

Should radiologists and pathologists talk to patients?

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TO THE EDITOR: The practice of radiology and pathology has changed dramatically in the past two decades. Increased use of multidisciplinary assessments and interventional techniques has meant greater exposure of patients to radiologists and pathologists. When patients undergo investigations, they are invariably anxious, usually expect the worst, and want the result as soon as possible. Therefore, there is pressure to provide an immediate answer to the problem at hand. In most instances, it would be possible to offer a diagnosis. However, many radiologists and pathologists are reluctant to discuss investigations with patients in detail.¹

During interventional procedures, radiologists and pathologists see patients only briefly; they often don't know all the facts about them, and are not ultimately responsible for their clinical management.¹ As the patient is only temporarily in the care of the radiologist or the pathologist, it is not appropriate to discuss complex issues or offer opinions and advice. Such advice may put the patient's doctor in an awkward position, forcing the referring practitioner to follow a course of action which may not be in the best interests of the patient.

At a patient's insistence, radiologists and pathologists can sometimes indicate to someone who has a clearly benign condition that the problem under investigation is unlikely to be serious.²⁻⁴ This may be the case with screening mammography, as, in most cases, the results are either normal or indicate a non-malignant condition. However, in diagnostic radiology and pathology, such an opinion is usually based on a

preliminary impression, which may change when all the facts are considered.

The cost of providing on-the-spot written reports to the patient has to be factored into the equation. It has been estimated that the additional cost of immediate reporting of results of screening mammography is about US\$28.22. When additional equipment and space were not required, the cost would increase by US\$4.38. Although most patients in the study preferred immediate reporting, they were unwilling to pay the additional fees.⁵ With respect to pathology, a formal fine-needle aspiration result can be delivered within an hour, but, for the reasons outlined above, this would not be advisable. Further, the pathologist's contract is with the referring doctor and the report is written in scientific language, which may not be easily understood by the patient, leading to unnecessary anxiety.

Giving bad news to a patient is not an easy task even for trained professionals. It is even harder for radiologists and pathologists who are not generally equipped to provide counselling and support, and who may not be indemnified by their insurers to carry out such tasks. Further, neither radiology departments nor pathology laboratories are suitable settings for giving bad news,¹ as very few support avenues are usually available to patients there.

Predicting the impact that bad news will have on a patient is extremely difficult, and radiologists and pathologists should, for compassionate and for medicolegal reasons, refrain from providing immediate answers to patients.

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5. Raza S, Rosen MP, Chorney K, et al. Patient expectation and cost of immediate reporting of screening mammography: talk isn't cheap. *Am J Roentgenol* 2001; 177: 579-583. □

Correspondents

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