

Turf Wars in Radiology: What Must Academic Radiology Do?

Vijay M. Rao, MD^a, David C. Levin, MD^{a,b}

In a previous article in this series, the authors called on private practice radiology groups to better support radiology research financially but also pointed out that academic radiology must make some changes as well. In this article, the authors discuss those changes in detail. They include revising the structure of the radiology residency, changing the timing of the American Board of Radiology oral examinations, requiring that all residents receive research training, and emphasizing the value of clinical and translational research. The Society of Chairmen of Academic Radiology Departments needs to assume a leadership role in implementing these changes.

Key Words: Academic radiology, medical economics, radiology research, radiology and radiologists, socioeconomic issues

J Am Coll Radiol 2007;4:622-625. Copyright © 2007 American College of Radiology

In a recent article in this series [1], we stressed that high-quality research conducted by academic radiology departments was a critical element in winning turf wars in imaging. If radiologists fail to do leading-edge research to advance the science of imaging, others will step in and do it, and they will then inevitably take over the clinical practice in the areas of that research. We pleaded the case for the financial support of academic radiology department research programs by the private practice community. We also pointed out that academic radiology has to take certain steps of its own to promote research and thereby help ensure the integrity of the field. In this article, we discuss some of those steps that need to be taken.

THE RADIOLOGY RESIDENCY

Significant changes must be made in the way radiology residents are trained. Others also have recently stressed the importance of this [2-4]. Currently, most radiology residents undergo 6 years of training: a clinical internship (often transitional), followed by 4 years of radiology residency and then an optional one-year subspecialty fellowship. The rate at which graduating residents take fellowships seems related to the job market. When private groups are actively recruiting and salary offers are

lucrative, many residents opt to go straight into practice without fellowships. When the job market slows down, residents realize that they need to have subspecialty expertise to make themselves more marketable, so more of them take fellowships. We believe that subspecialty expertise is important for all radiologists if they are to help provide high-quality patient care by being able to give informed and expert interpretations of imaging studies to their colleagues in other medical specialties.

As things stand now, the clinical internship is largely a waste of time, because it usually has no bearing on what subspecialty a radiology resident will pursue in the future. In addition, the fourth year of residency is now largely focused on preparation for the oral examination of the American Board of Radiology (ABR). Thus, it too is largely a waste of time in terms of useful training for future practice.

The model we strongly recommend is along the lines proposed by Arenson and Dunnick [2]. The clinical internship would be done away with and the residency would commence immediately after graduation from medical school. The residency would last 5 years and would consist of a core curriculum of 3 years, followed by a required subspecialty advanced training period (ATP) of 2 years. The 3-year core curriculum would provide basic training in all aspects of radiology but would not attempt to make trainees experts in every imaging subspecialty. As Arenson and Dunnick pointed out, radiology has become so broad and complex that no one can be considered an expert in the entire field. The 2-year required ATP would include subspecialty radiology training, rotations on the clinical services related to that im-

^aDepartment of Radiology, Thomas Jefferson University Hospital and Jefferson Medical College, Philadelphia, Pennsylvania.

^bHealthHelp, LLC, Houston, Texas.

Corresponding author and reprints: Vijay M. Rao, MD, Thomas Jefferson University Hospital, Department of Radiology, Main 1087, Philadelphia, PA 19107; e-mail: vijay.rao@jefferson.edu.

aging subspecialty, and research training. As an example, a 2-year ATP could be composed of 15 months of subspecialty radiology, 6 months of clinical rotations on related services, and 3 months of research. During the 3 months of research, 1 day per week of subspecialty radiology practice could be incorporated. When combined with approximately 3 months of training residents would receive in their areas of interest during the core curriculum, they would end up with more than 18 months of subspecialty radiology training after their completion of the 5-year program.

The 2-year ATP could replace some fellowships but would not necessarily have to do so. Those departments currently offering fellowship programs that are accredited by the Accreditation Council for Graduate Medical Education could continue to do so. Residents wanting additional subspecialty training or those wanting to add second subspecialties could continue to take them. The additional fellowship years could be tailored to the wishes of the sponsoring departments and could be totally devoted to subspecialty imaging training or could include varying periods of research or rotations on related clinical services.

Would our proposed 5-year program be feasible or acceptable to the ABR? It would seem so. The ABR has already approved the Holman research pathway [4,5] and a specialized interventional radiology track [4]. These two pathways provide radiology core curricula of, respectively, 27 and 32 months.

The major advantages of what we and Arenson and Dunnick [2] propose are that (1) every radiology resident would complete training with subspecialty expertise in at least one major area of the field, and (2) every resident would have some training in research. We cannot over-emphasize the importance of the latter. If academic radiology departments do not provide research training to their residents, they can hardly expect those residents to show much enthusiasm for an academic career in which knowledge of research methodology is crucial.

THE AMERICAN BOARD OF RADIOLOGY EXAMINATION

The timing of the oral ABR board examination should be changed. This also has been suggested by others [2, 6-8], but nothing has happened yet. Radiology is currently the only medical specialty in which the final board examination is given during residency [2,7,8]. The result has been that residents in most academic departments waste much or all of their fourth year consumed by "boards mania." We propose that the oral ABR examination be postponed until 2 years after the completion of all training. This would have several beneficial effects on the field and especially on radiology research. First, residents would

spend their final years of training learning to practice radiology at the highest subspecialty levels instead of trying to learn answers to anticipated board questions. As pointed out by Grossman and McGuinness [8], this enhances the value of radiologists to specialist clinicians and helps quell the arguments of those who might try to encroach on the practice of imaging. Second, they could assume a larger role in supervising and teaching their junior colleagues. This would free up faculty members, who could then devote that time to research. Third, the senior residents would be better able to concentrate on learning research methodology and doing research themselves. Fourth, some residents would likely decide to spend those first 2 postresidency years in academic radiology departments, where they could continue to refresh their knowledge of all aspects of radiology before the board examinations. This would help academic radiology departments recruit junior faculty members. These junior faculty members would be capable of doing research, and hopefully some of them would enjoy the experience enough to want to stay in academics permanently.

RESEARCH TRAINING

The leading research radiology departments should band together and require that all their residents undergo serious research training. This could be either along the lines of the Holman pathway [4] or perhaps by adding one more year of research to the 2-year ATP outlined above. It has been pointed out that 50% of all National Institutes of Health (NIH) grant funding to academic radiology goes to just 8 departments and that the next 30% goes to another 13 [9,10]. With graduating medical students beating down the doors to get into radiology residencies, these 21 elite research departments can afford to be very choosy. If they all as a group required their residents to train in and perform research, perhaps they might lose a few candidates who were not interested in research, but so what? Without any question, they still could easily fill their programs, and their trainees would be people who were interested in research and motivated to perform it. As recounted by Baum [9], this is exactly what took place among the leading academic departments of surgery in the country. The results have been that surgical research has improved and that most residents coming out of those programs end up in academic careers.

Because Medicare does not pay for research time for residents, funding of that time could be a problem. Some funding could come from existing research grants already in the departments, from department endowments or research funds, or perhaps from support provided by private practice radiology groups [1].

Download English Version:

<https://daneshyari.com/en/article/4232216>

Download Persian Version:

<https://daneshyari.com/article/4232216>

[Daneshyari.com](https://daneshyari.com)