

Radiologist: the newsman of the millennium

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ABSTRACT

Modern radiologists have a new cap to wear – The Newsman of the Millennium – thanks to the rapid advances in this field in the last fifty years or so. These advances have literally shifted our speciality from the confines of the “dark room” to the full glare of the “front stage” in the dynamic world of doctor-patient relationships.

Today a final diagnosis is rarely reached without any back-up from the field of radio-diagnosis. Often, the radiologist is the first one to pinpoint the diagnosis or to raise a suspicion of the most probable diagnosis in a given scenario. Things which appear good and glorious when disclosing good news become drastic and distasteful when the news is bad and dreadful. While disclosing an incurable ailment like cancer or a genetic disease, procedural complications, diagnostic errors or accidents, the newsman as well as the patient and referring colleagues undergo tremendous emotional turmoil.

This article focuses on the little-known role of the radiologist as the newsman of the millennium and reviews various strategies that can enable them to wear this hat with satisfaction and to deliver good as well as bad news with courage and confidence. © 2012 Biomedical Imaging and Intervention Journal. All rights reserved.

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Radio-diagnosis as a speciality has grown by leaps and bounds, thanks to the advances in science and technology. The earlier version of the radiologist was that of a specialist who reports plain radiographs or conventional radiography techniques like barium studies, intravenous urography and so on. Although they were helpful in reaching the final diagnosis in some cases, the news of this diagnosis was delivered by the referring doctor to the patient with little or no mention of the radiologist. As such, there was not much interaction or relationship with the patient as far as the radiologist, as a doctor, was concerned. Hence the question of the

radiologist as the newsman of the ailment did not arise. Radiologists were also happy to play the role of being in the backstage and the darkroom.

Then came the era of breakthroughs in science and technology. The armamentarium of this specialty was not merely confined to Roentgen rays alone as the quiver was now full with newer additions like the Ultrasound (USG) and Doppler, Computerised Tomography (CT scan), Magnetic Resonance Imaging (MRI) and Magnetic Resonance Spectroscopy (MRS).

Magnificent results from the use of these new additions ensured that, in most of the cases, the radiologist was the first one to pinpoint the correct diagnosis. Slowly patients, too, became aware of this development and began to interact more with the radiologist. Whether the radiologist is willing or

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unwilling, he/she has to take up this new role of being the newsman, the bearer of news about the patient's diagnosis – be it good or bad!

The inclusion of doctors into the Consumers Protection Act (CPA) in many nations gave impetus to the evidence-based practice where the physician or the surgeon adopted the policy of getting radiological as well as laboratory reports before committing to the clinical diagnosis and treatment of any patient. So to the chagrin of many and the joy of the few, the patient-radiologist interaction also grew by leaps and bounds. Therefore, what a radiologist says to a patient becomes important and cannot be avoided as the financial stakes involved in this interaction are high. These stakes may either be in the form of litigation risks (patient factor) for withholding vital health-related information, or in the form of reduced referrals by a particular practitioner if the radiologist directly disclosed the information rather than leaving it to the referred doctor to do so (referring doctor factor). Moreover, in many nations, it is the right of the patient (consumer) to know the results of the test (the commodity) for which he/she has paid.

To a doctor who is not trained in delivering bad news, it might seem very distressing and inhumane to disclose a deadly diagnosis to the patient or their relatives [1]. This stressful situation of the health service provider was even grimmer in the yesteryears when modern methods of managing incurable maladies were not as easily available; today, modern advances have made it possible to treat many 'deadly' diseases of the past. The most important reason that contributes to this emotional turmoil is the lack of a scientific approach towards delivering bad news, a phenomenon that is seen globally.

The radiologist thus assumes a new role - that of a specialist who pronounces the diagnosis of what ails the patient. This news can at times be good, when the results of the patient's radiological investigations are within normal limits or when they pinpoint a completely treatable malady such as pneumonia or a benign tumour; and thus guarantee a return ticket to health.

But when the same person diagnoses an illness which has no cure or reports procedural complications, diagnostic errors and accidents, all are taken aback. The aftermath that follows this often leaves the doctor as well as the patient in a lot of stress. The following examples will highlight this fact. Diagnosing a genetic disorder like Down's syndrome, achondroplasia or heart defects during routine prenatal ultrasound, and then attempting to declare or explain these results to the expectant parents, takes a heavy toll on the doctors. Similarly, diagnosing an inoperable tumour or metastatic spread on CT scan or MRI and conveying the news to the patient or relatives can be equally distraught. With the advances in metabolic imaging, MRS can diagnose inborn errors of metabolism [1] like Leigh's disease and Pyruvate dehydrogenase deficiency even in children. Explaining this to the parents is also daunting and calls for appropriate communication skills. The scenarios exemplified in this paragraph fall under the broad umbrella of "Bad News" which is defined as "Any

information that adversely and seriously affects an individual's view of his or her future." [2].

To any healthcare worker who is not trained in delivering bad news, the experience of disclosing the deadly diagnosis to the patient or their relatives is a difficult and daunting task [3]. With the modern role of the radiologist as the new newsman, breaking bad news is an important communication skill which the radiologist must master, as physicians, oncologists and surgeons have. A non-scientific approach in breaking bad news will not only create misunderstanding in the mind of the patient about the seriousness of the illness and his or her chances of survival [4-5], but it may also be a cause for litigation in the future.

To prevent this we must be aware of the components involved in this mighty task. The verbal component consists of delivering bad news, coupled with multiple skills like managing the patient's emotions, involving the patient and family members in decision-making, clarifying expectations about care and cure, and most importantly keeping their hopes alive [6].

The medico-legal implications must also be kept in mind as patients in many countries have to be provided with as much information as they desire about their illness and about all the available treatment options [7-8].

How human beings will respond to bad news is unpredictable. Some instantaneously become fearful, some go into denial mood, some enter the 'why me' stage while very few seek more information to start a complete recovery or make a quality-of-life decision plan. Hence the act of delivering the bad news and the response to it can be quite stressful and emotionally draining for the health service provider as well.

Important strategies for breaking bad news are:

1. The traditional method in which the bad news is directly delivered to the patient or relatives by the doctor after examining the patient when he is expected to pronounce his findings and decision about patients status and expected future. Many times this 'blunt on the face approach' may take them by surprise and result in emotional outbursts.
2. There is a new six-step protocol for breaking bad news called SPIKES [6], which emphasises that any complex communication task can be achieved only by a stepwise approach. The six steps involved in it are:
 - S – Setting up an interview: This needs mental rehearsal, arranging an uninterrupted session in adequate privacy with a relaxed patient and his dear ones if so desired or requested.
 - P – Patient's Perception: Open-ended questions are used to understand how the patient perceives the medical situation; before discussing medical findings with them.
 - I – Invitation by patient: Wait till the patient is ready and invites you to disclose the results.
 - K – Knowledge: Warning the patient that bad news is coming, give facts in bits that are apt as per their understanding so that they accept the news in the right spirit.
 - E – Emotions: Address patient's emotional

reactions with emphatic response and support them.

- S – Strategy: Discuss the future plan, when the patients are ready and offer all options only if asked. It is always better that the doctor who has referred the patient does this job.

The protocol not only increases the confidence of medical students as well as the practitioners in formulating a plan for breaking bad news, but also ensures that the bearer of bad news is less affected psychologically during the process of disclosure by following this protocol.

3. A Saudi Arabian [9] study on preferences of mothers regarding bad news about their newborns suggests that a “one-size-fits-all” approach is inappropriate. The approach has to be tailor-made. Hence the study advocates the use of a reversible, written informed consent kept in the mother’s medical records which can be utilised to guide the process of breaking bad news, if needed, as the best solution to this diversity in preferences.
4. BREAKS [10] is a modern protocol for breaking bad news. It involves following six steps: B – Background, R – Rapport building, E – Exploration of patients’ understanding, A – Announcement of the diagnosis, K – Kindling hope and S – Summarising the scenario. This is a recently introduced protocol that calls for discussion, further elaboration and expression so that breaking bad news truly becomes part of the art of medicine.

To summarise, communicating with distressed patients is difficult and demands deliberate measures to handle the grim situation. Doctors as well as patients suffer significant stress when subjected to this ordeal [11].

When the radiologist delivering the news becomes emotional, he might instill in himself a feeling of guilt and a sense of failure for not fulfilling the patient’s expectations. Moreover, modern advances in the field of medicine and surgery have also led to unrealistic expectations by patients of their doctors. In such an environment, poor communication skills by the newsman can lead to misunderstanding and ultimately results in physician burnout, stress and even litigation. That is why many avoid discussing distressing information about the poor prognosis.

But as communication is a skill, it can be learned and mastered with practice and experience. Therefore, radiologists, as the newsman of the millennium, must choose the appropriate protocol to deliver good as well as bad news after the radiological investigations if the results are sought for. It must also be remembered that there is no place for unsolicited advice in this situation.

These communication techniques are a useful start but they may not always be suitable for radiology because the workflow in the speciality of radio-diagnosis differs from the one to which the hard-core clinicians are exposed to. Better research is therefore needed to develop a suitable model. More light waits at the end of this tunnel as there is an increasing trend towards revising the curriculum to include ‘communication’ as a

basic competency. This also calls for positive input from the leading stakeholders who have a vital role in improving awareness and practice throughout the system by imparting communication tools to trainees and as well as the trained practising radiologists .

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