Pathologists and Patients: Can We Talk?

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Farmers in the City

All "heads" occupied at the multihead microscope. The white-haired chief of anatomic pathology—arguably the best pathologist in the state—"drives" the glass slides. Scanning. Then the tip of the green pointer abuts a nest of tumor. We have been there, done that. But today is different. The door to the sign-out room is firmly shut. And the chief's audience is quiet and attentive.

Initially, it was the closed door and quiet that arrested me as I walked by. Like many in his position, the chief is a raconteur. He thrives on attention and spirited discussion. Group case reviews, and even diagnostic "sign-out" sessions themselves, are typically all but boisterous. The sign-out room door is always open so residents or faculty in search of a "good case," or a good story, can step in. I notice our guests' appearance. Arm to beefy arm at the microscope, they are dressed in overalls. They are middle-aged, ruddy-faced, and blond-haired. Unmistakably, these are country folk, much like those one would encounter at the post office in the small towns that defined so much of that Midwestern state. Why, I wondered, were farmers at the city teaching hospital "'double'-scoping" cases with the chief.

Later I ask. The matriarch of a family has cancer, the chief tells me. The rural visitors to the department are the patient and her family, who had phoned and asked him to review her slides and discuss the case with them. It is that simple. And that "simple" visit almost a decade ago—of farmers and pathologist, and other instances like it, in which pathologists interact directly with patients (or families) over cases—is my focus here.

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Exceptions Highlight Rules

In pathology, consultation with a patient is a rare event. Yet, as intimated above and documented below, patients may on occasion request to speak with pathologists about their care. While most pathologists issue tens of thousands of diagnostic reports but generate few if any direct discussions with patients, others meet with patients with greater frequency. I propose that the suggestions and insights of the latter set of pathologists may help guide the former in future interactions with patients. Indeed, as patients become "better informed consumers" and gain increased access to their medical records (1) and medical information via the Internet, it is likely that requests for consultations with pathologists will become more common. If direct pathologist-patient interactions currently are exceptions that prove a rule, one might ask why the rule prevails and whether or not it is constructive. I will first discuss factors that reinforce the "rule" and then explore those "exceptional" circumstances in which it is broken. I will also address the potential significance of pathologist-patient encounters.

Pathologists, Patients, and the Doctor-Patient Relationship

It may seem natural that pathologists and patients do not routinely interact directly with each other. It can be instructive, however, to analyze factors that sustain the status quo. The lack of patient-pathologist interactions may be understood from the vantage points of patients, pathologists, and the doctor-patient relationship.

First, patients may simply be unaware of the work of pathologists (2). The former are told by clinicians that their specimens will be "sent to the lab," and that "a report will be issued in a few days." This information may lead patients to believe that the transformation of sample into diagnosis is effected by a "black box." The reports themselves are often unambiguous with regard to clinical questions or concerns ("Granulation tissue. There is no evidence of malignancy." "Adenocarcinoma, invasive."), and the name of the reporting pathologist is rarely com-

municated to patients (or to the general public in those circumstances in which other members of a patient's medical team are publicly identified [3]). A clear report, correlating with clinical circumstances and issued by a pathologist whose name is not linked to it, is unlikely to generate patient contact with a pathologist.

Anatomic pathologists, for their part, seemingly have had little need, incentive, or opportunity to speak with patients. Pertinent clinical information used to arrive at a diagnosis is provided by clinicians, so pathologists do not have to obtain data directly from patients. Further, fierce competition in health care, declining reimbursements, and the implementation of industrial productivity measures conspire to keep pathologists focused on "glass," not on discussion with the patients whose samples are on it.

Finally, and paradoxically, the doctor-patient relationship, as currently construed, itself largely precludes a direct pathologist-patient relationship. The former implies a clinician-patient relationship in which clinical data and specimens are obtained by clinicians, who also communicate the results of diagnostic studies directly to patients. Our reports, via clinicians, effectively speak for us, to patients.

If such powerful factors or forces, including the invisibility of pathologists to patients, pathology practice patterns, and the presence of a highly visible intermediary, the clinician, serve to isolate pathologists and patients from each other, one might surmise that they would never encounter each other.

Patients with Pathologists

Yet clearly they do. Vincent A. Memoli, M.D., a general surgical pathologist at Dartmouth-Hitchcock Medical Center, and Andrew E. Rosenberg, M.D., chief of bone and soft tissue pathology at Massachusetts General Hospital, have each discussed pathologic findings with more than 100 patients at their respective institutions. My discussion of why some patients ask to consult with a pathologist and what transpires in such encounters draws upon conversations with them as well as with several other pathologists and some clinicians.

Patients with a cognizance of pathologists and an understanding of the implications of pathologic diagnoses may be more likely than others to seek a consultation with a pathologist. It is not surprising, then, that many of the patients with whom Dr. Memoli has reviewed cases have been hospital employees, including technicians, nurses, or physicians. Lay people with access both to disease-specific medical information via various media and to their medical records (including pathology reports) also may perceive the importance of pathologic interpretation in their care. While a measure of awareness of the field of pathology may be a precondition for seeking a consultation, it does not explain the patient's decision to pursue one.

In simple—and general—terms, patients decide to speak to a pathologist because they seek information. The request for a discussion may come directly from the patient or may be communicated via a primary care physician, surgeon, or oncologist. Typically, a pathologic diagnosis already has been rendered and communicated to the patient by a clinician.

Patients may ask to discuss a specific facet of their pathology report. Some inquire about how the pathologist arrived at a diagnostic interpretation. They may ask if there is any uncertainty about the diagnosis or whether a second opinion is warranted. Publicity about new treatments prompts questions about the feasibility or advisability of performing additional special studies on tumors—for example, immunoperoxidase stains for HER-2.

Many patients who consult with a pathologist have cancer, or malignancy is in the differential diagnosis of their slides. These patients are "facing life-threatening, or at least, life-changing diagnoses," Dr. Memoli states. In the face of serious illness, they may be experiencing marked distress. Indeed, in these circumstances, the request for information involves "an attempt to objectify, or gain control over, a situation, rather than deal with it solely emotionally," according to Dr. Memoli. It follows that a pathologist who reviews pathology slides or discusses a report with a patient may experience the satisfaction of knowing that he or she has helped that individual cope with illness. In fact, after a positive consultation, "both parties feel gratified," avers Dr. Rosenberg, who has spoken with some patients in his hospital office or that of a clinician, and with others via telephone.

The manner in which pathologists conduct discussions may increase the likelihood of positive pathologist-patient interactions. On the basis of his experiences, Dr. Rosenberg advises that the pathologist should be empathetic toward the patient, a careful listener ("You need to understand what the patient is asking. . ."), truthful about the pathologic interpretation, and certain that any therapeutic recommendations that he or she might make are appropriate.

One facet of any consultation with a non-medical person will involve the translation of medical terms into layman's language. Accordingly, the pathologist needs to assess the level of sophistication of the patient so that appropriate language is chosen, according to Dr. Memoli. The pathologist, then, must

be a careful listener, as Dr. Rosenberg suggests, but also a careful speaker.

Indeed, a pathologist may choose not to speak about some topics. Even if asked, Dr. Memoli defers questions about treatment to the patient's clinician, because he feels that he is not expert about therapy. Some pathologists who have extensive experience in the diagnosis and treatment of certain diseases have the requisite knowledge to make recommendations regarding therapy. Clearly, any pathologist who does discuss treatment might tell a patient something different from what he has been advised by his clinician, thereby causing confusion. Indeed, any topic addressed in a pathologist-patient discussion might result in the communication of a message different from that given to the patient by a clinical doctor. Faced with the possibility of contradicting a clinician or confusing a patient, some pathologists may choose simply to refrain from meeting or speaking with patients, if at all possible.

Despite the theoretical risk of confusing communications about treatment, pathologist-patient encounters might result in patients getting a clearer picture about other critical aspects of their cases—for example, the diagnosis itself. One could posit that the author of the diagnostic pathology report is better equipped to explain it than a clinician, its usual translator. While, ideally, a well-written document should speak for itself, its creator is uniquely positioned to explicate and clarify any ambiguities about what has been written. Moreover, there is evidence to suggest that clinicians are lacking in their comprehension of pathology reports (4) and, accordingly, might not accurately explain their contents to patients.

Procedures can be employed in the course of pathologist-patient consultations that may promote good communication with the patient's primary clinician. As a matter of policy, Dr. Memoli phones the physician before and after meeting with a patient. At a minimum, the preliminary call serves to alert the clinician that a consultation is imminent; in those instances in which the physician has not directly referred the patient to the pathologist, the call functions as a "heads-up" that might be especially appreciated. In his follow-up conversation, Dr. Memoli advises the physician about the tenor of the meeting, the matters discussed, and any issues that he believes the clinician might subsequently need to address with the patient. "All (communication) loops should be closed," Dr. Memoli states. When feasible, a note written by the pathologist in the patient's chart following a consultation also can document the encounter and the subjects discussed.

Simultaneous Encounters: Patients, Pathologists, and Clinicians

Another mechanism to prevent confusion and facilitate communication among patients and the clinicians and pathologists with whom they might consult is for all three parties to meet simultaneously to discuss a patient's care. Multidisciplinary clinics held at some medical centers, such as the sarcoma clinic at Massachusetts General Hospital, provide a forum for such encounters. Designed for the convenience of patients, at these "one-stop" medical consultations specialists such as orthopedic surgeons, radiation oncologists, and pathologists talk about a case with each other and the patient (personal communication, Dr. Andrew E. Rosenberg).

Interdisciplinary tumor boards at which specialists discuss current cases and plan treatments have similarities to the clinics described above, but, in contrast, patients do not usually attend them. Later this year, the Comprehensive Breast Program at Dartmouth-Hitchcock Medical Center will hold an inaugural, innovative "mock tumor board" for the general public. Three typical cases of women with breast cancer will be discussed by the usual attendees at the weekly tumor conference, including oncologists, a breast pathologist, and radiation therapists. This unique window into tumor board likely will help the lay audience (which will include patients and their family members) gain a greater understanding of the role of pathologists on the teams of health professionals who provide for patients' care. For some of the lay conference attendees, it may suffice just to know that the person involved in the critical interpretation of their specimens regularly meets with clinicians. It will, however, be interesting to see if a greater cognizance of the role of pathology in oncology stimulates others to seek to pose questions directly to a pathologist involved in a current or future case.

Limitations, Disclaimer, and Affirmation

My comments herein are largely anecdotal and are not the product of experimental study. Only a modest number of pathologists and clinicians were queried about pathologist-patient encounters. The views of patients—both those who have and those who have not consulted with a pathologist—have not been investigated but are worthy of exploration. I have primarily focused on oncologic surgical pathology; however, patients consult with pathologists to discuss matters related to other branches of the profession; *e.g.*, they may inquire about the results of autopsies on family members. Finally, as a cytopathologist often assigned to the fine needle aspiration biopsy service, I am aware that some

pathologists presently have frequent daily direct contact with patients.

I do not claim that all patients should discuss their pathologic findings with a pathologist, nor would it be currently practical for them to do so. I do suggest that we might make the public—and clinicians—more aware of our availability to review cases with those patients (or families) who might desire these consultations. Systematic analysis of these encounters might identify subsets of patients most likely to be helped by them and delineate any associated risks. Some patients likely will benefit from these discussions by gaining a greater understanding of their diseases and treatments and an enhanced ability to cope with illness. In addition to the cognitive and emotional benefits that may accrue to patients, such encounters can bring pathologists closer to the source of their daily work. We know that helping patients is central to our vocational calling, but this notion may come into gratifyingly clear focus when sitting across from them at the microscope.

An Open Door

"I know you are busy," I told the chief after he had explained why the farmers had visited, "but I have one more question: Did they make an appointment to see you?" " No," he replied matter-of-factly, "I said to come whenever it was convenient, and that I'd see them then."

Perhaps we might try to keep this kind of metaphorical door more open, so that we might be even more helpful to the many people who rely on us for their care.

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