Letters to the Editor

The 2018 ASCO/CAP HER2 Testing in Breast Cancer Guideline Focused Update resulted from review of publications and communications indicating weaknesses in the previous 2013 ASCO/CAP HER2 Testing in Breast Cancer Guideline Update for less common ISH cases. Such collaboration among all those involved in HER2 testing is the way in which guidelines can be modified productively to improve their value. We are grateful to all those professionals such as the current authors who have taken the time and effort to share their experience.


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Thyroid Cancer Overdiagnosis and Malpractice Climate

To the Editor.—We read with great interest the article “Overdiagnosis of Thyroid Cancer,” which concisely summarizes the problem of thyroid cancer overdiagnosis. The article rightly frames overdiagnosis as an ethical issue, and identifies health care access and financial incentives as major drivers. However, the article places little emphasis on defensive medicine, another major driver of unnecessary diagnostic testing, and probably of thyroid cancer overdiagnosis.

Fear of litigation drives physicians of diverse types to adopt practice patterns designed to protect the physician from being sued, without necessarily benefiting the patient. While this classically involves clinicians ordering unnecessary diagnostic tests, pathologists are not immune. Survey-based studies have shown malpractice fears push many pathologists to diagnose malignancy in equivocal lesions, such as equivocal breast lesions and pigmented skin lesions.

Fears of litigation are not irrational. More than one-third of physicians have been sued at some point in their career. Among physicians older than 55 years, nearly half have been sued. In cancer patients, a major source of lawsuits is delayed diagnosis, wherein a patient is diagnosed with advanced disease and sues the clinical physician for failing to order diagnostic tests that would have detected the cancer at an earlier stage. Pathologists may also be sued for delayed diagnosis if a tumor is diagnosed as benign and thus treated conservatively, but later manifests malignant behavior. Lawsuits regarding thyroid cancer follow this trend. While recurrent laryngeal nerve injury is the leading cause of lawsuits in thyroid surgery, delayed diagnosis is the leading cause of malpractice lawsuits in thyroid cancer specifically. Indeed, the article describing this trend explicitly recommends liberal use of thyroid ultrasonography and fine-needle aspiration to mitigate the risk of being sued.

Defensive medicine is greater in states with higher risk of medical tort. Keeping with this, our group recently showed that the incidence of thyroid cancer is higher in states with higher rates of malpractice payout. The association held when controlling for other thyroid cancer risk factors, including health care access. The study concludes malpractice climate may be a social determinant of thyroid cancer risk. We suspect this association is the result of greater defensive medicine in states with higher tort risk, as practiced by clinical physicians who more readily order diagnostic tests, and pathologists who more readily diagnose carcinoma in equivocal tumors.

In addition to education and collaboration among disciplines, efforts to reduce thyroid cancer overdiagnosis should include tort reform, specifically reforms that diminish the incentive of physicians to practice defensive medicine. Until then, fear of litigation will...
continue to push physicians, particularly those practicing in high-risk climates, to continue to overdiagnose thyroid cancer.

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1. Schnadig VJ. Overdiagnosis of thyroid cancer: is this not an ethical issue for pathologists as well as radiologists and clinicians? Arch Pathol Lab Med. 2018;142(9):1018–1020.

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In Reply.—The authors, Warrick and Lengerich, correctly comment that tort reform is not addressed in my editorial. I acknowledge that fear of litigation influences pathologists’ reporting. Unfortunately, alarmist postings on the Internet and (heresy alert) social media are also major problems. As a pathologist not trained in law or political action, I wonder whether tort reform merely places a small bandage on a gaping wound. I hope that physicians can, themselves, improve communication and patient trust. When there is trust, patient education may also be effective. Delay in intervention for low-risk papillary microcarcinoma does not affect prognosis. Lethal papillary carcinomas are rare and present with high-risk features of clinically evident metastases or extra-thyroidal invasion.3 This suggests that lethal tumors metastasize while still subclinical and, likely, are biologically different than curable and nonprogressive neoplasms. Actually, more than 60 years ago, Crile4 wrote that “the ability of a papillary carcinoma of the thyroid to metastasize depends more on the biologic behavior of the tumor than on whether it is treated early in its clinical course.”5 Only now, researchers are confirming Crile’s beliefs.

The aims of my editorial are (1) to raise questions in the readers’ minds about the ethical dilemma and potential harms of overdiagnosis of occult thyroid nodules and (2) to suggest that pathologists’ comments may contribute to patient (and clinician) anxiety. Litigation fears are real; however, is defensive medicine truly ethical when the outcome can be angst, surgery, endless follow-up, and/or increased costs leading to bankruptcy? Payer6 has cited Dr Gunnar B. Sticker’s words on the subject: “If you practice to protect yourself, that is malpractice.” Because the authors raise the question of physician lawsuits fears, I must state that even more fear may be generated by what has been termed the “tyranny of guidelines.”4,5 Clinicians lament the loss of autonomy to care for their patients individually, and I lament the loss of freedom to tailor cytology reports to the individual patient for fear of retribution from supervisory-level administrative personnel. Pathologists must consider that fear and implementation of endless follow-up procedures can result from comments such as “risk for malignancy” in occult thyroid tumors and “endometrial cells in a woman over 45” in asymptomatic premenopausal or perimenopausal women. We should be studying these statements’ potential to cause patient and clinician anxiety as well as increase costs given that there is no convincing evidence that lives are saved. Cannot our comments regarding thyroid nodules (and endometrial cells) be given in less fear-generating terms? Why not state that most occult thyroid tumors behave in a benign or indolent fashion? This statement is evidence based, does not rule out what is called carcinoma, and is less likely to generate anxiety. It also may help to prevent ostracism and isolation of patients who request noninterventional follow-up. Sadly, Davis et al7 recently found that some patients who believed themselves overdiagnosed and requested nonintervention for atypical, suspicious, or “malignant” thyroid nodules felt that they were denied the support of their physicians and friends. One was even called “stupid.” I shudder to think that only when patients begin to sue for overdiagnosis will this problem be addressed.

Patient-specific comments should be allowable without fear of retribution by upper echelons when these comments are based on evidence, individual patient data, and care for patient well-being. Common sense is involved. Should we not be allowed to modify our comments regarding thyroid nodules (and endometrial cells) based on clinical findings and personal judgment?

Oscar Wilde has defined experience as a name given to our mistakes. As a thus-defined experienced pathologist, I believe that we must at least attempt to modify our behavior to lessen patient anxiety and harm, and to use clinical judgment, without fear of either litigation or enforcers of guidelines interpreted as dicta. I encourage pathologist discussions with patients, clinicians, and radiologists. Pathologists should not fear discussions with patients who request such conversations, as long as patients’ primary physicians are informed of their conversations. Does not such behavior have the potential to improve care and reduce patient dissatisfaction? Is it not possible that communication and building trust may be more effective than lobbying for tort reform?

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