



Intradepartmental consultations in surgical pathology: Review of a standardized process and factors influencing consultation rates and practices in an academic and community hospital setting

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ABSTRACT

Intradepartmental consultations (ICs) are important for quality assurance (QA) and ensuring diagnostic accuracy in surgical pathology. Few studies have reviewed pathologist factors that influence IC rates. Our study reviews IC data and factors that influence both formal (written) and informal (verbal) consultation practices among pathologists in academic and community hospital settings. Formal IC records from the academic hospital were collected and academic and community pathologists were invited to complete a survey about their IC practices. All centers had a formalized process for documenting ICs; however, 92% of academic and 90% of community pathologists also requested informal IC. The top reasons for selecting a particular colleague for IC was perceived level of expertise; however, interpersonal relationships and office proximity had a greater impact on informal IC practice. Top reasons for requesting a formal IC were mandatory (subspecialty defined) consultation and uncertainty regarding pathological findings. Advice on wording was a common reason for informal IC. Written documentation of IC aids in QA and determination of IC metrics; however, informal, undocumented ICs still occur. Reasons for IC and choice of consulting pathologist are multifactorial, and identifying these can help target quality improvement initiatives.

1. Introduction

Intradepartmental consultation (IC) in surgical pathology is the practice of asking one or more colleagues for a second opinion on a case, usually with the aim of improving diagnostic accuracy. IC is an important component of quality assurance (QA). ICs can occur directly, pathologist to pathologist, or through case conference or team rounds. ICs can be formal (FIC), where a pathologist asks for the written opinion of another pathologist, or informal (IIC), where a pathologist receives a verbal, often undocumented, opinion from a colleague.

Despite IC being a known reason for delayed turn-around time [1], it is perceived as essential for QA in a pathology laboratory [2,3]. There are published guidelines in Canada to encourage the use of IC which emphasize that not only should IC be performed, but it should also be documented to permit assessment of IC patterns and inform quality improvement (QI) initiatives[3,4].

Many studies have reported reasons for IC in specific organ systems where there may be difficult diagnoses or discrepancies in grading, staging and subtyping, such as in melanocytic lesions, bladder biopsies, and breast pathology [5–7]. Additional studies have examined the

discordance rates of a double review, such as prior to multidisciplinary rounds [8,9] and the role of IC in reducing error [2,10]. However, there is little information about factors influencing pathologists' decisions to seek IC or how they select a specific colleague.

The pathology department of the academic hospital in this study consists of 25 subspecialty pathologists and has a formalized process for documentation of ICs. Pathologists are encouraged to use an IC form (Fig. 1) and to document the IC in the final report. IC forms are stored in the pathology department, data on ICs requested and provided are kept, and anonymized individual pathologist IC rates are published quarterly. The community hospital departments surveyed consist of 17 pathologists; all reported a formalized process for documenting ICs at their institution.

This study aimed to 1) review IC data from a pathology department in an academic tertiary referral center, 2) stratify factors that influence FIC (written) and IIC (verbal) rates, 3) compare these with factors influencing IC rates of pathologists in community practice.

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LHSC DEPARTMENT OF PATHOLOGY		INTERNAL CONSULTATION FORM	
Accession #		Patient Name:	
		Age/Sex:	
<i>Relevant clinical information, specimen type, preliminary diagnosis, specific questions:</i>			
Requesting pathologist: _____		Date: _____	
<i>Write name/initials of consultant pathologist in box below. Consultant to write comments, slides reviewed and sign in space below.</i>			
	Slides reviewed:		

Fig. 1. Documentation form used for formal internal consultations (ICs) in the department of pathology at the London Health Sciences Center.

2. Methods

2.1. Academic hospital

FIC records at the academic hospital from January to December 2015 were retrieved and reviewed.

All pathologists were invited to complete an anonymous online survey regarding their FIC and IIC practice. For the purpose of the survey, FIC was defined as cases where a written opinion was requested using the departmental IC form, and IIC was defined as cases where a verbal opinion was received from a colleague, regardless of whether or not the IC was documented in the final report.

2.2. Community hospitals

Pathologists from 4 regional community hospitals (n = 17) were asked to complete the same survey.

3. Data collection and analysis

Data regarding the number of ICs requested and provided by each pathologist at the academic hospital were correlated with years of experience.

Pathologists in both surveys were asked to rank a predefined list of 1) reasons for requesting FIC and IICs and 2) factors influencing colleague choice for FIC and IIC; these factors were then given relative rankings based on weighted averages. The weighted average for each parameter was calculated by assigning a weight value according to the rank of each parameter, e.g., each time a parameter was ranked 1st by a participant it was given a score of 6 or 7 (depending on the total number of options); each time a parameter was ranked last by a participant, it was given a score of 1. These were summed for each parameter (weighted ranking), and then divided by the number of participants (weighted average). Relative weighted averages were compared

for each parameter.

Pathologists were also asked about factors that may deter them from seeking an IC from a colleague and their perceived impact of subspecialty rounds and publication of IC rates on their IC practice.

4. Results

4.1. Academic hospital

FIC was requested on 2769 surgical pathology cases (5% of total cases for 2015). With years of pathology staff experience, the ratio of requested to provided ICs tended to decrease (Fig. 2).

One hundred percent (25/25) of pathologists at the academic hospital completed the online survey regarding IC practice. Ninety-two percent of pathologists sometimes requested IIC; 72% of these never documented IIC in the final report, 18% sometimes documented IIC and 9% always documented IIC. FIC was documented in the final report always (77%) or most of the time (23%). The mean self-reported FIC to IIC rate was 3.5:1; FIC percentage ranged from 30% to 99.5%.

Ranked reasons for academic pathologists to request FIC and IIC are shown in Fig. 3a and ranked factors influencing colleague selection for FIC and IIC are shown in Fig. 3b.

A poor relationship with a colleague was a potential deterrent to FIC for 35% and to IIC for 67%. Forty-eight percent felt that team rounds in their subspecialty reduced the number of ICs they requested. Quarterly publication of de-identified pathologist IC rates either resulted in an increase in FIC or had no impact (Table 1).

4.2. Community hospitals

Fifty-nine percent (10/17) of pathologists completed the survey. Ninety percent of community pathologists requested IICs; 67% of these never documented IIC in the final report, and the remaining 33% sometimes documented IIC. FIC were documented in the report always

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