Communicating Results Directly to Patients:

Don't Ignore the Price Tag of This Added "Value"

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A cynic is the man who knows the price of everything but the value of nothing. —Oscar Wilde

It is unclear to whom Wilde was alluding. It may have been economists, but certainly not present-day radiologists, who are constantly in search for the seemingly elusive value of their professional existence. Attend any societal meeting, any academic discussion, speak to any radiology resident, and the word *value* is thrown around effortlessly and frequently, with *threat* and *extinction* coming in distant second and third.

One of the value-added paradigms is the direct communication of results to patients. This is not without intuitive foundations. In the era of health care reform, radiologists feel aggrieved that imaging is being singled out by Washington as the chief culprit for the exponential cost curve. Washington cares when patients care. Therefore, there can be no more potent advocate than the patient.

Yet radiologists remain invisible to the eye. It is a truism that the only time a patient knows his or her interpreting radiologist is when that radiologist's name appears on a bill for services generated. In the era of ever increasing copayments, this is more likely to engender resentment than goodwill, particularly if a patient cannot associate a face to a name.

The study by Kuhlman et al (1) in the current issue of *Academic Radiology* reaffirms the indifference of patients toward radiologists. This indifference is only partially explained by the general ignorance of the central role radiologists play in the medical decision-making process, a role that seems even more implausible when referring physicians pronounce the results of computed tomographic scans with utmost authority. At the heart of this indifference is the lack of understanding of who radiologists actually are. Are they technicians or medical doctors? Do they perform computed tomographic studies or interpret the examinations? People are never confused as to the role of neurosurgeons or cardiologists.

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Despite this cloak of anonymity, radiologists do form doctor-patient relationships the moment they interpret examinations (2). There is no slack in the professional and ethical obligations set upon radiologists just because, in the conduct of their job, they do not need to see patients directly. Courts have held that this obligation does, in certain circumstances, mandate that radiologists communicate results directly to patients (3).

Radiology is undergoing another change that is far more pernicious than declining reimbursements, although the latter will merely accelerate the process. This is corporatization. Teleradiology is only one manifestation. The ultimate sequela is the commoditization of the mind (4). When this happens, if it has not already, the only measure of the value of radiologists would be in their productivity. This is the death knell of the professionalism of any profession.

By presenting a dichotomy of either including the radiologist's name at the bottom of a report or meeting patients whose images we interpret, Kuhlman et al (1) have made a zealous and timely call to arms. However, these goals, no matter how sincere or justified, must meet the rocky coast of reality.

Communicating results directly to patients is a paradigm shift. Although the term *paradigm shift* is thrown around quite frivolously, this truly is a change in paradigm in the manner Thomas Kuhn (5), the coiner of the phrase, originally envisaged.

Hitherto, the radiologist has been the doctors' doctor. The relationship formed is principal-agent-agent, the first agent being the referring physician. This is similar to the relationship between management consultants and a firm that has hired them to provide information to improve their clients' investment portfolios. It is a relationship inherent in the nature of information providers (6).

If this relationship is broken volitionally and occasionally, it is likely to be without much wider reverberation. Just as no good deed goes unpunished, no initiative or gesture fails to occupy the charter of regulations. If professional organizations such as the American College of Radiology place in their guidelines that radiologists should communicate results directly to patients, in response to the frustration of value-seeking radiologists, this is likely to have far-reaching consequences.

"Guidelines" effortlessly become "mandates" in the courtroom. *Should* becomes *must*. The value-adding means become the end. One need broaden the imagination only marginally to predict some of the encumbrances, should that occur.

Because the interpretation of imaging is contextual, it can be expected that radiologists will narrow their differential diagnoses considerably once they have access to the main repositories of clinical information: patients. To what extent radiologists will be expected to extract the necessary clinical information from patients is not clear. Will it be restricted to histories, or would it involve physical examinations as well? This is already being done by interventional radiologists.

Because it can easily be argued, ex post facto, that the right diagnosis would have been reached if only the radiologist had asked the patient the right questions, performed the appropriate physical examination, radiologists will be exposing themselves to novel and off-the-beaten-track litigation routes, the scale of which one can never safely overestimate.

What then of incidental and equivocal findings? Such findings, for example, could potentially, albeit immensely improbably, turn out to be cancer. Radiologists will find that the burden of "clinical correlation" will fall upon them, and this task will be all the more challenging at a single time point.

In such circumstances, the desirability of follow-up imaging is not clear cut but depends on the preferences of patients, the level of risk aversion balanced against the probability of neoplasm, factoring the added burden of radiation exposure and overdiagnosis. The challenging nature of such consultations along with resource utilization must not be underestimated. However, this is the logical and natural end point if radiologists pursue a universal policy of direct communication of results to patients.

Radiologists will have to attend to the content and style of their reports to make them more patient friendly and less anxiety provoking for a population that is only a fingertip away from information glut on the internet. They may have to temper the addition of anatomic variants, injection granulomatas, fat-containing lipomas, and other findings of little clinical import in their reports. Much heed will have to be paid to lengthy qualifiers that feature in imaging reports, merely to express the probable normality of an organ.

It must be understood that "probably a hypertrophied column of Bertin but renal mass is not entirely excluded" may have a very different effect on a referring physician and a patient. The referring physician understands the language of the report and the basis for the lack of absolute precision, as he or she has read several thousand radiologic interpretations. However, patients do not have personal access to the same denominator, and because of the singularity of their experiences, they may insist that the mass be absolutely excluded.

Radiologists will have to document consultations with patients in terms of the nature, purpose, and items of discussion, particularly the controversial aspects. The magnitude of the additional transcription burden is not easy to predict, but given the generally upward trend of documentation, it is safe to assume that this burden is not likely to decline with time.

Patients will want to know the prognoses of and treatments for the conditions revealed. How will radiologists counsel them? How satisfied would patients be if given a diagnosis of "thymoma abutting the ascending aorta" and told to discuss the surgical options with their doctors? Radiologists must be careful that the information imparted to patients must not, without very good reason, contradict the message from their referring physicians, who generally would have vastly greater knowledge of the patients' conditions, preferences, and nuances.

This brings me to referring physicians. Will their opinions on the necessity and degree of communication between radiologists and patients matter? How standard are these opinions?

There are operational issues that need to be thought out very carefully. Assuming the radiologist interpreting an examination will be the one to directly communicate the results, it begs the question whether the interpreting radiologist will talk to the patient before or after the interpretation.

Where will the patient be placed in the interim? Will both plain radiographs as well as advanced imaging be discussed with patients? Will normal or abnormal results be discussed, or both? Who will make these choices and why?

Advocates for the direct communication of results to patients often lament that "radiologists are too busy to speak to patients." However, it is no good taking a derisory attitude toward time. Time is a valuable resource, along with manpower, of which there is not an infinite cache.

None of the problems are insurmountable, nor do I suggest that they should not be overcome. It is clear that direct communication of results to patients is a value-adding paradigm. However, there is no free lunch. There is a trade-off. In the enthusiasm brought about by a pressing necessity for change, one must be even more cognizant that details are not ignored or wished away.

Perhaps 1-hour consultations with patients discussing the aesthetics of the volume-rendered images of their renal vasculature and the merits and demerits of following up an incidental adrenal nodule of 16 Hounsfield units will be the staple of the radiologist of 2020. However, we are far from there presently.

Communication with patients is already in place. Sonologists speak to patients, even break bad news. Radiologists often consent high-risk patients for iodinated contrast and gadolinium. Radiologists performing cardiac computed tomography speak to patients when administering negatively chronotropic agents.

Indeed, the decision for the degree of universality of direct communication is best left to individual departments and interpreting radiologists, who can judge from their local milieus which examinations are best suited for radiologists to reaffirm in person their doctor-patient relationships.

There are interim steps. For instance, radiology departments may appoint a "radiologist of the day," who could greet some patients, inquire about the clinical nature of their visits, and offer contact details of the interpreting radiologists in case questions arise.

However, in responding to Oscar Wilde's quip, it is just as important for the pendulum not to swing to the other extreme, where we see value without ever acknowledging its price.

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