

Should We Think of Radiologists as Nonclinicians?

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A sharp line is often drawn between radiologists and clinicians. Recent articles in the blogosphere have included titles such as “Changing How Radiologists and Clinicians Communicate”¹, “The Relationship Between Radiologists and Clinicians”², and “What Clinicians Want From Radiology Reports”³. Each of these articles—and innumerable conversations taking place in offices, clinics, and hospitals all over the country—draws a distinction between radiologists and clinicians, implying that radiologists are nonclinicians.

There is of course some truth to this, but we believe that it obscures more of radiology’s nature than it illuminates. To avoid confusion, it would be better to refer to colleagues who refer patients to radiology as referring physicians, or perhaps in terms of the medical specialty they practice. In this age of expanding professional roles, including nurse practitioners and physician assistants, this designation often needs to be expanded to referring health professionals. But to imply that radiologists are nonclinicians does grave injustice to professionals who make vital contributions to patients.

In its contemporary medical usage, clinician distinguishes patient-care specialists from physicians who focus on education, research, and administrative work. Some clinicians have considerable direct contact with patients and others do not, but all clinicians have direct responsibility for patient care. Every time a radiologist protocols an imaging examination, wields an ultrasound transducer, produces a radiology report, or consults with a colleague about a patient’s case, the radiologist is functioning as a clinician, bearing direct responsibility for patient care.

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Yet even radiologists resist this notion. As the training pathway in interventional radiology shifts away from that of diagnostic radiology, some interventional radiologists may be increasingly tempted to think of their diagnostic imaging colleagues as nonclinicians. In fact, one interventional radiologist recently suggested just this. “Diagnostic radiologists do not have outpatient clinics, hold admitting privileges at the hospital, or routinely prescribe medications,” she said. “They simply look different from real clinicians.”

She could have continued. Diagnostic radiologists also typically do not constitute the patient’s first point of medical contact, as a high proportion of radiology patients are referred by health professionals in other fields. In addition, radiologists are not as deeply immersed in the electronic medical record, instead working largely in other systems, such as the radiology information system and the PACS. Finally, asked to name their physicians, few patients would mention diagnostic radiologists.

Yet we believe there are profound reasons for radiologists to resist the label of nonclinician and to work hard to bear the clinician’s mantle with pride. Consider the following true account of a radiologist’s role in the care of a patient. Although not representative of the typical time allocation of the radiologist in question, this case provides a good example of how a curious, astute, and dedicated diagnostic radiologist can not only merit inclusion as a clinician but also run at the head of the clinician pack.

A musculoskeletal radiologist was performing a sonographic examination of a young man for shoulder pain. The radiologist was cognizant of the very low probability of a rotator cuff tear in this clinical setting, but he soldiered ahead, painstakingly evaluating each of the tendons for pathology. As the radiologist pointed out the normal anatomy to the patient on the screen, he noticed what he called a “hangdog” expression on the patient’s face. It turned out that the man was disappointed that the examination was providing no explanation for his pain.

The radiologist launched into his standard discussion of the limitations of the examination and tried to reassure the patient that, although it had turned up no anatomic explanation for his pain, it did not

indicate in any way that his pain was not real. In talking further with the patient, the radiologist learned that the man had recently experienced a succession of injuries that piled one on top of another to the point that they were undermining his enjoyment of life. His account of some bizarre skateboarding accidents made the radiologist chuckle.

Some might say that the radiologist reacted inappropriately, finding amusement in the patient's misfortune, and perhaps even in some way mocking him. But in fact this very human response helped build an even better rapport between patient and physician. Their conversation continued longer than normal, to the point that the ultrasound technologist started pointing at the clock and shaking her head in disapproval, aware of the need to get the patient out of the room so a new one could be ushered in. But the radiologist kept listening.

The patient went on to describe a twisting injury of his foot that he had sustained two months previously, which had left him with persistent pain and disability. He had gone to the hospital for x-rays, but the results were normal. He then pulled out his cell phone and shared a "selfie" he had taken of the foot on the day after the accident. Through the cell phone's cracked screen, the radiologist glimpsed a classic Lisfranc injury. The radiologist urged the man to get another set of foot radiographs and see an orthopedic surgeon immediately.

The patient demurred. "You see," he said, "my injury is a workman's compensation case, and I cannot afford to seek any medical care without first consulting my case worker." Having become painfully familiar with the system over the past 2 months, the man felt certain that there was no way he could get approval inside of a month. Some would say this was not the radiologist's concern, and certainly not part of his formal job description. No one would have batted an eyelash had he not pursued the matter further. He could have simply said, "Let a clinician deal with it."

But he did not. Bowing to the insistent glances of the technologist, he ushered the patient out of the examination room. But he did not leave him. He remained at his side, listening to the man's tale of

woe about his attempts to navigate the health system. The man's colleagues at work were sympathetic but felt powerless to help him. Finally, the radiologist decided that he needed to take matters into his own hands. He insisted that the patient phone his case worker immediately. Overhearing the ensuing conversation, it was clear that she was nonplused by his diagnostic acumen.

"Hand me the phone," the radiologist said. After some minutes of explanation, including a rather detailed description of the patient's injury and the potentially dire long-term consequences if it remained untreated, the case worker's attitude toward the man's situation changed dramatically. It wasn't long before she had scheduled an appointment with an orthopedic surgeon for the next day. Subsequent evaluation demonstrated a missed Lisfranc fracture-dislocation that required open surgical reduction and fusion.

In the end, the radiologist spent 45 min on the case. The billing generated from the encounter reflected only a sonographic examination of the shoulder. The diagnosis was "normal." And to this day, the hospital information system contains no record of the radiologist's real contribution. From the interventional radiologist's point of view, each of these details would have provided further evidence that the radiologist was not functioning as a clinician. After all, his true impact was invisible to all the systems by which health care is measured today.

Yet the patient knew otherwise, and so did the radiologist. About 8 months later, the radiologist was working a routine day in the reading room when a technologist approached him and asked that he come and speak with a patient in the waiting room who had asked for him. It was the man with the Lisfranc injury, who was now doing much better. He had come by to say thanks and to introduce his mother. He wanted her to meet the doctor who had taken a moment to listen, making a huge difference in his care.

So is a diagnostic radiologist a clinician? Consider these words of the late, great Harry Mellins⁴:

The diagnostic radiologist is a clinician who has sacrificed one of the greatest glories of the practice of medicine and its greatest responsibility—daily contact with the ill and their families—in order to concentrate more on the essence of our profession, the pathology of the living. This he sees through the medium of shadows, which has left him open to the charge of not quite being a real clinician. But shadows, after all, are real. What are we to one another and what is the world to any of us but an inverted image on the retina? Seeing is done with the mind... The radiologist perceives the shadow, sees the lesion, and imagines the man. The bedside physician sees the man, perceives the signs, and imagines the lesion. They practice from the outside in and we from the inside out. But both are clinicians, for in truth there is no other kind of doctor worthy of the name.

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