# Pathologists’ Roundtable - Targeting the Complexities of Professional Practice Evaluation

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**Julie McDowell:**

In this CAP cast, Digital Content Committee Chair, Dr. Michael Misialek leads a discussion about ongoing professional practice evaluation, or OPPE, and focus professional practice evaluation, or FPPE. The discussion features three fellow CAP members, Dr. Brian Le, a pathologist with Novant Health in Charlotte, North Carolina, Dr. Moira Larsen, an executive director of MedStar Medical Group Pathology in the Baltimore, Washington DC region, and Dr. Erin Rubin, a pathologist and professor of pathology at the University of Colorado Anschutz Medical Campus.

**Dr. Michael Misialek:**

Thank you, everybody for joining us. We appreciate you taking the time to listen in and hope that you are able to take something away from our discussion. What we are going to be talking about is ongoing professional practice evaluations and focus professional practice evaluations reviews. We're going to go through the background, what they're for. We'll get insight into experience from our experts on the panel here, which cross widely diverse practice demographics. So, if you're listening, you're likely to be represented by somebody on the panel here as far as where you're practicing.

Just to set the stage a bit, I'd like to give a brief intro to what OPPE is. It's a screening tool to evaluate practitioners with privileges and identify clinicians with unacceptable quality of care. It's not designed to identify clinicians who are delivering good or excellent care. It's a screening tool. FPPE is more of an in-depth tool that's a follow-up process to determine the validity of any positives found in the OPPE review. It's a method to establish competency of new clinicians with no history of performance at an institution. So, to start things off, I'd like to go around the group here and get everybody's experience with OPPE and FPPE. We can start off with Dr. Erin Rubin.

**Dr. Erin Rubin:**

Hi, thank you. My name is Erin Rubin and I'm professor at the University of Colorado in the Anschutz Medical Campus, and I've been a practicing pathologist for around 20 years, and have worked at several different academic institutions across America, and so I have personal experience dealing with for sure the FPPE, F-P-P-E. Every time you start a new institution, you have to go through the screening where you have to look at so many different frozen sections and so many different cases in your subspecialty area or general surgical pathology. And then after that, then you have our annual evaluations that go through your one year and five year plan. And so I can talk about this more in depth as the podcast continues.

**Dr. Michael Misialek:**

Wonderful. Thank you for your insight, Dr. Larsen, what's been your experience?

**Dr. Moira Larsen:**

Thank you, Dr. Misialek. I'm really glad to be here and talk about this. As mentioned, I'm the Physician Executive Director of MedStar Medical Group, and at this time I oversee the pathologists at nine hospitals, one academic, one very large urban and seven community hospitals, but I have served as medical director at three of those community hospitals over my nearly 30 year career. And when OPPE and FPPE first came out, it was very confusing for everyone, and what I learned was that because this is a Joint Commission mandate, and as you very well described in your introduction, is meant to discover physicians who are behaving below the standard of care. It's really not meant to establish competency. The requirements and rules are going to be set by your institution. This is used for credentialing and we need to try to shoehorn, if you will, the things that we look at in pathologists into a structure that our credentialing committees and medical staff offices are very used to using for general clinicians.

Where they can look at a full set of patient care records and determine if the clinician did the right thing, we need to identify criteria within the six areas of competency that hopefully are things we're already measuring, but will serve the same purpose. So, really a lot of the challenge has been to try and shoehorn what we do in pathology, how we measure what we do in pathology into the construct of the Joint Commission and the general practitioner in our hospitals.

**Dr. Michael Misialek:**

Wonderful. Thank you very much for that excellent description. Dr. Le, what's been your experience with OPPE and FPPE?

**Dr. Brian Le:**

Thank you. Thank you very much for having me. And my background is that I've been in practice for 14 years outside of training, and I've always been playing the role of a frontline pathologist. I have not had any administrative role or supervisory role over another pathologist or groups of pathologists. My experience with OPPE and FPPE really began about four or five years ago when the hospital where I was employed was inspected by the Joint Commission, and it became apparent that OPPE wasn't routinely performed on various members of the medical staff, and that was the beginning of OPPE for us.

To me, over the past few years, OPPE has been basically an invisible force. We go by the criterion. The loose criterion is that if they don't uncover any problems, then no news is good news. If OPPE does uncover something about our performance level, then that's when we would hear something more, our directors from our chairs. So, from my perspective of OPPE, we know the basic criteria, the basic category domains that are being looked at, and as long as we do our jobs and we don't trigger any investigations, then every six months or sometimes every year, our performance is reviewed, the parameters are also reviewed, and we basically get the green light to proceed.

As usual, my experience with FPPE has been part of the experience of joining a new hospital. Since four or five years ago, I have joined a new practice, and as part of the credentialing process for my new health system, I was immediately placed on two back-to-back cycles of FPPE, each lasting about four months, during which time as Dr. Rubin, Dr. Larsen mentioned my practice, my frozen section accuracy, my turnaround time, my interactions with various staff members of the laboratory and of the institutions have been reviewed. Some of those parameters are really not visible to me, which I think is a good thing because then I'm not overly preoccupied with the way that they're being collected. But those have been my experience with OPPE and FPPE so far.

**Dr. Michael Misialek:**

You very much. We look forward to hearing some of your insight as the discussion progresses, particularly being on the receiving end of some of these reviews and what that feels like. I'd like to spend a little bit of time on talking about the elements that are in OPPE and FPPE, how they were chosen, what you use at your institution. Maybe start off with Dr. Rubin.

**Dr. Erin Rubin:**

My experience, I think I'm more like Dr. Le in terms of definitely being more on the receiving end of these things than the person overseeing them, and not with the OPPE, but with the FPPE. And what I've found in changing institutions is that they are mandated by the Joint Commission, but how they actually materialize and how they're actually presented are different at each institution. And so the last institution where I was, they had a series of slides that were decades old and faded, and then trying to make the diagnosis on these when you couldn't even identify the cells because they were so faded. And that was one of the first jobs that was assigned to me was revamping the study set so that we could actually give an exam that was readable by the people, the new faculty members that were coming.

I think that the FPPE is a good idea because when you're interviewing people, faculty to join the institution, you only have a day or two to meet them and interview, and it's a way of making sure that you didn't make a mistake, because there's usually a brief time where you can let people go without serious repercussions. In academic institutions, there are strict guidelines on how to hire and fire people. And in private practice, I think it's a lot easier. And there are pros and cons with that in terms of job security. But in terms of what's given for the FPPE, it is a series of things such as peer case review, monitor practice patterns, proficiency testing results, amended reports, turnaround times, complaints filed, input from other departments and clinicians and malpractice cases. Many of those data points are collected over a series of time. But when you are first hired at an institution, you normally have to go through a series of X number of frozen sections and X number of surgical pathology cases before you can be given independent signup privileges, and you co-sign with another pathologist for a designated period of time.

And that really differs from institution to institution in my experience. At my current institution, we didn't have a study set that we had to go through, but rather just X number of cases that had to be co-signed with the primary pathologist, not being me, but rather another pathologist. I think it is a good idea not only for just screening the new people that are coming in, but for also establishing working relationships with your colleagues, because you double scope with your colleagues and it just helps you to initiate these relationships that will be ongoing throughout your entire career at that institution.

**Dr. Michael Misialek:**

That was terrific. Thank you very much. Dr. Larsen, maybe speak a bit about what you use in your evaluation, the particular domains that are required elements, how you chose which indicators to use, and is that your experience that most places are using these?

**Dr. Moira Larsen:**

Absolutely. First, let me point out that there's a real distinction between OPPE, FPPE and pathologist competency. Pathologist competency is mandated by the College of American Pathologists, and those are the measures and the practices we use to establish that someone is efficiently, effectively, and appropriately practicing in our setting. That's the positive side of the thing. That's where we demonstrate that we are competent to make diagnoses, we're using our training. We're not causing any trouble in the department, we're communicating with people. OPPE and FPPE are sort of a small slice of that that is used by credentialing. But just like regular competency for physicians in education, there are six domains that have to be covered by your criteria. The first one is patient care. And the sorts of measures that we've used to look at that are frozen section final diagnosis correlations, correlations of diagnoses with outside consultation cases, just a brief measure that you're capturing that shows that the diagnoses that are being rendered are appropriate.

The next one is medical and clinical knowledge, and we tend to use people's CME records, and proof that they are keeping up with appropriate measures of education within their area of specialty, expertise and pathology, meeting the criteria needed for credentialing, meeting the criteria needed for licensing. As well, part of that has to do with whether or not the pathology reports you're issuing or understandable to the clinicians. Are we getting questions from clinicians saying, "Hey, what was Dr. X saying in that report? Could you put it in the words you would've used? Because I don't quite understand whether he was telling me that this patient has this disease or has dysplasia or not. The words were too vague for me."

Practice-based learning and improvement is another criterion. Again, records of education can be used for this, demonstration that you've gained a new skill, brought something new, taught the department, taught the medical technologists. Interpersonal communication skills is another area that's required as a discipline. And in this area, of course, we use things like complaints by physicians, observed interactions between the pathologists and various clinicians as well as their peers and the medical technologists. This is where you try and pick up the people who are disruptive physicians or bad actors that are causing challenges. Professionalism goes to turnaround time. Do you show up for meetings? Are you at departmental meetings? Are you taking your fair share of call? Are you not unduly burdening your peers by disappearing all the time and leaving someone to cover your work?

And finally, systems-based practice. What we've used for that is actually the CAP measures are requiring synoptic reporting for cancer, because the synoptic reports for cancer require you to understand the disease and work with the clinicians in order to understand the system of practice. And those are measures we're already keeping track of for the department so that we do use that in that context. Also for members of our departments who have responsibilities in the clinical laboratory, interacting with the hematology oncologists with coagulation and other hematology testing, are they keeping up to date with that and working with those clinicians to bring appropriate testing in place? Are they doing a quality improvement project with that group of people in order to bring those systems together and show that those practices are in place? Quite honestly, for OPPE, we have always worked to strip it down to the most basic criteria that are very easy to measure on a one page grid with these six different competencies, one or two measures for each. Did the pathologist meet it or not? And we save the detailed workups for our pathologist competency.

Another thing that I think is important to understand with the FPPE, as both doctors Rubin and Le have described it, it's very effective at onboarding clinicians. In our case, we take the first 20 to 50 cases that one signs out and it's reviewed by a second pathologist. And we check the language on the report, we check the diagnoses, make sure it's what we would say. We go through a competency exercise, can you interpret breast prognostic marker immuno histochemical stains? We'll use old proficiency tests and give that to the new person to see if they call it the way they were in that proficiency test. Those sorts of things go into the FPPE and getting someone up and running.

But I would like to point out that FPPE is not just for when you find a problem with OPPE. You can run, as was explained to me by my chief medical officer at a hospital, an FPPE within the department at any time if there's a clinician for whom you find a need. For example, in my community practices, we have a very high level of performance on GI biopsies. Most of my community hospital pathologists have GI fellowship training or have many years of experience, so that when we hired a new pathologist, it was someone who it turns out did not come from a very strong GI pathology background, and did not understand or recognized reactive gastropathy.

This was not a catastrophic issue that would've required reporting to the credentialing group at the hospital that this pathologist couldn't practice. But within the department, we wanted to formally and did set up a formal focused professional practice evaluation, asking this person to take a specific CAP course related to gastritis, asking them to look at a bunch of test cases, and actually wrote up that over the course of three months, this person did those studies, reviewed those cases, continued to have their cases reviewed with another pathologist, and satisfactorily completed an FPPE that was completely interdepartmental.

And all we had to do with our medical staff office and credentialing is say, "Dr. X had a challenge. We performed a departmental FPPE and it was satisfactorily completed, and he's performing as all of our other pathologists are," and keep moving along. If the credentials committee wanted to know more, yes, we would've revealed it to them, but they were very happy with that sort of report, so that the FPPE is a way we have flexibility that allows us to bring people up to the level of practice that we expect in our locations and based on our specimen types.

**Dr. Michael Misialek:**

Wonderful. Thank you very much. And you touch on a great point that the data we generate with these evaluations is not strictly for internal use and may be very amenable to sharing with other departments in certain settings such as quality or safety committees where there may be an issue identified and you're able to show to the other members of the medical staff that you can assure them you have high quality of processes in place that will detect any sort of deviations and measures to improve the performance there. So, I think that's a great point for listeners to be aware of. This is a excellent tool for pathologists to be more visible in their settings, in their departments and their institutions, and to be real leaders in quality and safety. I'd like to continue going around the table here and touch upon some concerns or misconceptions that each of you have encountered related to OPPE. We will start with Dr. Le who's next in line.

**Dr. Brian Le:**

Yes, thank you. One of the misconceptions that I feel we've had with OPPE and FPPE are those that Dr. Larsen just clarified. Many folks still have confusion as to what the differences are. Whereby OPPE is a screening tool. FPPE is a more focused tool that usually has a purpose and an intended target and intended objective. The other issue or concern that has occasionally arisen with OPPE is the expected target for the indicators in each of the domains. For example, an expected target for turnaround time may be 90% of biopsies are signed out within one day of receipt in the laboratory. So, that may be one of the expected targets for that particular indicator.

And the concern that would arise under that is that sometimes the target is not realistic or is not realistic for a specific subspecialty. If I was to sign out renal pathology or neuropathology cases, and that's 90% of my practice, I wouldn't be able to turn around 90% of those cases in 24 hours. And so the thought that the parameters, the indicators and domains are all encompassing across the entire spectrum of pathology can be a source of concern. But generally, I do see that these expected targets are negotiated and are discussed before they're implemented so that they are no misunderstandings.

**Dr. Michael Misialek:**

Great. Thanks. Thanks very much. Dr. Rubin, how about your biggest concerns or misconceptions that you've encountered?

**Dr. Erin Rubin:**

I'd like to echo what Dr. Le has touched on in terms of turnaround time because I'm a medical liver pathologist, and these cases are very time consuming, and you need to contact the clinicians in order to generate your diagnoses. And with the majority of my work being tertiary care in a academic institution, the majority of my cases take a tremendous amount of time in order to turn them around. It's not reactive gastropathy, as Dr. Larsen brought up earlier, these are not cases that you can turn off in one day. They usually require obtaining previous biopsies from outside institutions, doing comparison, having tumor boards with the clinicians, and having quite a bit of discussion.

And so metrics, although such a powerful tool that we have in our subspecialty, because everything can be tracked on these software programs that we have, they can also be seen as an enemy as well. So, looking at the type of work that each of the pathologists are doing are definitely important in tracking these data and numbers. And so I think a lot of the hesitancy that pathologists have in completing these evaluation forms is because of the metrics that have been collected, and the type of specimens that are being obtained at each of the institution types. So, a private practice GI pod lab that's going to be bringing in colon biopsies and upper GI biopsies, those turnaround times should have a high expectation of being very, very fast. And you can't put those same numbers on academic institutions looking at post-transplant biopsies in which you have to review five previous biopsies in order to come up with your diagnosis.

Other things that Dr. Larsen talked about in terms of patient care, medical knowledge, practice-based learning, these differ in academic versus private practice. Because in my day, I really hold many different hats of working with residents, attending tumor boards, the type of cases that I have to review. And so these guidelines that must be completed, patient care, well, the types of patients are very different, and the way you interact with your clinicians is very different. So, I'm not sure, but maybe Dr. Le can say, I'll have frequently, so I'm on liver service this week, that I'll have the entire team of hepatologists walking down the hall together and drop in my office and we'll review cases together unannounced. Whereas, is that something that you experience in your institution, Dr. Le?

**Dr. Brian Le:**

Yes, at least in my practice, which is a hybrid between more routine cases and more difficult detailed cases. So, it's exactly as you described, for more routine biopsies, a GI biopsy, a GYN biopsy, those are things that I can sign out almost in the dark without much interactions and much hesitancy. But for cases that are complicated such as a brain biopsy, a brain tumor, those are areas in which I may get two or three clinicians calling me on the same day about the same case or dropping by unexpectedly.

So, I can definitely empathize with the high complexity of cases that you go through, and that would pose a challenge to OPPE. Because just as Dr. Rubin mentioned, some of the cases that have achieved such a high level of complexity, those are not the cases whereby a turnaround time in 24 hours is indicative of quality. In fact, if you rush through a certain case like a bone marrow biopsy, a liver biopsy, a brain biopsy, and try to turn it out within 24 hours, that should actually play a negative impact on how much attention you've paid to it and how much analysis you've done to it. And that's where I reiterate what Dr. Rubin says, in some scenarios, it's not a one size fit all, and the traditional quality metric is actually, I would argue, be detrimental to quality care.

**Dr. Michael Misialek:**

Great, thank you. Turning to Dr. Larsen, in your experience across multiple different institutions, how do you normalize for some of these concerns about practice of individual pathologists who may have differing levels of complexity of cases and turnaround time? Is there a way to assign a difficulty factor? How do you use it in your practice?

**Dr. Moira Larsen:**

It's a great question, and I think that what both of my colleagues have been saying is that there really is no one size fits all with OPPE. It is institution and credentialing department specific. Again, that's a place where it's very different from pathologist competency. Any one of us that does CAP inspections knows the sorts of things we want to see in order to establish pathologist competency. The OPPE measures need to be something that whoever in your department has the responsibility for reporting them to the medical staff office and credentialing, has the ability to communicate with those folks, has the ability to negotiate with those folks. So, it might be that we are not looking at turnaround time as a measure at this institution because there's so much variability. Or if someone like Dr. Rubin who is such a specialist also does some routine cases, maybe you do say, "We're going to look at turnaround time, but we're just going to look at uncomplicated gastric biopsies and appendices for turnaround time," And define it in a way that allows that metric to become more even for everyone.

Yes, it does have to be very generic. And again, that's why OPPE has to be a very different beast from pathologist competency. We tend to be detail oriented. We tend to try and drive it down the competency lane, but you really don't have to be that detailed to submit OPPE criteria. You just need to be able to define them, assign them to each of the six domains of competency and agree upon them with your credentialing office and your medical staff office, and let your pathologists know what it is you're going to be reporting.

**Dr. Michael Misialek:**

Great. Thank you. I'm sure many of our listeners, this is ringing true with them and have very similar experiences. Have we missed any key challenges that we want to touch upon that some of the listeners may be thinking about or want to ask a question? Dr. Rubin, what's been your biggest challenges related to OPPE?

**Dr. Erin Rubin:**

So, I think the biggest challenge is what we have been touching on, which is who is reading the data that's being collected and what's being used with that data? And there does seem, in the majority of institutions where I've worked, Dr. Larsen is not the head of the institution, and where she's able to see the true variability, and colors, and shapes, and understand that the whole goal is to give the best possible patient care as well as support the staff and make them feel encouraged, and motivated, and want to do well and keep a positive attitude looking forward. And many times when data is collected on individuals, it feels very much like a punishment, especially if they're given graphs and charts of turnaround times, and subspecialties, and how they compare inter-institutionally. And there is a way to take that data and give it back to the pathologists in a way that makes them feel motivated and special and want to do better, but it takes effort.

It's very easy to take that data and throw it back and circle the name and say, "Why are you standing out?" And that has been the biggest challenge, that metrics can be used in a very deconstructive way and they can be used very constructively. And it takes effort and creativity to collect that data and make people feel like superstars, rather than collect that data and use it as a punishment technique. And all of these data that's being collected, both at the time of starting your new position and throughout your career, I think is very helpful, especially because pathologists are data-driven, and we like seeing data, and we like to see where we are and how we compare to others. But how to morph that into something good and creative is really, really a challenge.

And I think Dr. Larsen and her group has done a phenomenal job of doing that, but it really takes a leader that is focused on that and that knows that they're telling their faculty, "We have to do this for the Joint Commission, but the data that's being collected, this is how we're going to use it, and this is how we're going to share it with each other in order to make our group stronger and better, and that our patients are going to be diagnosed well, that the reports are going to be understandable by the clinicians that are reading them, and that it's a win, and how you can use that in a constructive manner".

And so that's the challenge that I've seen, and different institutions handle it really, really differently. I mean, here at the University of Colorado, I've been supported tremendously by my colleagues in the GI subspecialty, and we really work as a team to make sure that the diagnosis are generated in a timely fashion and are accurate. But it really takes a team effort and we do it in a small way with our small group. But I think what Dr. Larsen has done with her many institutions, I think if she could expand on that and how she, because I've worked with her one-on-one, so I know her more on a personal level, but how she can share that with the listeners on how you can do that from a leader perspective to really use these metrics in a constructive way.

**Dr. Michael Misialek:**

Excellent point. Well said. And I think as we known much of pathology is as much a science as it is in art. I think looking at the data of these quality metrics is not only a science, but it's an art in how you utilize that data. And like you said, how do we use it to better the department? And let's turn back to Dr. Larsen and get her thoughts on that challenge.

**Dr. Moira Larsen:**

Well, I think that as we've said, first of all, it's a requirement. You have to find a way to do it. I think it's very important for pathologists who are leaders of departments, who are the ones who are crafting these plans, to have open, honest, and high quality communications with chief medical officers, with the chair of the credentials committee, with the medical staff office. You get back to the issue of pathology department in terms of numbers of practitioners, is usually one of the smaller departments in any facility, whether it's a hospital or a surgery center. However, we have an unduly large burden of having to deliver information that leads to patient care. Most of the other practitioners don't entirely understand what we do. So, that by having good communication and the ability to truly relate to these folks, we have the ability to craft our quality measures in a way that makes sense for us, and that we can explain to them why the measures we're using that are so different from what they use for all of the patient facing clinicians, actually do make sense and do lead to higher levels of quality.

So, that again gets back to the whole idea of as a leader, you have to get out of the department. You have to be able to develop those relationships in order to craft the measures that will have meaning. It's also really important to know what your institutional policy is for OPPE and FPPE, because the pathology department overarching structure and theory has to match that of the institution. Typically, all of the measures in OPPE and FPPE have to be defined. They have to be metrics. They have to be measured. You have to say who's going to measure them, what your source of data is, what your source of truth is, and you have to indicate what the consequences are for adverse findings. Usually those consequences live at the institutional level because this is a Joint Commission requirement, so that if you have an adverse OPPE or FPPE, you follow institutional policy. But again, this isn't our competency. This is a requirement that's a screening tool to find a clinician who is really falling behind, someone who might have a medical condition that is impeding their ability to practice. And therefore these are sort of broad swaths. These are very general criteria, and you really shouldn't nickel and dime yourself with a whole lot of items. Only one or two measures for each of these six domains is what's required. Hopefully your institution has a policy that allows you to limit it like that, but communication is the key.

**Dr. Michael Misialek:**

Well said. Thank you very much, Dr. Larsen. Dr. Rubin, can you speak about your experience at an academic institution? Has it been a factor in faculty recruitment and tenure? Any issues that have come up there with OPPE and FPPE?

**Dr. Erin Rubin:**

So, from an academic institution, it's really an extension of what all of us who are MDs have gone through from the very beginning. So, my daughter who was applying to medical school this term, she had to take the MCAT, and she had to apply through this online application system. And every part of our career has these tremendous hurdles and guidelines and criteria that have to be met from the very beginning, even as an undergraduate. And so for the faculty who are trying to join an institution, they understand that this is just a continuation of being a physician. And it started as an undergraduate, and it continues all the way up until you are a faculty. And learning which boxes have to be checked and filled in are absolutely just part of our career. It's nothing different or abnormal. And when faculty are looking for jobs here at the University of Colorado, they're not going to be concerned about the FPPE that have to be done because there are so many other guidelines.

And I mean, I have to take a series of online tests in order to do research at this institution. I have to do the same thing to practice medicine here with the state boards, and I'm grandfathered in so I don't have to be credentialed through the American Board of Pathology, but most of my colleagues do. And so yes, this is part of what every pathologist has to do in joining an institution, but it's really just an extension of the list of things that have to be done. And we know that we're being evaluated and tested at all times, and we've chosen this career from the very start. So, I don't think that there's any hurdles of it in the actual institution of filling out these questionnaires and being co-signed and evaluated in terms of patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, systems-based practice.

These domains that Dr. Larsen were talking about, and I just repeated right now, are exactly word for word for what the residents have to undergo every single year in their residency training. And so this is merely extended into the faculty now, when they were before limited to just residency training, now it's moved over to faculty, but these are well-known words and domains that we practice under. And so I really don't see them as hurdles. But as I emphasized before, and want to emphasize again, how to take these things and run with them in a positive way, and make them attainable goals that will want us to succeed and be better physicians, better teachers, and better researchers. And it can be done because that's the basis of what these domains indicate.

**Dr. Michael Misialek:**

Wonderful. Thank you very much. Well said Indeed. Dr. Le, our listeners can't see, but I've noticed you nodding a lot here in the discussion that's been going on with Dr. Rubin and Dr. Larsen, some of the points that both of them have spoken about. In your experience, you want to add some thoughts here as well?

**Dr. Brian Le:**

I really enjoy hearing what Dr. Rubin and Dr. Larsen have said, because I think one of the challenges that we have, and one of the concerning thoughts is that a lot of the anxiety and the fear behind and the dread behind OPPE and FPPE, is that of perception. But as Dr. Larsen said, OPPE and FPPE are not a substitute for pathologist competency. But I think some of the perceptions that many folks would have is that they are an equivalent to a competency measurement. And so that's where some of the anxiety and dread may come from. Going back to what Dr. Rubin said, where I nod my head especially, is that the positive behind OPPE and FPPE is that it holds every physician accountable, whether you are in training or whether you are a faculty member.

Let's face it. I mean, FPPE and OPPE are things that were not really part of our vocabulary 10 years ago. It's really in the past decade, in the past five years, that they've really become part of the forefront, and that's why we discuss them much more robustly these days. Back when I was in training, we never heard of FPPE or OPPE for the faculty, so, we felt as if the residents were the only physicians who were being watched and being evaluated. So, with the affirmation from Dr. Rubin and from Dr. Larsen, we're getting the message that this is not optional, this applies to everyone, and that is a cooperative effort. No one is exempt, no institution is exempt from this requirement.

**Dr. Michael Misialek:**

Thank you. I'd like to go around the table and just get some closing thoughts from our experts about the complexities of professional practice evaluation, and perhaps some pearls for our listeners to take home and hopefully use to dig further in and improve the program that they may have at their institution. So, Dr. Le, we'll start with you, as you were just saying a few things on the topic.

**Dr. Brian Le:**

I think that the OPPE and FPPE parameters are here to stay. They're fact of life. There's no point in denying them or ignoring them, just to embrace them and accept them for what they are, which are essentially screening tools. I do reiterate what my colleagues say in that the communication behind the parameters is what is key, so that folks are utilizing the report coming out of OPPE and FPPE constructively, and not take it personally or deconstructively, as Dr. Rubin said.

**Dr. Michael Misialek:**

Wonderful. Thank you. A lot of points that I'm sure resonate with listeners, and Dr. Rubin, some closing thoughts from you to share with the listeners.

**Dr. Erin Rubin:**

So, I would like to echo what Dr. Le said that these ongoing professional practice evaluation, OPPE, and the focus professional practice evaluation, the FPPE, could be seen as parameters to constrict us or make us feel somewhat confined. But know that we have chosen a superlative career for ourselves, and there's so much flexibility, and that pathology is an amazing subspecialty. And even though these things exist, it should in no way or form impair our ability to be and practice as we do.

And I just went through the last month, I was teaching the first year medical students and trying to encourage them to go into pathology because of the diversity of our field, and how many different subspecialties that we have that no one really knows about the breadth of what we offer to our patients. And in my career, I've worn so many different hats, and my day is so diverse. It's not about just reading slides all day. And we have an amazing subspecialty of medicine and I feel very privileged to be in this field of pathology.

**Dr. Michael Misialek:**

Thank you very much for the inspiring words. Dr. Larsen, some final thoughts from you.

**Dr. Moira Larsen:**

Sure. And while I believe everything that Drs. Rubin and Le have said and echo their feelings about our field, I'm going to be a little more practical here and just state that it is important to recognize that OPPE and FPPE are evaluations that are mandatory. The more we understand them, what they were, how the Joint Commission defines them, what the expectations are, the better we can work within those confines to set up a system that works for us, and to make sure that we meet the spirit and the requirement of the law in order to help keep our hospitals in accreditation, in order to help keep our departments in accreditation, and especially to recognize that the OPPE and FPPE are not the be all and end all, that pathologist competency is really the mechanism we need to use to do all the detailed, extensive work to establish the bonafides of our pathology teams.

**Dr. Michael Misialek:**

Wonderful. Thank you. Thank you, all of our experts here. Thank you for listening. If you want to find out more information, you can go to the cap.org webpage. There's abundant information under Practice Issues and Pathologists, the Practice Management section located under the Member Resources tab. Thank you again for your time and we hope you were able to find this discussion valuable.

**Julie McDowell:**

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