A Problem That Is Older than the Hills: The Communication Gap between the Pathologist and the Surgeon

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The grievance of the surgical pathologist who does not receive relevant clinical information on the laboratory request slip accompanying a tissue specimen is well known to all practicing pathologists – and to many surgeons as well. As an ocular pathologist who has been in business for over 40 years, I feel comfortable suggesting that this problem is as old as the practice of pathology itself [1, 2]. In ocular pathology, this issue seems particularly bizarre because many ocular pathologists (including myself) function as surgeons in different ophthalmic specialties, but when they are wearing their pathologist's hat, their communication with other surgical colleagues is known to suffer [2, 3].

A rather small group of the surgeons I have dealt with over the years achieve to avoid this practice; these are truly knowledgeable, obsessive-compulsive clinicians who often know more pathology than I do, and they are not embarrassed to use it in their practice. Some of them even call you ahead of time, letting you know that a case of such and such will be coming your way; these people are very practical, and they discuss the patient with you, offering just the right amount of information succinctly and in a short time. This sort of surgeon is a blessing to have around; they often advance the case in your mind, bringing to the fore possibilities you may not readily consider.

S/he may even make you to be prepared for an impending case, particularly if it is related to a frozen section. These physicians are helpful, but also quite demanding; they often ask to review the slides with you and may question your diagnosis if the clinical picture does not merit it, in their view. As a summary, even one or two of these surgeons may set an active stage of continuing medical education and provide endless stimulus for everyone; unfortunately, not many of these physicians are in practice anymore.

In my experience, most of the remaining surgeons constitute the other extreme as two main groups; in one group, the laboratory requests submitted with the specimens do not contain any pertinent information at all but only identify the location of the tissue removal, which is frequently already known to the pathologist, especially after the slides are prepared. Examples of this category include, “left eye,” “conjunctiva, OS,” “right orbit tumor” etc. [4].

The request slips from the second group contain bits and pieces of ambiguous information about the clinical picture, in difficult to decipher scribble, habitually studied with typos and usually not following a logical sequence of clinical progress. You know right away that this is not a message drafted by the surgeon or at least not

from an experienced surgeon; these may be coming from a medical student, a first-year resident or a nurse's aide.

Throughout my professional life, I have wondered about this peculiar phenomenon. What could be the explanations for *not* providing sufficient and/or proper clinical information with the specimen request form when it is transported from the operating room to the laboratory? I thought of several possibilities below; no doubt, my pathologist and surgeon co-workers may come up with other possibilities and possibly more convincing reasons.

1. Not being sure of the clinical picture.

This is the first thing that comes to mind. It may be true that in certain cases, one may not be sure of the clinical picture and therefore cannot bring himself to set out a suitable narrative on the slip. Although this may be true in a few instances, I do not believe that this is a major cause. First of all, in medicine, absolute certainty is rare in many situations; moreover, in many scenarios, the biopsy is done to provide an answer to clinical dilemmas in the first place.

2. Not appreciating the significance of clinical detail for the analysis of a tissue specimen.

Some surgeons follow medieval dogmas such as "all the pathologist needs is the tissue" or "not to bias the pathologist's interpretation with clinical info." Although these concepts are gradually changing, the lack of information on laboratory slips continues to be a fact of life.

3. Not having time at the end of a surgical case or a biopsy in the clinic.

These time-conscious surgeons routinely delegate the job to a junior physician or to a technician who cannot sort out the important pieces of information to write on the request. How often do we run into the clinical history that is scribbled in as "eyelid lesion?"

4. Not having a well-coordinated team and a full-proof setting in the operating theater.

This situation can be classified under "general chaos," where everything in the operating theater is disorganized, tardy, and ineffective; so, the tissue submission to the laboratory suffers as much as other activities.

Submission of adequate clinical history appears to be influenced by procedural issues (electronic vs. manual submission forms), size of hospital, number of surgeons and pathologists, and particularly the closeness of interaction and communication between pathologists and particularly the closeness of interaction and communication between pathologists and clinicians. The pathologist asks the surgeon to provide clinical information with the specimen, not because it could not be found in other ways (EPIC, paper medical records, telephone conversation, e-mail etc.) but because it is the right thing to do for record keeping and saving time for everyone. Most importantly, when the surgeon chooses to communicate, s/he offers the best information; not only in terms of pertinent medical data but also his/her clinical judgement as the most qualified person for the patient. Paradoxically, I also feel that stylistic improvements of report structuring with electronic medical records can interfere with comprehension further and even may increase the number of misunderstandings and, thus, medical errors [5, 6]. I am at the end of my bipolar career as an eye surgeon and an ocular pathologist and I have not noticed any improvement in the communication gap between the pathologists and clinicians in my time; it is most likely that this will continue to be a problem many years to come.

Disclosure Statement

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