

Meet Bill Culp

Julia Gates, MD



William “Bill” Culp, professor of radiology and surgery at the University of Arkansas for Medical Sciences, practiced general radiology for nearly two decades before completing an IR fellowship at the age of 52 to “feel whole” and undergo a career change. Over the last 15 years or so, Bill has collaborated on nearly 50 peer-reviewed papers, on most of which he has been the first author. Bill has attracted nearly \$3 million in grant funding, the largest of which was in excess of \$2 million for “Ischemic Stroke Treatment With Microbubbles, a Novel Clot Lysis Therapeutic,” NIH/NHLBI. Since 2005, Bill has applied for and received two patents. This year, Bill was awarded his department’s Teacher of the Year prize (although he maintains that it was by accident). Bill is the father of five and has inspired one of his sons to follow in his peripheral interventional footsteps: having just completed medical school, his son intends to pursue a career in interventional cardiology. I recently discussed these experiences with Bill.

Why private practice?

I had a growing family and did not want them to grow up in a city. Good schools and living conditions were the primary push at that stage of our lives.

Why a change to academic practice?

There had to be more than turning the crank for really good pay. The large amount of income was actually embarrassing to me. The focus on that by the businesspersons of our group was not why I got into medicine. I was more at home seeing an interventional patient and doing something for that patient than comparing a series of CT studies documenting the growth of a patient’s cancer.

Would you recommend a similar path to people finishing a fellowship?

Everyone gets to make their own mistakes! I could have a lot more success in academics with another 10 years to spend here. I could have made a lot more money in private practice had I stayed there. We are not locked in to any single path. My path—19 years in private, 14 years in academics and 2 years of sailing along the way—is certainly not a bad one. Each part taught me lots. Each had real value. Each has really good people involved who can be fun to be around. Private practice gave me the financial ability to do some things in academics. It seems to have worked out well.



**“IR is not simulators
and computer games.
It is medicine.”**

William Combs Culp, MD

What advice would you give to people with educational debt, high mortgages and young families?

Debt is a huge problem. While there are some loan forgiveness programs out there for researchers, most simply have to pay them off. I find that our young docs are almost slaves to their debt. I recommend reading and following the ideas in “The Millionaire Next Door.” Much of this debt is avoidable. The rest can be tolerated at average pay levels of academic places. The problem is one of much richer private practices raising expectations and souring the academic situation that is actually OK to good. But, I certainly understand that making two or three times the income has real appeal. I make one-third of what my old group is making. They fly first class. I sit in the back, even going to Europe. (I do get to stand up at the podium when I get there.) Enjoy the kids when they can be enjoyed. They grow up and get into their own lives (and have scattered from Arkansas to Anchorage). This paraphrases my grandfather’s advice from a 1935 book he wrote. Same problems then and now. Biggest problem I have been unable to solve—besides stroke.

What is your pet peeve about IR?

I do not get to establish a good doctor–patient relationship very often. The load of too many cases makes that very hard now. I need to have a human to relate to—not just a figure under a drape.

What is your pet peeve about IR training for residents?

Many residents seem to excel at computer games and not relating to human patients. A few years ago I discovered that passing the boards is only a computer game now. Some of the worst IR residents (who literally could not stick a needle in a patient) got great scores on boards because they did computer prep very well. Book smart and hopeless in the procedure room are not why an interventionalist is on this earth. Still, some residents are wonderful in dozens of ways including the good hand-eye coordination of doing procedures and justify the effort of teaching them.

What is your pet peeve about IR training for fellows?

Fellows are even better. They like procedures. Now, if they learn to develop a doctor–patient relationship and are not just technical wizards, they can eventually claim to be real human beings. I have seen most of our fellows continue learning technique after graduation. That is expected. The ones who learn about their own personal mission in life after a few years in practice are even luckier. Often a particular patient or particular problem will give us that education and focus. A focus makes a lot of things fall into place. A life without

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focus cannot excel. But, I cannot teach that in a formal training program. Each resident or fellow must find his or her impossible dream on one's own, and then, try to make it possible. That is called research for some. Or, practice for others. Or, teaching for others. Or, a calling of a different flavor for others.

What do you recommend to people in small or non-academic or geographically remote institutions who want to do research (i.e., is there a way to circumvent a large medical center home base)?

It is very hard to do research without the research community around you. On the other hand, it forces one to do his own scratching all over the world for help. You meet some very interesting folks that way. The Internet is a huge advantage we enjoy now. It has greatly reduced the requirement for a complete on-site research community. That concept is as outdated as the 1950s. We currently have three R01 proposals in review and two of the three have more than one-half of the work scheduled to be done on other campuses. Good collaborators can be found anywhere in the world. Still, I *really* envy those with a tradition of good research and a department machine to accomplish it. I just would not choose to live in a big city to gain that advantage. It is not worth it to me and is not really necessary. Half a dozen people can be gathered in any little place—even Little Rock—and, with that core group, real work can be done.

The lack of mentors is the single biggest problem in small universities. A good mentor could have made my work go twice as fast. This might be a way for SIR to really help, arranging contacts along this line. (If I were a young researcher working down the hall from someone like N. Goldberg, I would be twice as excited, twice as productive and three times as tired.) The lack of time is not restricted to small places. That is a universal problem and really ranks second only to the lack of mentors. My private practice days have allowed me to take a cut in pay to ensure my research time is protected. That is an important line to draw in the sand. Otherwise, there is always another clinical case that requires attention. Time, time, time: last week I did more than 91 hours on the clock. But, if it was not what I wanted to do, it would have been zero.

Where do you see IR in 10 years? In 20 years?

Ten years is a long time and at the same time, just a blink away. We will be even more essential to patient care. We pick up procedures and do them better, and other services forget how to do procedures. Even the largest pleural effusions now come to us. What I drained blind on the floor as an intern in 1968 is now a special procedure in IR. Crazy, but that is what is happening. We had the pleasure of building IR in the 70s and 80s on a vascular foundation. You and others will have the pleasure of rebuilding it again and again over the very long future it will enjoy. Ten years, 20, it doesn't matter. If we have tricks in our bag, we will be fully employed. The only question is, "What tricks will they be?" You and others will certainly lose the old tricks as they become commodities. You have the opportunity to develop and define the new ones yourself. Choose well and it will be rewarding.

Where do you see fellowship programs in 10 years? In 20 years?

Fellows want to have a sure thing to learn and permanent turf, as we all do. But life is not that way at all. We define what we do by our ambitions and our efforts and our dumb luck. The downturn in fellows makes no sense to me at all. I have never been busier, my days never longer. And 90 percent of what I do now did not exist when I was a resident. Fifty percent did not exist when I was a fellow 15 years ago. Come on, folks, it is a changing world, always has been, and we thrive with change if we are leaders. If we are not going to lead, someone will run right over us and rightfully so. How do you become a leader? Do some research; clinical research has direct application and can be done anywhere. Do what Barry and Ernie and Dick and a long list of others have done so well in areas that interest you. That is what they did and they rebuilt medicine. If you are worth your salt, you too will contribute. And, be active in the Society. Folks who fight in the reimbursement wars and standards and turf issues are real heroes. They get no positive feedback from patients to support them in the middle of a too-long day. They are exceptionally valuable to us all. Support SIR and SIRD with your service as well as your dollars. Participate and the future will be what you make of it.

What is (are) the best aspect(s) of IR?

First, the patients I get to work for. They educate me so often about what really matters. Then the people we get to work with and their dedication! The list of exceptional people in medicine is endless. And, I get to associate with them! What a treat! (You may wonder where science, research and procedures went on this list. Tools of the trade are what they are. Though I take real pride in a procedure well done, the real focus is human.)

The real question is "What are you called to do?" If you are a super teacher, teach. If you are drawn to research, research. If you are called to deliver medical care to the folks who need it, practice clinical medicine. If you are called to making money, there is a special place for those who are greedy too. The money varies a great deal in these areas, but the satisfaction of knowing that you are doing what should be done is a huge reward.

If you are not sure, practice clinical interventional radiology for a while and learn the rewards of taking care of your own patients. I have really been educated by some folks in their last days of life, draining bile and attacking their tumors together. Until the super students we get in radiology experience this on their own, they may just be sterile machines instead of caring physicians. Some dying folks really know how to live. Read *Tuesdays with Morrie*.

For a take-home message, Bill said that his biggest unfulfilled ambition is to witness a resurgence in academic radiology with first rate IR faculty filling the dozens of empty positions awaiting them across the country. "This is the weakest link and the biggest hope for our specialty." ♦