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Radiology Services in Australia: The Director's Highlights

Interviewee:

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What Led You to a Career in Medical Imaging?

I chose medicine because it is ethical, innovative and one can help a lot of people. I started as a resident in neurosurgery in Paris in 1979, but on returning to Australia, found there were no training positions available. I entered general practice for a few years but decided that specialisation was more interesting. A friend had done radiology and passed the exams, and, having been fascinated by images studied during medical school, I thought it might be a suitable avenue. I commenced my training at the age of 37. These days, on selection panels, I have sympathy for doctors looking for a radiology career having tried other streams. It is a brave choice as committees often frown upon candidates moving between specialties.

What is Your Role Within the RANZCR?

I am chairman of three committees:

- The South Pacific Radiology Liaison Committee provides education and support for some of the 17 South Pacific Island nations. Radiologists and radiographers visit centres to provide training, give advice, and provide some service work.
- The Committee of the Directors of Academic Departments is a forum for ideas about management, common problems, and the challenges of working in a complex environment such as a teaching hospital.
- The Committee of Academic Radiologists brings together radiologists who wish to share ideas and learn about research, teaching, quality, innovation, and management.

How are Most National Radiology Services Financed?

Australian citizens have free medical cover for almost all conditions. Funding is by a 1.5% tax surcharge on most taxpayers with an additional 9% of the GDP spent on healthcare. The difference is made up by money from general revenue in the federal budget. 35% of Australians also pay for private health insurance that covers private hospital charges and extra services such as dental, physiotherapy, drugs, and prostheses. By law, private health insurers cannot discriminate between the healthy and the unwell customers. Contributions are the same, and chronic conditions are covered from 12 months after joining.

The industry here help with education and research as best they can but there are not many local companies who can compete with the large manufacturers and providers in Europe and the US. Academic research is funded by the government, industry, universities, and foundations. Radiology often finds it difficult to compete with general medicine and surgery departments for a share of the research funds. We now cooperate more with them.

Up to 60% of the radiology services in Australia are performed in the private sector and we are closer in practice to the European approach to imaging rather than the US, in that ultrasound is used more, and we are more, can I say, 'discerning' in selecting imaging.

How is Education Structured?

Training is a five-year course in the combined New Zealand and Australia programme. In the first year there is an exam in physics and anatomy. Pass rate on the first attempt is around 80%. The first year training is mostly in ultrasound and CT so that the registrar can be on call, often after six months training and a test of basic trauma imaging. In our hospital, one registrar stays until 9pm and then the night registrar starts. He or she

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does seven straight nights of 11.5 hours until 8.30am when the overnight work is checked. That makes 80 hours, and the registrar has the remainder of the fortnight off duty.

The final exam is in the fourth year. It is a multiple choice exam in radiodiagnosis, a multiple choice exam in pathology, a simulated reporting session, and seven oral exams of 25 minute each, in neuroradiology and head and neck, women's imaging, chest, musculoskeletal, gastrointestinal and genitourinary, paediatrics, and pathology. Because the requirement is that all 10 parts of the exam need to be satisfactorily completed, the pass rate on the first attempt for the exam is around 40%. Only the parts that were failed need to be re-examined six months later.

The fifth year can be spent in an advanced training position in Australia, or often in North America or Europe.

The College of Radiologists has just completed a curriculum for the training programme and it is soon to be introduced. It has some common features with the Canadian system, CanMED, which encourages doctors to be medical experts, collaborators, health advocates, communicators, scholars, professionals, educators, and managers.

The Royal Australian and New Zealand College of Radiologists is trialling the British NHS internet eLearning system for training in the first three years: the Radiology – Integrated Training Initiative R-ITI. It looks promising.

Does Geographic Spread Hamper Access to Services for Patients in Australia and New Zealand?

Geographic spread is a particular problem. Australia is 14 times the size of France in area and 80% of the population live within 50km of the coast. The people living away from the coastline have restricted access to services caused by distances to travel and access to sophisticated imaging modalities. Radiologists prefer to live in the larger urban centres and this exacerbates the problem. PACS and RIS systems can help with this. One of the private radiology practices has established an Australia-wide network with the server located in Sydney. It works without significant delays, even though Sydney on the east coast is 4,000km from Perth out west.

Is Academic Radiology Well-Structured and Well-Funded?

Academic radiology is not well-structured or -funded. Traditionally it has been a service-oriented specialty with fee-for-service government funding expanding the private sector, and the public sector constrained by budgets and bureaucratic management.

Fortunately, that is changing. Radiation oncology in Australia and New Zealand is something of a model of how to get organised with research and resources. Diagnostic radiology is following. Several centres have reasonable research bases. Most of the work concerns clinical research, less on translational research, and basic research is almost only at the universities. Some leading research projects focus on MRI and new radiopharmaceuticals.

Please Tell Us About the Most Interesting Case You Experienced in Your Medical Career so Far.

One of my "hobbies" relates to the case of a man convicted of homicide when his 28-year-old lawyer fiancée was found dead in the bath. The prosecution said it was homicidal drowning. There was a similar case in New Zealand where the radiologist made the diagnosis of an epileptic seizure because of the bilateral posterior dislocation of the shoulders on the CXR. Not so easy though in the case where I am giving advice to the defence, no CXR, the body was cremated.

It seems likely that the death was due to sudden adult death syndrome, but the forensic evidence, a poorly performed autopsy, hidden evidence, media reporting, and unprofessional conduct led to conviction for 25 years. I have spent hundreds of hours on this case over the last nine years with a small but growing band of supporters. Medicine sometimes seems to move slowly, the law is something else.

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