

In memoriam: Richard E. Horowitz, MD | 1931-2017

May 2017—Richard E. Horowitz, MD, a member of the CAP Board of Governors from 1997 to 2000, died March 15 at age 85 of complications from lung cancer.

Dr. Horowitz is a past member of the CAP's House of Delegates and the CAP's Practice and Education, Government Affairs, and Public Affairs councils. He was chair of the Outcomes and Performance Measures committees and a longtime member of the Committee on Computerized Laboratory Systems. He was a member, vice president, and president of the CAP Foundation Board of Directors.



Dr. Horowitz

"What I remember about him, really, is his integrity," says Paul Bachner, MD, who served as CAP president from 1999 to 2001. "He was just the kind of person who would always say what he thought was right. He was not a victim of political correctness. He would speak the truth."

"He was someone everyone respected," adds Dr. Bachner, a professor and immediate past chairman of the Department of Pathology and Laboratory Medicine, University of Kentucky, where he has served as director of laboratories since 1993. "He was an advocate for many things that weren't always terribly popular," such as use of the autopsy as a quality tool in medicine.

Dr. Horowitz took his advocacy to a public forum when, in a letter to the editor of the *Wall Street Journal*, published Sept. 22, 2016, he took his oncologist to task for not attending the autopsies of clinical trial patients.

"I think Richard saw that as a failure of quality control, a failure of the real role of the investigative physician," says CAP president Richard C. Friedberg, MD, PhD, who described Dr. Horowitz's letter to the editor in his column in the February 2017 issue of CAP TODAY. Noting that Dr. Horowitz used his own experience as a lung cancer patient to drive home his point in the *Wall Street Journal* letter, Dr. Friedberg wrote that Dr. Horowitz was "a pathologist to the core, the physician inseparable from the scientist."

Dr. Horowitz was a clinical professor of pathology at the UCLA School of Medicine and at the USC School of Medicine. He was director of laboratories and senior pathologist at Saint Joseph Medical Center in Burbank, Calif., for 27 years before returning to teaching in 1995. He was a past president of the Los Angeles Society of Pathologists and the Pathology Section of the California Medical Association.

Elizabeth Wagar, MD, a member of the CAP Board of Governors, met Dr. Horowitz when she was residency director at UCLA and needed assistance teaching management to residents. Someone recommended Dr. Horowitz as an expert in the field, and the two pathologists bonded over a shared interest in teaching good pathology techniques and good management.

What began as a "happy and collegial arrangement to develop management training" for UCLA, USC, Cedars-Sinai in Los Angeles, the West Los Angeles VA Medical Center, and UC-Irvine culminated in CAP Press' *Laboratory Administration for Pathologists*, published in 2011. Drs. Horowitz and Wagar and Gene P. Siegal, MD, PhD, intended

to “contribute a standardized educational approach for the rather unique area of management for pathologists,” says Dr. Wagar, a professor and chair of the Department of Laboratory Medicine at the University of Texas MD Anderson Cancer Center.

“That book has become sort of a bible, I would say, for laboratory management administration,” Dr. Bachner says. “I use it very much in my teaching of pathology residents. It’s become the main resource.”

Dr. Bachner notes with pride that it was he who convinced Dr. Horowitz to run for the CAP Board of Governors. “First of all, he was very knowledgeable, not only about the scientific side of medicine and pathology but also about administrative matters, organizational matters,” says Dr. Bachner. “He was very insightful about financial issues, fiscal issues, and he brought all of those skill sets to the CAP Board.”

To pathology, Dr. Wagar says, he brought his “total dedication to the profession and an unbiased perspective of the role pathology has in patient care.

“He could clearly be an advocate for autopsy at one moment, and then another moment be an advocate for clinical chemistry training in pathology.”

Colleagues speak warmly of how Dr. Horowitz’s integrity imbued his conversational gifts, which he employed to make his opinion known while honoring the dissenting views of his partners.

“He was the kind of person who was free with his advice but not critical of what you were doing,” Dr. Wagar says. “In other words, you felt that you got a response that could be helpful as compared to a critique. And he did that on multiple occasions for me, right up until two months before he died. He was a tremendous person in that way.”

Dr. Friedberg recalls receiving many notes from Dr. Horowitz, when he agreed and disagreed with something Dr. Friedberg had written. “He was very much a fan of dialogue and discussion in a way that is rapidly disappearing,” he says.

“He was not afraid of saying what he believed in,” Dr. Wagar says, “but never in a way that was offensive.”

Dr. Wagar recalls Dr. Horowitz’s sophistication, noting that he wore a tuxedo to CAP award events out of respect for the honorees. When Dr. Wagar attended the memorial service for Dr. Horowitz in Los Angeles on March 21 with her husband, Michael, and Dr. Friedberg, she advised the men to wear ties despite the warm weather. “Dr. Horowitz would wear a tie,” she said.

In the last year of his life, Dr. Horowitz wrote not just his letter to the *Wall Street Journal* but also an article published in the *Archives of Pathology & Laboratory Medicine* (Horowitz RE, et al. 2017;141[2]:186-187). He also worked with the CAP Autopsy Committee, and he spoke to the head of the U.S. Department of Veterans Affairs after writing a letter to the VA about the importance of autopsies.

“Instead of choosing to do small things, he chose to do big things, like contribute to the science of pathology,” Dr. Wagar says. “It’s a wonderful sense of what an honorable man he was.”

Dr. Horowitz is survived by his wife, Nona, three daughters, and four grandchildren.

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‘It is incumbent on oncologists to obtain autopsies’

Here is part of what George Lundberg, MD, chief medical officer and editor in chief, CollabRx, and editor in chief of the “Curious Dr. George” blog on the CollabRx website, posted April 19 about (and from) Dr. Richard Horowitz:

American pathology lost one of its greatest leaders (and I lost one of my best friends) when Richard Horowitz died on March 15, 2017 in Los Angeles, Calif. Still of sharp mind and keen humor, he died with dignity and grace, in a manner of his own choice during home hospice care, of metastatic non-small-cell adenocarcinoma of the lung.

Richard and I met across an autopsy table at the old LA County General Hospital in summer 1967. We bonded and remained colleagues and friends who shared many professional beliefs based on personal experiences for 50 years.

Richard was born in Vienna, Austria, on May 17, 1931. He left Austria with his parents to flee Hitler's scourge in 1939.

Richard's total course of illness after initial diagnosis (malignant pleural effusion discovered at a routine annual medical checkup with established widespread metastases) was nine months. He tried "precision oncology"; his cancer was found to harbor an EGFR mutation, so he was begun on erlotinib. He experienced adverse effects of such severity that he decided to decline further "curative" therapy of any sort and quickly moved into palliative home-hospice care.

His final (of many) contributions to the CollabRx discussion group posted this year on Feb. 25 [in response to a Q&A on developments in precision medicine for treating cancer]. It reads:

You are making pronouncements and decisions based on insufficient knowledge. Until the use of autopsies becomes the standard of whether the new therapy worked or how the new therapy's side effects caused the death, we do not have adequate data. I previously sent the following:

1. A letter sent to the Wall Street Journal (published on Sept. 22, 2016): "... The autopsy is a credible outcome measure; nothing else can attest as convincingly to the accuracy of a diagnosis or the efficacy of a therapy. Few, if any, clinical trials utilize the autopsy to test their hypotheses. ..."

2. A short composite of the many autopsies I have personally done: The patient has stage IV lung cancer; all standard therapy has failed. The patient is coerced into treatment, first with targeted therapy and later with immunotherapy. Soon he experiences diarrhea—the oncologist "handles" that with loperamide, which results in annoying constipation. Then after a few days, there is marked increase in dyspnea—is it a progression of the disease, perhaps carcinomatous pneumonia or therapy-related (autoimmune) interstitial pneumonitis? Well, that can certainly be treated with steroids. Oh, the oncologist forgot to tell the patient that he needs CNS radiation because of brain metastases. So the patient is given a course of radiation therapy—unfortunately, there is significant cerebral edema. Again the oncologist ameliorates that with steroids; however, the cognitive impairment and confusion persist. About the same time there are cardiac arrhythmias—are they due to metastases to the heart or due to "autoimmune" myocarditis? No worry, add more steroids. Regrettably, a mixed bacterial and fungal pneumonia develops and that, of course, is treated with powerful antibiotics. Within a brief period of time another bout of diarrhea, this time due to *C. difficile*, develops and progresses into a dire megacolon that appears about to perforate. The patient is taken to surgery; the colon has, in fact, perforated and a segment is resected. In the surgical ICU the early signs of sepsis appear; soon septic shock ensues and the patient dies after prolonged intensive, but futile, care. The surgeon requests an autopsy, the oncologist does not attend the autopsy and does not answer the call when informed of the cause of death.

In September 2015 the National Academy of Sciences/IOM released its report "Improving Diagnosis in Health Care." The report listed eight goals and multiple recommendations. Goal 4 was to develop and deploy approaches to identify, learn from, and reduce diagnostic errors and near misses in clinical practice, and recommendation 4C was that HHS should provide funding ... to conduct routine postmortem examinations on a representative sample of patient deaths. It is incumbent on oncologists to obtain autopsies—then they will know if their "magic bullet" worked or killed. —R. E. Horowitz, MD