How Well Do We Communicate Autopsy Findings to Next of Kin?

To the Editor.—Keys and colleagues1 are to be commended for their demonstration that the autopsy meets important needs for many families, a finding consistent with prior work cited in the article. The claim that autopsies findings could be communicated better is hard to dispute.

I do, however, have reservations about the first sentence in the abstract. To quote directly: “A failure of communication among families, physicians, and pathologists is recognized as a major cause of declining autopsy rates and may be involved in increased litigation.”1 Hopefully the authors, reviewers, and the editors of this journal do not really believe that pathologists are not physicians. Perhaps the words “primary care” should have preceded physician in this sentence.

Although autopsies are more likely to be beneficial than harmful to physician defendants in medical malpractice litigation,2 the claim by Keys and colleagues1 that a decline in the number of autopsies has lead to increased malpractice litigation does not necessarily follow. Changes in ways in which medicine is practiced, increasing expectations of the public, and activity of malpractice attorneys are likely causes of increased litigation, at least for primary care physicians.

Keys and colleagues1 do not present or cite any data that indicate that poor communication involving families has led to the decline in autopsies. In fact, the data that Keys’ group presents, as well as those they cite, indicate a reasonably high level of satisfaction among families who do permit an autopsy. The reasons for the decline of the autopsy are complex and include interaction among professional, technical, and financial issues, but it seems unlikely that failure of communication involving physicians and families is one of them.

In Reply.—Thank you for the opportunity to respond to this letter to the editor. We feel the author makes some valid points that contribute to the debate on the role/value of communication and the autopsy. We also feel the author has misinterpreted some of our statements. In particular, our sentence, “[a] failure of communication among families, physicians, and pathologists is recognized as a major cause of declining autopsy rates and may be involved in increased litigation,” appears to have caused some confusion. First, we do not state that a decline in autopsy rates may be involved in increased litigation but that a failure of communication may be involved in increased litigation. Second, we did not intend to imply that pathologists are not physicians, although we agree that the wording we chose was somewhat ambiguous. In retrospect, it would have been more precise if we had qualified “physicians” in that sentence by saying “treatment (or primary care) physicians” to differentiate their role from that of the pathologist.

The author of the letter raises a substantive criticism in his last paragraph, that is, that we “do not present or cite any data that indicate that poor communication involving families has led to the decline in autopsies.” He also points out that the decline of the autopsy is multifactorial. We agree with the latter opinion. We also agree that there is limited direct evidence that poor communication with families has contributed to the decline in autopsy rates. However, several studies have shown that the major factor for low autopsy rates is a failure to ask for consent.5,6 This is surely a breakdown in communication. There is also much indirect evidence for our opinion that better communication with families leads to higher autopsy rates.

We have identified several studies that address the indirect evidence that good communication with families is an effective way to increase autopsy rates. In one of these, McPhee4 states that improving communication with clinicians and families is an important requirement for maximizing autopsy benefits. In addition to improving direct communication with families, the author also recommended “educating both medical professionals and public citizens about the value of autopsy (eg, featuring autopsy results in medical conferences, distributing educational materials, and using print and electronic media).”4 Resident interns reported insufficient guidance and difficulty with answering technical questions with respect to autopsies and expressed interest in developing better communication skills with families by improving communication and support from pathology residents.5 Lack of training in communication is not restricted to internists; 48% of surgeons reported a lack of competence in gaining consent for autopsy and could benefit from formal training in communication.6 The next of kin’s perceptions of the autopsy are also an important factor to consider when requesting consent for an autopsy.7 When families’ concerns and questions were addressed in a formalized setting, 62% of parents consented to an autopsy for their child.7

In conclusion, we feel it is reasonable to suggest that good communication between pathologists, primary care physicians, and families about the role and benefits of autopsies would increase autopsy rates.
Letters to the Editor

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The authors have no relevant financial interest in the products or companies described in this article.

In Reply.—We appreciate the comments on our report examining the necessity of surgical excision for atypical lobular hyperplasia (ALH) and lobular carcinoma in situ (LCIS) diagnosed on core biopsy. We stand by our conclusion that surgical excision is indicated for all percutaneous core biopsies diagnosed as ALH or LCIS, because a significant percentage will show carcinoma at excision. Although 2 of the 3 cases that were upgraded showed a clear pathologic-radiologic discordance and would have been excised anyway, the third case did not. This radiologic finding in this case was microcalcification, and the pathologic diagnosis at excision was ductal carcinoma in situ (DCIS). The authors of this letter state that DCIS is a nonmalignant diagnosis, and thus disagree with its significance. Ductal carcinoma in situ is a noninvasive malignant neoplasm, classified as stage 0 in the American Joint Committee on Cancer staging system, and it must be treated as such. Although it is true that 35 of 38 patients in our study had benign findings at excision, 8% had a malignancy at excision. The summary of other studies presented in Table 3 in our article shows upgrade rates to cancer at excision at an average of 13% for ALH cases and 20% for LCIS cases, again supporting excision. The authors of this letter note that the extent of lobular neoplasia may predict whether or not excision is warranted. This work was cited in the discussion section of our article. We did not tabulate the extent of involvement in our study.

In the report by Cangiarella et al examining the necessity of surgical excision for atypical lobular hyperplasia (ALH) and lobular carcinoma in situ (LCIS) diagnosed on core biopsy, the authors did not include a review of the literature. Arch Pathol Lab Med. 2008;132(6):979–983.

No conflict of interest.

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