
Collegiality and dermatology

Richard Gordon Glogau, MD
San Francisco, California

I believe my good and learned colleague Dr Ackerman raises an interesting issue. Is it inherently unprofessional or unethical for a dermatologist who has performed a skin biopsy as part of his evaluation of a patient to render a pathology diagnosis as an additional part of his care of the patient? From the purest of motives, Dr Ackerman argues against such a practice since these dermatologists are only “pretending” to be dermatopathologists, driven by pure financial greed. But I see it differently.

In this age of increasingly unrestrained medical expense, there is no way that every biopsy specimen can generate the sort of expense that is routinely billed by our colleagues in tertiary referral dermatopathology practices. Neither can every headache receive the assurance of a magnetic resonance imaging scan in the emergency department, nor every case of chest pain receive the benediction of the interventional cardiologist. Hence many of us commit the cardinal sin of triaging the “simple” from the “complex” cases, filtering the cases that truly benefit from consultation, often from more than one dermatopathologist at a time. Because of insurance limitations, many of these cases are precluded from tertiary dermatopathology consultation with colleagues whose opinions we trust. To obtain consultation from a consultant dermatopathologist, the cost frequently comes out of my pocket, not the patient’s insurance company’s nor the patient’s.

The issue of dermatologists “pretending” to be dermatopathologists brings to my mind a parallel. It is the practice of many dermatopathologists to insert surgical instructions as part of their written conclusion and diagnosis of a specimen. To further explain,

depending on the dermatopathologist, I may receive a written report that can be summarized as follows: The tissue is described as X, the diagnosis is most certainly Y (*although Ya, Yb, and Yc are included as possible alternate diagnoses, usually without the benefit of probabilities*). Further surgery Z is necessary (*or recommended, warranted, etc.*)

I always then scan the clinical history section at that point to see if, in the request for consultation, I actually did provide the patient’s age; sex; previous medical and surgical history; the location of the lesion; the quality of the skin; the general medical status of the patient; the potential cosmetic impact of further surgery; the patient’s degree of apprehension, degree of cancer phobia, or sense of well-being; previous experience with surgical and radiation therapies; upcoming social and work schedules spouse’s or children’s concerns; or any of the other variables that go into selecting the appropriate therapy for the patient.

I gather from the recommendation that the dermatopathologist is not aware of the cornucopia of therapies (many nonsurgical) that dermatologists have at their disposal these days. If they are aware of the options, then why do they insist on locking us into a prescribed therapy that may not be best for the patient about whom they know nothing except the tiny piece of tissue they have examined?

While I do (truly, I do) value the opinion of my learned colleagues, do you not “pretend” to be an expert in the application of surgical therapies to the problem at hand in much the same way as I “pretend” to be a dermatopathologist? If I am taking a biopsy specimen of a suspected basal cell carcinoma on the nose, I usually do not require a consultative opinion and frequently would rather not risk obtaining one that would preach to me what the recommended therapy might be. I prefer to see exactly what the nature of the suspected tumor appears to be and am frequently swayed to one therapy or another depending of the type and extent of the tumor that I see under the microscope. Certainly getting a written report of “basal cell carcinoma, nose” does nothing for either the patient or me. And I have received such boilerplate reports from recognized dermatopathologists. And what

From the Department of Dermatology, University of California, San Francisco.

Funding sources: None.

Conflicts of interest: None disclosed.

Reprint requests: Richard Gordon Glogau, MD, University of California, San Francisco, Dermatology, 350 Parnassus Ave, Suite 400, San Francisco, CA 94117. E-mail: rglogau@aol.com.

J Am Acad Dermatol 2005;53:701-2.

0190-9622/\$30.00

© 2005 by the American Academy of Dermatology, Inc.

doi:10.1016/j.jaad.2005.06.028

might the motives be for such interpretation in these cases? Volume, cost, and level of reimbursement, one might suspect.

But there is a deeper unease underlying Dr Ackerman's argument. What he implies is that the practice of interpreting one's own slides is symptomatic of a larger moral corruption, something like equating a dermatologist's attempts at dermatopathology with quackery. It is, after all, mentioned along with wholly unrelated but equally distasteful sins of false forensic witness, the sale of cosmetic products, some vague reference to invisible inflammation as a cause of wrinkling, and an unfortunate recent burst of misogyny by the beleaguered president of Harvard University. I might suggest a better list of common practice sins, Dr Ackerman, such as upcoding, fee splitting, redundant and excessive return appointments, demeaning colleagues' prior care, etc, etc.

John Stuart Mill said, "Men are men before they are lawyers, or physicians, or merchants, or manufacturers; and if you make them capable and sensible men, they will make themselves capable and sensible lawyers or physicians."¹ There is no point in impugning a professional practice because it may be abused by a small fraction of practitioners. The fact that some cardiothoracic surgeons engage in sham

surgery does not argue for the wholesale elimination of bypass surgery, but it probably does serve as a warning that you had best pick your physician with great care these days. And that is the implied point of Dr Ackerman's argument with which I wholeheartedly agree.

The great British Prime Minister William Gladstone wrote, "The disease of an evil conscience is beyond the practice of all the physicians of all the countries in the world."² It is not the dermatologist's interpretation of slides that is evil but the disease of evil conscience that offends us. If, in fact, the goal of the slide interpretation is pure greed, then I join Dr Ackerman in his objection. However, I think it is certainly not the case for the majority of my colleagues who continue to strive to do their best for their patients, and that includes the dermatopathologists who occasionally stray into surgery with the best of intentions.

REFERENCES

1. Mill JS. Inaugural address to the University of St Andrews, St Andrews, Scotland, Feb 1, 1867. In: *Dissertations and discussions*. 3rd ed. London: Longmans, Green, Reader, and Dyer; 1875. p. 335.
2. Gladstone WE. Speech. In: *Bartlett's Familiar Quotations*. 17th ed. New York, NY: Little, Brown; 2002.