The Royal College of Pathologists
Pathology: the science behind the cure

Non-Mandatory Guidance on Independent Reporting in Diagnostic Neuropathology

Background

The DN Specialty Advisory Committee (SAC) has expressed a strong interest in supporting independent reporting and providing guidance for DN trainees on independent reporting in the specialty, ideally from ST4 onwards. It plays a crucial role in the post-FRCPath Part 2 training period in preparation for safe consultant practice. Increasingly, there is a strong appetite to introduce the practice pre-Part 2 exam in order to nurture independent reporting as a routine process early on in a safe supported environment and starting with 'easy' cases. This growing appetite by both trainers and trainees is echoed in a few relatively recent RCPath Bulletin contributions.[1,2,3] Essentially, the process encompasses the safe transition from supervised to independent reporting and has to be tailored to the individuals within the context of the departments they work in.

This non-mandatory guidance takes into account the views of the DN SAC as well as the current body of DN trainees who have been consulted over the past few months.

Independent reporting at various stages

There is a strong desire by trainees to divide the specific guidance on suitable cases into **pre-FRCPath Part 2** and **post-FRCPath Part 2 (after the exam has been passed)**. Whilst independent reporting in the post-FRCPath Part 2 training period is highly recommended in order to achieve the necessary CCT competencies it is understood that not all departments or trainees may be comfortable and willing to engage with this practice pre-exam. It remains, however, desirable.

Special considerations for DN

Whilst in general histopathology strategies on independent reporting often rely on the distinction between malignant and benign, it is clear that in neuropathology this distinction often does not predict the complexity of a surgical case and that in many instances neoplastic pathology such as a typical glioblastoma will be more straightforward to report by a trainee than a non-neoplastic biopsy for possible vasculitis, infection etc. On the other hand, service users will require some reassurance and may not be willing to accept independent reporting of glioblastomas by trainees pre-exam. It is envisaged that this should not be an issue for the post-exam period. These types of considerations need to be taken into account.

Where do the responsibilities lie?

One of the main concerns regarding independent reporting relates to the question of who has the overall responsibility should a trainee make a mistake. Is it the consultant who signed off the trainee as competent or is it the trainee? It is understood that the **responsibility for reports (NHS cases)** being signed off solely by a trainee lies with the trainee under usual NHS indemnity. This arrangement can be variable between trusts. Hence, the issue should be discussed and agreed with management prior to the start of the independent reporting process. Also, we recommend that trainees seek trainee membership with one of the medical defence unions. **It is absolutely essential, that the trainee feels supported and in a position to seek advice at any time** in order to allow for safe independent reporting. There should not be undue pressure on trainees to authorise reports when they do not feel comfortable to do so. Support should be tailored and difficulties explored in a sensitive manner. **Trainees must not independently report non-NHS or private work.**

What about mistakes?

'Errare human est (to err is human)'. In our safety-conscious environment we occasionally forget that, whilst it is extremely important to try and avoid mistakes whenever possible and to have systems in place to help with this, we remain human and as such mistakes do happen. Trainees and trainers need to be mindful of this and **approach mistakes in a compassionate and supportive manner.** The routine processes for investigating and learning from mistakes should be followed and there should be no attached stigma. An open constructive and supportive learning environment will help to prevent similar mistakes from happening to oneself and others. The trainee should be aware of the procedures for reporting incidents, handling complaints by the trust and clinical governance policies. This concern relating to independent reporting has been captured and discussed very well by Dr Matthew Clarke (current Chair of the Training Advisory Committee TAC) in one of the recent RCPath Bulletin contributions on independent reporting.[3]

Guide on Suitable Cases

a) Pre-FRCPath Part 2 exam (ST4 or above)

The following list comprises categories of cases deemed to be suitable for independent reporting by the majority of our current trainees and the training team. It serves as a general guide. Not every single case within these categories will be straightforward and, therefore, a bit of 'common sense' will be necessary:

- Tumours: schwannoma, meninigioma (WHO grade I), metastatic carcinoma (with straightforward immunohistochemistry panel and known primary
- Vascular lesions: straightforward malformations (AVM, cavernoma) and haemorrhages
- Temporal artery biopsies: either florid giant cell arteritis or no inflammation (avoid grey areas)
- Acellular / virtually acellular CSFs

b) Post-FRCPath Part 2 exam (after passing the exam)

If independent reporting was not initiated pre-Part 2 it should start with 'easy' cases as outlined above. It is envisaged that the trainee will be able to expand his / her repertoire swiftly to include cases as listed below. This is a guide and individual trainees should be able to negotiate with their departments, which cases they feel comfortable with reporting as they progress.

- Tumours: all meningiomas and straightforward primary CNS tumours (e.g. glioblastomas, ependymomas, pilocytic astrocytomas), common metastases, common pituitary adenomas, straightforward integrated reporting to include IDH status, MGMT status, BRAF testing, histone testing.
- Intraoperative smears: gradual support to independence depending on individual levels of confidence (e.g. sitting with consultant but taking the lead, looking at smears first and deciding whether to show to the consultant next door prior to phoning the result through, consultant can be called back but not in the department…)
- Post mortem neuropathology: depending on the experience level straightforward cases could be reported (e.g. brain donations with clear algorithm for characterisation). Coroner's cases require the consent and support of the coroner.
- Other specialist areas depending on trainee's specialist interest: may include straightforward muscle biopsies, ophthalmic cases (e.g. simple cysts, skin tags, basal cell carcinoma, chalazion) and intraepidermal nerve fibre density (IENFD) assessments for skin biopsies.

A practical step-by-step guide

- The process should be initiated and led by the trainee
- The number of cases to be independently reported and the level of difficulty handled are to be gradually increased with prior agreement with the educational supervisor.
- One suggested approach is to start with a 'two pile' method. In this the trainee divides his / her work into two piles – one of which they can report without additional help from the consultant (easy pile) and the other pile with the more difficult cases. Initially both piles will be checked by

the supervising consultant with the aim that over time the easy pile will grow bigger than the difficult one. However, the speed of transition will vary from trainee to trainee.

- Independent reporting is a gradual dynamic process. The trainee can start to take more responsibility for their report and working up cases. Any cases where doubt exists should be discussed with a named consultant who should be mentioned on the report, which can then still be signed off by the trainee. Naturally, trainees should be confident of the diagnosis when signing out the cases. Therefore, it is very important that the trainee should have access to a named consultant for a particular day or week in order to show cases to. As confidence grows the trainee would work up cases to full immunohistochemistry and special stains as required with preparation of a report and then consult a named person for additional advice as needed. Equally, if a trainee is really 'uncomfortable' about a particular case they should be able to refer it back to the consultant free of pressure.
- Trainees should be familiar with the pathology software when authorising reports having received prior induction into the process.
- The workload going to a trainee during this period has to be carefully regulated so that they are not overloaded. There is no absolute minimum number for independent reporting. Hence a fixed number or type of specimen per week can be agreed and aimed for after local discussion.
- The trainee should have access to a named consultant in order to show any difficult cases for a particular day or week. As confidence grows the trainee would work up cases to full immunohistochemistry and special stains as required with preparation of a report and then consult a named person for additional advice.
- It is advisable that **WHO grade II – IV diagnoses (except straightforward glioblastomas and meningiomas), especially new biopsy diagnoses** are to be double reported with a consultant. This 'pragmatic' approach is generally well received by the MDTs and also reduces any future anxiety for the trainee and consultants should any complaints arise. It is to be emphasised that when double reporting with a consultant, the trainee should lead the way in the main work-up of every case they deal with.
- To reiterate: the **responsibility for reports (NHS cases)** being signed off solely by a trainee lies with the trainee under usual NHS indemnity. This arrangement can be variable between trusts. Hence, the issue should be discussed and agreed with management prior to the start of the independent reporting process. We also recommend that trainees seek trainee membership with one of the medical defence unions. **Trainees must not independently report non-NHS or private Histology work.**
- Trainees are advised to keep a log number and types of specimens independently reported by them in the training portfolio.
- It is advised to **audit** approximately 10% of the trainee's reports to check for accuracy and content within a few weeks of the commencement of independent reporting. It is envisaged that departments will have their own independent reporting SOP, which will include the process of auditing independent reporting.

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Endorsed by Prof T Dawson (SAC Chair) and the DN SAC (9th October 2019)

References:

1. Monaghan H and Mathers M. Keeping our services running: independent reporting by trainees should be considered? Letters. The Bulletin of the Royal College of Pathologists. Number 182, page 132, April 2018.

2. Liebmann R. Reply to Keeping Our Services Running: independent reporting by trainees should be considered? The Bulletin of the Royal College of Pathologists. Number 182, page 133, April 2018.

3. Clarke M. Independent reporting: making sure trainees are equipped for the next step. Training section. The Bulletin of the Royal College of Pathologists. Number 187, pages 168-169, July 2019.