Communication & inter-personal skills? But I’m a radiologist…

Madam, Communication and Interpersonal Skills (CIPS) comprise an integral component of medical professionalism.1-4 Effective CIPS augment quality health care delivery, patient satisfaction, outcomes and physician’s confidence.1,3,5 Quite understandably, regulatory bodies such as Accreditation Council for Graduate Medical Education (USA), General Medical Council (UK) and College of Physicians and Surgeons (Pakistan) have mandated their incorporation into every residency programme.

Typically, the need for CIPS is considered equivalent to the volume of direct patient interaction. Perhaps this is why CIPS are not deemed priority training areas for radiologists.3 The neglect is reflected by the fact that radiology residents perceive themselves inadequately skilled for communicating with the patients and deem such situations stressful.1,2,6

A radiologist carries the unique responsibility of communicating with the patients, families, referring physicians and other members of the health care team; there is potential for loss of information at each interface.2,4,5 The routine scenarios include discussing appropriateness of the requested procedure, taking informed consent for it and sharing its findings.4,6 At times, the situation may be more complex e.g. when a patient inquires about the foetal well-being at the end of a routine ultrasound exam during which foetal anomaly/demise has been detected.4 A considerable proportion of this communication is verbal, especially in acute care setting. An accurate diagnosis may be rendered futile, with possible ethical implications, if not communicated effectively, in time, to the appropriate person.4,5 Added to it is the limited duration of radiologist-patient interaction plus a lack of pre-existing rapport6 and the need for training “consultants of consultants” in CIPS could not be any more obvious.4,6

This can be achieved through CIPS curricula comprising of clearly defined objectives, effective learning strategies such as role modeling or high fidelity simulations and reliable techniques to gauge adequacy of these attributes.1,2,5,6 The curriculum should emphasize long term inculcation of basic principles of CIPS more than the amount of knowledge attained.5,6

Currently, CIPS training for radiology residents in Pakistan is limited to workshops organized by College of
Physician and Surgeons, Pakistan. While the first two components of a curriculum exist in somewhat unsophisticated forms, the ‘tail that wags the dog’ i.e. methods of assessment are missing altogether. We urge both leaders and learners in radiology to realize the critical role of CIPS in the practice of radiology and to strive for developing CIPS curricula tailored to radiology and the local needs. Such efforts can be instrumental for excellence in radiology.

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Letter to the Editor

Treatment of Achalasia: Let’s put surgery in its right context

Madam, We read with interest the report of Ahmed et al in which they described the medical and surgical management of achalasia in 46 patients over a five-year period from their specialist units of a research centre and teaching hospital. The authors have made a significant effort to provide an addition to the local literature. However, we were disappointed to read the conclusions. The impression given in their conclusion in favour of pneumatic dilatation for the treatment of achalasia is biased, unscientific and misleading.

The authors have not provided any robust scientific evidence in their study to support their conclusions. The success rate of pneumatic dilatation is 81% in comparison with 80% following surgical myotomy. Their patient groups are only very broadly defined and the study lacks detail regarding pre-operative status and operative technique. Reference is made to subjective assessment at 4 weeks and 6 months with repeat endoscopic treatment or referral to surgeons but lacks detail and the overall duration of follow up or use of objective assessments of ‘clinical success’ are absent. Even allowing for the limitations of a retrospective study the conclusions remain only very general. They are unsupported by statistical comparison between what may very well be heterogenous groups. Questions remain: who benefits in the unit, for how long and by how much?

Moreover, in their discussion they have neglected recent advancements showing a significantly improved result using Laparoscopic Heller Myotomy (LHM). This is reflected by the fact that their most contemporary reference concerning pneumatic dilatation originates from 2005 yet not a single paper regarding the outcome of surgical intervention from recent literature is cited, reflecting a bias in favour of medical management of achalasia.

Achalasia remains a condition with an incompletely understood pathogenesis. Treatment approaches are largely palliative and aim to achieve relaxation or dilatation of the lower oesophagus. Admittedly, clear dominance of one approach has not been established even in large trials. There is recognition that multiple treatment modalities over an extended period of time may be required. It is additionally recognised that certain sub-groups - particularly the frail elderly - may benefit from the less invasive endoscopic approach with botulinum toxin injection, although the benefit remains short-lived. Modern surgical management has progressed to recognition of a new gold-standard surgical approach — that of the Laparoscopic Heller Myotomy. This is frequently combined with fundoplication, although controversy remains regarding the degree of fundal wrapping and the optimal myotomy length. No explicit reference is made to such techniques. Additionally, prior endoscopic dilatation has been demonstrated to worsen subsequent surgical outcome, a fact of which patients should be aware in informed decision making process.

Several studies have shown surgical myotomy to provide superior long term symptoms relief as compared with non-surgical intervention. Structured, objectively assessed reports yield impressive short-term results. A cohort of 113 patients undergoing LHM declared 91.2% to be symptom-free at median follow up 2 years, a result in keeping with much of the contemporary literature. The focus of current studies is to refine the technique, comparing the influence of

References