op their own standards rather than have them imposed by government bureaucrats, JDs, or MBAs, it would seem appropriate that the Board of Directors of the American Society of Dermatopathology consider the standardization of some methods in dermatopathology, especially in the area of NDIS, but also addressing optimal handling of tumor re-excisions, and possibly practical indications for immunohistochemistry.

While each of us may feel some limitation of independent judgment in our practice by following such standards, we could probably achieve a higher quality of service to our patients and clients. Not the least consideration is that adherence to a generally accepted standard is the best form of defense.

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Reply 2

The authors raise two critical questions in their empirical survey of how diagnostic dermatopathologists deal with establishing a tumor diagnosis when none is detected on the initial slide(s). These are summarized as follows:

1. Is there a standard way in which dermatopathologists search for tumor in specimens in which none is detected in the initial sections?

2. Should there be a standard by which the dermatopathologist is considered to have fulfilled his responsibllity in examining sufficient tissue from a given specimen to say that there is no tumor present?

The first question is factual in nature and is addressed through the use of a survey. According to the results of this survey, no uniform standard of searching for the additional evidence of tumor has evolved in the practice of dermatopathology. Each of the 43 respondents used *some* method to pursue negatives, but the methods themselves varied considerably and included serials, levels, step sections, etc. What is not addressed in the article is how often additional sections were useful in solving the problem posed by the clinical question. The answer to this question requires scientific study and may indeed serve as a basis for directing a dermatopathologist's method of practice.

The second question posed by the authors has broader implications as it involves value judgments concerning the art of dermatopathology and the ethical responsibility of the practitioner. There does exist a standard by which the dermatopathologist rules out the presence of tumor: When a biopsy is submitted and the initial sections do not show tumor (given the appropriate clinical history), the onus of proof is on the dermatopathologist to either prove that the tumor is present, to explain a reason for the clinical findings when there is a discrepancy, or to deplete the block in an attempt to explain the clinical question. The block can be sectioned in stages (according to the discretion of the examiner) and monitored at each stage, usually in a relatively simple manner depending on the size of the tissue, as well as why and how it was embedded in the block. Ultimately, the diagnosis of a tumor will be established, an alternative diagnosis rendered, or the tissue will be depleted in the process. In any case, the dermatopathologist will have provided the essential information needed for the diagnosis.

That said, I am not opposed to anyone's attempt to establish technical standards within the diagnostic standard discussed above provided they can marshal evidence for their position. In fact, I have championed the development of such standards in the past (1). However, it must be remembered that a technical standard can never be substituted for one's *judgment* of the facts, i.e., a diagnostic standard. The diagnostic standard requires that the information from each case be integrated fully and the clinical context be considered carefully prior to drawing any conclusions. The diagnostic standard is the ultimate purpose of any technical standard, and dermatopathologists must not allow themselves to use the latter as a justification for abdicating their responsibilities as interpreters of and decision makers about complex medical information.

References

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