the Executive War College.

The cornerstone of the Vanderbilt approach, Dr. Laposata explained, is the diagnostic management team. These are collaborations among clinicians and pathologists to develop disease-specific, algorithm-based reflex test ordering. These standard operating protocols are derived from evidence-based guidelines.

Dr. Laposata

To help the physician understand the test results, a patient-specific, expert-driven narrative is provided for all evaluations in a number of specialty areas. This involves the interpretation of all evaluations in these areas of laboratory medicine—not just cases in which the physician asks for help to understand the meaning of the test results. This, Dr. Laposata said, transforms clinical lab test interpretation into something that works like anatomic pathology and radiology, where patient-specific interpretations are provided for all cases by specialists in the field.

This and other lab initiatives save Vanderbilt about $3 million each year by, for example, cutting unnecessary testing for leukemia and ordering pharmacogenomics testing to determine which patients do not get the expected antiplatelet effect from clopidogrel. While it costs Vanderbilt $300 per patient to order the pharmacogenomics testing, looking only at that side of the equation is shortsighted, Dr. Laposata said.

"It costs about $25,000 to bring someone in with a thrombosed stent. What if we can prevent one of those? It more than pays for the pharmacogenomics," he told the crowd of more than 800.

The diagnostic management teams take on all cases that emerge from the special coagulation laboratory, all hematopathology cases, each sentinel case from microbiology, and every transfusion case that involves transfusion reactions, massive transfusions, handling errors, and Rh incompatibility. Vanderbilt is expanding the approach to endocrinology, toxicology, and autoimmunity on the clinical lab side. The diagnostic management team is also active in neuropathology, with plans to expand it to all other areas of anatomic pathology.

Clinicians need lab reports that include concise, meaningful, individualized narratives, said Dr. Laposata, the Edward and Nancy Fody professor of pathology at Vanderbilt University School of Medicine. He will take over as pathology chair at the University of Texas Medical Branch at Galveston in July. He recounted, to appreciative peals of laughter from the audience, the first time he sent a report to a neurologist with a simplified narrative explaining which tests were ordered, why, and the results' clinical importance for the patient's care.

"Hey, Mike, under the numbers today there was a paragraph," Dr. Laposata recalled the neurologist saying in a phone call. "I understood it! And I handed it to the nurse who is also taking care of this patient, and she understood it!"

This kind of narrative report is now standard practice in the Vanderbilt clinical laboratory, Dr. Laposata said.
Robert L. Michel, editor-in-chief of *The Dark Report*, says the 30-second standing ovation Dr. Laposata received at the meeting in March was a first.

"In the 19 years we've produced this event, and that covers at least 800 people who have graced the podium, I cannot think of anyone else who got a standing ovation," Michel tells CAP TODAY.

“More to the point, these attendees are leaders in their own labs and recognize the commitment and zeal it takes to accomplish integrated diagnostics per Michael Laposata’s vision,” he adds. “That’s because of all the inertia that exists with hospitals and physicians’ practices. It was very clear that this standing ovation was the audience’s recognition of his extraordinary commitment and the level of energy he has invested to achieve those phenomenal results. For these reasons, that moment was all the more moving for Mike and the audience both.”

—Kevin B. O’Reilly

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Cancer care and patient demands

Despite claims suggesting otherwise, inappropriate cancer patient demands are few and rarely lead to unnecessary tests and treatments from their health care providers, according to new results from a study that was presented by researchers in the Abramson Cancer Center and the Perelman School of Medicine at the University of Pennsylvania during the annual meeting of the American Society of Clinical Oncology in Chicago in early June.

The Penn Medicine team, including lead author Keerthi Gogineni, MD, MSHP, an instructor in the Division of Hematology-Oncology in the Abramson center, surveyed 26 oncologists and nurse practitioners immediately after patient encounters at the center—2,050 in total—to determine frequency of patient requests or demands for tests and treatment, whether those requests were appropriate, whether they were granted, and why (abstract No. 6530).

“The results from this new study help debunk many of the misconceptions people have about patient demands leading to unnecessary tests and treatments as a major source of higher health care costs in the U.S.,” Dr. Gogineni said in a statement. “In this study, inappropriate cancer patient demands were uncommon, and in less than one percent of the cases did providers order an inappropriate treatment or test when requested by patients.

“Clinicians felt that the majority of patient-directed requests were appropriate,” she added. “The data suggests that rather than being driven by patients to employ low-value, high-cost care, most of the time oncologists and nurse practitioners incorporated patients’ requests into a suitable plan of action.”

Questions about patient demands were raised last year after results from a study presented at ASCO by Penn Medicine researchers revealed that more than 80 percent of the general public, 69 percent of patients, and 70 percent of doctors surveyed believed hospitals and doctors conducted unnecessary tests and provided unnecessary treatments, and over 50 percent believed patients requested unnecessary tests or treatments.

To find out, the team broke down the 177 encounters in which patients had requests or demands regarding treatment or tests. Nearly 80 percent of the time, the requests or demands from patients were deemed appropriate by the clinician and followed through. The rest were considered inappropriate based on the clinician’s judgment and were not ordered. Of the total number of encounters, there were only four instances (0.2 percent) in which a clinician ordered an inappropriate test or treatment because of a patient’s demand.

The patient base was mostly non-Hispanic white (73 percent), with a mean age of 60. Overall, 42 percent had advanced stage or refractory disease, and 66 percent were undergoing active treatment—49.5 percent had palliative intent.

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FDA OKs Qiagen Therascreen KRAS to guide treatment, Artus *C. diff* kit

Qiagen’s Therascreen KRAS RGQ PCR kit received Food and Drug Administration approval to guide the treatment of metastatic colorectal cancer patients with Amgen’s Vectibix (panitumumab).

Qiagen’s Artus *C. difficile* QS-RGQ MDx kit has been cleared by the FDA to qualitatively detect *Clostridium difficile*.

In addition, the FDA has granted 510(k) regulatory clearance for the QIAsymphony RGQ MDx system, Qiagen's automation platform.

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Beckman Coulter's phi named in NCCN guidelines

Beckman Coulter's Prostate Health Index (phi) has been recommended by the National Comprehensive Cancer Network as a blood test to improve specificity for prostate cancer detection in its recently updated clinical practice guidelines.

"It is exciting to see phi recommended in the NCCN guidelines. I started offering phi to my patients this year and it has proven to be a valuable addition to our shared decisionmaking process," said William Catalona, MD, principal investigator on the Prostate Health Index clinical study, in a statement. He is a urologist at Northwestern Medicine and director of the Clinical Prostate Cancer Program at the Robert H. Lurie Comprehensive Cancer Center of Northwestern University.