

Anatomic Pathology Practice in the Philippines



The practice of Anatomic Pathology in the Philippines had been rather simple since the start in the early 1950s. The pathologist does a gross examination and description of the specimen submitted, takes sections for processing and reads and interprets the stained slide; thereafter issuing a Surgical Pathology report or in the case of autopsies, a Final Anatomic Diagnosis.

In the early 90s, immunohistochemistry (IHC) was introduced and had since become more accessible to most if not all pathologists. Molecular methods were introduced later at the advent of the 21st century. In-situ hybridization was initially used for her-2 neu in breast cancer cases but is now applied to other tumors.

The practice has largely been left to its own devices by regulatory authorities as the focus was on the upliftment of clinical laboratories and rightly so. In contrast to Clinical Pathology, which up until recently was more focused on supervision, quality assurance and continuing improvement by the Clinical Pathologist, Anatomic Pathologists actually render clinical diagnoses based on the gross and microscopic properties of the specimen and in correlation with clinical findings. The tissue processing is a necessary step to produce a quality microscopic slide but is largely a mechanical process, mediated by the histotechnologist who processes, cuts and stains the tissue section. It is similar to the Radiologist's practice where the images are sent to him/her for interpretation, again based on knowledge gained during residency training and specialization. Nowadays though, Radiologists rarely give unequivocal diagnoses but rather offer several considerations. In contrast, Anatomic Pathologists state unequivocal diagnoses in the large majority of cases. Thus, he/she is the ultimate arbiter of the patients' conditions.

Now comes disconcerting news on the new regulations concerning Anatomic Pathology in which all tertiary labs/hospitals are required to have histopathology sections. On the surface, this appears to be a progressive step. We all want the ideal situation. However, it appears this is based on an odd concept that the surgical pathology slides have to be produced in the same hospital/lab where the pathologist practices, or else the reading of a slide produced elsewhere is fraudulent.

This is probably an extension of the doctrine in Clinical Pathology where labs that outsource tests are required to send out the original results from the referral lab and not transfer the results to their own forms and letterheads. There is no issue about the requirement because the outsourced tests are purely the product of the referral lab which must be credited for the result, or investigated if the result is erroneous. However, in practically all instances, Anatomic Pathologists are not hospital/lab employees but are rather on a contractual basis or are free agents. Their rendering of diagnoses is subject to possible litigation when misdiagnosis is alleged but in which the hospital/lab carries no obligation or responsibility. The Anatomic Pathologist carries the ultimate responsibility for his/her diagnosis, from the initial gross examination all the way to interpreting the microscopic section, which may not necessarily come from the same lab he/she practices in.

In fact, this odd theory falls apart when you consider that many cases are referred from other institutions for second, third or fourth opinions. So, does it make the Surgical Pathologist who renders a second opinion liable for fraud just because he/she read slides from another hospital? If so, then current best practices will no longer be observed since the original diagnosis will be the one and only diagnosis. This will have to assume that we pathologists are perfect, which we are not, being prone to error as much as the next person. Which is why we have quality procedures in place in most progressive hospitals of requiring a second pathologist's opinion before releasing a diagnosis of malignancy. By the way, does this circumscription not constitute an infringement on the right to practice of pathologists, being free agents?

Assuming these issues are ironed out and the requirement is put in place, we have to contend with several issues that will impact its implementation. First is the issue of maintaining viability of the histopathology section, which requires a hefty financial investment in equipment and in manpower, not to mention the provision of additional space which most labs are hard up to provide. Many hospitals have cut down on the number of beds in operation because of nursing staff shortages. Some hospitals that are built to have 400 beds can only manage to open 100 beds. This number is only the possible occupancy but oftentimes, censuses are lower, thus the probability that there will be enough surgical pathology specimens to process in its histopathology lab is low. Will the hospital now raise its charges for surgical pathology specimens to levels that will maintain its histopathology operation? Will Philhealth or private insurance companies reimburse at those levels? Probably not.

What may happen is the hospital or laboratory will have to downgrade to secondary status if it cannot comply with the histopathology section requirement. It will mean further shrinkage of the hospital's operations and scope, which may eventually lead to its closure since Philhealth reimbursement is tied to the hospital category.

The next problem is staffing. For the longest time, histotechnology has not been properly taught or practiced. There is a dearth of good histotechnologists in the country since those who have been trained have gone to other countries in search of better opportunities.

We already have a shortage of medical technologists for the clinical lab. On top of this, we have even less histotechnologists who are properly trained. Staffing a histopathology section will definitely be a challenge.

Thus, the Surgical Pathologist has to contend with poor quality sections increasing the possibility of diagnostic error. It is vital that we have the highest quality microscopic sections to come up with the correct diagnosis.

In summary, the requirement for tertiary hospitals/labs to have a histopathology section is fraught with many implications. There are professional issues of infringement on the right to practice one's profession and the privilege of patients to avail of a second opinion. It will create a crisis in smaller hospitals that cannot afford to invest in histopathology equipment or hire more techs, possibly causing them to downgrade their category with subsequent loss of income. It will be problematic for hospitals to hire histotechs or train them since there are no training opportunities for histopathology. Surgical pathology slide quality will be an issue if they are forced to hire untrained staff, leading to possible increase in diagnostic errors by pathologists.

All these do not augur well for our patients or health care system. We must find a way to address the issues before enforcing the requirement.

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The author has been practicing Anatomic and Clinical Pathology in the Philippines since 1988. He was responsible for popularizing the use of immunohistochemistry through his lectures at the Philippine Society of Pathologists Inc. annual conventions and establishing the first full scale IHC section at St. Luke's Medical Center in the 1990s which has the most extensive menu of markers in the country as well as setting up in-situ hybridization testing using fluorescence (2008) and chromogenic (2002) methods. As the Liborio Gomez Memorial Lecturer in 2007, he emphasized the need for good quality surgical pathology microscopic slides and followed up with the founding of HistoSolutions Inc. in 2015 to provide quality routine H&E and IHC sections at reasonable prices to benefit both pathologists and the general public nationwide. He has co-authored the book, "Basic Histopathologic Techniques" in 2014.

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