

KEYNOTE LECTURE

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Doctor–patient relationship in oncologic radiology

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Abstract

Progress in medicine and changes in our society have led to an increasing number of patients with cancer and a change in the doctor–patient relationship. Patients rights are now defined in several countries by laws. The course of cancer involves numerous imaging examinations in which the radiologist is primarily involved. It is often the radiologist who discovers abnormalities and who must break the news to the patient. This task is made all the more difficult by the radiologist's lack of specific training in the management of difficult situations such as announcing bad news. There is a high risk of inappropriate responses that can have a seriously damaging effect on the patient's state of mind. Even with the best intentions, it can be very profitable to review and improve our relational modalities and to more effectively meet the patient's increasing demand for information. The radiologist's technical know-how is not sufficient, as he must also be able to give just the right amount of information based on his clinical competence, and his relationship with patients while respecting their wishes and their rights.

Keywords: Doctor–patient relationship; cancer; communication skills; radiology.

Introduction

The continually increasing life expectancy, the growing incidence of certain cancers and progress in treatment have led to an increasing number of cancer patients to be managed at all stages of the disease. Imaging examinations are increasingly numerous and are repeated throughout the course of the disease, and radiologists are faced with the anxiety of their patients and the need to announce bad news. In our experience we have observed the difficulties sometimes encountered when trying to establish a good quality relationship with some patients; there is the risk of inappropriate behaviour and unfortunate remarks that remain engraved in the patient's memory^[1,2].

Supervised by a psychiatrist working in a cancer centre, three radiologists review their practices and analyse their relational modalities in an attempt to improve their relationship with cancer patients based on better communication skills^[3]. Although there is no universally valid standard approach, a better understanding of the sources and manifestations of the patient's anxiety, training in

certain interview techniques, application of a number of rules of organization of clinical departments and individual behaviour of personnel, based on deliberate empathy with the patient, while respecting of their integrity and their rights, are the basis for improved patient management.

Although we may feel that we are doing the right thing in our everyday practice, our medical behaviour must evolve because the doctor–patient relationship has changed along with changes in society, mentalities, medical practice and modes of access to information^[4]. Patients now more often want to understand their disease and develop a more balanced relationship with their doctor. Patients are better informed by the media, internet or associations and they are also more demanding, resulting in a certain questioning of the medical system^[1].

In 1988, the French Huriet law brought research into the open, allowing the patient to actively participate in the therapeutic approach, with the introduction of informed consent. The patient, who was previously the object of care, has become the subject of care or a partner in

care. With the law of 4 March 2002, 'the doctor is now required to prove that he/she has provided honest, clear and appropriate information ...', 'and to ensure that it has been clearly understood'.

However, it would be all too simple to rely on legal texts to avoid the complexity of relationships with patients suffering from serious diseases. It is not because patients have the right to know about their state of health that it can be announced without taking certain precautions. Even when they express the right or the need to know, many patients do not actually want to know all of the truth and some do not want to know anything at all^[5,6]. Understanding of the patient's exact expectations in terms of information always requires detailed and comprehensive analysis of the patient, with the possibility of surprise reactions, obliging the doctor making the announcement to be particularly attentive during this key step in the relationship^[7-10].

Specificities of the doctor-patient relationship in cancer imaging

The course of cancer involves repeated complementary investigations, especially imaging. All these examinations are stressful for patients, related to the procedure itself (injections, pain, claustrophobia) and especially the result, an immediate verdict that determines subsequent treatment and the patient's life. Many patients, including those considered to be cured and undergoing systematic surveillance, express their anxiety in relation to these follow-up assessments, their difficulty with repeatedly dealing with the uncertainty and anxiety of the future. The manifestations of their relief at the end of examination, when they are told that everything is normal, clearly reflect their previous anxiety: 'I could kiss you!', 'I haven't slept all night', 'You can't imagine what I've been going through'.

The radiologist is in the forefront, often discovers abnormalities^[11] and must find the first words, without being able to propose a treatment, that may partially reassure the patient by establishing a 'joint treatment project'. This task is made all the more difficult by the radiologist's lack of specific training in psychology, and in the management of difficult situations such as announcing bad news.

In highly anxiogenic situations, such as the incidental discovery of metastases, an emotional response may take over and, in these circumstances, there is a great risk of a clumsy or inappropriate approach that can be damaging to the patient.

After a radiological examination, the relationship with a patient is brief; the radiologist has little information concerning the patient's psychological or somatic state. The radiologist does not always know what the patient has already been told about his/her disease, hence the importance of networking, a shared medical file

and especially the 'information given' heading, in which the prescribing doctor indicates what he/she has told the patient. There is no universal solution; the radiologist must adapt his/her personal approach to each individual case, requiring reflection about his/her relational modalities. The radiologist must have the necessary know-how, but mastery of the technique is not sufficient and must be accompanied by an ability to establish an attentive relationship with the patient. The radiologist must know just how much to say to the patient, but especially not standing in the corridor, between two doors, in just a few minutes. Although there may not be a good way to announce bad news, there are certainly bad ways. Finally, the radiologist must be able to provide the patient with clinical competence, empathy and respect of their desires and their rights, those defined by law and those that they rightly claim in the name of respect, listening, information and psychological support^[11].

The sources and manifestations of the patient's anxiety

Emotions and anxiety may be expressed in verbal, non-verbal and behavioural attitudes, such as fear, sadness, disappointment, anger, and sometimes also by aggressiveness perceptible even in the waiting room, which can be de-dramatized by dialogue. Agitation, lack of understanding of simple instructions, false conviviality, perspiration, tachycardia perceptible underneath the ultrasound transducer are all manifestations of anxiety.

Some patients try to blame their disease on someone, either themselves ('I waited too long'), or on another person, particularly doctors ('He missed the diagnosis'). These comments are sometimes related to the lack of dialogue with previous doctors. Some patients feel as if they are being judged ('they are sitting examinations') or that they are incapable, as they are considered to be a 'poor responder' to chemotherapy. We sometimes meet warm, charming, courageous patients, with whom the personnel often become over-attached. Inversely, vindictive and aggressive patients are perceived as unpleasant and are sometimes rejected, while we tend to forget or pay less attention to silent, withdrawn patients, whose apparent passivity often reflects a high level of anxiety. It is essential for the doctor to be aware of the patient's emotional state, to avoid the reflex of being unpleasant to a vindictive patient, or destabilized by a very anxious patient.

How can the relationship with the patient be improved, what are the practical aspects on which we can act?

The first step consists of examining and questioning our practices and learning a number of basic elements

of the doctor–patient relationship and announcement of bad news^[12], a problem which has been the subject of numerous publications in the literature. In particular, it is important to learn the elements of a negotiated communication between doctor and patient^[13]. The doctor possesses precise and structured information about the patient's disease; the appointment list or session and the time allotted to each patient are clearly defined, and the doctor must adopt a rational approach to the situation. The doctor enters into a professional relationship with the patient; the situation is commonplace for the doctor, who remains independent. The patient, on the other hand, is in an exceptional situation and is dependent on the healthcare professional. The relationship is very important for the patient, regardless of the time allotted, and the patient's approach is essentially subjective. The risk, as in a game of tug-of-war, is that each person tries to draw the other into his/her own world, while a good quality relationship requires each person to make an effort to understand the other, to negotiate a compromise, an alliance, allowing elaboration of a joint project. It is the doctor's role to structure the modalities of the relationship, which subsequently determines the patient's attitudes and reactions.

The paramedical team's training and motivation also play an important role. Technicians, nurse-aids, nurses, and secretaries participate in information, each in his/her own field of competence. They help to reassure the patient, explain the examination, its uncomfortable aspects, inform the radiologist about the patient's physical and psychological state, and obtain the patient's request for the results. The head of department plays a decisive role, as he/she defines the team's common values and rules of behaviour, for example: reinforce the quality of patient reception and the availability of each member of staff; avoid making patients wait or explain the reasons for the delay, give an approximate waiting time; avoid, whenever possible, making children, bedridden patients and patients with an infusion share the same waiting room^[12]. Before the examination, it is important to prepare the dialogue with the patient, carefully read the patient's file when it is available and examine the psycho-oncologist's notes when the patient has received a psychological or psychiatric assessment.

In contact with the patient, the fact of introducing oneself and indicating one's qualification (the patient does not have the same questions for a nurse-aid as for the doctor), introducing a junior doctor, when present, and briefly explaining the procedure, contributes to the development of a relationship of confidence^[1,12].

In general, the attitude towards the patient must be based on empathetic and respectful listening. Empathy consists of an attitude of relational openness and not the expression of one's own emotions. It must be deliberate, systematic and professional, in order to control personal feelings of sympathy or, on the contrary, sometimes feelings of antipathy generated spontaneously by the

first minutes of the interaction. A relational protocol composed of tact and attentive listening must be applied.

By definition, cancer imaging procedures are anxiogenic, independently of the radiologist, who cannot assume the patient's burden of anxiety in his/her place. The situation is clearly unbalanced, a long way from the ideal partnership relationship, but it reflects the event experienced jointly by the radiologist and the patient from very different points of view.

During the examination, especially examinations involving direct contact with patients, such as ultrasound, the radiologist must avoid the various disturbances inherent to the life of the department; do not be interrupted by the telephone, lock the door during internal examinations, cover naked patients with a sheet, give clear explanations when seeking a colleague for another opinion. Talking to another person, discussing technical problems, showing surprise in front of the screen, resulting in a patient–doctor–screen 'triangular relationship' with the anxious patient attentively watching the doctor's face and interpreting his/her every reaction^[14], only tend to increase the patient's anxiety.

In some clinical settings, after computed tomography (CT) scan or magnetic resonance imaging (MRI), patients are systematically seen by the radiologist, which raises the problem of patients who do not wish to be informed, and this wish must be respected. In hospitals in general and in cancer centres in particular, radiologists only see those patients who explicitly request a consultation, which is far from always being the case. Many patients do not ask for anything, while others demand to see the doctor and are willing to wait until the examination has been interpreted. Regardless of the conditions, the patient must be seen in an adequate setting, ideally in a room devoted to this purpose. The physician's attitude must consist of acceptance of a dialogue allowing the patient to talk and ask questions, by looking at the patient directly and by listening to him/her without ever saying too much, without saying more than the patient has asked for. It is useless, for example, to give too many medical and technical explanations and to describe the lesions in detail.

It is important to carefully listen to the formulation of the patient's questions, as some patients, despite significant treatments, have a poor knowledge about their disease or do not want to know about it, and sometimes drop words like 'cancer' or 'metastases' to see whether their attending physician is telling the truth. They try to verify the existence of a possible contradiction between various doctors, or they may simply use these words to express their suffering. If the patient feels that the doctor is receptive, they may take advantage of this opportunity to talk and ask questions that they have never asked, and sometimes pour out their feelings. The relationship between the radiologist and the patient at the end of examination is sometimes a difficult moment, but it can provide the patient with an opportunity to talk, which often surprises the patient himself. For some patients,

the radiologist's receptive attitude and the possibility of a dialogue may have a paradoxically distressing effect. They become suddenly afraid of hearing too much or may not want an 'outside' doctor to interfere with their disease and cross the barriers that they are trying to set up. These patients do not ask any questions, either because they do not want to hear the answers or because they only want to deal with their attending physician. It is important to respect this desire and to never give results when the patient does not specifically ask for them or answer questions that have not been formulated.

Interview techniques, transmission of information

The patient often reacts by remaining silent or by formulating the question by removing the question mark: 'you didn't see anything abnormal', 'nothing nasty', 'everything OK', which correspond more to statements than real questions. In these 'rhetorical questions', the interrogative tone is adopted 'not to indicate a doubt and trigger a reply, but to indicate, on the contrary, a solid conviction and to defy those to whom one is talking to deny this certainty or even to reply'^[15]. Other patients claim: 'you can tell me everything', 'I know all about my disease' which can just as easily mean: 'I already know enough!' or 'I hope you're not going to find something else!'.

Avoid focussing on technical aspects: 'you have a hypoechoic nodule in the left lobe of the liver' or falsely reassuring paternalist attitudes ('It could be worse', 'but everyone has to die some day, I am also going to die!', or 'the progression is not generalized, the brain CT is normal')^[13] or inappropriate premature solutions ('you'll be better after chemotherapy'). Changing the subject raised by the patient without transition or suddenly doing something else all too obviously reflects the doctor's lack of interest or embarrassment.

The absence of transition or excessively abrupt transitions tend to disrupt the communication. It is useful to reformulate what has been said, to repeat the patient's last sentences. The patient can also be encouraged to talk about his/her health and ongoing treatments. The fact that the radiologist is able to look at and listen to the patient indicates that he/she is not afraid of dialogue and patients often want to talk about things other than their cancer.

The most difficult relational situation occurs when the radiologist detects clinically unsuspected lesions during a routine follow-up examination. Although the radiologist cannot say that the examination is normal, he also cannot insist on a painful truth that the patient does not want to hear. The doctor should indicate that there is a doubt that needs to be clarified by other examinations, but regardless of what he says or does, he will trigger a terrible anxiety in the patient. Emotions take over in this situation, often making calm communication very

difficult^[13]. It may be legitimate, in these circumstances, to use excuses such as the need to review the patient's file or old films, the need to perform other examinations to define a probable abnormality, in agreement with the attending physician. It is useful, in all of these cases, to prepare the subsequent course, for example by calling to inform the chemotherapist or surgeon that new lesions have been found before he/she sees the patient.

The interview should be closed by accompanying the patient to the door and directing him/her to the next appointment.

Particular cases

Parents of children with a malignant tumour are very well informed by clinicians; they know about the disease, the size of the tumour, the course, risks, statistics, etc. They raise precise questions that can be easily answered by the radiologist. The long-term surveillance of children treated several years previously and cured of a malignant disease such as lymphoma or Wilms' tumour is one of the more pleasant moments of cancer radiology. Over time, a real relationship is formed between the child, the parents and the doctor who examines the child with an atraumatic apparatus (especially in the case of ultrasound). This relationship is reinforced by the unspoken memory of the very difficult times of the initial diagnosis and follow-up examinations during chemotherapy. The radiologist must avoid talking exclusively to the parents^[12], but must also talk to the child about his/her disease. The situation is more difficult when lesions progress or in the case of recurrence. When the clinical signs are suggestive of recurrence, the parents expect that the examination will confirm this suspicion, which is obviously a major source of anxiety. The radiologist cannot hide the truth. At most, he can mention the treatment options that will be proposed by the clinical teams.

For elderly patients, increasingly numerous in oncology, it is useful to recognize and distinguish the main geriatric syndromes, especially depression and concomitant diseases such as deafness. Although the natural tendency is to talk to the accompanying person, the elderly person must not be ignored by excluding him/her from the discussion. Another natural tendency, especially among younger doctors, is to consider age-disease and age-death correlations to be 'normal'. The great majority of elderly people, even when they are ill, do not want to die any more than younger people (except in the case of severe depression, where morbid thoughts can be expressed to the various healthcare professionals dealing with the patient). A survey conducted by Slevin *et al.*^[16] showed that 60% of elderly patients were willing to accept chemotherapy even for a benefit of only 1% on survival, while less than 20% of nurses and oncologists reported that they would accept this option.

In the context of clinical trials, patients receiving yet another line of chemotherapy, often with metastatic

disease, are theoretically well informed about their state, and have signed an informed consent form. They place great hopes in the new treatment, despite the complex procedure related to the protocol (numerous examinations, questionnaires, visits), which sometimes represents an additional factor of reassurance. They are very cooperative, more optimistic and obviously very depressed when treatment fails.

Very tired and weak patients, who have suffered for a long time, and at the terminal phase of their disease, generally do not ask any questions. Sometimes, however, they disconcertingly ask the radiologist to confirm that the examination is normal, while disease progression is obvious, but repressed or masked. The question is formulated in the affirmative and these patients do not expect an impossible answer.

Patients with a genetic predisposition live with feelings of uncertainty and are submitted to a routine of ritual and annual surveillance^[17], and often the weight of their family history. Although they do not have any symptoms, they are always at risk of a diagnostic discovery and a potentially mutilating treatment, a situation that can accentuate anxiety especially during the period preceding screening examinations. Paradoxically, some patients experience a form of relief at the announcement of the diagnosis of cancer ('At last I am going to get rid of it').

Relations with referring physicians

Several international surveys^[9,18–20] have shown that clinicians and radiologists agree that the radiologist should inform the patient about the results of a normal or only slightly pathological examination. However, when the examination is frankly abnormal, radiologists and especially clinicians are not in favour of the radiologist giving the results^[9,18]. Another survey showed that 70% of patients wanted to have the results immediately after a CT scan^[21]. Oncologists increasingly tend to ask radiologists to prepare the patient for bad news^[6,11]. Clinicians use imaging to give explanations to their patients and to justify the treatment decision. They increasingly show the tumour to the patients, as some patients need to be faced with this reality in order to accept the announcement and intensive treatment, or, on the contrary, discontinuation of an ineffective treatment. Note that absence of direct information (face-to-face or by telephone) to the clinician by the radiologist is a new cause for lawsuits in the United States^[22], even when the report sent by mail is explicit.

Radiologists cannot hide behind the technical aspects of their specialty, as they are faced with these problems of announcement and dialogue with cancer patients. They must become involved, but, like other doctors, they lack time, resources and training. In an imaging department or clinic, for many reasons, there is a high risk of psychological aggression, but it also provides room for expression that differs from a visit to the doctor.

The patient meets another doctor, with whom he/she is often alone, which gives him/her an opportunity to talk about his/her disease, suffering or something completely different. Listening and dialogue requires a personal effort from the doctor, which may not be easy, but which is truly worth the trouble.

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