

SOCIETY FOR PEDIATRIC PATHOLOGY

NEWSLETTER

Fall 1995

FROM THE EDITOR'S DESK

Those of us who have heard were shocked by the untimely and tragic death of our colleague Dr. Sudesh Kapur (See "In Memoriam" on page 2).

Dr. Steve Qualman has issued his report from the Society for Pediatric Pathology Practice Committee. While it is lengthy, I think it is a very useful document, and he and his Committee are to be congratulated.

The charge to the Committee was to address Denis Benjamin's challenge "How much is necessary" (Pediatric Pathology 1994; 14; 755-6, Editorial). A list of specimens exempt from the requirement that they be submitted for pathologic examination is included. Caveat - if such specimens are received, they should be accessioned, examined and reported grossly. Enlarged or normal appearing tonsils should be examined histologically. A suggestion was made that it might be wise to hold onto representative fixed blocks for three months should a request for examination come later.

The vexing question of managed care is the "Talk of the Town." The managed patient and the managed physician are subservient to unscrupulous mega-salaried corporate management, who are endangering patient care in the country. Hopefully, there will be a wake-up call soon. Maybe it will take a Ralph Nader to do this. We should debate this issue in our Society.

Dr. John Masten in his article "Healthcare Reform and Laboratory Management" capsulized the parameters of this on-going reform.

Kudos go out to Dr. Elizabeth Perlman for the outstanding interim meeting that she hosted in Baltimore.

Best Wishes.

John Fisher MD.

PRESIDENT'S MESSAGE

- Joel E. Haas, MD

"A Sad Time and Interesting Times"

I am saddened by the unexpected death of friend and colleague, Sudesh Kapur, MD. We expect the old to die and we mourn their passing. Sudesh was not old. We do not expect our peers to die. Some, choosing to deal with death as a career, may be better or worse prepared to deal with such loss. I grieve for Sudesh's family and her colleagues at DC Children's Hospital. I grieve for us all, diminished by this tragedy. We will miss her.

Recently the Internet SPP Email List has seen discussions of difficult diagnostic problems, and practice customs in surgical and autopsy pathology. Most enlightening was the discussion over the "place and nature" of a discussion of clinical-pathologic correlation in an autopsy report. A dozen or more Email messages serve to encourage the professional role of the pediatric pathologists in meaningful professional dialogue and outcome assessment.

During a recent talk the President of NACHRI related that approximately 45 free standing children's hospitals exist in the US and Canada. Apparently 14 of these are included in a 600 mile radius circle centered in the northeast US. California allegedly claims 12 children's hospitals! What will be the counterpart of these figures 10 years from now?

Pediatric pathologists are anxious about their laboratories confronted with restructuring of "health care insurance" or "managed care." Though not relief for pain I offer a retrospective on one outcome. In 1988 the six hospitals of the Detroit Medical Center "shed" their individual laboratories to unite behind a central laboratory system. A commercial laboratory was retained to provide services. The Children's Hospital, like the others, retained an "on-site" stat lab (owned and operated by the central lab) and continued to retain a pediatric pathologist medical director to assure that children's special needs did not get lost in the larger laboratory milieu. After 5 years, the commercial contract was terminated in favor of a newly formed corporate subsidiary to the Detroit Medical Center. The Chair of Pathology and an accomplished businessman serve as President and Executive Director respectively of the "Detroit Medical Center University Laboratories." The Pathology Chiefs at constituent hospitals serve advisory and approving roles in all professional medical matters. Each hospital administration budgets and contracts individually with the central laboratory for a flat annual fee to cover all anatomic and clinical pathology services. Dollar costs per test are among the lowest of comparable LMIP figures in the nation. The Children's Hospital of Michigan bills patients for inpatient testing when possible. It is not deprived of ancillary benefits of patient admissions covered by managed care payers who refuse to pay for lab tests "not sent to their laboratory." The Children's hospital and the Laboratory thrive in a mutually supportive relationship.

Included with this newsletter:

INFORMATION ON

- Young Investigator Award
- Hotel and Travel for the 1996 Annual Meeting
- 1996 Slide Survey
- Managed care issues at Annual Meeting
- 1996 Annual Meeting

In Memoriam

It is with sorrow that we inform you of the death of Sudesh Kapur, Pediatric Pathologist at the Children's National Medical Center in Washington, DC, Associate Professor at George Washington University Medical Center, and an active member of the Society for Pediatric Pathology. She was severely burned in an accident at home on September 22, 1995 and passed away on October 3, 1995. A memorial service was held at the Gandhi Memorial Center in Washington, DC on October 7, 1995. Our hearts go out to her grieving husband Shakti and children Namzita and Navin. For those who wish, donations may be made to the Gandhi Memorial Center or the Montgomery County Association for Hearing Impaired Children, PO Box 6610, Silver Springs, MD 20916.

Second Annual Meeting of the Metropolitan Pediatric Pathology Club Dena Selby, MD

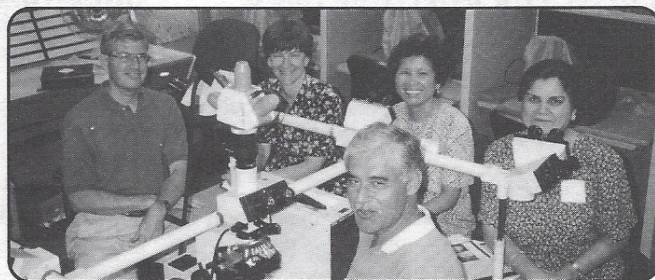
The second annual Saturday Meeting of the Metropolitan Pediatric Pathology Club was held on September 9, 1995 at the Armed Forces Institute of Pathology. It was attended by Drs. Askin and Perlman from Johns Hopkins University School of Medicine, Dr. Sun from University of Maryland Hospital, Drs. Kapur and Selby from Children's National Medical Center, Drs. Stocker and Conran from the Uniformed Services University of Health Sciences and Drs. Sotelo-Avila and Dickey from the Armed Forces Institute of Pathology Department of Pediatric Pathology.

Dr. Sotelo-Avila began the session by showing a sequestered meningocele of the scalp. Dr. Dickey showed a case of an unusual seed mimicking a parasite in the appendix of an Eskimo child. Dr. Perlman showed two pineal glands, a colon infected with *Entamoeba histolytica*, an inflammatory pseudotumor of the urinary bladder, lymphoid predominant thymoma, and a pheochromocytoma. Dr. Kapur showed a sequestered meningocele of the scalp, a post bone marrow transplant EBV-related lymphoproliferative disorder/lymphoma and a myocarditis/encephalitis due to Coxsackie B2. Dr. Shelby showed Meckel-Gruber Syndrome and a persistent cloaca; both were autopsy cases. Dr. Conran showed a small cell variant of hepatoblastoma. Dr. Sun's cases included leiomyosarcomas involving the sinus, GI tract and endobronchial region in a 7 year old with congenital HIV infection, and a rhabdomyosarcoma of the testis in an 11 year old. Some discussion during the session included histiocytoid cardiomyopathy. Dr. Sotelo-Avila kindly found a slide of this entity from his files to show to the group.

The meeting reconvened at a restaurant for the remainder of the evening, also attended by Mrs. Askin and Mrs. Stocker. A lively

discussion of many various topics occurred, and everyone celebrated the end of a month long drought as rain began to fall outside the window of the restaurant.

The Metropolitan Pediatric Pathology Club meets once a month, generally on the morning of the third Tuesday, usually beginning with a journal club, followed by sharing of interesting cases. The location varies from month to month throughout the Metropolitan area. For additional information contact Dr. Selby at 202-884-2051.



Drs. Geln Dickey, Elizabeth Perlman, Chen-Chin Sun, Sudesh Kapur and Cirilo Sotelo-Avila

Practice Committee Survey Results Stephen J. Qualman, MD

In November of 1994, a practice survey was sent to all SPP members which included 23 topics covering a spectrum of practice concerns. Each individual was asked to rate each topic listed as an Important (I), Relevant (R), Backburner (B), or Unimportant (U) issue to him/her as a practicing pediatric pathologist. Responses were weighted numerically from 0 points (Unimportant) to 4 points (Important) and topics were ranked by total weighted score.

Seventy-four responses were obtained from 50 institutions. The top seven responses, ranked as either Important or Relevant by 85% or more of respondents are given below:

- Topic 5: The role of the pathologist in a Physician Hospital Organization (PHO) (95% of respondents)
- Topic 16: Creative/efficient/medically appropriate approaches to the restructuring of pediatric laboratories (88.9% of respondents)
- Topic 8: Laboratory involvement in hospital development of critical pathways (88.5% of respondents)
- Topic 19: The role of molecular pathology testing in the pediatric laboratory (87% of respondents)
- Topic 15: Diagnostic testing algorithms (should we establish minimum practice standards in our service activities?) (86.2% of respondents)
- Topic 12: Approaches to the measurement and control of laboratory utilization practices (84.5% of respondents)
- Topic 1: The status of decentralized laboratory testing in pediatric laboratories (84.5% of respondents)

Clearly in analyzing these results, there is a strong feeling amongst the respondents about the importance of management and quality improvement issues in today's service-oriented pediatric laboratory. In this issue of the SPP Newsletter we have begun to address some of these issues (primarily item 15, triage of surgical specimens for examination).

In future issues of the Newsletter, the Practice Committee will address the management issues considered important to the practicing pediatric pathologist, through position papers which reflect opinions garnered from the Medical Directors of laboratories within the discipline.

*Friendship is like a bank account,
you can't continue to draw on it
without making deposits.*

Anonymous

The "Point-Counterpoint" Issues of Tissue Examination and Diagnosis in a Managed Care Setting - A Report of the SPP Practice Committee

Stephen Qualman, MD - Chair

Dr. Denis Benjamin has raised the issue of what is necessary for the pediatric pathologist to do in terms of microscopic examination of tissues (How much is necessary? *Pediatr Pathol*, 1994; 14:755-6). He notes "I recall a time, not too long ago, when everything removed in the operating room required the blessing of the hospital Pathologist." He also comments that "Perhaps half of all our specimens are of this ilk-submitted to us, not for our expert opinion or diagnostic consultation, but because it is prescribed... Perhaps it is time for the practice committee of the Society for Pediatric Pathology to help us develop guidelines for which specimens should have a careful gross examination only, which warrant a more detailed look, and which could be happily consigned to the landfill." There will be no unanimity on this point amongst SPP members. What follows is an editorial with another viewpoint on this matter submitted by Douglas C. Anthony, MD, PhD, Director of Neuropathology at Children's Hospital, Boston, MA. In addition, criteria from another Children's Hospital (Dr. Popek, Texas Children's Hospital) regarding the exemption of specimens from pathologic exemption per the surgeon's discretion are presented. Finally, the diagnostic yield from microscopic examination of routine surgical specimens in the experience of multiple pediatric pathologists is presented.

Quality and Cost are Inter-related in Pathology

Douglas C. Anthony, MD, PhD

In a recent editorial (above), an opinion to limit the processing of specimens in pathology laboratories was presented, citing tonsillectomy specimens as particularly dreadful. Which specimens should we embed, which should we examine microscopically, and which should simply be discarded? In exploring the reasons for processing specimens, three reasons were offered: diagnosis, legislation, and tradition. With these reasons for examining specimens, arguments can be developed that 50% of the specimens do not need to be examined and may be "happily consigned to the local landfill."

There are other good reasons why specimens are examined by pathologists; however, these reasons can, and should be explained if money is spent in their pursuit. I propose five reasons why pathologists should examine tissue: diagnosis, pathologic review, documentation, preservation of a resource, and research. Since there is only one overlapping rationale with those above, it is apparent that the importance of legislation and tradition as rationale for our actions is in question.

Legislation and tradition Passive resistance and activism are powerful means of dealing with inappropriate legislation.

Although there are guidelines and policies of hospitals and regulatory agencies that govern the disposition of tissue, if the policy is senseless and wasteful, it should be changed. We also cannot be hand-tied by tradition, and it seems we have not. Comparing a pathology department with that of only 20 years ago, few remnants of the old system exist. Changes in staffing need, updating of computer systems, and changes in the physical plant all occur with great speed. Electron microscopes, immunoperoxidase facilities, *in situ* hybridization, PCR methods, and molecular diagnostics laboratories are markers of the contempt we show for tradition. And, so while we remember history of our practice with admiration for those who helped us achieve our current level of understanding, we abandon archaic processes and replace them with the most modern and economical practices.

Diagnosis Most would agree that making diagnoses is the main reason that specimens are examined. It is a time-consuming and high-pressured part of our job, but it is exciting and rewarding, with positive feedback from primary physicians who let us know how much they need our diagnosis (often yesterday). We share interesting cases with each other, and are proud of the diagnostic work that we do. But the handling of specimen involves more than making our star diagnosis.

Pathologic review One reason that we process specimens is to review the work of others who are removing tissue from patients. This pathologic review is objective, permanent, and is most effective when consistently invoked: if tissue is removed from a patient, the case will be reviewed by a pathologist. This review process differs from peer-review in that it is based, not on the clinical record, but independent histologic data. It is an objective review that generates both a permanent sample as the primary data and a report.

It is true that there is nothing exciting about reviewing the typical appendix, but the act of review serves as a guarantor of quality. Offering to let the surgeon determine which case to submit completely undermines this pathologic review process.

Documentation Documentation is different than review, and is at an even lower level on the scales of interest and glamour. When examining the section of fallopian tube or vagal nerve, no diagnostic acumen is needed. Of course, we have all seen exciting cases that arise during the simple documentation of a case. I will never forget the intracerebral "blood clot" specimen that had Aspergillus, and how that finding changed the patient's prognosis and therapeutic plan! But this is the diagnostic role and, therefore, a separate issue. In some cases we are just documenting. It is an objective process, and serves as documentation of procedure should questions arise later. Interestingly, this documentation is also a permanent sample. Recently a small piece of connective tissue was retrieved at this hospital as the only remaining sample from a patient who had died of a genetic disease. No autopsy was performed, and the mother was pregnant and wanted to know if the fetus was affected. That piece of "worthless" tissue, saved in a warehouse for 3 years, was the basis for genetic evaluation and counseling on the continuation of the pregnancy.

Resource It may sound strange to think of specimens like tonsils as a resource, but we use them to teach about recognition of site from the histologic finding, to recognize *Actinomyces*, and to learn and remain familiar with different types of lymphoid hyperplasia. We use this tissue to develop special stains and to make sure the stains are working. In our laboratory, tonsils are the control tissue for lymphocyte panel and proliferation markers.

Research The difference between a mess of junk and a treasure trove is often how you view it and how you use it. There are many remaining questions about why some children need tonsillectomy; it seems premature to simply discard all this tissue and consider the issue resolved. One day we will look back on our ignorance in disbelief, just as I look back now on the older methods for handling muscle and nerve biopsies and how we viewed them as uninformative pathologically. We should keep in mind that there were those who said that nothing useful would ever come from the examination of any surgically-removed tissue.

Cost and benefits In order to determine whether things are worth doing, we have to compare the benefits to the cost. Our patients benefit from the diagnoses that are rendered immediately, and by the service we provide in retaining this tissue and making it available to them or their families for future analyses. The primary physicians benefit from our efforts, not only from the diagnoses on difficult cases, but also from our roles in vigilance for new trends in specimens submission and our role in guaranteeing quality for the hospital. Finally, the process is beneficial to society in the retention of tissue for research. All the benefits of the pathologic knowledge that we enjoy today and provide for our patients are the result of this process in the past.

The cost of anatomic pathology services, including both the "diagnostically important" and "useless" ones, is approximately 1% of the total hospital budget. In Massachusetts, the cost of a single H&E stained slide is approximately 1% of the cost of tonsillectomy.

Whether the value of this practice is worth 1% is a judgement that should not feel constrained to continue out of respect for tradition, or for fear of breaking rules and regulations. We must evaluate the benefits of the diagnostic, review, documentation, resource, and research roles, and compare it to the costs.

Dr. Anthony makes an intellectual appeal to us as academic physicians which I think has merit. However, clearly there are specimens which fit into the "incidentally removed" category which may not require microscopic examination.

The Pathology Department at Texas Children's Hospital has approached such categories by offering the surgeon in defined categories the option of submitting specimens as specified below.

The following list (per Dr. Edwina Popek) of specimen types is currently exempt from the requirement that all surgical specimens be submitted for pathologic evaluation. However, if such specimens are received they should be accessioned, examined and reported.

- Dental:** Teeth removed for dental caries
Mobile primary teeth
Impacted teeth
Dental restorations or dental appliances
Arch bars and wires
Bone plate and screws
- General:** Foreign bodies removed surgically from superficial sites
Medical appliances (i.e. central venous catheters, etc.)
- Gynecology:** Vaginal foreign bodies
- Hand:** Skin from syndactyly
Nail plates
- Ophthalmology:** Extraocular muscle and tendon tissue removed during strabismus surgery
Redundant skin and subcutaneous tissue from oculoplastic procedures done in patients without underlying malignant or systemic disease
- Orthopedics:** Orthopedic hardware
Bone from osteotomies
Tissue from scoliosis fusions (i.e. ligamentum flavum, disc material)
Joint capsule
Ligamentum tears
- ENT:** Coins from the esophagus and other foreign bodies from the aerodigestive tract removed endoscopically
- Plastics:** Septum or ear cartilage after augmentation
Resected tissues from cleft lip or nose surgery (i.e. skin, mucosa, etc.)

If such specimens are received it should be assumed that the surgeon wishes these to be fully examined and a pathologic examination should be carefully and completely performed.

The Texas Children's approach deals with some of the "hardware" specimens that come through all our services, but does

not address the issue of routine tissue surgical specimens and the need (or not) for tissue microscopic examinations.

At Children's Hospital, Columbus, Ohio, we have defined "routine" surgical specimens to include: hernia sacs at any site, tonsils and adenoids, foreskins removed in the operating room, and thymectomies incidental to congenital heart repairs. All these specimens are cut in by histotechnicians with hand stamps for preprinted "fill-in-the-blank" gross descriptions and microscopic diagnoses. The pathologist first sees the case as a single hematoxylin-eosin slide per case no matter the specimen size. All routine cases are signed out by the pathologist on autopsy service as filler work within one month's time. There are lesser costs involved in this approach which has allowed us to continue this practice with our surgical colleagues. Consequently, we can offer specific figures on microscopic diagnostic yields for each routine specimen category spanning many years. These data are provided below.

Incidental Diagnostic Yield - Routine Surgical Specimens

Category of Tissue	# of Specimens per five years	Total # Diagnostic (%)	Diagnoses (#)
Tonsils and Adenoids	16,095	20(0.12%)	Storage disease(2) Viral infection(2) Abscess/granuloma(16)
Hernia sac, inguinal	2,072	32(1.5%)	Adrenal rest (23) Vas/epididymis(9)
Thymus	283	8(2.8%)	Langerhans' cell histiocytosis(1) Cysts(7)
Foreskin	2,029	11(0.55%)	Balanitis xerotica obliterans(8) Dermatofibroma(1) Neurofibroma(1) Hemangioma(1)

Dr. Carmen Steigman has noted a similar diagnostic yield of inadvertently sampled vas deferens (1 to 2 per year) over a 15 year period examining inguinal hernia sacs.

Through the SPP E-mail network, Dr. Ron Jaffe, Children's Hospital of Pittsburgh, noted an incidental diagnostic yield of 3 cases (2 herpes infections, 1 Tangier disease) in a decade of examination of tonsils and adenoids. All other clinically relevant conditions-peritonsillar abscess, EBV post-transplant lymphoproliferation and frank malignancies were directed biopsies of suspected lesions or abnormally enlarged tonsils.

There have been at least 11 other institutions (via E-mail) offering comments and approaches to the handling of routine surgical specimens and tonsils/adenoids in particular. There does seem to be a consensus on some points:

1. There is a certain yield of incidental microscopic diagnoses, but the clinical relevance of these diagnoses and the small percentage(s) of the yield clearly call the effort of routine microscopic examination into question.
2. Pathology Departments should continue to receive these gross specimens for documentation, quality control, and research purposes.

(Continued on page 8)

Healthcare Reform and Laboratory Management

John M. Matsen, MD
Vice President for Health Sciences
University of Utah

OBJECTIVES:

1. To help the learner understand health care reform status.
2. To provide perspective as to changes which will occur.
3. To characterize challenges the laboratories will face in healthcare reform.

I. Healthcare reform

A. What is happening in healthcare in general

1. A pressure to reduce costs.
2. The rapid development of managed care organizations and integrated delivery networks
3. An enhanced emphasis on primary care delivery.
4. A shift in where health care will be delivered.
5. A shift from the focus on disease to a focus on the management of the health of populations.
6. An increasing insistence on value received for dollar paid.
7. Cost shifting for education and research will be less and less possible.
8. Physician group practice will be increasingly emphasized.
9. Physician and managed care organizations will be expected to participate increasingly in risk acceptance.
10. There will be an increasing emphasis on management of information and the enhancement of decision making.
11. An emphasis on practice guidelines and outcomes research.

B. Health Care Reform is Well Underway

1. Hospitals, HMO's, clinics, doctor groups are merging and structuring the health care to be offered to the community.
2. Reducing health care costs is essential to employers.
3. Small and medium sized employers are moving to managed care.
4. Erosion of early retiree health benefits - their benefits are in question.
5. Increase in employer coalitions and purchasing groups, pooling risk.
6. More state reform movements.
7. More HMOs and health networks seeking accreditation. (Business and Health, 1995)

C. In a recent survey, 22% of office-based MD's indicated they have made a practice change (sell or PHO) and 44% indicate they will do so in next year. (M.E. 10/94)

D. Managed Care - P.P.O.s must:

1. Incorporate more complex utilization management techniques.
2. Assume risk.
3. Ensure quality and patient satisfaction.
4. Be accountable.
5. Distinguish primary and specialty care.
6. Create specialty products to segment risk.
7. Deliver specific patient services at specific prices. (Cerne/Sokolov HHN 10/93)

E. "If it doesn't change the relationship between the physician and the patient, in a positive way, it won't work." Brent James, MD (1995)

F. Study of 10 Hospital Systems on the Integration of Not-for-profit Healthcare Systems.

"The single strongest correlation that influences profitability and quality is physician-system integration. You cannot coordinate services and eliminate duplication unless you integrate physicians into the system." (Steven Shortell, PhD, Northwestern University, 10/93)

G. Shortell Integration Study - 10/93

Areas of beneficial physician integration:

1. Sharing common clinical procedures among operating units.
2. Sharing a consolidated laboratory and radiology group.
3. Coordinating tertiary services, e.g. oncology, cardiology, etc.
4. Medical records integration.
5. Etc.

(S. Shortell, PhD, Northwestern University, (Study of 10 Hospital Systems)

H. "Systems with greater clinical integration of services are more profitable and can offer higher-quality patient care than less-integrated systems."

(S. Shortell - 10/93 - Study of 10 Hospital Systems)

I. Physician impact on healthcare expenditures

1. Direct expenditures for physicians make up 20% of healthcare costs, but physicians are responsible (directly and indirectly) for 70 - 75% of all healthcare costs. (1995)

J. Integrated Service Networks:

1. Owns key elements of the system.
2. Held clinically and financially accountable.
3. Is vertically integrated -
 - a. One governance structure.
 - b. Is at financial risk.
 - c. Has strong physician leadership.
 - d. Has advanced information systems.
 - e. Coordinated and seamless clinical integration.
4. There will be removal of excess capacity -
 - a. Hospital beds.
 - b. Specialists
 - c. "This will be a critical and difficult process." (H. Bailit, D.M.D., PhD., Sr. V.P., Aetna, 9/94)

K. Characteristics of Integrated Systems

1. Physicians play a key leadership role in the organization.
2. Organizational structure facilitates common

management and coordination of all elements of the system.

3. Primary-care physicians are economically integrated into the system and incentivized.
4. Primary-care locations provide geographical coverage of the system's service area. Consumers/patients must have reasonable access.
5. The system is appropriately sized; the number and mix of specialists and hospital capacity match the needs of the market.
6. Physicians themselves are integrated, often forming new or joining existing medical group practices.
7. The system owns its own health plan or can enter into "single signature contracts" with other health plans or large employers.
8. The financial incentives of physicians, hospitals, and health plans are aligned.
9. Communications systems are in place to provide ready access to information.
10. The system has access to capital and the ability to shift financial resources.

Modified from Healthcare Forum Journal, March/April 1994)

L. Managed care plan costs are lower than traditional indemnity costs.

1. Average 1992 per employee cost, by plan type:
 - a. Traditional Indemnity - 3979
 - b. PPO - 3664
 - c. POS - 3625
 - d. HMO - 3348

(Business & Health/November 1993)

M. The potential is for up to 60% decrease in hospital days and up to a 30% decrease in hospital revenue.

II. The Hospital Laboratory - 1995-1996

A. Projections

Overall acute care hospital average length of stay will range from 3.0 - 4.0 days

Inpatient tests/discharge will range between 15-20 where inpatient acuity levels are modest, and will range between 30 - 35 where most tertiary care is provided.

80% of all inpatient and outpatient healthcare will be provided under some form of risk sharing system.

(D. Wood 1994)

Comments

More surgical procedures will be performed in outpatient settings. Many acute care beds will be replaced with sub-acute care beds.

Benchmarks are being developed to measure patient outcomes based on the number of mix of tests/DRG.

Large numbers of PHO's, managed care plans, employer groups, and other constituencies will develop risk sharing programs.

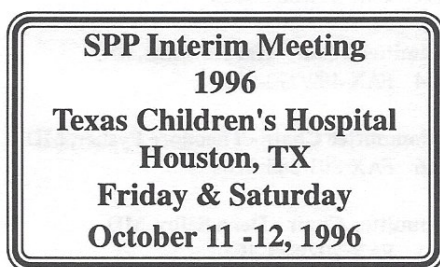
B. HCFA has released draft policy changes for the manner in which Medicare pays for automated laboratory profiles that has significant financial implications for laboratories. (1/95)

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The Gordon L. Vawter Award

The Vawter Award recognizes the best platform or poster presentation by a pathologist in training (fellow, resident, medical or dental student) at the Spring and Fall meeting of the Society. Presenter must be first author of the presentation and must identify work as being in competition for this award by checking off appropriate box in abstract form. The winner will receive an illuminated certificate, \$500.00 cash award, and an award notification will be published in the Society Newsletter.

At the 1995 Interim Meeting of the Society for Pediatric Pathology held in Baltimore, the Vawter Award was given to Glenda Hendson, MD of B.C. Children's Hospital, Department of Surgical Pathology, 4480 Oak Street, Vancouver, B.C. V6H 3V4 for her paper "Umbilical Cord Torsion in Stillbirths."



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- C. High volume testing will be automated. Large national labs will have only one-quarter the staff they now have. (1995-1997)
 - D. People who manage large labs will more like bioengineers than like medical technicians.
 - E. Will depend on expert systems and those who supervise will be more like plant managers.
 - F. "Information management is the second major wave that will hit in healthcare reform." (D.E. Detmer, MD - 1994)
 - G. Inducement
 - "Federal law prohibits giving or receiving anything of value in exchange for the referral of a Medicare or Medicaid patient."
 - H. The swing to primary care emphasis will put more pressure on the laboratorian for practitioner assistance in lab use and interpretation.
- III. The Laboratory Challenge - 1995
- A. Understand and control costs.
 - B. Prepare to service managed care.
 - C. Know your environment and adjust to it.
 - D. Service/quality will give way in some settings to pressure for pricing.
 - E. Accommodate to the realities of new-patient testing.
 - F. Maintain an educational focus on new technology
 - G. Seek means of linking electronically with users of your services.
 - H. Develop alliances/liaisons and be affirmative in consolidating wise relationships.
 - I. We cannot direct the wind, but we can adjust our sails.

POSTION ANNOUNCEMENTS

Clinical Director, Department of Laboratory Medicine - St. Christopher's Hospital for Children is a 183-bed tertiary care pediatric hospital that has provided Philadelphia and the Delaware Valley with service for the past century. The Department processes 750,000 tests per year and is divided into sections of Chemistry, Hematology, Transfusion Medicine, Microbiology, Virology, and Cytogenetics, each section under the direction of either an M.D. or Ph.D. The position includes a senior faculty appointment with the newly combined Medical College of Pennsylvania and Hahnemann University School of Medicine. Applicants must be an MD or MD., PhD with board certification in Clinical Pathology or one of the subspecialties listed above. A minimum of two years experience as a Section Chief or Laboratory Director is required, preferably in a pediatric institution. Demonstrated ability to balance and support the needs of education, research and clinical activities is mandatory.

Send CV and the names of three references to: Carroll Caulfield, Room 2121 (Annex), St. Christopher's Hospital for Children, Erie Avenue at Front Street, Philadelphia, PA 19134.

Fellowship in Pediatric Pathology, The Children's Hospital of Buffalo - Applications are being accepted immediately for a Fellowship in Pediatric Pathology at the Children's Hospital of Buffalo, State University of New York at Buffalo, due to an unexpected vacancy.

The requirements of the program are an MD degree and three to four years of training in anatomic and clinical pathology. The salary will be commensurate with the level of training of the candidate. Must be licensable in New York State.

Applicants will have exposure to pediatric pathology, placentology, perinatal and gynecologic pathology. Responsibilities will include service, teaching and research.

The Children's Hospital of Buffalo is the only free-standing Children's Hospital in New York State. The hospital also has an OB/GYN service associated with the institution. It is unique in that apart from being a children's hospital, it is also the regional center for high-risk pregnancies. There are 313 beds of which 174 are pediatric, 54 intensive care nursery, 18 intensive care and 67 maternal beds.

Interested candidates should send a curriculum vitae and the names of three references to: John E. Fisher, MD, Head, Department of Pathology, The Children's Hospital of Buffalo, 219 Bryant Street, Buffalo, NY 14222. The Children's Hospital of Buffalo is an EO/AAE.

Pediatric Pathologist, Children's National Medical Center, Washington, DC - is recruiting for a pathologist with interest in pediatric pathology at the rank of Assistant Professor. The Children's Hospital is affiliated with George Washington University School of Medicine. Inquires should be addressed to Roma S. Chandra, MD, Chairman, Department of Pathology, Children's National Medical Center, 111 Michigan Avenue, NW, Washington, DC 20010.

*Kind words can be short and easy to speak,
but their echoes are truly endless.*

Mother Teresa

(continued from page 5)

Beyond these two points, there is no consensus amongst pediatric pathologists. Certainly, directed microscopic examination of grossly The Pathology Department at Texas Children's Hospital has approached such categories by offering the surgeon in defined categories the option of submitting specimens as specified below. by everyone. It also may be wise to hold onto representative fixed sections for three months should request for examination come later. Beyond this approach, our clinical colleagues may eventually (if not already) ask us to defer uniform microscopic examinations in the era of a shrinking health care dollar.

**What a wonderful life I've had!
I only wish I realized it sooner.**

Colette (French Novelist)

Welcome

Regular Members:

Bernard, Chantal, MD -Montreal Children's Hospital
Bhattacharjee, Meenakshi B., MD -Texas Children's Hospital
Carmen, Chirita -"Maria Curie" Children's Hospital, Romania
Davis, Mary Margaret, MD -Riley Hospital for Children
Gail Donaldson, MD - Buffalo, NY
Fligner, Corinne L., MD -UWMC Hospital Pathology
Gaskin, David, MD -Montreal Children's Hospital
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*I long to accomplish a great and noble task,
but it is my chief duty to accomplish small tasks
as if they were great and noble*

Helen Keller