John S. Abele, MD, FCAP

A Matter of Honesty

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On his mentors in the early days of fine needle aspiration

As the cofounder of Outpatient Pathology Associates (OPA) in Sacramento, California, where four staff pathologists performed aspiration biopsy cytology (ABC) on an estimated 2,200 nodules from clinic patients last year, John S. Abele, MD, FCAP, knows how to read body language. Many patients, he knows, harbor fears about possible malignancy that they have not yet voiced, even to their referring physicians.

So when he enters the examining room to perform an ABC, Dr. Abele first seeks to assess his patient's affect. If there is tension, he tries to ease it, and humor often works. "When I see the patient looking worried and anxious," Dr. Abele says, "sometimes I will say, 'Don't worry, my tremor is not too bad today' while shaking my hand a little. Better than Valium. It works every time."

In 1978, Dr. Abele completed his anatomic and clinical pathology residencies at the University of California San Francisco (UCSF) and joined the full-time faculty. He remained there for the next four years, initially focused on gynecologic cytopathology. Fine-needle aspiration was very new and little understood at the time, he says, but endocrinologists were clamoring for thyroid FNA analysis.

"We had a faculty meeting," Dr. Abele remembers. "The chair got up and said, 'We need someone to do this,' and they went around the room. The vice chair was too busy, the vice-vice chair was too busy, and eventually there were three people standing—me, Ted (Theodore R. Miller, MD), and the janitor; and the janitor wasn't about to volunteer. So Ted and I became FNA cytopathology, but we didn't know what we were doing."

"In Pap smear cytology, it's what the nucleus is doing in the cell," Dr. Abele says, "but in FNA cytology it's how the whole group is behaving." Drs. Abele and Miller didn't understand that

until a visiting professor from Sweden, Britt-Marie Ljung, MD, FCAP, set them straight and arranged for the two to study FNA for two months at the Karolinska Hospital in Stockholm.

Upon returning home, they were ready for the graduate course: meeting the expectations of those who would be their mentors—breast surgeons, head and neck surgeons, oncologists, and thyroid specialists. “They put us in our place,” Dr. Abele remembers. “We had to make it work clinically.” He learned to adopt the treating clinician’s point of view.

When Dr. Abele left academia for private practice (continuing as a part-time associate clinical professor of pathology), he took that lesson with him. From the moment he meets a patient, he is his or her clinician, both caring and direct.

“Dealing with patients is a matter of honesty,” Dr. Abele says. If patients are relatively calm at the start of the appointment, he gives them the option of learning his preliminary impressions, underscoring that the final diagnosis will not come until the next morning. Of course, cases that can be diagnosed on the basis of a clinical impression are rare. But the pathologists at OPA have performed and/or interpreted 127,000 biopsies over the past 25 years, including a good number—about 4,400 nodules last year, for example—referred by physicians from 21 states. When there is a strong clinical impression and the patient has indicated willingness to hear the preliminary diagnosis, Dr. Abele says, he will share it.

“I explain that I’m fairly certain this is going to be cancer,” Dr. Abele says, but he doesn’t stop there. “I say, ‘This is what we’re going to do about it. I’m going to get the diagnosis tomorrow, and I’m going to get it to your doctor first thing. We are going to get this fixed.’”

An isolated diagnosis of cancer is terrifying, Dr. Abele says, “but a diagnosis that says we’re going to get to work on it, well, people can get their hands around that.”

Over many thousands of ABCs, Dr. Abele has come to believe that, for his clinic patients, sharing the diagnosis and helping them process the information is part of his job. “There are articles about the cancer diagnosis,” he says.” People don’t hear it the first three or four times. Not infrequently, we will have talked about it three times by the time they see their doctor. My goal is that they will hear it by the time they see their doctors three days later. They will be more focused then, than they would be if days had passed and nothing had happened, and then they got the cancer diagnosis from their doctor.”

“It’s patient care,” Dr. Abele concludes. “It’s taking care of them.”