Medical-Legal

Geoffrey J. Gottlieb, M.D.

Question

1. Should a pathologist make recommendations to a clinician about management of a patient or should a pathologist make diagnoses only—and no more?

2. If a pathologist does advise therapy, should it be in the form of a "recommendation" or an unambiguous statement, such as "The neoplasm should be removed in its entirety with a narrow margin?

3. When a pathologist makes a recommendation about management to a clinician, does that mandate a clinician to follow the recommendation?

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3. When a pathologist makes a recommendation about management to a clinician, does that mandate a clinician to follow the recommendation?

Responses of Dermatologists (most of whom are dermatopathologists):

Jules Altman, M.D.

Dermatologist; Warren, Michigan

After discussion with my associates in the practice of dermatology, we all believe that a pathologist *should*make recommendations to the clinician about management.

We believe further that when a pathologist makes a recommendation, it does to some degree mandate the clinician to follow it.

Jorge L. Sanchez, M.D.

Department of Dermatology, University of Puerto Rico; San Juan, Puerto Rico

1. Yes, the pathologist should see himself (or herself) as a consultant and try to transmit in the pathology report any information that may help the clinician come to a correct diagnosis and thereby assist in management properly. The pathologist should make a diagnosis—and more.

2. If a pathologist does advise therapy, it should be based on his or her observations and special knowledge about the disease being diagnosed. Because the final word belongs to the clinician (who is in direct contact with the patient), any advice should be informative and in the form of a "recommendation."

3. No. Any recommendation about management should be phrased such in a way that the clinician is given full right to make final determinations without being obliged by the recommendation of a pathologist.

Heinz Kutzner, M.D.

Dermatologist; Friedrichshafen, Germany

1. In my experience, the map of the medical profession is a dense patchwork of overlapping fields of responsibility, studded with white zones of ignorance. One of the major fallacies of our profession, and a major source of suboptimal treatment, is the one doctor-one patient doctrine, with only one person in charge and supposedly knowing it all. The only way to reduce errors, misunderstandings, and incorrect treatment is a maximum degree of redundancy in regard to the information provided by one expert to another, in this case to the patient's physician, who should be privy to all the information the pathologist deems valuable.

In particular, giving the bare histopathologic diagnosis of *pemphigus vulgaris* to an experienced dermatologist suffices, but when dealing with a psychiatrist it is mandatory to add that *pemphigus vulgaris* may be induced by certain drugs. Oncologists do not have to be told that dermatofibrosarcoma protuberans must be excised with wide margins—but quite a few surgeons and most general practitioners need this information badly. Why limit a diagnosis to leukemia cutis if there is the possibility to append a short note reminding that "aleukemic"

leukemia cutis may be the first indication of approaching systemic leukemia? In order to keep this method from drifting into the bizarre and legally hazardous, the pathologist must respect its Achilles' heel: The professional profile of the colleague at the receiving end must be taken into account. The comments of the histopathologist should focus on major points of misunderstanding and on new developments in the field. The comments of the pathologist should avoid any apodictic statements. Comments regarding treatment always must be given with utmost care—and should be limited to exceptional instances only.

2. A well-phrased, albeit quite timid, recommendation in most cases is much more welcome than a forceful command. Apodictic statements are counterproductive. I consider them "go-to-jail" cards and avoid them whenever possible.

3. In the world of medicine, a written recommendation by an expert (even if he or she is an expert in a quite different field) carries enormous weight and it takes considerable effort to opt for alternative solutions. Clinicians, therefore, should not be jeopardized by needless recommendations about management. On the other hand, pathologists should not shy away from suggesting a procedure that they consider mandatory. If clinical circumstances are compatible with the suggested treatment, clinicians must oblige.

John C. Maize, M.D.

Department of Dermatology, Medical University of South Carolina; Charleston, South Carolina

The primary responsibility of a pathologist is to make a timely and accurate diagnosis. I do not think that it is the role of a pathologist to make a recommendation to the clinician about management unless there is a specific request from the clinician, in which case the pathologist should use his or her judgment regarding his or her qualifications to make the recommendation requested.

I believe that the advice given by the pathologist should always be regarded as a recommendation, as is the information that is provided in a consultation by a clinician. It is the responsibility of the treating physician to determine if the advice is appropriate and whether it should be implemented. If there are established guidelines of therapy, and the pathologist has a different viewpoint, then both the accepted viewpoint and the variant viewpoint should be expressed.

If the physician requests a recommendation from the pathologist and the pathologist responds with a recommendation, then the treating physician must decide how that information is utilized best. I do not think that under any circumstances the recommendations of the pathologist should be regarded as a mandate. My assumption is that the request by the clinician for a recommendation about management would come only when there is ambiguity about the process or the management of it appropriately.

Lorenzo Cerroni, M.D.

Department of Dermatology, University of Graz; Graz, Austria

1. A pathologist should provide all information necessary for the best possible management of the patient according to current standards, that is, a precise diagnosis and, if available, all other information that can be useful for clinicians in order to treat the patient optimally.

2. All statements written in a pathology report should be clear, concise, and unambiguous.

3. Clinicians should integrate information obtained by pathologists with the clinical picture and with all other clinical and laboratory data. The result of a single diagnostic test, i.e., examination by microscopy, does not mandate clinicians to a particular treatment or to treat the patient at all, even less so a "recommendation" by a colleague.

Helmut Kerl, M.D.

Department of Dermatology, University of Graz; Graz, Austria

1. The pathologist should not restrict himself to pure diagnostic statements. For instance, when a pathologist is uncertain about a diagnosis, it may be advisable to recommend complete excision of a particular neoplasm. That will be greatly appreciated by most clinicians.

2. The pathologist should only give "recommendations" from his point of view. The final decision is that of the clinician, who has to consider the recommendation of the pathologist along with all other aspects pertinent to the patient, including age, general condition, social circumstances, anatomic site of the lesion, etc.

3. A recommendation is not a mandate.

Bernhard Zelger, M.D.

Department of Dermatology, University of Innsbruck; Innsbruck, Austria

I am in a special position, acting both as a busy dermatologist and dermatopathologist at the University Hospital of the Leopold-Franzens-University Innsbruck, Innsbruck, Austria. As a dermatopathologist

1. I make recommendations about management to clinicians (including myself) every day.

2. I try to give an unambiguous statement, but

3. I also know that a clinician cannot always follow the recommendation of the (dermato)pathologist. Clinical circumstances, such as general health, extent and severity of

diseases, con comitant disorders, which are not always known to the (dermato)pathologist, may not allow a recommendation about management to be followed. Last, the patient himself or herself may have a point of view different from that of the clinician or the pathologist. I am aware of many such instances, so the answer to question 3 is "no!"

I do not see any reason why general pathologists should not act in the same way as I do as a dermatopathologist, assuming they have the education and knowledge. It is no shame for a pathologist to advise about the gold standard in regard to therapy, and it should be no offense to a clinician to get good advice, particularly when it is free!

Hiromaro Kiryu, M.D.

Department of Dermatology, Fukuoka University School of Medicine; Fukuoka, Japan

1. Basically no. A pathologist is not a clinician who can manage the patient directly, and does not even know the patient's face or character. Because a pathologist has no communication or relationship with the patient, recommendation about management should not be stated even if it is correct.

2. For the aforementioned reasons, a pathologist should make only a simple statement of fact when therapy is concerned.

3. No. A clinician is not required to obey the recommendation of a pathologist in regard to therapy.

Almut Böer, M.D.

Dermatologist; Maintal, Germany

1. A pathologist should make a diagnosis only.

2. If a pathologist does advise therapy, it should be in the form of a recommendation.

3. No.

In my opinion, the clinician has the responsibility for the management of the patient, including treatment. In order to manage properly, a correct diagnosis is needed and that often can be made by the pathologist alone (and that is the pathologist's responsibility). A correct diagnosis often requires clinico-pathologic correlation, which should be done by the clinician, who collects and correlates all of information in pathology reports and laboratory investigations of the patient.

A pathologist does not know the particular situation of the patient, only the clinician does. And

that is exactly why a statement or recommendation of a pathologist cannot mandate a clinician to follow it (e.g., a pathologist recommends "removal of a lesion in its entirety with a narrow margin," but the location of the lesion prohibits further surgery and the clinician then decides in favor of radiation therapy).

Luis Requena, M.D.

Department of Dermatology, Universidad Autónoma; Madrid, Spain

1. Pathologists in general and dermatopathologists in particular should provide the clinician with as much information as can be obtained from sections of tissue from the biopsy specimen they have studied. Obviously, diagnosis is most important, but sometimes other factors must be considered.

2. In the realm of pathology reports concerning neoplasms, the benign or malignant nature of the neoplasm is the main point and a statement about the complete or incomplete excision of the neoplasm should be included when the surgeon has sought to obtain free margins. If the neoplasm is benign but excised completely, the clinician should know that the neoplasm may persist, but still there is no need to re-excise the lesion.

3. If the recommendation of a pathologist is logical and pertinent, the clinician should follow the suggestion, although the final decision is the responsibility of the clinician alone. Recommendations from a pathologist about treatment may be helpful to a clinician, but only if that pathologist is informed fully about the personal or familial history, associated diseases, or medications that the patient is taking. That kind of information may be crucial to enable a decision about the best treatment for each individual patient.

Carlo F. Tomasini, M.D.

Department of Dermatology, University of Turin; Turin, Italy

1. The dermatopathologist's primary goal is to render the very best answer to the question posed by the clinician, namely, what is the diagnosis? If a neoplasm has not been removed completely, the pathologist must address that fact in the report, but not give recommendations of any kind regarding further surgical procedures (i.e., re-excision with wide or narrow margins) or any other therapeutic indications. In such circumstances, the clinician should use his/her own judgment based on all the information available to make the final decision about a therapeutic strategy or laboratory investigation.

If a neoplasm has not been removed completely and the pathologist is unable to make a definite diagnosis, he should address that clearly in the report and recommend another biopsy or a complete excision of the neoplasm. These kinds of recommendations are crucial for care of the patient and should be made unambiguously by the pathologist. Another situation where a recommendation should be made is in the field of proliferation of lymphocytes. It is well

recognized that a small incisional biopsy or a shave biopsy of a nodular or diffuse infiltrate of lymphocytes limits enormously rendering a diagnosis definitively, especially when the question of the clinician is "lymphoma versus pseudolymphoma." In such circumstances, a recommendation of another biopsy and other laboratory studies, such as molecular genetic ones or examination of the peripheral blood, is advisable.

In sum, a pathologist should not give recommendations unless the recommendations are crucial to coming to a correct diagnosis of a disease.

2.Generally, a pathologist should not advise therapy.

3. No. A recommendation of a pathologist need not be acted on by a clinician. A recommendation should be considered analogous to a recommendation of any consultant and may or may not be followed.

Responses of General Pathologists (all of whom are dermatopathologists).

Philip E. LeBoit, M.D.

Section of Dermatopathology, University of California, San Francisco; San Francisco, California

These are all good questions with no "right" answers. The questions are framed in a generic manner, but I have framed my answers specifically pertaining to dermatologists and to dermatopathologists.

1. In an ideal world, all clinical dermatologists would be versant in the natural history and management of dermatologic diseases, both common and rare ones. Unfortunately, many dermatologists do not keep up with advances in medical dermatology. This leads to a situation in which the dermatopathologist is sometimes compelled to educate the clinician about the nature (and, sometimes, treatment) of a rare condition. I seldom do this in reports, but I do get asked questions on the telephone about how to treat patients.

In regard to neoplasms, the dermatopathologist is in an excellent position to judge whether an excision is complete or not, and can help with making decisions about whether additional surgery is indicated or not. The more rare the diagnosis, the more likely the pathologist can be of help.

2. In an ideal world, I would make recommendations. Given the sensitivity to medico-legal liability that many physicians have, a recommendation sometimes is taken as an imperative. On the other hand, there are some clinicians who need to be clobbered over the head regarding the necessity to re-excise a melanocytic neoplasm. I have even heard of clinicians who did not re-excise a melanoma because they could not see with the naked eye any residuum of it. Because

of this latter breed, I find myself making unambiguous statements, such as that just stated. I try to do this sensibly. If a patient is 100 years old, a re-excision is a major procedure, and I might write something like "If the patient's medical condition permits, complete re-excision of this site should be performed."

3. I do not think that there is a mandate for a clinician to follow a pathologist's recommendations anymore than there is one for a pathologist to accept a clinician's diagnoses. What is mandated is for clinicians to consider the recommendation, and if they do not follow it, state the reasons why they are not doing so. Better yet, they should call the pathologist and discuss the matter.

Noreen Walsh, M.D.

Department of Pathology, Dalhousie University, Halifax, Nova Scotia, Canada

1. As part of a medical team involved in patient care, I do not feel constrained to make a diagnosis only. A comprehensive pathology report bears much information, apart from diagnosis, that affects treatment, and I do not regard it as forbidden to make a recommendation about management. In practice, I approach each case on an individual basis, tailor my report to the specific circumstances of it, and make a recommendation about management when I believe it will be helpful.

2. Integration of clinical and laboratory (e.g., histopathological) information is essential to the delivery of optimal patient care. To facilitate this integration, it is important that clinicians have a thoughtful concept of matters histopathological and pathologists of matters clinical. Nevertheless, the balance of expertise in interpretation of histopathological information usually rests with the pathologist, as it does with the clinician in interpretation of clinical data and determination of a specific approach to management. In this context, I believe that a pathologist, when commenting on management, should do so in the form of a recommendation and not a fiat.

3. In my view, no physician mandates the actions of another. Clinical and laboratory data should be shared between members of a medical team to foster collegial and constructive interaction about management optimally. The final decision about management is the responsibility of the clinician.

Mark A. Hurt, M.D.

Dermatopathologist; Maryland Heights, Missouri

1.*Diagnosis* is defined in the Second Edition of the Oxford English Dictionary (1989) as follows:

"Determination of the nature of a diseased condition; identification of a disease by careful investigation of its symptoms and history; also, the opinion (formally stated) resulting from

such investigation."

Although the fundamental basis for treatment is grounded in diagnosis, a diagnosis *qua* diagnosis often is insufficient for the recommendation of specific therapy, because one cannot understand the clinical context of the patient based on diagnosis alone. Correlation requires a clinician who will take the information implied by a diagnosis, weigh it in the context of other clinical findings in a patient, and then undertake treatment. Moreover, in most cases the pathologist will not be the clinician, too, and should not put himself in the position of taking on liability for suggestions concerning treatment. Recommendations of a pathologist about treatment may subject the clinician to greater liability by seeming to compel a certain type of treatment by the clinician.

As a principle, if the diagnosis is definitive, i.e., if it *is* a diagnosis, rather than a string of words in a line in a pathology report, no recommendation about management should be made. Pathologists are in the "it is *this"*business, not the *"this* is how it should be treated" business (unless, of course, the pathologist also is acting as the clinician and taking on that responsibility). The fundamental role of a pathologist is to render a specific diagnosis in the language of clinical medicine, not to offer specific therapy.

It may be appropriate for the pathologist to correlate some diagnoses to specific clinical conditions or syndromes, such as sebaceous neoplasms in Muir-Torre syndrome. This type of correlation, however, still is primarily one of diagnosis; it is still an issue of identification, not of therapy.

2. To *recommend* is to "counsel, advise" according to the *Oxford English Dictionary,* Second Edition (1989). If a pathologist offers advice on therapy, it should be a recommendation only, and then only in cases in which the diagnosis is uncertain.

Only the clinician is in direct contact with the patient and knows fully the particular context. It would be presumptuous, and dangerous, of a pathologist to make any unqualified statement in a pathology report that would serve to force the clinician into a certain type of treatment, unless the pathologist is willing to serve as the clinician.

As a practical matter, I recommend specific management only in relation to uncertainties in diagnosis, most often in relation to proliferations of melanocytes. Even then, my recommendations are offered merely as suggestions for treatment, e.g., that more tissue be obtained in an attempt to establish a diagnosis or to clarify a dilemma in diagnosis. When I cannot make a diagnosis definitively, I state what I think is the most likely diagnosis and why; in such an instance, I often recommend complete excision of a neoplasm for purposes of assessing margins (I send sections of some of these cases to other dermatopathologists for a second opinion). The clinicians with whom I work always have appreciated this. Effective communication between pathologist and clinician is critical in these circumstances.

3. A *mandate* is defined by the *Oxford English Dictionary,* 2nd edition (1989) as "a command, order, injunction." The implication clearly is one of compulsion legally. Compulsion should not be the standard by which plans for treatment are made; only rational argument and sound reasoning should be the standard for treatment.

The clinician does not have to follow any recommendations by a pathologist. If a clinician dissents, the dissent should be noted in the patient's record and the reasons for it noted duly.

The only "mandate" (I use quotation marks because no one can force a mind to think) that a clinician must have is to use his mind to consider evidence that will benefit his patient. The clinician should use the information provided by a pathologist in the context of other information of which he is aware about the patient. The clinician is obligated to question every diagnosis of a pathologist and judge whether the diagnosis makes sense. Any recommendation made by a pathologist should be accepted or rejected on this basis, when appropriate, after discussion with a pathologist.

The clinician should take responsibility for speaking directly to the pathologist of record about inaccurate, unwanted, unnecessary, or misleading verbiage, and insist that the report be modified if information in it is inappropriate.

David Weedon, M.D.

Dermatopathologist; Indooroopilly, Australia

Pathologists should be very careful in making recommendations to a clinician about the management of a patient because doing so places the onus on the clinician to follow that recommendation. Furthermore, the pathologist generally is unaware of pertinent clinical features that might influence the ability of the clinician to implement the recommendation. For example, I do not advise clinicians to excise melanomas more widely, although most of my colleagues do.

As a recent follow-up study of Merkel cell carcinomas diagnosed in this practice showed, many clinicians did nothing further in response to that diagnosis. For that reason, I now add a comment to my report as follows: "A study, in progress, suggests that better results are obtained with this tumor if the patient receives wide primary excision of the lesion followed by radiotherapy."

In other circumstances where I make recommendations about management (such as squamous-cell carcinoma with perineural invasion), I invariably use the words "it might be prudent" rather than a more prescriptive phrase that includes the world "should."

Peter J. Heenan, M.D.

Dermatopathologist; Nedlands, Australia

1. The experienced clinician should know that a diagnosis of malignancy in a biopsy report means that the neoplasm should be excised completely and that if the primary excision is incomplete, re-excision should be performed. The pathologist should not need to make

recommendations, routinely, to experienced clinicians about management of patients.

2. Advice about therapy, when considered necessary by the pathologist or requested by the clinician, should be given as a recommendation, leaving the clinician to make the final decision concerning management after due consideration of all the relevant factors, and in accord with the wishes of the patient.

3. The final decision on management in all instances rests with the clinician. Recommendations by pathologists, therefore, should merit careful consideration by the clinician without necessarily being the last word on future management. Some clinicians feel that a recommendation by the pathologist may be seen as binding legally, but, in my view, it should be taken as advice based on expert interpretation of histopathologic features rather than an edict that compels. Recommendations by pathologists are often made without knowledge of all the pertinent facts of the case.

In the situation where a clinician is less experienced, a pathologist may think it necessary to emphasize that certain histopathological findings indicate that a certain course of action is advisable.

Omar P. Sangueza, M.D.

Director of Dermatopathology, Wake Forest University; Winston-Salem, North Carolina

1. It not only is desirable but also an obligation of the pathologist to make recommendations about the management of certain neoplasms, namely, melanocytic ones. The pathologist is in the best position to observe the nature of the condition and to determine if it has been removed in its entirety. I make those recommendations in my practice daily.

2. What kind of recommendation by a pathologist depends on the physician who will receive the report. For dermatologists, a general statement about management may suffice. For physicians in other specialties and who are not conversant with management of skin lesions, more specific recommendations are needed. They may pertain to which neoplasms require complete removal and which do not.

3. In the current state of affairs, many clinicians feel obligated to follow the recommendations of a pathologist, even though those recommendations may not be in the best interest of the patient. This is unfortunate because it is indicative of how defensive medicine today is being practiced. All too often it is not designed to protect patients but to avoid the possibility of litigation.

Carlos Diaz-Cascajo, M.D.

Center for Dermatopathology Freiburg; Freiburg, Germany

Training in pathology is based on morphology and, therefore, the experience of pathologists in management of diseases in most instances is limited. If, however, a melanoma is very close to the surgical margins, I usually recommend re-excision in order to be sure that the lesion is removed completely. I consider that one part of my job. In all these years, no clinician ever has asked me whether or not regional lymph nodes should be removed or chemotherapy should or should not be given (having reviewed the literature about these subjects I have to thank them for that!)

I cannot mandate clinicians to perform a re-excision of a melanoma that is removed incompletely or that comes very close to the surgical margins, but I do not remember a situation in which I recommended re-excision and a clinician did not perform it. I think that if a clinician has enough confidence to send a biopsy specimen for diagnosis, he/she also has enough confidence to do a re-excision if I recommend it.

Tim McCalmont, M.D.

Dermatopathologist, University of California, San Francisco; San Francisco, California

1. I believe it is appropriate for a pathologist to make recommendations to a clinician about management, and I do not believe that the role of the pathologist should be restricted to rendering diagnoses by microscopy exclusively.

Perhaps my view is skewed by virtue of the fact that I practice in an academic setting. I find that clinicians who refer specimens to our laboratory seek the recommendations of our pathologists regarding a wide variety of issues, including additional considerations in the differential diagnosis, thoughts for clinical testing that might hone the diagnosis, suggestions regarding stains or testing that the pathologist might arrange to narrow the differential diagnosis, and ideas regarding additional surgery. Based on this experience over a period of years, I have taken to making explicit recommendations in the report, and I do not recall any instance in which the referring physician has questioned the appropriateness of it. I confess to being entertained by reports from others that cross my desk that contain phrases such as "further re-excision is warranted if clinically indicated." How can a clinician determine if it is "indicated" to perform further surgery when the means to assessing the nature of the process and the margins of it is based on conventional microscopy?

2. I believe that the pathologist can offer either "recommendations" or "unambiguous statements," depending on the circumstances. There are certain situations, such as those that arise in the surgical management of neoplasms (especially melanocytic ones), where an unambiguous statement is almost unavoidable. Most clinicians with whom we interact relish the inclusion of such statements as a component of a pathology report.

3. When a clinician receives a recommendation from a pathologist, the individual has received, in essence, a consultation from a knowledgeable peer. In the practice of medicine, I do not believe that one is required or "mandated" to follow every recommendation of a consultant. However, if one disregards the recommendation of a consultant that is proved by time to be

judicious, then one might be held liable for the decision.