Change the Spot!

After 35 years of being a teacher for postgraduate radiology courses, I have come to know that success or failure at the postgraduate examinations in radiology, as it is practiced today, is very much dependant on how a student fares in the “Spots.”

And, what are these hallowed spots?

Every candidate is expected to go through several images—typically about 40—in as many minutes and make a diagnosis. Depending on whether the examiners are “benign” or “malignant,” the spots may be easy, difficult, or even impossible ones. Not even a single word of the clinical background of the case is ever given.

Now, we come to the interesting part—how are these spots chosen by the examiners?

Each examiner has a coveted collection of key spots that he or she brings along to the exam.

Usually, the chief examiner gets to show the bulk of the spots with a spattering of films from the other examiners.

In being a supervisor at these examinations, on several occasions, I have gotten to see the innards of the practical examinations and I have never seen examiners honestly look at the spots from their coexaminers and see if they can themselves make the diagnosis in under 1 min, without any clinical story. I am saying this with no sense of ridicule of the examiners. Perhaps, they are just captives of an entrenched system of examinations the world over.

Obviously, we are in unfair territory here.

But where are the alternatives—many have asked me?

As a matter of fact, it would be very simple to find solutions to this issue if the powers that be huddle in a conference and find out simple solutions to this apparently complex problem. For example, instead of spots, there could be multiple short cases in which there is a discussion between the examiner and the examinee.

And finally, God forbid, if spots are to remain an integral part of all examinations, let me suggest the following method for scoring the candidates.

In an impartial environment, the examiners should look at the spots from coexaminers in less than 1 min and they are scored on this. The total of marks that each of the examiners gets on the other examiners spots is averaged for all four examiners and that should be considered as 100% marks. That, I feel, would be a good way to salvage a bad situation.

But, we are going away from the main point of this article.

What I am saying is that in real life radiology, there is never ever a situation where you have to make a diagnosis on a single film in less than 1 min., unless one is a security staff in an airport baggage belt!

In real-life radiology, you see contemplation, discussion, and decision because the patient and the anxious family are waiting for you.

And finally, if you have been a university teacher in radiology, when was the last time you talked to a patient about the history or the examination findings or explained to a patient before or after a diagnostic radiological examination?

When was the last time you led by example?

In 1989, in an editorial in the Indian Journal of Radiology and Imaging, I had said “Stop the Spot.”[1] Nothing seems to have changed in the last 30 years.

So, here again is my—shouting from the rooftop—call about postgraduate radiology examinations.

“Change the Spot”

And if you don’t, in the next few years, intelligent machines will make all the qualified spotters redundant and then it would have been too late.

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Sir,

This is with reference to the editorial by the past Editor-in-Chief, Dr. Chander Mohan entitled "Is next-generation radiologist ready for the challenges?"; published in Jan-Mar 2019 issue of IJRI. I completely agree with the fact that GenNext radiologists should be ready and prepared for the growing challenges in radiology practice. To attain this objective, we need to become clinical radiologists and always adopt "Patient-centric approach" and "problem-solving attitude" in radiology.

As Radiology and Imaging science is one of the most dynamic branches where new concepts are being converted to clinical applications in a seemingly endless manner. It is vital for us to remain updated with the latest trends in imaging and practice "lifelong learning." I am sure of at least one thing in Medicine that - "The only thing constant in Medicine is CHANGE." Change for the better, change for the betterment of the society, and change for the betterment of the healthcare system.

As we talk about the challenges posed by the wave of artificial intelligence (AI), it is even more important for radiologists to understand that AI may replace a radiologist, but AI will never replace a clinical radiologist. Radiologists, therefore, need to always understand the story behind the image and connect with the patient so as to become an integral part of the patient care.

In this era of ever-expanding super-specialization and continually evolving imaging sciences, the suffering patient should feel assured rather than awed. The reforms in healthcare are meant to benefit the patients, and therefore, "patient-centric approach" should be adopted. When we talk of a better diagnostic yield from a diagnostic test, this cannot be attained at the cost of the patient's suffering. Agreeably, the imaging test is also for the patient's benefit, but it is vital to understand the difference between a "pretty" image and a "diagnostic quality" image. The purpose of imaging is to achieve a diagnostic quality image from a clinical stand-point so as to provide an answer to a specific clinical query. If the patient compliance is not optimal owing to his physical or mental ailment, the imaging specialist should not complain, as long as the diagnostic quality is attained. After all, the "imaging test" is for the "patient" and not the vice versa. Radiologists need to understand these issues and should be more flexible in terms of imaging protocols. In given clinical circumstances, every attempt should be made to generate the "diagnostic quality" image with minimal patient discomfort.

At the same time, radiologist needs to "sensitize" themselves to the emergency conditions in the clinical practice. As we head toward the disease diagnosis with a particular imaging investigation, we need to understand the clinical background and the subsequent clinical course. This may require a telephonic conversation with the referring clinician. We need to anticipate the impact of imaging investigations on clinical decisions and act accordingly. This may require immediate reporting and conveying the results to the clinical colleague. Even if a radiologist cannot generate a final report owing to a busy

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