

The Visible Radiologist

Be visible or risk disappearing as a specialty was the message of the professional challenges session at ECR on Friday 8 March.

Professor Adam from London suggested that radiology should be surfing the crest of the wave, as the premier specialty of the 21st century, central to modern patient care. However, radiologists are often viewed with suspicion, due to the high capital costs of imaging equipment and the less visible benefits. Hospitals try to control the costs of imaging by emphasising volume over quality, trying to reduce overuse and encouraging the commoditisation of radiology. He suggested that radiology is a specialty on borrowed time because of this. Now images are much easier for non-radiologists to interpret. For many, the radiology report is viewed as the end product. But if that is the case, then radiologists are shooting themselves in the foot. One school of thought advocates radiologists concentrate on superspecialty consulting. Adam takes a different view - that is not enough to sustain radiology, and low prestige and low pay for routine work would devalue the whole profession. The reason why radiologists do not communicate directly with patients is cultural, not economic. It can be done - train radiologists in communication skills, provide consulting rooms in the radiology department and establish communication links with referrers. Start modestly and focus on the studies causing anxiety to patients. If radiology does not rise to the challenge, image interpretation by clinicians will increase and the market will be reluctant to meet the cost of image interpretation by radiologists. Adam is confident that radiology will adapt.

Professor Maas from Amsterdam is a strong advocate of embedding radiology in the medical curriculum. Students today are homo 'zappiens', digital natives who expect interactivity in their learning. At his institution they combine radiology with anatomy in the medical curriculum. PACS is an advantage - these digital native students like the computers! As the doctors who are most used to working with computers, the radiology department will be home for the students. At his university they have a very well regarded course combining ultrasound checks with a physical examination, where the ultrasound is checked by residents to see if it is correct. Radiology teaching should be represented in all preclinical and clinical years, using interactive case based teaching. If students gain a higher opinion of radiology when taught in the preclinical years, they will retain this positive attitude after they graduate. The message from Maas was that early visibility is essential so that the medical leaders of the future are trained with adequate radiology input. In the department use a select group of radiology teachers, include radiology only assessment, and the department chair's policy should be that education is crucial. Lastly provide serious clinical clerkships so that students get positive experience.

Prof. Jim Reekers from Amsterdam recommended that radiologists need to leave the economic model behind which leads to commoditisation and adopt the spider model. Like the spider, the radiologist needs to be at the centre of the hospital 'web'. Where appropriate, provide results to patients directly, he suggested. He himself hands patients his contact details. If you communicate directly with patients, you are part of the decision making process. The clinical diagnostic unit model where for example the chest physician connects with the chest radiologist and they work as a team is ideal. Build an open department, central in the hospital with easy access, create spaces for information transfer like conference rooms, and build dedicated workplaces for each radiological subspecialty.

Prof. de Kerviler from Paris compared the issue to 'where's wally'. To find Wally you need to know what he looks like, and it's the same for radiologists. Some subspecialties are already visible, such as mammographic, paediatric radiology and gastrointestinal radiology. He said that imaging services can be seen as commodities distinguished by cost rather than expertise, radiologists are viewed as consultants rather than doctors and there is a perception that radiologists add little value to the clinical paradigm. When clinicians have such easy access to PACS they may feel that they do not need radiologists. At his institution the multidisciplinary tumour board is a valuable event, where the team review imaging data, get clinical data, discuss strategy, grab papers from non radiology journals, and refresh their knowledge. The role of radiologists in performing biopsies is also crucial. He urged, 'Be visible, become essential, get involved, have your say and make a difference.'

The panel discussion addressed the use of imaging equipment by other specialities. Radiologists should be the referee for patients and clinicians in deciding on treatment, suggested Reekers.

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