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Conceptual Paper

Euphemisms and Delineations in Cellular Pathology

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Organization and Environment of my team

My organization consists of me and my staff as we are aimed primarily at providing early cancer detection services to one and all- General Physicians, and various specialists- Gastroenterologists, Surgeons, Gynaecologists etc. We do mostly General Surgical Histopathology/ Non Gynaecology and Gynaecology Cytological work (Screening in the form of Pap Smears/Guided and Non-guided Fine Needle Aspiration Cytology as office procedures and Bone Marrow Aspirations to rule out various Anaemias/Leukaemias/Myelodysplastic Syndromes/ Platelet Disorders etc). Reporting is done by me and my team assists me in performing procedures and appropriate processing for various samples, maintaining records, maintaining quality, handling patients etc. For guided FNAC,s I work with many ultrasonologists, as provided by the institution/working freelance. I have a good rapport with my entire team, referring doctors/radiologists/technicians etc. My histopathology technologist is extremely essential and complimentary to my work, he understands my requirements for particular sections (thin/variously stained for special stains for different disease processes etc). For Bone marrow aspirations I rely on the trained and competent staff at the operation theatre who assist me with the procedure and the processing is done by my staff.

Challenges faced, Strategies Implemented, Influencing and Engaging those around, Motivating

Juniors, Sustainability, Culture Change, Pushing Boundaries, Breaking Down Barriers, Risk Taking To build up the friendly environment and the rapport I share with my working team, I had to initially and even now so sometimes, work with them hand in hand for various procedures, establishing standards in processing/ staining, managing timings and formulating/evolving working procedures, thus form close corroborative working relations. Even now, as and when we replace a team member, the new entrant is advised and briefed on our way of working, cohesive, with a team spirit, to present a single working unit to the people we provide our services. Initially when I started independent practice, the surrounding GP's and Consultants were a bit skeptical of my work as I was too young to launch out on my own. Though I did not receive any major complaints, I did receive a few inputs about simplifying my work as my reports, they said were too technically worded, concise and exacting and at times they had a difficulty in interpreting them. Something which even now I have not been able to manage, as to deviate from technicality I felt could destroy the essence/or alter the quality of my report-which could be unfair to all-the patients, the referring doctors and me as I would then lose the freedom of expression of my opinion-professional or otherwise.

In the first three to four years of independent practice, few of my cases(slides), both histopath and cytopath were requested by the patient/referring doctor for a second opinion, especially malignancies and were sent to practically all the teaching institutes and large corporate hospitals in Delhi, of which there are quite a few. I got a positive feedback from all of them, except an occasional, politely worded query from a patient's relative. Subsequent to which and with the doctor's initial queries/inputs, I started spending a few minutes with every patient trying to explain to him my report in simple terms (without modifying the written part), the disease process per se, its evolution and possible treatment modalities, while being careful of any imposition/infringement on the rights of the treating doctor or the oncologist (medical/surgical). Similarly, I handled the queries of the General Practitioners/ referring Surgeons/Gynaecologists/Gastroenterologists, telephonically while discussing my provisional diagnosis, asking for clinical inputs when in doubt or when faced with some technical error and explaining my reports (especially differential diagnosis where expensive immunohistochemical stains were required, something to which I did not have much access to because of the cost factor and patient's limited paying capacity. I would then refer such

cases to tertiary care hospitals with a written request and then confirm my diagnosis at a later stage). But this strategy worked well and did not let me down as I was honest in my implementation. My feedback/inputs, written reporting and verbal follow-ups influenced a large number of doctors in the clinical segment, infact all specialities I was interacting with, all involved with general surgical histopathology/general practitioners who learnt the value and referred patients for Fine Needle Aspirations, interpret reports, treat some and refer some patients, as per diagnosis/Gynaecologists for guided FNAC's/Pap smears for screening. Pathologists, I feel I have not been able to influence much but I do wish they would take a leaf out of my book.

After my initial trial run of about 3 - 4 years (from Jan 1996 till mid 1999), I did not have much difficulty in sustaining my work with the methodology I had gradually evolved. It was well accepted by my peers in all faculties. Independent(single handed) reporting of histopathology/cytopathology samples (where there is little, if any, chance of issuing a retraction/modification) and early detection of malignant/premalignant conditions, though much appreciated, is fraught with much risk (an unusual concept especially for one so young as I was when I launched out on my own and took some getting used to), even as there is an increased patient awareness, the formulation of the consumer protection act and the possibility of being entangled in a litigation, claims of negligence/error/fraud, even though one may not have been intentionally dishonest or grossly negligent.

As far as changes in culture or pushing boundaries is concerned, I'm still working at it. Trying to bring about change in the way medicine is practised and perceived, thinking and evolving new modalities, trying to bring about its implementation in my own small way and hoping people will understand and emulate me.

Quantifiable and Measurable improvement in patient care

As perceived by all doctors patients and subspecialities I and my team provide services to, the early detection of malignancies and premalignant conditions provides much insight into the disease process, the aetiology of neoplasia, the cultural, environmental, genetic and preventable influences in the occurrences of malignancies and premalignancies with the requisite stimulus required for the conversion of premalignant lesions to frank, invasive cancer and the time required to do so.

Gynae cytology that we do in the innumerable pap smears identifies patients within the spectrum of non-specific inflammatory/fungal/parasitic infections, intraepithelial neoplasia till the occurrence of frank, invasive cancer. Similarly fine needle aspirations that we do as a simple office procedure, identifies patients with metastatic malignancies, cases with h/o tobacco intake and deposits in cervical lymph nodes, inguinal lymph nodes with deposits from cervical cancer, primary age-related lymphomas, chronic inflammatory conditions such as granulomas secondary to mycobacterial/fungal infections, goitrous or diffuse enlargement of the thyroid or solitary thyroid nodules, Guided FNAC's for metastatic liver or primary hepatocellular carcinomas, Ovarian cysts with associated syndromes or the common cystic lesion of the skin are some of the diagnosis we offer to the patients. Procedures in the minor OT such as Bone Marrow Aspirations to diagnose, classify and quantify varieties of anaemia, white cell and platelet disorders and myelodysplastic syndromes, all assist the clinical segment to treat and counsel the patients accordingly. For a select category of infertile patients and nearby. Gynaecologists, I and my team offer some Assisted Reproductive Technologies such as preparing seminal samples for Intrauterine Insemination.

The methodology I and my team have evolved and use to arrive at a conclusion or a diagnosis is a need based, self-evolved one, and consists of taking a brief but a relevant clinical history, examining the patients within the relevant parameters as well as co-relating other investigative findings such as the clinical exam, the CT/MRI or plain radiographs, serological/haematological/biochemical investigations etc. All the above mentioned steps taken ensure that our error is minimized, we make fewer mistakes and be safe against a possible complaint or a litigation (which apart from being unpleasant, is quite an expensive proposition). These benefits are also in the interest of the patient. The General Surgical Histopathology and Non-Gynae Cytology reporting that I do ensures that keep abreast of all the chapters/systems given in the text required for reporting and I tend to refer to the text practically everyday. I also attend to regular CME's in other disciplines of medicine viz (medicine/gastroenterology/cardiology/gynaecology/nephrology etc) to keep abreast of the latest developments in the respective fields. It helps in better co-relation. While history taking and doing the procedure, the interaction with the patient

was confidence inspiring at the same time increasing awareness of the public about the all important role of the pathologist. It was also a cost effective measure as most procedures are done in one attempt and not repeated. However repeated procedural work for different patients added to the expertise and diagnostic accuracy, at the same time reducing patient discomfort. Attending CME's ensured we understood the limitations/restrictions experienced, the pitfalls encountered by the diagnosing pathologist, yet highlighting the quality of services rendered, the importance of which cannot be underestimated or overemphasized. Once the diagnosis or a suitable differential is made and the patient is referred to the appropriate tertiary care centre and is taken up for the appropriate treatment modality (Radiotherapy/Chemotherapy/Surgical Intervention) as decided by the treating Medical Oncologist, resulting in early diagnosis, proper and timely treatment. All these measures reduce the psychological stress or trauma endured by the patients, reduce hospital stay, less number of subsequent follow-up visits, reduction in iatrogenic infections and an overall cost benefit to all, the patient, his family, the insurance concerns, the hospitals, reduced load on public sector facilities and proper utilization of the taxpayer's money, the benefits on the society are multifold.

Since I am working independently, I do not have a Chief Referee, only Colleagues that I interact with.

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