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 intervention 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.² 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 or benign, or indicate the possibility of it. 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 $US4.38. Although most patients, in the study referred to, were unwilling to pay the additional fees,³ 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 pathology departments nor pathology laboratories are suitable settings for giving bad news,² 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.


The demise of a planned randomised controlled trial in an urban Aboriginal medical service

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TO THE EDITOR: Jammal’s editorial¹ about our report of a failed randomised controlled trial (RCT)² in an Aboriginal medical service helps to explain why researchers might be reluctant to submit articles describing unsuccessful trials, thus preventing others from the specific opportunity to learn from such experiences. The main point of our article was to describe the manifest difficulties of implementing an RCT — the evidence “gold standard” — in this type of setting. Interestingly, Jammal largely attributes these difficulties to incompetence or naivety (or both) on the part of the researchers and funders, rather than to complexities inherent in the study design, the setting and the intervention.

A separately funded pilot study is, in principle, a good idea, but extremely difficult to get funding for in today’s environment. Of course, we did conduct a pilot — that, in fact, was what we reported — but it is unclear how this would have helped us better estimate absolute prevalences and effect sizes for intervention and control groups, as a substantial number of participants, followed up for six months, would have been needed to do this.

Nord is it clear how taking a population approach and distributing guidelines to all drinkers rather than offering personalised advice to hazardous drinkers would have helped — firstly, because we were specifically trialling the internationally validated brief intervention, and secondly, because the effect size of the alternative approach was known."

..."nor do we agree that the blood tests were diminishing a social problem³. They were intended not only to provide robust outcome measures (a mark of a good trial),

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but also tangible evidence to clients of the health effects of alcohol, shown from previous research to be well received by Aboriginal people.1,2 They were not a requirement for participation.

Further, that we should have got around the potentially off-putting business of seeking informed consent by bypassing this step almost defies comment. While trials of some therapeutic interventions can be undertaken blind with patient consent using placebos, this does not mean that where blinding is not possible patient consent should be done away with in order to avoid a Hawthorne effect!

However, we do agree with Jamrozik on one point — nothing about this study or our report could reasonably “compound any negative perceptions about Aboriginal Medical Services and Aboriginal patients”.

3. Hunter RA, Hall W, Spargo R. Distribution committees of the National Health and Medical Research Council (NHMRC) in 1998. Sibthorpe et al identified their difficulties as primarily the result of having overestimated the number of suitable participants, for a number of complex reasons. Jamrozik’s criticisms rest disproportionately with the NHMRC and are based on procedures and processes in effect in 1996 and 1997, yet they are informed by contemporary knowledge and wisdom. This seems somewhat anomalous.

In 2000, the NHMRC revised its system for assessing research applications. This involved several developments which would have taken place irrespective of the content of this application had they been instituted in 1996. Some of these include:

- the introduction of the Indigenous Health Research Panel (IHRP), which provides advice on cultural appropriateness, community consultation and methods in applications with an Indigenous component (most members are Indigenous people);
- the opportunity for IHRP to make stipulations upon which funding is contingent;
- also of significance was the establishment of the Research Agenda Working Group (RAWG), which oversees the formulation of intervention-based criteria. Colloquially known as the “Darwin criteria”, these principles ensure that all Indigenous research design has:
  - sufficient Indigenous community consultation and participation;
  - transferability (of the methods to other settings); and
  - sustainability (of resulting changes).

The NHMRC was disappointed that the study by Sibthorpe et al did not proceed and did not result in usable data to inform a significant problem. However, it is also important to recognise that unanticipated outcomes, which can often lead to either, very positive results, are an integral part of the learning process.

The NHMRC has supported Australian health and medical research since 1936. It has a strong commitment to ensuring the continuing evolution of its procedures and practices. The new systems implemented in 2000 were designed to ensure the continuing tradition of funding high quality, relevant and applicable research.