HealthManagement
Promoting Management and Leadership

Volume 8 - Issue 2, 2008 - Cover Story:Streamlining Emergency Radiology Services

The Changing Board Exam Schedule in the US:

General Radiologists to be Re-homed in the ER Department?

Author

Dr. Stephen R. Baker

New Jersey Medical School

New York, US

bakersr@umdnj.edu

General Radiologists to be Re-Homed in the ER Department?

Change, though a constant in radiology, does not always announce its arrival. Though the introduction of a new modality, for example, is readily manifest, in contradistinction, some profound changes are the result of gradual alterations of attitude or slowly developing realignments of opportunities or subliminal redirection of perspectives held by regulators, policy planners, or competitors. Such subtle developments are generally perceptible by those attuned to look for such trends, though most radiologists may be caught unawares.

Just such a metamorphosis will soon occur in the US. Today, advances in imaging are leaving those who profess only general capabilities in radiology in the uncomfortable position of not being that essential after all. Anatomy and gross pathology can now be observed readily in 3D arrays, revealed in multiplanar reformations rendering composite images which are relatively easy to interpret. Our once-exclusive proprietorship of the intellectual manipulation of the 2D to 3D transformation has been challenged.

Such a sea-change threatens to engulf the claims of expertise formerly and until recently held by general radiologists. Because of the vast and accumulating expanse of newly available information engendered by technical advances, they can now no longer lay claim to the possession of recondite knowledge and knowhow. Other specialists who care for patients directly can now have at their disposal, detailed static depictions of disease as well as video clips and exciting functional data. Hence, by dint of accessibility to this new diagnostic armamentarium, more and more reliance will be placed on those radiologists who are specialised in the referrer's discipline.

The neurosurgeon will still benefit from the insights of the neuroradiologist and the thoracic surgeon will continue to seek advice from the chest radiologist. But the general radiologist increasingly will have less and less to offer to their traditional referrers. After all, our clinical colleagues' residency education and practice are suffused now with sophisticated image instruction. Many have gained technical facility with image-guided procedures. From now on the radiologist must be a specialist to other specialists or face obsolescence.

Of course, this job category will not disappear overnight. In small and outlying facilities, the general radiologist will stay vital but in a gradually reducing role, servicing primary physicians and other caregivers who have had relatively little training in imaging interpretation. Yet in hospitals of at least medium size, larger radiology groups must become more differentiated along subspecialty lines if they want to keep their "turf ".

US Radiology Education Faces Overhaul

Radiology education must adapt to this actuality. US radiologists can no longer be reassured that their four years of residency education, which is now the longest interval between internship and fellowship of any non-surgical specialty, should continue to exist as is. Recent calls to change the timing, content and context of the written and oral boards are motivated by a desire to redirect residency education to emphasise subspecialty options.

And these calls have been heard! Despite objections from those reluctant to change, the American Board of Radiology has taken the step of fundamentally reorienting residency training. The traditional oral board exam with the candidate and reviewer in close communication will be replaced by computer-directed tests. Moreover, the exam schedule will be altered. The present written exam taken in the fourth year will be replaced by an image-rich, comprehensive, qualifying test occurring sometime after 30 months of residency and the aforementioned oral exam will be supplanted by a certifying exam focusing predominantly on areas the candidate wishes to pursue in practice. This latter exam will take place two to three months after the completion of the fellowship year.

The effect of the institution of those changes will stimulate subspecialty training which will likely commence after the initial exam, allowing for much of the last period of residency to focus on the intensive development of expertise in one or two realms of subspecialty knowledge in preparation for the continuance of focused training in a fellowship to follow in the fifth year of radiology training.

General Radiologist to be Re-Homed in the ER Department?

But what about the person who does not want to specialise? What would the fifth year entail and what are the opportunities for practice? Regrettably but inevitably, the tasks assigned to the generalist of today will likely diminish as radiology groups become larger and more specialty organised. But the effective “generalist” of tomorrow will have a role to play if his focus is on the urgent and emergently ill and injured.

Just as technology has driven radiology towards subspecialisation as an imperative, so too will clinical demand drive radiologists towards round-the-clock and often on-site coverage. Where is the predominant locus of after-hours practice? The emergency suite of course. Teleradiology may suffice for ER coverage in small hospitals. However, for larger, busier institutions the in-house radiologist will be a necessity if diagnostic imaging is to remain within our specialty and not be apportioned to ER physicians and trauma surgeons. Such an individual will have to demonstrate advanced knowledge of general modalities adapted to all emergently ill and trauma patients, because by definition, emergency radiology cannot be confined to one technology or one organ system or one body region or one patient age group but to one spectrum of conditions defined by urgency of presentation.

Emergency Radiologists the “Odd Man Out”?

Over the years, emergency radiologists in the US have been in many ways the odd man out. They do not have a separate component of the oral board exam through which knowledge and skill are tested even though there is a curriculum entailing emergency radiology’s distinctive corpus of knowledge.

Currently, only a few emergency radiology fellowships exist. In various departmental schema, emergency radiology has been an afterthought, despite the fact that in some hospitals up to 50% or even more imaging studies take place in the emergency suite. With the expected transformation of radiology education towards encouragement of specialty training, it is time now for emergency radiology to claim that it too can provide a meaningful experience for those who wish not to be bound by a focus on a modality or part of the body and yet claim special expertise. Guidance and instruction must be provided to enable newly minted radiologists to be regarded as the successors to general radiologist, specialists dedicated to serving the emergently ill and injured and the highly trained physicians and surgeons who care for them.

Conclusion

To me, the path ahead is clear. Emergency radiology is a distinct discipline as evidenced by the creation of a focused curriculum, and a willingness of its practitioners to be available at any time. Emergency radiologists are conversant with new imaging techniques and are comfortable with maintaining a continuing dialogue with emergency physicians and trauma surgeons. If emergency radiologists and general radiologists fail to recognise these inevitable changes they may face obsolescence, and fall victim to the vagaries of technology which, fundamentally, does not owe the practitioners of radiology anything.

Published on : Thu, 1 May 2008