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Transformation of Pathologists: Responding in a Volatile, Uncertain, Complex, and Ambiguous Environment
Hernandez JS, Allen TC (Mayo Clinic, Scottsdale, AZ; Univ of Texas Health Science Ctr Tyler)
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Background.—Pathologists are suffering a general discontent, frustration, disappointment, and even burnout. These negative attitudes develop in response to their current environment, which is characterized by volatility, uncertainty, complexity, and ambiguity (VUCA). What this means and how pathologists can turn things around were discussed.

VUCA Causes and Responses.—Pathologists experience volatility in the rapidly changing state of molecular/genetic/personalized/tailored medicine. Uncertainty can be related to political agitation over the current state of health care delivery and spending. Complexity can come from the constantly changing and increasing demands on pathology-resident education. Ambiguity arises when pathologists try to satisfy the different demands placed on them in private and academic spheres. In response to these influences, pathologists find that they can no longer offer straightforward answers to straightforward questions, but must deal with a new set of communication and practice behaviors.

Best Responses.—To counteract the influence of VUCA, pathologists need to prepare themselves to cope with the challenges in different and novel ways. To counteract volatility, pathologists must ask laboratory teams to translate their data into information that can be used, then practice communicating clearly and in ways that others can understand. Volatility can then become vision. Uncertainty can be managed by instituting challenges to the mental models that pathologists generally use. Red-teaming can help. This approach introduces a devil’s advocate to offset the influence of “group-think.” Flexibility in planning can also neutralize the effects of uncertainty. These moves turn uncertainty to understanding. Complexity can be addressed by developing collaborative leaders who see the big picture and lead peers to work collaboratively, thereby achieving more corporately
requesting. Currently, many laboratories are exploring demand management using a plethora of disparate approaches. Hence, this review seeks to provide a ‘toolkit’ with the view to allowing laboratories to develop a standardised demand management strategy (Fig 1).

Like other sectors of the health economy, laboratory medicine is under increasing pressure to remove inefficiencies and reduce costs, while maintaining or improving standards. In the United Kingdom, this is reflected in a Department of Health drive to make £500 million in savings in laboratory medicine by a package of measures, including large-scale laboratory reorganization. Attention has focused on laboratory medicine as a potential source of savings, presumably because their costs are perceived as being easily identifiable and quantifiable, despite the fact that expenditure on this area accounts for only 3% to 4% of the UK national health budget. However, in an attempt to meet targets such as those outlined in the Carter Report, laboratories are increasingly looking at demand management as a means of reducing the cost of unnecessary pathology investigations. Estimates of inappropriate requesting vary greatly among studies, although the Carter Report gave an overall estimate of around 25%. This review examines the drivers for demand management, investigates how we define and detect an inappropriate request, and provides tools to limit such requests. It also discusses the wider impact of implementation of demand management approaches. It provides a series of specific recommendations with a view to helping the reader develop a wide-ranging demand management strategy (Fig 1).

M. G. Bissell, MD, PhD, MPH
A major application of tumor biomarkers is in serial monitoring of cancer patients, but there are no published guidelines on how to evaluate biomarkers for this purpose. The European Group on Tumor Markers has convened a multidisciplinary panel of scientists to develop guidance on the design of such monitoring trials. The panel proposes a 4-phase model for biomarker-monitoring trials analogous to that in use for the investigation of new drugs. In phase I, biomarker kinetics and correlation with tumor burden are assessed. Phase II evaluates the ability of the biomarker to identify, exclude, and/or predict a change in disease status. In phase III, the effectiveness of tumor biomarker-guided intervention is assessed by measuring patient outcome in randomized trials. Phase IV consists of an audit of the long-term effects after biomarker monitoring has been included into standard patient care. Systematic well-designed evaluations of biomarkers for monitoring may provide a stronger evidence base that might enable their earlier use in evaluating responses to cancer therapy.
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