Pathologists going “live”: lessons from a developing country on giving a human face to pathology

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In 1998, I signed up for a 2-year commitment with the United Nations Volunteers, a division of the United Nations Development Program, seeking excitement and a different perspective on pathology practice. Fresh out of fellowship, I looked forward to the challenges of working in a region short on pathologists, far from the comforting embrace of a First World teaching hospital. I travelled to western Jamaica to become the only pathologist in Montego Bay, at a 500-bed regional hospital with a catchment population of almost half a million.

I worked 12-hour days, 7 days a week. My time was fully occupied with examining surgical pathology specimens, setting up a fine-needle aspiration practice, looking after laboratory administration and conducting autopsies.

It was while I was preparing for an autopsy shortly after my arrival that my First World notions of the nature of the pathologist–patient relationship were challenged. Assuming that all I had to do was to issue a preliminary report after the autopsy with a carefully worded statement about the potential cause of death, I was astonished when the deceased’s relatives demanded to be present during the procedure. The patient, an elderly man with a long history of heart disease, had died a day earlier. His relatives were concerned that he had not received proper medical care and did not believe that he had had cardiac problems.

The hospital’s administrators assured me that this was an acceptable practice. I explained the conduct that was expected during an autopsy to the family. My team and I passed out masks to the 4 relatives who would observe the autopsy and then proceeded with the dissection. Not one of them flinched during the procedure. I showed them the enlarged heart with a thickened left ventricle, the severely occluded, calcified coronary vessels and heavy lungs and explained the disease. Their mood changed from belligerence to something more subdued, almost apologetic.

Eventually I became accustomed to having up to a half-dozen relatives in the autopsy suite, a few feet from the dissection. Occasionally some would ask questions or insist on copies of photographs taken during the autopsy. Not infrequently a few got sick, vomited or left before we were finished.

Although I initially found it awkward, there were significant benefits to having relatives observe the autopsy. It became my standard practice to conduct post-mortem briefings with the family, much as a surgeon would do with relatives outside the operating room. By encouraging relatives to be present during the entire procedure and to ask questions I was able to significantly reduce the time I had to spend on autopsies. The practice probably also kept the hospital out of court when irate relatives threatened to sue for explanations that they alleged were not forthcoming from my clinical colleagues. One instance was of an elderly man who had died of esophageal cancer. His family was suspicious about his “sudden death” and demanded an autopsy. Within 10 minutes of cracking the chest I showed them a 10-cm fungating esophageal mass and multiple intrathoracic metastases. Of course, the autopsy findings were not always as unequivocal.

For some autopsies, large numbers of people wanted to attend, and we were faced with the challenge of limiting access. Before the autopsy of a policeman who had died in hospital following a gunshot wound to the abdomen, at least 25 police officials were crammed into the autopsy suite. Rumour had it that the police rank and file felt that the hospital had been negligent in his care, and the situation was tense. The police were advised that, unless the witnesses were limited to the investigating officer and about 3 other officials, the autopsy would not be performed. That emptied the room pretty quickly, although I did have to participate in a press conference subsequently.

A similar openness existed with respect to fine-needle aspirations. Although I did not have a formal agreement with my clinical colleagues concerning the disclosure of results to patients, I was permitted to exercise my discretion, especially when the procedure was a follow-up in a patient with a previously diagnosed cancer. I do not recall receiving a single complaint from any clinician because I had disclosed the result.

My administrative work in the laboratory included troubleshooting. For this I relied heavily on the experience of very supportive senior technologists. It seemed easier to sort out certain problems before I was officially made aware of their existence, so with the technologists’ encouragement I performed daily “rounds” from the top floor of the hospital to the bottom. I visited the wards at a time of day when the senior physicians were available, and my rounds gave me an excellent opportunity to listen to the day’s complaints and occasionally resolve them. My presence on the wards also gave the pathology department a human face, fostering trust.

Now that I am back in North America, I miss the degree of patient interaction to which I had become accustomed. However, with the increasing accessibility of medical information on the Internet[1,2] and with patients demanding a more influential role in the management of their diseases[3–6] it seems that the nature of the pathologist–patient relationship in North America will change.

The culture and legal climate in North America are different from those in regions such as the Caribbean, but pathologists everywhere will inevitably be challenged to be more expressive in their dealings with patients. I hope we respond robustly to the challenge.

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