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Job Prospects for Radiologists in the United States



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The golden age of radiology in the United States has drawn to a close. Perhaps after a period of adjustment, a new resplendent silver age might occur but for the present and medium term the prospects are guarded.

Why the gloomy assessment? In order to offer an incisive analysis we need to understand the peculiarities of radiology in the United States including its predominant current means of reimbursement as well as the history of its demography over the past twenty years.

Unlike in most other developed countries, in the U.S. the dominant employment mode for radiologists is membership in a group private practice. The group may service only one hospital or just one outpatient imaging centre, but the larger ones often cover at least several clinical sites. Over the past 40 years such groups have continued to grow, expanding from a characteristic size of five or six practitioners in the 1970s to much larger associations of radiologists today, sometimes consisting of 50 or more members. Nowadays an assemblage of ten or fewer is considered small.

The way American radiologists earn their money is to do imaging - the more the better. They will endeavour to increase their volume of studies encompassing more modalities, especially the more highly rewarded ones like CT, MR or PET. The upside of this arrangement (and it has been 'up' for a long time), is that our fee for service system rewards demand.

Yet, to a great extent radiologists continue to create that demand through recommendations for further studies in their reports to referrers. But external forces that restrict that demand are strengthening in many ways. Among the countervailing impingements are:

- denials of imaging examinations by insurance companies;
- lower reimbursement per studies performed;
- fear of radiation by patients and clinicians alike;
- generally unfavourable economic considerations which hinder discretionary spending;
- competition for imaging from other specialists;
- and prospective further government limitations through more intrusive regulation.

In the face of these sanctions, to preserve the income of partners, group private practices have tended to become reluctant to take on new staff, lessening opportunities for those seeking entrance into the pool of employed radiologists.

The 'golden age' reached its zenith in the first few years of this century. In the 1990s when President Clinton floated his ill-fated healthcare proposal, the conventional wisdom was that the constraints of managed care would induce behavioural changes regarding imaging utilisation among referrers, and would perforce clamp down on urgings for radiologic services.

Therefore it was thought that we should reduce the number of residency slots. Many programs did just that. In 1996, radiology training positions had been decreased from about a thousand a year in 1990 to 850 just at the time that the Medicare cap on reimbursement for radiology positions for all specialties was introduced which further restricted payment. The cap remains intact unchanged since 16 years ago.

But coincidentally, and insidiously at first, CT volume increased because of advances in speed and clarity of image generation and definition and to a lesser extent by similar innovations with MR. So the combination of fewer radiologists being produced and much more work being done – the standard supply and demand disjunction- raised the income of radiologists. At the same time, cap or no cap, many radiology residency programs soon decided to take on more trainees bearing the costs locally. So by 2004 there were 1150 radiology residents per year in the pipeline.

These newly minted radiologists are now out of the pipeline, looking for jobs. Meanwhile imaging growth has slowed and

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Medicare reimbursement has been selectively cut. For example, until recently if you did a CT of the 'belly' you could have billed fully for both the abdomen and the pelvis portions of the exam. Now you receive only one full payment for one body region and only half for an extension of images to one contiguous one.

Well, where are we now? It must be understood that today for the most part, prospective hirers are not looking for radiologists per se. They are rather seeking subspecialty-trained radiologists who in the main in large academic practices will focus on their particular subspecialty at all times. In contrast, in private practice groups, even in large ones, you can expect to do what your fellowship trained you for during the day. But after hours and on weekends and holidays you will be assigned to imaging areas outside your subspecialty focus.

In the U.S. 95 percent of graduating residents take a fellowship year right after completing their four year residency. The board exams have been restructured not only to get rid of the terrifying multipartite oral test but more importantly to both acknowledge and foster the pursuit of subspecialisation.

The major fellowship choices are: abdominal imaging, neuroradiology, musculoskeletal imaging, paediatric radiology, interventional radiology and breast radiology. Far fewer young radiologists choose fellowships in chest, cardiac, emergency radiology or nuclear medicine, while some opt for MR only training programmes or combinations like women's imaging consisting of breast imaging studies and abdominal and pelvic ultrasound examinations over a one year term. There now are more fellowship positions nationally than there are graduating residents to fill them. Annually there are numerous vacancies in programs in paediatric radiology, neuroradiology and interventional radiology.

Among all subspecialties, at present, newly trained abdominal radiologists are now experiencing the most difficulty in finding employment or at least being chosen for a practice experience they like in a location they want. It should be presumed that the surfeit of abdominal imagers will persist. Already the starting salaries of those radiologists have declined.

On the other hand prospects remain brighter for breast imagers. The steady supply of middle-aged women, the tacit national agreement to reimburse for breast imaging studies and the public demand for ready availability of that service together are important sustaining factors as is the growth of highly compensated imaging modalities and procedures exclusively placed within the domain of breast radiology.

Paediatric radiologists tend to aggregate in big hospitals, both academic and non-academic, where their patient population is centred. For them there is still a balance between job offers and job seekers.

Overall there has not been even a meagre reduction in residency slots, so about eleven hundred young radiologists are entering the job market every year, more than offsetting those who are retiring. Hence for the foreseeable future, the job market for most junior subspecialists in radiology will likely tighten even more.

But one thing more should be remembered. Today average salaries for radiologists in general are over \$400,000 per annum and somewhat higher for interventional radiologists. That puts them in fifth or sixth place among all specialists in the United States in terms of annual income. Average starting salaries for those just out of fellowships used to be about \$300,000. Most radiologists are (through payment for their work alone) in the bottom part of the top one percent of American income earners.

So some may bemoan the loss of the pot of gold they may think they are entitled to after a decade or more of strenuous preparation, debt accretion and general denial of leisure that accompanies the training interval from medical school through residency. Yet if they get a job, and most all eventually will, they will not starve and probably will not scrimp too much either.

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