
Volume - 5 - Issue 1, 2006 - Country Focus

The Position of Hospital-Based Radiology in Belgium

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The position of hospital-based radiology in Belgium (excluding academic institutions) is structured according to the type of hospital - private or public- and in conformity with hospital size, generally expressed as the number of beds.

In this article I have presented an overview only, using unofficial data from well-known, large hospitals, published anonymously, and without relying on official statistics. Peerreviewed literature comes almost exclusively from the US. Very little peer-reviewed research has been done on radiology management issues in Belgium itself.

The organization of radiology practice in Belgium hospitals is by radiological team. Every hospital has a radiology team. The individual workload is decided by the team, and is simply calculated as the total workload divided by the number of team members. The decision to enlarge this group is usually at the discretion of the existing members, with minimal involvement from the hospital administration. I am describing here the ideal situation. However, in practice, more and more hospital administrators and hospital boards try to influence the number of radiologists in 'their' hospital as well as the individual profile of prospective candidates. It is widely accepted that a high degree of involvement by the hospital administration results in less dynamic teams, with more individual friction and personal conflict between group members.

Investment in new equipment is generally initiated by the radiology team, and specifications for such equipment are routinely compiled by radiologists. The type and brand are usually decided on the basis of previous experience with vendors, based, more often than not, on who is the market leader in a specific technology. However, the same general rules apply to new equipment as to recruiting colleagues; hospital administrations

like to interfere in the choice of equipment and sometime try to force unsuitable choices on team members, often in the teeth of fierce opposition. The circumstances under which radiologists own their own equipment, hire facilities in the hospital and sell their professional services on an self-employed basis to the hospital is gradually becoming a rarity. Other resources (technicians, nurses, disposables, film) as well as equipment are normally paid for by the hospital, whilst the team receives a pre-arranged percentage of the gross income received by that department. This percentage may be revised from time to time and proposals for fee reviews may be put forward by both parties (hospital administrators and the radiology team). These reviews sometime lead to interminable, inconclusive discussions.

The right to install and operate an MRI unit is strictly controlled by the government and is only permitted if the hospital in question fulfils certain specific criteria, such as size and number of admissions per year. However, the regulations are changed on a regular basis, and this has led to a series of MRI-installation 'waves' in the past.

There are no up-to-date statistics on PACS penetration, but my impression is that at least eighty percent of hospitals are in the process of acquiring a PACS system. A minority of the hospitals (15-20%) already operate a fullblown (film-less) PACS system, incorporating RIS and voice recognition. Acceptance of PACS, however, is not universal, although most clinicians generally regard it as an advantage. PACS acceptance amongst ICU, CCU and emergency physicians is lower, where its introduction faces the same well-known problems as our US colleagues have encountered. (1)

In larger teams, organ system-oriented subspecialization is gradually taking over, although specialisation by modality is still common within the majority of hospitals. There are reasons of convenience and rational working practice which mitigate against the introduction of organ-specific structures. In fact, in some small teams, there is insufficient work for single target organ specialists and radiologists exclusively trained or experienced in a single organ systems are viewed as a burden rather than an asset. This, together with the logical desire to optimize and distribute individual workloads results in a situation where the most highly sought-after radiologists are those with a broad radiological

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background combined with practical expertise in a few organ-oriented subspecialties, where they may be considered local experts.

Turf battles between clinicians and radiologists are especially problematic in the area of abdominal ultrasound and duplex doppler. However the Belgian government is reluctant to encourage self-referral, and tries to discourage imaging activities by clinicians through reduced reimbursement rates for self-referred ultrasound. Vascular imaging procedures have almost all taken over by vascular surgeons and cardiologists, though there remain a few large centres of excellence, in which activities in this field are stable or even growing. This situation appears to mirror the position in the US, where the complexity and type of procedure undertaken is congruent with the size of the radiology team (2). Cardiac CT, cardiac MRI and carotid stenting will be a major arena for future discussion and, possibly, dispute.

Whereas, in the past, a consultation with a radiologist used to be a matter of personal preference - some clinicians like to interact, some don't - the practice of clinical oncology has been reorganized under new state regulation. 'Horizontal' teams consisting of the clinician(s), radiation oncologist, medical oncologist, oncologic surgeon, imaging specialist and pathologist convene on a regular basis (minimum once per week) and try to optimise staging, treatment and follow-up. (MOC, multidisciplinary oncology consultation). Extrapolation of this approach to other pathologies can be confidently anticipated in the future of radiological services in Belgium.

Published on : Sun, 12 Feb 2006