



THE AGA KHAN UNIVERSITY

eCommons@AKU

Medical College Documents

Medical College, Pakistan

October 2013

Patient communication in radiology: current status of breaking bad news among radiologists and radiology trainees in Pakistan

Ranish Deedar Ali Khawaja
Aga Khan University

Waseem Akhtar

Ali Khawaja
Irfan

Hira Irfan

Mohammad Naeem

See next page for additional authors

Follow this and additional works at: https://ecommons.aku.edu/pakistan_fhs_mc_mc



Part of the [Medical Sciences Commons](#)

Recommended Citation

Ali Khawaja, R. D., Akhtar, W., Khawaja, A., Irfan, H., Naeem, M., Memon, M. (2013). Patient communication in radiology: current status of breaking bad news among radiologists and radiology trainees in Pakistan. *Journal of the College of Physicians and Surgeons Pakistan*, 23(10), 761-763.

Available at: https://ecommons.aku.edu/pakistan_fhs_mc_mc/67

Authors

Ranish Deedar Ali Khawaja, Waseem Akhtar, Ali Khawaja, Hira Irfan, Mohammad Naeem, and Mukhtiar Memon

Patient Communication in Radiology: Current Status of Breaking Bad News Among Radiologists and Radiology Trainees in Pakistan

Ranish Deedar Ali Khawaja¹, Waseem Akhtar², Ali Khawaja¹, Hira Irfan³, Mohammad Naeem³ and Mukhtiar Memon⁴

ABSTRACT

Breaking bad news can be an intimidating task for any physician. The aim of this study was to record the practices of breaking bad news to the patients by Pakistani radiologists and trainees. The radiologists and trainees attending the 26th National Radiological Conference in October 2010 in Karachi, Pakistan, were surveyed. The response rate was 76%. The respondents included residents (51%), private practicing radiologists (28%), academic radiologists (13%), and other trainees (8%). Most of the academic radiologists communicated with their patients. The daily frequency of breaking bad news by residents was noted, which was highest in the public teaching hospitals (71%). For severe abnormalities such as malignancy, 50% residents, 55% of the academic radiologists and 74% of the private practicing radiologists were very uncomfortable in disclosure of results. Differences in frequency of communication with patients were noticed with both different training levels, and different settings of practice in a developing country.

Key Words: Radiology. Breaking bad news. Radiologists. Residents.

Bad news is defined as “any news that drastically and negatively alters the patient's view of his or her future”.¹ Due to inadequate communication skills training, medical professionals have found it difficult to deal with breaking bad news in real life scenarios.¹ Much has been emphasized on training medical professionals in communication skills in the West, however, with limited research in radiologists' perspective, it is still in initial stages in Pakistan. Only two studies have been carried out in Pakistan in this regard; one addressing the patient's perspective while receiving bad news whereas the second focused on the awareness and training of the physicians about palliative medicine.^{2,3}

Since not much has been looked upon radiologists' perspective in delivering bad news.

The aim of this study was to record the practices of breaking bad news to the patients by Pakistani radiologists and trainees.

A cross-sectional survey was conducted among the radiologists and trainees attending the 26th National Conference of Radiology in Karachi, Pakistan on 29 – 31

October 2010. Only the consenting participants were included.

Strictly confidentiality of both the participants and teaching hospitals was maintained. International participants were excluded. The questionnaires were self-administered, and informed consent was taken from all the participants. Data entry and analysis was done on Statistical Package for Social Sciences (SPSS) version 11. Categorical variables were reported as number (percentage). Pearson's chi-square test and student's t-test were used for calculation of p-values. All p-values reported less than 0.05 was considered significant at 95% confidence interval. Calculations excluded the missing responses.

The overall response rate was 76% (228/300). The mean age of the participants was 36 ± 8 years (range 24 – 69; 51% females). Most of the attendees belonged to Karachi (66%), followed by Lahore (15%), Islamabad (4%), Peshawar (4%), Quetta (3%), and other regions (8%) of Pakistan. The conference participants included radiology residents (51%), private practicing radiologists (28%), academic radiologists (13%), and other trainees (8%) such as fellows, radiographers etc. Most of the participants were practicing or being trained in the public teaching hospitals (50%) compared to those practicing in both private teaching hospitals (27%), and private practice settings (23%). Only 23% (53/228) of the respondents had done their fellowship in radiology or being trained for fellowship.

Most of the radiologists in teaching hospitals communicated with their patients on a daily basis (imparted both voluntarily and on patients' request). However, a variable response was received from the radiologists in private

¹ Medical Student, The Aga Khan University, Karachi.

² Department of Radiology, The Aga Khan University Hospital, Karachi.

³ Medical Student, Dow University of Health Sciences, Karachi.

⁴ Department of Radiology, Civil Hospital, Dow University of Health Sciences, Karachi.

Correspondence: Dr. Waseem Akhtar, A-602, Al-Aman Housing Society, Behind Aga Khan University, Gulshan-e-Iqbal, Block 14, Karachi.

E-mail: ali.ranish@gmail.com

Received: March 28, 2012; Accepted: April 30, 2013.

practice, and radiology trainees (residents). Among them, 27% denied of having any communication with their patients. While 25% of the participants communicated with their patients 'most of the times' followed by 22% who communicated with 'every patient'. When asked about how often the participants had to deliver bad news during their encounter with their patients, most of them reported either 'occasionally' (31%) or 'never' (30%).

Most of the residents (56%) and private practicing radiologists (71%) were not trained in delivering bad news during their training. Respondents at teaching hospitals were more likely to be trained in communication and interpersonal skills (CIPS) than private practice radiologists (51% vs. 38%; $p = 0.058$). The latter were less likely to be interested in obtaining further training in delivering bad news ($p < 0.05$). Residents were more likely to be interested in obtaining further training to deliver bad news than radiologists (64% vs. 51%; $p = 0.048$).

When given the following situation: "If an adult patient who knows why a radiologic examination is being performed and what is being sought asks to know the results from the radiologist, the radiologist should answer truthfully (and immediately contact the referring physician with the results and the fact that the patient has been informed)", most of the participants strongly agreed 44% vs. 13% who strongly disagreed. The response to this situation has been related to the setting of workplace in Figure 1.

Participants were asked to score from 1 to 10 to some relevant clinical radiology issues, with 1 referring to 'very uncomfortable state' and 10 referring to 'very comfortable state'. Most of the participants responded for an uncomfortable level when asking patients for a need for extra views, recommending a patient for a biopsy, disclosing abnormal results of either malignancy

or non-malignancy. Fifty four percent of the participants felt 'comfortable' while communicating normal radiological findings.

First year residents were more likely to communicate with every patient than senior residents. They were more likely to deliver bad news on an occasional frequency than senior residents who mostly reported 'never' with regard to frequency of breaking bad news. Fourth year residents were less likely to be interested in obtaining further training in breaking bad news than junior residents.

Though multiple surveys have shown that majority of patients prefer full and immediate disclosure of their disease,² a physician still has the massive responsibility to assess the requirements of an individual and patients who prefer limited information. This can lead them to face equal amount of stress and anxiety in delivering the news. It is a matter of precise management and many studies endorse the conclusion of a personal approach and keeping utmost vigilance when making such a decision.^{4,5} On the other hand, radiological findings can be non-specific, and breaking a bad news merely considering the imaging appearance can be ironic and counterproductive. Additionally, radiologists usually do not know much about the patient's history, treatment options and psychosocial implications of a specific disease so the information at times may be inaccurate, especially if imparted by a junior colleague.

Levitsky *et al.* found that if the results are normal, 89% of radiologists and 76% of referring physicians said that radiologist should provide information. If the results are mildly abnormal, 81% of radiologists and 57% of referring physicians opted for release of information. However, if results are severely abnormal, only 33% of radiologists and 28% of referring physicians think that the radiologist should provide the information.⁶ In developing a departmental policy on informing patients of the results of imaging studies, radiologists should bear several points in mind. First, such policies should probably be uniform through a healthcare organization so that there are not wide divergences in practice across the departments. Second, it is generally good for radiologists to inform patients of normal results to alleviate unwarranted anxiety. When unexpected or alarming findings are encountered, radiologists can always contact referring physicians to find out how they would like to handle the situation. In general, it is good for radiologists and referring physicians to know one another well enough and they should know how to handle such situations.⁷ However, in western countries radiologists are legally bound to communicate immediately critical results to the referring physicians and/or emergency department staff. This is true for scenarios when time may be extremely important, especially if the referring physician is difficult to contact.

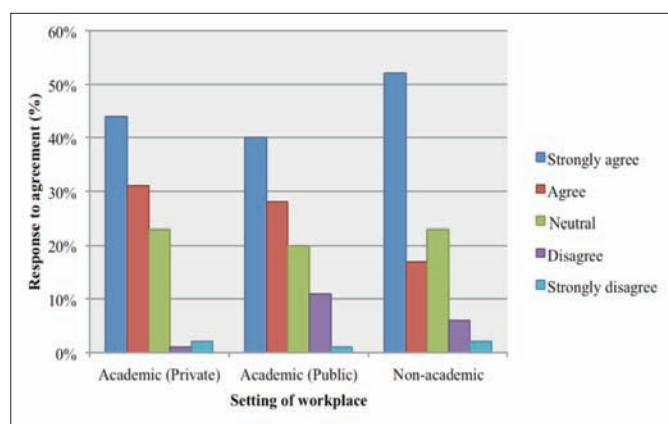


Figure 1: Response to the situation* according to the setting of workplace. Respondents practicing in non-academic private practice settings (n = 52), academic public hospitals (n = 115), academic private hospitals (n = 61).

* "If an adult patient who knows why a radiologic examination is being performed and what is being sought asks to know the results from the radiologist, the radiologist should answer truthfully (and immediately contact the referring physician with the results and the fact that the patient has been informed)."

That is, in cases where the physician is difficult to contact and the results should be communicated to patients, may be 100% of the time. Also, there is a need to understand how the referring physicians in our country see communication of radiologists of the findings to their patients. This can become a lead point to study and evaluate their response to this communication.

Issues like cancer, that are increasingly becoming common, intensify the need to deliver news with compassion. This requires good understanding of cultural norms of the locale, with adequate communication and interpersonal skills (CIPS). Due to increased knowledge and technological advances in communication, patients and their families inquire about the outcome of the scans as quickly as possible and the general physician might not be the best person to reveal it. The nature of results, whether promising or abnormal, does little to modify their selecting radiologists for this task.⁸ Oddly, hesitation is observed on the part of consulting radiologists; the present data revealed that almost half of the participants expressed low comfort levels when it comes to telling merely as much as normal imaging results to their patients.

To conclude the study findings, radiologists and residents trained in private hospitals communicated frequently with patients. Academic radiologists were less reluctant in disclosure of abnormal results to patients.

Differences in frequency of communication with patients, and disclosure of normal to abnormal imaging results have been observed in private and academic settings. Such variations are associated with both different training levels, and different settings of practice in Pakistan.

REFERENCES

1. Buckman R. Breaking bad news: Why is it so difficult? *BMJ* 1984; **288**:1597-9.
2. Ishaque S, Saleem T, Khawaja FB, Qidwai W. Breaking bad news: exploring patient's perspective and expectations. *J Pak Med Assoc* 2010; **60**:407-11.
3. Abbas SQ, Muhammad SR, Mubeen SM, Abbas SZ. Awareness of palliative medicine among Pakistani doctors: a survey. *J Pak Med Assoc* 2004; **54**:195-9.
4. Vandekieft GK. Breaking bad news. *Am Fam Physician* 2001; **64**:1975-8.
5. Minichiello TA, Ling D, Ucci DK. Breaking bad news: a practical approach for the hospitalist. *J Hosp Med* 2007; **2**:415-21.
6. Levitsky DB, Frank MS, Richardson ML, Shneidman RJ. How should radiologists reply when patient ask about their diagnoses? A survey of radiologists' and clinicians' preference. *AJR Am J Roentgenol* 1993; **161**:433-6.
7. Smith JN, Gunderman RB. Should we inform patients of radiology results? *Radiology* 2010; **255**:317-21.
8. Schreiber MH, Leonard M Jr, Rieniets CY. Disclosure of imaging findings to patients directly by radiologists: survey of patients' preferences. *AJR Am J Roentgenol* 1995; **165**:467-9.

