

## ETHICS CASE

### I Might Have Some Bad News: Disclosing Preliminary Pathology Results

Commentary by Michael H. Roh, MD, PhD, and Andrew G. Shuman, MD

#### Abstract

Cytopathology is a subspecialty of pathology in which pathologists frequently interact directly with patients. Often this interaction is in the context of fine needle aspiration (FNA) procedures performed at the bedside by the cytopathologist or by another clinician with the cytopathologist present. Patient requests for preliminary results in such settings raise fundamental questions about professional scope of practice and communication of uncertainty that apply not merely to pathologists but to all clinicians. In certain settings, cytopathologists may share preliminary diagnostic impressions directly with patients. Essential to these conversations is the need to articulate potential uncertainty about both the diagnosis and next steps. In addition, the involvement and notification of the referring physician is obligatory, both for care coordination and to ensure that patients receive a consistent message.

#### Case

Dr. H is a cytopathologist who performs and interprets fine needle aspirations (FNAs) of suspicious lesions, typically at a patient's bedside. Often, a radiologist obtains the sample with the help of radiologic image guidance, and the cytopathologist examines a portion of the sample in the form of Diff-Quik®-stained smears under a microscope during the rapid onsite evaluation (ROSE), used primarily to assess whether a sample is adequate. This procedure can offer the opportunity to disclose a preliminary diagnosis. The remainder of the sample is subsequently processed by the lab after the conclusion of the procedure. A diagnosis is not given until the sample is processed by the cytopathology laboratory and all the slides are evaluated under the microscope. If necessary, additional tests are ordered on this final sample prior to diagnosis.

One morning, Dr. H is attending his patient, Mr. Smith, a man with a history of melanoma who presented with a new soft tissue lesion in his abdomen. Mr. Smith's oncologist has consulted radiology for an ultrasound-guided FNA of the lesion, and Dr. H is on site as the attending pathologist to review the slides. As Dr. H is concluding his review of the Diff-Quik-stained smears, Mr. Smith says that he wants very badly to get his diagnosis today. Dr. H explains that the final report will not be released until all the slides are evaluated, probably the next day or the day after. "I know it's hard to wait," Dr. H says,

continuing, “Typically the lab processes the specimen so that I can better evaluate the cells under a microscope and order additional tests if necessary.” Mr. Smith seems exasperated at this and pleads, “Please, doctor, please tell me what you see. If it’s bad news, I’ll have my family around me tonight. If it’s good news, we’ll celebrate. I beg you to just tell me what you see.”

Looking at the Diff-Quik-stained smears from Mr. Smith’s sample under the microscope at his bedside, Dr. H sees cells that are clearly indicative of a malignancy. Nonetheless, he cannot definitively identify these cells as a metastatic melanoma or another primary cancer (e.g., metastatic carcinoma), and he wonders how to answer Mr. Smith.

### **Commentary**

The scenario depicted above involving a cytopathologist—a subspecialist in pathology who frequently interacts directly with patients—is not uncommon. There is no single “right” answer to the question of how this specific situation, in which the patient pleads for a preliminary diagnosis from the cytopathologist, should be handled.

Mr. Smith’s request raises fundamental questions about professional [scope of practice](#) and communication of uncertainty that apply not merely to pathologists but to all clinicians. Many patients are aware that a pathologist is able to assess a specimen quickly and offer a preliminary diagnosis at the bedside. This is, indeed, the objective of ROSE—to assess specimen adequacy at the time of the procedure, while the patient is still available for collection of additional diagnostic material if indicated, and to determine the urgency and [necessity of additional testing](#) as part of the specimen analysis. From the cytopathologist’s perspective, addressing a direct question from an anxious patient for which there might not be a clear answer is, at the very least, awkward.

Cytopathologists have different approaches to these sorts of situations, especially if a preliminary diagnosis represents potential “[bad news](#)” or when cursory examination of the slides is fraught with uncertainty. In some cases, organizations and systems can be designed so that this situation does not arise (i.e., when the pathologist and his or her microscope are physically separate from the patient’s room) [1]. In others, physical proximity will render these sorts of patient–cytopathologist interactions more routine, commonplace, and perhaps even expected. To address the question posed, it is useful to consider the professional responsibility of pathologists as distinct from the complexities of communicating uncertainty to a patient.

### **Ownership and Responsibility to Disclose to the Patient and the Referring Physician**

By nature of training, accreditation, and professional standing, pathologists are physicians and subject to the same standards and expectations as all physicians. In many cases, pathologists are physically detached from the patients whose care they influence, but physical separation does not obviate pathologists’ duty to patients whose cells appear on a slide. In this regard, the obligation and responsibility of a pathologist are very

different from those of a laboratory technician who might face a similar situation, as the pathologist has a sense of professional ownership in cases and has to honor the fidelity intrinsic to all physician-patient relationships.

*Obligation to disclose to the patient.* Principles of honesty and good faith apply to all physicians, so evading an [obligation to share a preliminary diagnosis](#) with a patient who desires that information can be perceived as dishonest and could have deleterious effects on the patient's emotional state and trust in the health care system. Jay Katz's landmark work, *The Silent World of Doctor and Patient*, clearly makes the case for open and earnest dialogue and vociferously rejects physician silence [2]. Direct communication between the pathologist and his or her clinical colleagues is a central tenet of professionalism, and the same honesty and openness apply to the patient-pathologist relationship. Essentially serving as a physician liaison between his clinical colleagues and his patient (and the specimen itself), Dr. H need not hide behind the microscope; instead, he should feel empowered to share a preliminary impression with the patient *if he chooses*. The nuanced way in which this information is disclosed is, of course, critical.

*Obligation to disclose to the patient's referring physician.* As is increasingly true in today's practice of medicine, patient care is team-based. In this case, it might be presumed that the oncologist and referring physician who diagnosed Mr. Smith's abdominal mass or treated his melanoma has an established relationship with Mr. Smith and that Dr. H is a "new face." One critical consideration in such cases is to ensure that Mr. Smith's care is not fragmented by the practical reality of subspecialized care or by [transitions in care](#) from one physician to another. The importance of communication between Dr. H and Mr. Smith's other consulting physicians cannot be overstated.

Dr. H must recognize that he is part of a multidisciplinary cadre that consists of Mr. Smith's clinicians, and that sharing a preliminary diagnosis is only the first step toward management of Mr. Smith's lesion. The referring physician presumably knows more about Mr. Smith and is in the best position to use the diagnostic information at hand for advising the patient about next steps.

Often, a patient's questions for the cytopathologist pertain not only to the preliminary diagnosis but also to the implications of that diagnosis for prognosis and subsequent management. These issues, of course, are best addressed by the referring clinician. Therefore, it is necessary for the pathologist to make the referring physician aware of the events and details surrounding the FNA procedure, including the working diagnosis—emphasizing that it is only a preliminary diagnosis—and what the patient knows. This way, the clinician can prepare to engage in a conversation with the patient who is undoubtedly anxiously awaiting more information. Such instances can even stimulate [collaborative dialogue](#) between cytopathologists and referring clinicians about best practices for sharing preliminary diagnostic impressions with patients.

### **Uncertainty as a Barrier to Disclosure**

Like all medical interactions, each patient encounter involving a pathologist is unique, and different factors affect the comfort level and openness of the discourse. There are two major [barriers to disclosure](#) of information in this case, both relating to uncertainty.

*Diagnostic uncertainty.* In this scenario, the cytopathologist providing ROSE is uncertain about the diagnosis at the time of the procedure, even if he or she suspects malignancy, and is thus unsure of the clinical management implications of the eventual diagnosis. Second, the cytopathologist's ability to [communicate uncertainty](#) to the patient might be limited both by the absence of established patient-physician rapport and by the pathologist's lack of familiarity with the patient's disease trajectory and prior history. In addition, pathologists in general have less direct patient contact than other physicians, which might make them feel less equipped or comfortable engaging in difficult, emotion-laden conversations that require admission of uncertainty or potential error [3, 4]. However, reticence among physicians to disclose errors and admit uncertainty is not a problem unique to pathologists [5].

Assuming that Dr. H is comfortable disclosing information at the time of the encounter, it is important for him to emphasize that the preliminary diagnosis is, in fact, preliminary. He should tell the patient that the preliminary diagnosis is subject to change based upon further microscopic evaluation of the entire specimen and slides and possibly additional tests on the sample (e.g., immunohistochemistry and molecular diagnostic testing). One challenge in communicating this information is to avoid an error often committed by physicians in any specialty when sharing difficult news: using medical jargon and dwelling on details that are confusing and less relevant to the main message. In other words, statements such as "Based on what I see preliminarily under the microscope, I am concerned" or "I am worried about the possibility of cancer here, but I am not entirely sure," will resonate very differently than "the cells are polymorphous and have prominent nucleoli.... S100 immunohistochemistry is necessary for clarification."

This case is particularly tricky because the preliminary diagnosis represents "bad news" and, at the same time, is fraught with uncertainty about the exact nature of the malignant cells (metastatic melanoma versus another neoplastic entity). Patient-physician encounters that involve disclosure of bad news must strike a balance between sharing information openly and recognizing uncertainty, all while demonstrating compassion. Thus, it would also be entirely reasonable for Dr. H to state honestly that he understands and can [empathize](#) with Mr. Smith's concern but is not at liberty to provide exact, specific, and potentially speculative diagnostic information based purely upon the rapid onsite evaluation, the primary purpose of which is to ensure that the sample is adequate for the lab testing that will follow. On the other hand, if the cytopathologist's preliminary impression is that of a benign process, he or she might reassure the patient

accordingly. Nonetheless, the cytopathologist needs to disclose to the patient that only a portion of the material is being examined microscopically at the time of the procedure and that the possibility of discovering abnormal cells upon review of the entire specimen still exists.

*Uncertainty about legal liability.* Another consideration that can affect the cytopathologist's behavior in this case is fear of legal liability and [malpractice](#). The uncertainty inherent in the interpretation of a subset of FNA cases has been the subject of intense scrutiny and led to a movement in which this uncertainty and the potential for discrepancy between preliminary and final diagnoses is articulated in formal pathology reports [6]. One method of codifying this information is adoption of "common language" for result reporting, which is now standard for reporting Pap testing and thyroid nodule FNA biopsies [7, 8], and which recognizes the uncertainty of cytopathology diagnoses within the result itself (e.g., "follicular lesion of undetermined significance" is one of the six diagnostic categories in the Bethesda System for Reporting Thyroid Cytopathology [9]) [7, 8]. Other fields are adopting similar language that relates not only to diagnosis but also to subsequent steps in management of care [10]. Moving a step further, [quality assurance standards](#) require clear communication of the diagnosis and its implications—and the limitations thereof—as well as technical consistency, as articulated in a classic set of professional guidelines from the Papanicolaou Society of Cytopathology [11].

## Conclusion

There is no doubt that Dr. H is, indeed, Mr. Smith's doctor in this setting. Thus, it would be appropriate—and, in fact, very reasonable—for Dr. H to share his initial preliminary diagnostic impression with Mr. Smith. Essential to such a conversation would be the need to articulate uncertainty about both the ultimate diagnosis and next steps. In addition, the involvement and notification of the referring physician would be obligatory, both for care coordination and to ensure that Mr. Smith receives a consistent message. Nevertheless, Dr. H should defer disclosure in this setting for the reasons just discussed. However, this does not liberate him from his inviolable obligation to provide comfort and compassion to Mr. Smith and coordination of his care moving forward.

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