Information on the Multispecialty Radiologist (MSR) concept


This paper was authored by an ACR Task Force following debate and discussion at an ACR Board of Chancellors meeting. It reviews the progression from a predominantly general radiologist workforce to the current environment of an increasingly subspecialized workforce with many single specialty radiologists (SSRs). The paper introduces and defines the concept of a multispecialty radiologist (MSR) who could blend the strengths of increased specialization with the broader knowledge and coverage that can be provided by a general radiologist. The paper recognizes that the optimal workforce would include SSRs, MSRs, and general radiologists, with the distribution of manpower in a specific situation dependent on local needs. The paper concludes with a call for the ACR to form a steering committee under the Commission on General, Small, and Rural Practices to guide and coordinate College efforts in supporting the MSR.


Dr. Haggar in a letter to the editor comments on the MSR concept in relationship to his busy community practice. His letter and the authors’ reply recognize the need for a wide variety of radiologist skills to meet the needs of a varied workplace.

Discussion of General vs Specialized Radiology


In these paired opinion pieces, Dr. Breslau and Strax summarize their point-counterpoint arguments that were presented to the ACR Board of Chancellors and Council Steering Committee in October 2011. The subsequent discussion led to the appointment of the task force that developed the concept of the Multispecialty Radiologist, as reported in the paper “The General Radiologist in the 21st Century”.


Dr. Pressman in his 2008 ACR Presidential Address promotes increased specialization in radiology as a means of elevating radiology practice, becoming more involved with clinical care, and actively interacting with patients and referring clinicians. He sees this as the route to distinction and necessary to prevent extinction.


Dr. Atlas advocates for increased subspecialization in radiology as a necessary for the survival of the profession due to the increasing complexity of imaging. He also notes that other fields of medicine are more specialized than radiology, and those specialist clinicians expect similar specialization and expertise from radiologists. Dr. Atlas promotes fully specialized radiology with fellowship trained radiologists.


In letters to the editor, Drs. Williams and Luttenton respond to Dr. Atlas. While expressing some support for specialization and fellowship training, they also support the role of more general radiologists and self-trained subspecialists.


The authors report on the 2008 ACR Forum, which met in January 2008 to address current and future models on radiology practice. The discussion recognizes the importance of the issue of specialization. The Forum did not specifically advocate for a specific model but recognized the trend toward increasing specialization. Among many other recommendations, the Forum recommended research on the effects of specialization on the quality of patient care.


Dr. Jha discusses the dilemma of increased specialization vs the need for some general radiology knowledge, with an emphasis on radiologist training.

Dr. Fleishon discusses the future role of the general radiologist in light of increasing subspecialization and the impending changes to the ABR examination process. He advocates for a continued strong core training in general radiology.


This commentary from the business community supports the value of the generalist compared to the specialist in the business arena.

**Manpower Issues and Surveys in Diagnostic Radiology**


The authors report on an electronic survey performed by the ACR Commission on Human Resources in 2012 to assess the workforce situation for US diagnostic radiologists. While the primary focus of the survey was on hiring, the survey also addressed the specialties of radiologists in practice and expected to be hired. Practice leaders responding to the survey categorized 35% of the current diagnostic radiology workforce as general radiologists and 65% as subspecialists. There was no dominant subspecialty. The largest specialty group was body imagers at 9%, followed by general interventional radiologists at 8%, neuroradiologists at 7%, and breast imagers at 6%. In 2011 20% of newly hired radiologists were classified as general radiologists. Looking forward, respondents expected that 14% of new hires in 2012 and 18% in 2014 would be general radiologists. While those figures reflect a shift toward more specialization compared to the existing workforce, the percentages of general radiologists projected for future hire equaled or exceeded any specific subspecialty.


The authors report on a survey performed in 2008 of practicing radiologists, radiation oncologists, and trainees regarding the state of subspecialization in practice and in training curricula. While they found that about 75% of radiologists consider themselves to be subspecialists, overall those
specialists only spent about 50% of their time in their primary subspecialty. The remainder of their time was spent in other subspecialty areas or in “general radiology”. The authors also acknowledge the potential effects of upcoming changes to the American Board of Radiology exam process, which will become effective in 2013.


The authors report on an older ACR survey performed in 2003 which showed that 69% of practicing radiologists specialized to at least a small extent. 31% of radiologists spent at least 70% of their work time in a single subspecialty. Younger radiologists and radiologists in academic practices were more likely to be specialized while solo radiologists were less likely to be specialized.

Changes in Diagnostic Radiology Residency Training and the American Board of Radiology (ABR) Exam Process


The ABR on its website summarizes the “Exam of the Future”, which will be implemented in 2013 for diagnostic radiology residents who began their training in 2010. Those residents will take a computerized “core exam” covering 18 areas of diagnostic radiology at the beginning of October 2013. In future years, the core exam will be given in June, after 36 months of training. A subsequent “certifying exam” will be given 15 months after the completion of diagnostic radiology residency. Thus, the first certifying exam will be administered in October 2015. The certifying exam will include mandatory modules on “Noninterpretive Skills” and “Essentials of Diagnostic Radiology” and three modules chosen from 13 clinical practice areas and selected by the individual based on training, experience, and practice emphasis. One, two, or three different practice areas may be selected.


This document outlines requirements of diagnostic radiology residencies, effective July 1, 2008.

Drs. Amis and Dunnick, writing as Chair of the Diagnostic Radiology Residency Review Committee (RRC) and as President of the American Board of Radiology (ABR) respectively, discuss the joint efforts of the RRC and ABR to improve radiology education. Those discussions led to revision of the diagnostic radiology residency curriculum with three years of core training followed by a core exam and one year of elective training. At the time of the paper, there was discussion of eliminating the clinical year and allowing two years of elective training at the end of residency, but that change has not occurred.


The authors report on a survey of radiology residents related to the elective fourth year of radiology residency. The majority of respondents indicated that they would like to spend at least half of their fourth year in a single specialty area.


The authors report from the Association of Program Directors in Radiology (APDR) Residency Restructuring Committee, which was formed in response to changes in training mandated by the ACGME and in the ABR examination process. The discussion and recommendations related to the fourth year of residency training may have implications for the MSR concept.