2016 Clinical Radiology New Fellows Survey Report

The Royal Australian and New Zealand College of Radiologists®

Faculty of Clinical Radiology

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1. INTRODUCTION

All members who obtained fellowship (including IMGs) between January 2012 and September 2016 were invited to participate in a short, online New Fellows Survey (NFS) during August-November, 2016, in order to understand the experiences newly qualified radiologists face as they enter the employment market.

2. METHODOLOGY

The survey was developed and piloted amongst members of the College secretariat and Radiology Workforce Committee prior to being distributed and was based on the 2015 Clinical Radiology Trainee Exit Survey.

A total of 572 members were invited, with the names, email addresses and fellowship dates being obtained from the RANZCR membership database. The survey was created using SurveyMonkey™ and its feature of emailing personalised invitations to participants was used. The survey was open for thirteen weeks (22 August – 14 November). Weekly reminders were sent through SurveyMonkey™ to non-respondents and those who had started but not completed the survey.

Data were analysed using IBM SPSS Statistics v.19 software.

3. RESULTS

There was an overall response rate of 35.3% (n=202) from 572 invitees, which corresponds to an error level of 5.5% at 95% confidence. Note that the error level does not consider any bias that the respondents may have towards certain answers in questions. Males made up 63.9% of respondents, females made up 25.3% of respondents while the genders for 10.9% of respondents could not be determined. Of the 572 invitees, 68.0% were male and 32.0% were female. Response rates within gender groupings were similar, with 33.2% of males and 27.9% of females responding.

Note that the number of respondents for particular sections may be less than the total number of respondents because respondents could skip questions based on their answers to previous questions. In particular, these include respondents who are currently undertaking accredited nuclear medicine training or respondents who are currently undertaking a fellowship.

3.1. Training

Participants were asked to identify the state/territory or country in which they commenced and completed their training, as well as the state/territory or country in which they currently resided in at the time of the survey (Table 1).

Table 1: Location of training compared to current location

	Commenced Training		Completed Training		Current Location	
Location	**n**	**(%)**	**n**	**(%)**	**n**	**(%)**
New South Wales	22	(13.9)	32	(20.3)	34	(21.5)
Victoria	25	(15.8)	38	(24.1)	31	(19.6)
Queensland	31	(19.6)	33	(20.9)	31	(19.6)
South Australia/Northern Territory	14	(8.9)	14	(8.9)	13	(8.2)
Tasmania	2	(1.3)	1	(0.6)	2	(1.3)
Western Australia	6	(3.8)	14	(8.9)	15	(9.5)
Australian Capital Territory	1	(0.6)	2	(1.3)	2	(1.3)
New Zealand	19	(12.0)	17	(10.8)	13	(8.2)
Overseas	38	(24.1)	7*	(4.4)*	17	(10.8)
Total	**158**	**(100.0)**	**158**	**(100.0)**	**158**	**(100.0)**

* Overseas was not an option for this question in the survey but several respondents indicated that they completed training overseas in another question.

After completing their training, 10.8% (n = 17) of respondents reported moving overseas. Note that these respondents may include those who completed their training overseas.

Those who had relocated state/territory or country were asked to indicate the reason for the move. 58 respondents provided a reason; 32.8% (n = 19) of respondents reported it was for family reasons, 17.2% (n = 10) reported it was due to lifestyle choices, 12.1% (n = 7) reported it was due to working conditions and 3.4% (n = 2) reported it was due to the quality of training. 12.1% (n = 7) commented that they had relocated due to fellowships opportunities, 13.8% (n = 8) said that they were overseas trained and 6.9% (n = 4) provided other reasons.

The majority of respondents who moved overseas relocated to North America (n = 6; Canada = 1; United States = 5), 5 moved to Singapore, 4 relocated to the United Kingdom, 1 moved to South Africa and 1 respondent did not give a clear answer.

3.2. Skill Confidence

Participants were asked to rate their confidence when they entered the workforce with a number of radiological procedures (Table 2). A five-point scale (not at all confident through to extremely confident) was provided.

Table 2: Skill confidence upon entering the workforce

	Not at all confident		A little confident		Confident		Quite confident		Extremely confident	
Skill	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Breadth of safe knowledge and skill (not necessarily depth)	2	(1.4)	13	(8.8)	58	(39.2)	59	(39.9)	16	(10.8)
Angiography	55	(36.9)	35	(23.5)	29	(19.5)	15	(10.1)	15	(10.1)
DEXA BMD	65	(43.0)	38	(25.2)	29	(19.2)	11	(7.3)	8	(5.3)
Mammography	26	(17.2)	46	(30.5)	44	(29.1)	22	(14.6)	13	(8.6)
Breast Ultrasound	9	(6.0)	38	(25.2)	55	(36.4)	32	(21.2)	17	(11.3)
Breast MRI	105	(70.5)	18	(12.1)	11	(7.4)	9	(6.0)	6	(4.0)
Cardiac (CTCA)	114	(76.5)	16	(10.7)	8	(5.4)	6	(4.0)	5	(3.4)
Cardiac (MRI)	127	(84.7)	12	(8.0)	4	(2.7)	1	(0.7)	6	(4.0)
CT Colonography	81	(54.4)	36	(24.2)	20	(13.4)	9	(6.0)	3	(2.0)
Gynaecological imaging	2	(1.3)	30	(19.9)	55	(36.4)	43	(28.5)	21	(13.9)
Obstetric imaging	7	(4.6)	34	(22.5)	50	(33.1)	47	(31.1)	13	(8.6)
MSK (other than MRI)	4	(2.7)	26	(17.4)	49	(32.9)	55	(36.9)	15	(10.1)
MSK MRI	21	(14.4)	46	(31.5)	34	(23.3)	34	(23.3)	11	(7.5)
Nuclear Medicine	94	(62.7)	38	(25.3)	13	(8.7)	2	(1.3)	3	(2.0)
Neuroradiology	2	(1.3)	19	(12.7)	63	(42.0)	46	(30.7)	20	(13.3)
Paediatrics	3	(2.0)	41	(27.3)	67	(44.7)	29	(19.3)	10	(6.7)
Procedural radiology (imaging guided biopsies, drainages and injections)	6	(4.0)	17	(11.4)	42	(28.2)	55	(36.9)	29	(19.5)
DSA Angiography	76	(50.7)	36	(24.0)	12	(8.0)	12	(8.0)	14	(9.3)
Vascular diagnosis (Non DSA)	15	(10.0)	31	(20.7)	62	(41.3)	28	(18.7)	14	(9.3)
Interventional Radiology (vascular, urological, and/or biliary)	62	(41.6)	40	(26.8)	25	(16.8)	10	(6.7)	12	(8.1)

3.3. Sub-Specialisation

The majority of respondents (59.9%, n = 121) reported that they have undertaken a sub-specialist fellowship. These 121 respondents indicated their sub-specialty areas, with a range of 1-4 sub-specialty fellowships being completed (Table 3). There were 20 different sub-specialty fields noted, with MRI, Breast Imaging, MSK, Interventional Radiology, Neuroradiology, Paediatric Radiology and Body Imaging being the most commonly reported sub-specialty. Note that respondents could select multiple sub-specialties.

Table 3: Type of Sub-Specialty Fellowship Undertaken*

	Fellowships Taken	
Sub-Specialty Area	**n**	**(%)**
MRI	32	(14.9)
Breast Imaging	24	(11.2)
MSK	23	(10.7)
Interventional Radiology	22	(10.2)
Neuroradiology	19	(8.8)
Paediatric Radiology	17	(7.9)
Body Imaging	17	(7.9)
Abdominal imaging	12	(5.6)
General Radiology	8	(3.7)
Nuclear Medicine	6	(2.8)
Cardiac	6	(2.8)
Thoracic Imaging	5	(2.3)
Oncology Imaging	5	(2.3)
Cross Sectional Imaging	5	(2.3)
Interventional Neuroradiology	4	(1.9)
Vascular Radiology	3	(1.4)
Chest Imaging	3	(1.4)
PET	2	(0.9)
Pelvic Imaging	1	(0.5)
Gynaecological Imaging	1	(0.5)
Total	**215**	**(100.0)**

*Respondents could input multiple sub-specialty fellowships

Respondents were asked how long each fellowship took in months. Respondents could select a range of months between 1 month and >12 months. The results (Table 4) show that on average, respondents took 10.6 months to complete their sub-specialty fellowship and that the most common fellowship durations are 12 months, 6 months and >12 months.

Table 4: Duration of Sub-Specialty Fellowships Undertaken*

	Fellowships Taken	
Duration (Months)	**n**	**(%)**
3	5	(2.5)
4	1	(0.5)
6	48	(23.5)
7	4	(2.0)
8	2	(1.0)
9	6	(2.9)
10	2	(1.0)
11	4	(2.0)
12	106	(52.0)
>12	26	(12.7)
Total	**204**	**(100.0)**

*Respondents could input multiple sub-specialty fellowships

The country in which these fellowships were undertaken was also asked (Table 5), with the most common countries being Australia, Canada, US and the UK.

Table 5: Country where Sub-Specialty Fellowship was Undertaken*

	Fellowships Taken	
Country	**n**	**(%)**
Australia	132	(65.3)
Canada	23	(11.4)
US	18	(8.9)
UK	10	(5.0)
New Zealand	6	(3.0)
Singapore	4	(2.0)
India	3	(1.5)
Germany	2	(1.0)
Switzerland	1	(0.5)
Philippines	1	(0.5)
South Korea	1	(0.5)
Ireland	1	(0.5)
Total	**202**	**(100.0)**

*Respondents could input multiple sub-specialty fellowships

Respondents were asked if they were currently undertaking a sub-specialist fellowship. A small portion of respondents (14.4%, n = 29) indicated that they were currently undertaking a fellowship. Like the respondents who indicated that they have undertaken sub-specialist fellowships, these respondents also indicated their sub-specialty areas with a range of 1-4 sub-specialty fellowships being completed. The common sub-specialty areas were MSK (17.5%, n = 7), Breast Imaging (17.5%, n = 7), Neuroradiology (15.0%, n = 6) and Interventional Radiology (12.5%, n = 5).

Respondents were also asked about the duration of each fellowship that they were undertaking. Respondents could select a range of months between 1 month and >12 months. The results showed

that on average, the duration of a sub-specialty fellowship was 11.3 months and that the most common fellowship durations are 12 months (62.8%, n = 27), 6 months (16.3%, n = 7) and >12 months (11.6%, n = 5).

The country in which these fellowships were undertaking was also asked, with the most common countries being Australia (60.0%, n = 24), Canada (17.5%, n = 7) and the UK (12.5%, n = 5).

3.4. Dual-trained Nuclear Medicine

A small number of respondents (4.95%, n = 10) indicated that they were currently undertaking accredited Nuclear Medicine training.

For respondents who were not considering Nuclear Medicine training, 57.0% (n = 98) indicated that they were not interested in Nuclear Medicine, 25.6% (n = 44) thought that the duration of the training program was too long or said that they didn't want to do any extra training, 5.8% (n = 10) indicated that they were occupied with other matters and 2.9% (n = 5) said that they would only be interested in PET and would do PET training as a separate program.

3.5. Employment

Respondents were asked whether they were offered a consultant position, which they accepted, before looking for employment. 41.2% (n = 63) were not offered or did not accept a consultant position, 30.1% (n = 46) were offered a consultant position but not at their training site and 28.8% (n = 44) were offered a consultant position at their training site.

Respondents who were not offered or did not accept a consultant position were asked how long they spent looking for a position and their expectations (Table 6). Expectations on time taken to find a position were evenly spread between 0 to more than 12 weeks. More than a third of respondents (39.7%, n = 25), however, indicated that it took them only 0-2 weeks to find a position.

Table 6: Time Spent/Expected to Find a Position

	Time Spent		Time Expected	
Time Period	**n**	**(%)**	**n**	**(%)**
0-2 weeks	25	(39.7)	13	(21.0)
2-4 weeks	10	(15.9)	11	(17.7)
4-8 weeks	10	(15.9)	13	(21.0)
8-12 weeks	10	(15.9)	12	(19.4)
> 12 weeks	8	(12.7)	13	(21.0)
Total	**63**	**(100.0)**	**62**	**(100.0)**

Respondents were asked how many public and private positions they applied for (Table 7). The majority of respondents indicated that they applied for 1 – 2 public positions (75.8%, n = 47) and 1 – 2 private positions (75.4%, n = 43).

Table 7: Number of Public/Private Positions Applied

Number of Positions	Public		Private	
	n	(%)	n	(%)
0	1	(1.6)	2	(3.5)
1 - 2	47	(75.8)	43	(75.4)
3 - 5	13	(21.0)	10	(17.5)
6 - 10	1	(1.6)	1	(1.8)
11 - 15	0	(0.0)	1	(1.8)
Total	**62**	**(100.0)**	**57**	**(100.0)**

1 respondent who was “not working as a radiologist but looking for such work” was asked similar questions. They indicated that they have been looking for employment for 4 – 8 weeks, expected the search to take 0 – 2 weeks and have applied for 1-2 public positions and 1-2 private positions.

3.6. Work Status

Respondents were asked about their current work status. The majority of respondents (94.9%, n = 150) indicated that they were “currently working as a consultant radiologist”. 3.8% (n = 6) respondents indicated that they were “not working (due to parental leave, sabbatical, etc)”, 1 respondent indicated that they were “not working as a radiologist but looking for such work” and 1 respondent indicated that they were “working as [a] radiology registrar”.

Respondents were asked to comment on their number of work sessions. The majority of respondents (83.1%, n = 113) said that they were working “about the right number of sessions”, 14.0% (n = 19) respondents indicated that they were working “too many sessions” and 2.9% (n = 4) respondents said that they were working “too few sessions”.

Respondents were asked on their employment status; whether they were working full-time or part-time and whether they were public or private (Table 8). 75.8% (n = 116) of respondents said that they were working full-time. 40.5% (n = 62) of respondents indicated that they were working in private, 23.5% (n = 36) indicated that they were working in public and 35.9% (n = 55) indicated that they were working in both public and private.

Table 8: Employment Status

Employment Status	Responses	
	n	(%)
Full-time (Public)	28	(18.3)
Full-time (Private: corporate)	34	(22.2)
Full-time (Private: independent practice)	14	(9.2)
Full-time (Public/Private)	40	(26.1)
Part-time (Public)	8	(5.2)
Part-time (Private: corporate)	9	(5.9)
Part-time (Private: independent practice)	5	(3.3)
Part-time (Public/Private)	15	(9.8)
Total	**153**	(100.0)

The 37 respondents (24.2%) who worked part-time equate to 26.6 FTE clinical radiologists (11.8FTE in public; 14.8FTE in private). 82.9% (n = 29) reported that they had a “personal preference” for part-time employment, 1 responded that they were “unable to find a full-time position”, 1 indicated that they had other part time employment and 4 had other reasons, such as parental responsibilities and work overload. 45.9% (n = 17) of respondents were female while the genders of 18.9% (n = 7) of respondents could not be determined.

3.7. Rural/Regional

74.8% (n = 151) of respondents were asked if they were working in a rural/regional or non-tertiary (New Zealand) area. 21.9% (n = 33) work and reside in the same area and 7.3% (n = 11) work but do not reside in the same area.

Respondents who were not working in rural/regional or non-tertiary areas were asked whether they would consider working in these areas. 63.9% (n = 69) would not consider it.

Three main factors emerged as to why rural/regional or non-tertiary areas would not be considered:

- Family (e.g. partner’s career, children’s education, family support networks);
- Preference for lifestyle in metropolitan areas
- Limited opportunities in rural/regional areas

A number of respondents noted that they are not interested or have conflicting lifestyle choices.

Respondents who considered working in rural/regional or non-tertiary areas (36.1%, n = 39) were asked the conditions they would require before considering working in a rural/regional area. The main conditions were salary bonuses (n = 24), access to leave to return to city (n = 19), ability to return to employment in a city (n = 18) and short travel time/distance (n = 16).

3.8. Job Satisfaction

74.3% (n = 150) of respondents were asked to rate their job satisfaction. Out of those 150, 78.7% (n = 98) were satisfied or very satisfied, 14.7% (n = 22) were neutral or unsure and 6.7% (n = 10) were dissatisfied or very dissatisfied.

16.7% (n = 25) of respondents qualified their level of satisfaction, including comments related to work overload (n = 4), not working in their desired position/sector (n = 3), poor remuneration in the public sector (n = 2), uncertain future for radiology (n = 2) and understaffed departments (n = 2). 1 respondent indicated that they currently have a good work/life balance.

3.9. Training Satisfaction

When asked if they were “satisfied with the training [they] received”, 64.4% (n = 38) of respondents agreed with the statement, 20.3% (n = 12) strongly agreed with the statement and 15.3% (n = 9) were neutral or unsure.

Some respondents commented that they didn’t get enough training in MRI (n = 3), while other respondents felt that the training was variable and the effectiveness of said training was dependent on several factors, e.g. working in private/public, hospitals in which training was undertaken (n = 3). Some respondents commented that they were very satisfied with the training they received (n = 2).

3.10. Career Satisfaction

When asked if they were “satisfied with [their] career choice”, the majority of respondents strongly agreed (46.7%, n = 28) or agreed (46.7%, n = 28). 6.7% (n = 4) of respondents were neutral or unsure.

When asked to comment, 2 respondents commented that they were satisfied with their remuneration and career opportunities and 1 respondent said that they were satisfied with radiology but would have preferred to pursue interventional radiology. 1 respondent commented that they were unsatisfied with the 10-year moratorium for IMGs.

3.11. Awareness of 2014 radiology Workplace Survey Results

When asked if they were aware of the following results of the College’s 2014 Radiology Workplace Survey, 56.7% (n = 34) answered No and 43.3% (n = 26) answered Yes:

> *High demand for generalist radiologists (particularly those who have a subspecialty skill in MSK, Tier B intervention and/or breast imaging),*
>
> *High demand for: on-site non-metro radiologists to replace off-site (teleradiology) reporting of non-metro studies; nuclear medicine radiologists; radiologist prepared to work after hours to provide on-call services (whether by teleradiology or on-site)*

3.12. The Job Market

Participants were asked to comment on their thoughts of the current job market in Australia/New Zealand. 115 (55.4%) respondents provided comments.

47.8% (n = 55) of respondents believed that the demand for radiologists was healthy.

9.6% (n = 11) of respondents commented that the public jobs were scarce;

> *“For the past few years, overall there's [been] limited public positions when compared to private, which we've been told is due to dhb funding. I think this will be detrimental to our public system if it continues for more than another 2 to 3 years. Even over the past 2.5 years, I have noticed quite significant increase in our workload and yet we cannot employ more people to meet the demand. We will soon all be overworked and [I] personally will think [a] change in workplace [is needed] to improve work-life balance”*

7.8% (n = 9) of respondents said that there was an oversupply of trainees and 6.1% (n = 7) believed that there will be an oversupply of radiologists in the future.

6.1% (n = 7) believed that there was decreasing demand/oversupply of radiologists in metropolitan centres.

6.1% (n = 7) commented that the increasing corporatisation of radiology and increasing trend to hiring multiple VMOs was an issue:

> *“Increasing trend to hiring of multiple VMOs (at half pay rates) to perform the job of a full time consultant as a cost-cutting exercise is concerning and should be limited to specific indications.”*

"I feel that tertiary public hospitals are being forced to degrade their services owing to funding constraints. Tertiary hospitals in Victoria appear to preferentially hire VMO's on lower wages rather than full time specialists, which discourages candidates working in the public system, and forces them into the private system."

"Too much corporate involvement. Corporations spending millions for computerized reporting. Which I believe should be contained and controlled as Radiology is our job and livelihood. Number of trainees is planned based on Oncall roster satisfaction vs future job security."

4.3% (n = 5) believed that there is currently a demand shortage for radiologists:

"It is not as good as 5-10 years ago when you were given a job at the hospital you trained at before you even finish. There seems to be more and more people looking for work and it is hard to find a job. If this trend continues then wages will decrease. There are too many trainees currently."

3.5% (n = 4) perceived that there was a supply shortage in rural areas.

Overall, while it seems that a good number of respondents were happy with the current job market, the majority still do have some concerns on the health and future prospects of the job market for radiologists.

3.13. College Improvement and Further Comments

Respondents were asked to comment on where the College could improve and to provide any further comments.

67 (33.2%) respondents provided advice on where the College could improve. 17.9% (n = 12) believed that the College should provide more information/insight into the training and employment process and provide more education opportunities:

"Provide real life stories/experiences on what its really like to try and find fellowships/a job and what work and life as a consultant radiologist is really like - this hasn't been done at all, to my knowledge."

"Felt at the end of my training, there were certain areas I did not feel as confident in - did not get enough experience in. I wasn't rostered in these modalities as often as I would have liked but since I had completed and passed my exams, other registrars who still had their exams had first preference in these areas."

"Should arrange some hands on [workshops] for MSK interventions ultrasound and CT guided, breast and other interventions [throughout] the year so that we have plenty of choices available to attend and increase our experience."

"Transition to consultant is poorly managed. As soon as the part 2 exam is done the college provides not further guidance or support. Education sessions on how CPD points work, options about medical indemnity insurance, help for overseas fellowships are all lacking. This is especially disappointing considering the training has increased by a year which is spend essentially as workhorses for the public hospitals."

13.4% (n = 9) said that the College should perform more advocacy work:

"The college needs to provide leadership and advocacy for radiology broadly. Which means defending the services we currently provide and looking to actively take over other services."

11.9% (n = 8) indicated that the College should limit the influence on radiology by non – radiologists and ensure that non – radiologists also maintain the same standards as radiologists when performing the same tasks/procedures:

"We need to safeguard our specialty from other specialties taking over imaging. For example CT coronaries. In our institution, this is now almost fully controlled by cardiology and we have to limit the number of radiologists who can read them as we cannot meet the number of studies needed as per college policy to remain accredited. I understand the cardiologist do not have such criteria for their college and as long as they've done a previous fellowship in imaging with adequate numbers, they don't have annual criteria to remain accredited. I think if we are going to allow other specialities to delve into imaging, they have to be accredited by the same criteria and I think the college needs to push for this and come up with a policy to this effect. We are seeing obstetricians reading ultrasound and signing themselves as sonologists, but I personally know of a case where a mother almost died due to their mistake and because they disregarded radiologists' opinions, and somehow was not held accountable. Even worse, our trainees are now not allowed to scan in their high risk maternity clinics due to limited numbers but their trainees come to us to do scans. I think if we let others do imaging without the required duration of training or exams to make sure they are competent, we are not only putting patients in harms way, we are weakening our specialty and people will start to forget we are physicians too. And honestly, if we have pathology as a part of our part two exams as it makes us better radiologists, it is only fair if other specialties who wants to do imaging sits an equivalent exam station examined by radiologists before they can start reading any scans, which I think should still have radiology input. We have to do a pathology mcq and viva but we will never be so brazen to pretend we can interpret microscopic slides, so why are we allowing others to do so with our specialty?"

"Advocate for quality over quantity. Rebates should be indexed (sooner than 2020). Widespread bulk billing should be discouraged as this leads to a need for bulk throughput to maintain revenue. The uneven playing field of MRI licensing should be overthrown as it gives unfair competitive advantage to longstanding (corporate) practices). And finally, ownership of radiology practices should be by radiologists only (as it is for pharmacies) - not [miscellaneous] corporate companies and shareholders who only care about profit margins. Currently radiology prioritises quantity far too much and it is eroding quality and our reputation as a profession."

"Aid in maintaining the quality of radiology work, which in my opinion continues to be stretched by the ever increasing demand to report more in private practice. I'm not sure if there is a role to be played by the college to somehow govern/restrict the quantity of reports performed by a radiologist on a daily basis to maintain a certain level of quality."

"To have an enforceable standard for those that manage radiologists. Corporates seem to get away with doing what they like to young radiologists who are just looking for employment. Using their impersonal model to demand more and more work for the same pay while not giving any regard to the radiologist's well being."

"I feel very pressured to cut corners in private practice … I would like the college to be more proactive is ensuring our skill base is being protected and not eroded by technicians, and also ensure appropriate standards be maintained"

6.0% (n = 4) advised that the College should standardise the exam/accreditation system:

"1. [Overhaul] the Part 2 exam which is not a fair exam. You could fail the exam with a reasonable knowledge and you could pass it with not knowing enough. I believe in "" the same case the

same examiner"" for each candidate. 2. To develop a standard approach in qualifying the overseas graduates specially with the current saturating market for radiologists."

"Quality of training is very variable. Achieving a uniformly high standard should be priority."

3.0% (n = 2) believed that there should be more public awareness on radiology:

"There still remains a very low level of awareness in the general public as to who we are, in particular who interventional radiologists are. I think we could do more to publicise who we are. Added to this, our junior medical staff also have an embarrassingly low understanding of radiology/radiologists. I have surveyed our interns for the last 2 years and overall there is an appallingly low. 64% of interns consider their general radiology knowledge as either poor or nil. 90% of interns consider their IR knowledge either poor or nil. 93% were taught what angiography/plasty was by either cardiology or vascular surgery. 94% of interns thought the most important factors for student exposure to IR are general radiology departments and lectures, but a small minority have ever had a radiology elective and radiology rarely gets a mention in lectures at medical school. I don't know if it is strictly the role of RANZCR, but we probably need to promote our specialty in medical schools by making sure we have good representation in lecture halls and clinical attachments."

3.0% (n = 2) believed that the CPD system should be streamlined:

"CPD documentation system is too clunky and not streamlined or user-friendly. It is an extremely inelegant system."

Respondents were also asked to provide further comment concerning the radiology workforce in Australia/New Zealand. Notable comments are provided below:

"The radiology workforce can be a set of complex issues and [it's] not the same experience for everyone. The questions in this survey may not be exposing the true issues, though hopefully people's answers in the free text can give the College a better idea of what [it's] like."

"Regional radiologist recruitment is a real concern. Teleradiology, while a sufficient stop gap measure, is not a sustainable solution. From experience and from feedback from our referring clinicians, the telerad experience falls well short of locally based radiologists. While subspecialty imaging is important in major centres, good generalists are worth their weight in regional centres. The quality of AON/DWS rads varies wildly. We need some way to get local grads to head regional? Incentives? Establish formal links with subspecialty imagers in major centres for more support (most important for small dependants)."

"The college needs to work harder to accredit more training sites outside the main cities, such that there is a more even distribution of radiologists. Trainees who train in the country are more likely to work in the country!"

4. CONCLUSION

As with respondents of the 2011 Trainee Exit Survey, graduates who exited the RANZCR training program between January 2012 and September 2016 raised concerns about the current job market, particularly with the scarcity of public jobs and the increased number of trainees entering the training program. Increase in trainees and scarcity in public jobs makes the market more competitive, particularly in the larger Australian urban centres (Sydney, Melbourne and Adelaide in particular), and the public sector. Compared with the 2011 Survey, a greater proportion of the 2016 New Fellows Survey respondents expected to take more than 2 weeks to find a position; however, the distribution of the duration spent looking for a position was similar between the 2016 Survey and the 2011 Survey. The proportion of respondents expecting their job search to take 2 weeks or less has decreased since 2011 which may indicate a growing perception of a tougher and more competitive job market.

Rural and regional workforces remain a topical issue. As was the situation in 2011, respondents acknowledge that jobs in these areas are available; however, salary, distance, opportunity to return to metropolitan centres and/or employment in metropolitan centres were identified as the key incentives for recently graduated radiologists to move to these areas.

Respondents to the 2011 Survey believed that there were too many trainees in the system and concerns that the market would be “flooded with graduates in the next few years”. Five years on and there are still similar sentiments being echoed. Increasing corporatisation of radiology and worsening working conditions for radiologists were new issues that have emerged since the 2011 Survey.

Nearly twenty-five percent of the 2016 Survey respondents reported working part-time, almost one and half times the proportion of those who worked part-time in the 2011 Survey. A lower proportion of part-time radiologists are female (70% in 2011; 46% in 2016), although this should be considered with the fact that the genders of several respondents could not be identified. Modernisation of the workforce remains a major (but not the only) factor in early career working hours. The RANZCR will continue to monitor this to ascertain whether this is a clear trend.