Episode 37: Leading Through Crisis
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Dr. Rubin: Hello and welcome to "Taking the Lead," a podcast from the Radiology Leadership Institute that profiles radiologists as leaders, seeking insight and inspiration from a variety of perspectives and experiences. I'm Geoff Rubin. Today, I'm speaking with Dana Smetherman, a breast imager who serves as the chair of radiology and associate medical director for the medical specialties at Oschner Medical Center in New Orleans, Louisiana.

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Dr. Smetherman chairs the breast commission of the American College of Radiology and is a member of the board of chancellors of the ACR. She has served as president of the Radiological Society of Louisiana, board member for the National Accrediting Program of Breast Centers, chair of the Technical Exhibits Committee of the Radiological Society of North America, advisor to the Current Procedural Terminology Panel of the American Medical Association, and board member and schools and scholarships chair for the Harvard Club of Louisiana.

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Dr. Rubin: Dana, welcome.

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Dr. Smetherman: Thank you. Thank you so much for having me.

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Dr. Rubin: We are delighted to have a chance to speak to you today. Let's first explore your origins. Where were you born?

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Dr. Smetherman: I was born in New Orleans.

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Dr. Rubin: How about that? Fantastic. And what did your parents do for a living?

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Dr. Smetherman: My father is a lawyer and my mother is a teacher. She's both an English and speech teacher and she was a dancing teacher.

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Dr. Rubin: Okay. And so when you were growing up, both of them were working outside the home?

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Dr. Smetherman: Oh, yes. My entire life. In fact, my mother only retired about two years ago. My father has been retired a little bit longer, but he still works a little.

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Dr. Rubin: And were they in New Orleans for their entire life too?

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Dr. Smetherman: Pretty much, yes. They were both born in New Orleans. We did wind up moving to Houston when I was in grammar school. But other than that, both of them have lived in New Orleans their entire lives.

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Dr. Rubin: So how many generations back do you go?

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Dr. Smetherman: Quite a few. Three of my four grandparents were born in New Orleans and I think all but two of my great-grandparents were born in New Orleans. Now, that's a little bit inaccurate. My mother's father, my grandfather, was actually born in a little town called Sheraton, Louisiana, which is about two hours away, so. But lots of Louisiana roots.

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Dr. Rubin: Yeah. Yeah. That's fantastic. You know, growing up, was it your sense that most of the people that you came into contact with also had deep roots in Louisiana?

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Dr. Smetherman: Yeah. You know, Louisiana and New Orleans, in particular, tends to be a place where people either don't leave or they tend to come back. And so it is quite common for many of the people that I knew growing up to have all of their grandparents living there. No multiple generations, no great aunts, great, great aunts, lots of cousins. So yeah, it's still that way to a certain extent.

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Dr. Rubin: When you were growing up, did you have a sense that you were growing up in a rather unique place?

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Dr. Smetherman: I will say that I did once we moved to Houston, which was at that time, particularly where we lived, was a less unique place. So my father was an attorney. He worked for Shell and as with many of the big oil companies, wound up moving to Houston in the '70s. When we got there, actually none of our neighbors were from Houston. They were from California, they were from New Jersey, they were from Boston. They were from all over the place, but there was almost nobody who was actually from Houston. And I was not accustomed to that because up until that point, when we lived in New Orleans and actually afterwards, pretty much everybody that we knew was from New Orleans had been born in New Orleans. So I think I realized then...I think our childhood in Houston and in suburbia in Houston was a much more kind of generic American kind of childhood.

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Dr. Rubin: How about brothers and sisters?

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Dr. Smetherman: I have three younger sisters.

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Dr. Rubin: Okay. How much younger do they go?

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Dr. Smetherman: So I have one sister who is a year younger than I am, I have a sister who's two years younger than I am, and then there's a gap, and my youngest sister is nine years younger than I am. So we had three in a row and then a gap and then a caboose, basically.

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Dr. Rubin: Yeah. So what was life like for you growing up in New Orleans being the oldest of three sisters?

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Dr. Smetherman: Yeah. My parents always say that there was a lot of conversation in our house. We were a pretty talkative bunch, but it was really tremendously fun. I think it was wonderful having two siblings who were so close in age because you could always play games kind of at the same level. And we had my mother who, as I said before, was a dancing teacher. When I was young, before we moved to Houston, her dance studio was in our house. And so we had a basement and that's where the studio was. And so, you know, we basically had this big dancing studio that was in our house with ballet bars and all of these things. And a lot of our friends would come and they were in our dancing classes. So that was fun. And it was big enough that we were able to learn how to roller skate and actually ride our bikes inside. And it was really convenient to learn how to roller skate if you could hold a bar that went all the way along the wall. So it was fun. It was really tremendously fun. And then my youngest sister was actually born when we were living in Houston. And I think when you have a big gap like that, there really isn't much sibling rivalry because it's like, you know, it's everybody's baby, right? And so that was really, really fun too.

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Dr. Rubin: It must've been hard for you guys to leave that big room with the dance studio and such?

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Dr. Smetherman: It was. You know, we did miss it. Although there were many, many things that we loved about living in Houston and living kind of a much more typical American suburban lifestyle. And, of course, we missed our family because all of our relatives were still in New Orleans. Although we made many friends, some of whom we're

still friends with when we lived in Houston, but then when we moved back when I was kind of at the end of middle school, you know, we were thrilled to be back home. You know, we went back for Mardi Gras every year when we were growing up, living in Houston, and went back for a lot of holidays and things. And my parents both just, you know, loved New Orleans, loved the culture, loved the food, all of that. And so even when we were living in Houston, we did come back, you know, many times a year to see our family members.

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Dr. Rubin: Would you say your love of New Orleans runs as deep as your parents?

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Dr. Smetherman: I think so. You know, I definitely, when I was in high school, I don't know that I envisioned myself living in New Orleans forever, but every time I was at a fork in the road, whether it was after medical school or when I had been in neurology residency, I switched into radiology and I was up in Connecticut at Yale. The better option was to come back to New Orleans, to Oschner, which is where I still work, to do my radiology training. After hurricane Katrina was kind of another fork in the road, but it turned out that the right choice was to stay in New Orleans. So I definitely looked over the years but wound up back in New Orleans eventually. And I will say like for...my husband is also from New Orleans and it has really been fun for my children to be able to grow up, knowing so many generations of their family and seeing them all the time. So I think it's really enriched their experience as well.

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Dr. Rubin: Yeah. Fantastic to be able to share that identity. Getting back to the growing up years, and I guess after you came back from Houston, you mentioned the end of medical school, your high school years were in New Orleans.

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Dr. Smetherman: In New Orleans. Mm-hmm.

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Dr. Rubin: What was your first job outside the home that you can recall?

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Dr. Smetherman: Okay. Yeah. I always had jobs in high school. So I did a lot of tutoring in high school with other students. I actually worked in a warehouse in the summers. A friend of my father's, my father was an amateur pilot. A lot of his friends were pilots. He owned a plane at different times when we were in high school and then when I was an adult. And so a friend of his owned, basically an aviation parts company and they always needed extra help in the summer. So one of my cousins and I actually worked in the warehouse and did the inventory, which was an air-conditioned warehouse in the summer in New Orleans. So that was a challenge, but, you know, we worked hard. We were thrilled because it was a little bit above minimum wage, which at that time for two high school students, we were pretty happy

about that. But yeah, so tutoring. I also worked in summer camps. I had the chance to do that. So that was fun as well.

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Dr. Rubin: It's impressive that you have that strong work ethic. What would you say led to that? What made you wanna go out and earn?

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Dr. Smetherman: Well, number one, I did need money. It was nice to have a little extra spending money. So that was always fun. But yeah, I always had a lot of energy. So in the summers from the time that I was even in middle school, I would actually find different things to do. So I auditioned for...after seventh grade, I auditioned for a play that was put on by the New Orleans Recreation Department. And I got into that play. So I did that that summer. And then the following summer, I did a summer music camp that was at Loyola University and then would work tutoring on and off. The next summer I had a job as a summer camp counselor. So I think I always had a lot of energy too, and I wanted to do different things, meet different people. So yeah. I don't know, maybe I was easily bored or whatever, but I certainly, during the summers, I was never the person that was gonna be sort of just hanging out. I always wanted to do something.

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Dr. Rubin: Any leadership roles that you can recall from those days?

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Dr. Smetherman: Gosh. Yeah. So in high school, goodness gracious. Let's see. I was the president of the drama society. I had various other, you know, leadership roles in the class. I was head of like the fundraising committee. I was very involved in our school plays and musicals and regular plays. And I was often fortunate enough to have a lead in the plays, all that dancing, growing up, and some singing and stuff. And so, yeah, I had lots of different leadership roles. Often it was the job that maybe nobody else felt like doing and I would be, you know, tapped to take that on.

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Dr. Rubin: It's a theme that we've heard amongst some of our guests, but it sounds like it was just sort of internal motivation to take on these positions. You enjoy them.

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Dr. Smetherman: Yes. And, you know, and I was not...I figured out how to get from one place to other. I'd arrange carpools or, you know, I would...I took the streetcar. New Orleans has this, you know, lovely historic streetcar and Loyola where I did a summer music camp and I took some ballet lessons over the years. I was able to get on the street car and go from school. So I kind of, you know, even though my parents were obviously pretty busy, my mother with four children and working, I always figured it out. I figured out some way to get where I wanted to go. But back then you could drive at 15. And certainly, with all those

younger siblings, my parents were quite eager for me to start driving. And so I was able to drive a lot of places too. But, yeah. And it was just fun. I was delighted that I was able to, you know, to go and do all those different things.

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Dr. Rubin: Yeah. Absolutely. Now you mentioned that you were in Boston. Gaining entrance to Harvard University as an undergrad is no small feat. How do you sort of contextualize your upbringing in New Orleans and how that led you into Harvard?

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Dr. Smetherman: So, yeah. Really, really interesting. Both of my parents went to Loyola. So no one in my family had really gone away anywhere out of state for college. But, you know, I worked really hard. I had good grades, had good test scores and actually, I had some idea that I wanted to be a doctor. And one of my friends from Houston, her father was a doctor. And so as I was kind of going through, looking at colleges and different things, you know, I talked to my college counselors and my parents said, "Why don't you give Dr. Gato a call and just see if he has any thoughts about where you might wanna go to college?" And I was like, "Oh, yeah. Okay." And so, you know, I talked to him and he was like at, "Well, what are your sat scores and what are your grades?" And he was like, you know...and I was thinking, "Well, I might wanna go out of state. Like maybe I'll go back to rice."

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And he goes, "I think I should apply to some Ivy League schools." And I was like, "Well, okay. I hadn't really thought of that, but, you know, sure. Why not?" And then was fortunate enough to get accepted to several and decided to go to Harvard. It was very, very different from where I had lived growing up, but just would not trade those four years for anything. Just absolutely cherish that time and made so many friends, so many people that I'm still friends with. I have been able to be, as you mentioned, involved in the Harvard Club of Louisiana and, you know, made a lot of friends that way too. So just really enriched my whole life.

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Dr. Rubin: If you were to sort of touch on one or two nuggets from those years that really give you that strong, you know, sense of appreciation, what would they be?

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Dr. Smetherman: Well, you know, definitely my four roommates who it was just wonderful getting to know all of them. I'm still friends with all of them. We get on Zoom calls at least once a month. And then also my house, I was in Winthrop House, which I just adored. I have many, many friends from there as well, and we had lots of different house activities, again, house plays and musicals, always continued to do that. And, you know, just being in the dining hall there. We had lots of parties in the house. So, you know, really just enjoyed that community.

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Dr. Rubin: Super. Now, I mean, you were so engaged in a lot of extracurricular activities in high school. Did that continue when you were at Harvard?

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Dr. Smetherman: It did. Yes. I continued. I was in the Harvard Radcliffe chorus. I, again, as we as talking about before, did musicals and plays, I actually had the chance to choreograph a couple of things, singing in some...we would have like a house, a Winthrop house, like review. And so I was able to sing in that with some friends. So yeah, I kept pretty busy. I actually rode intramural crew. That was a very distinct and unusual experience. Would never have, you know, thought of doing that when I was in high school. I also played intramural soccer. So, again, just totally things that were...nothing I really came across when I was in high school, but super enjoyable. And, you know, that's kind of what college is about too, kind of exploring yourself, trying all kinds of different things, meeting different people. So, yeah. I had a good time.

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Dr. Rubin: Sounds like you had a full experience. That is excellent. Now, I know that you studied biology and you mentioned you had an inkling that you wanted to go into medicine. What was it about a career in medicine that attracted you at that early age?

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Dr. Smetherman: So I always loved science. I loved learning about science. There really were not any other physicians in my family, but I could look at my parents and we had a lot of teachers and lawyers in our family and I'd be like, "Not really sure that's what I wanna do." And, in fact, a couple of summers during college I worked for my uncle's law firm doing work on some big trials cases that they had going on and summarizing depositions and I could see that I just didn't think that that was gonna be that interesting in the long haul, you know, these cases would stretch on for years, and years, and years and years. And, you know, I could just see, I'm not really sure that that's gonna be something that's gonna make me happy in the long run. So, yeah. I liked science. Did have the chance to work one summer at LSU Medical School. Worked on a little project about asbestos and got to spend some time with the oncologist there, including...they actually had the acting chancellor at that time, was an oncologist. So I got to work with her. And so that, I think, really solidified it for me.

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Dr. Rubin: Remarkable that as an undergrad visiting over the summer, that you managed to link up with the acting chancellor of the university.

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Dr. Smetherman: Yes. That was a very fortunate, you know, basically at that time, the Harvard Club of Louisiana had almost like a summer jobs bureau. And so if you, you know, you could basically sort of throw your name in the hat and they would see if there was anybody who was affiliated with the club who might have a summer internship or something like that. And it turned out that at that time, LSU was going through a lawsuit about some asbestos remediation that had happened and so they needed somebody to put together

basically a little pamphlet that was part of the work that talked about asbestos and asbestos exposure and the risks of that and who was at risk, etc. And so that's mostly what I did that summer, but I also got to go like on rounds in the hospital and go to the clinic. And so I got to see not just working on that project, but also really kind of getting to see what physicians did. So.

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Dr. Rubin: Yeah. Really nice. Now, you graduated from Harvard, you wanted to go to medical school, and I guess you just couldn't stay away from new Orleans any more than four years, you went right back to Tulane. Did you consider another location?

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Dr. Smetherman: I did. And actually, at the end, it was down...it was between Baylor in Houston and Tulane in New Orleans and LSU. I'd gotten into LSU. There were a couple of interesting things that you could do at Tulane. So I was able to get a master's in public health in the same four years as my medical degree. And at that time, if you were already enrolled in one graduate school, they would let you get a full scholarship if you did a second graduate degree at the same time. And the school of public health was downtown. It was right around the corner from the medical school. And so there were usually 10 or so medical students every year who took advantage of that program. And so that, you know, factored in a little bit into my decision to go to Tulane. And, you know, I wound up getting that master's in public health, which has, I think, again, enriched my career over the years, given me kind of a different perspective even as a radiologist on healthcare and practice and medicine.

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Dr. Rubin: Yeah. I'm interested in exploring that a little bit. Firstly, you mentioned that there was the opportunity to attend another graduate program but you gravitated to public health. At that moment when you haven't even yet entered medical school, what was it that you saw in the public health arena as something that attracted you?

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Dr. Smetherman: So I was very interested even then in kind of how healthcare fits into the larger context of society, how disease prevention was a part of it, how you might interact with different governmental agencies, how does it all link together? And back then, you know, it was more fragmented than a lot of healthcare is today, but that was what really drew me to it. They also had a really interesting... So Tulane school of public health is a school of public health and tropical medicine. And so that also lent itself to some interesting opportunities on the infectious diseases side. And if you were in that program, your senior year, you could do an international health rotation where you could spend three months in... They had a selection of different foreign countries and that would count as one of your internal medicine electives and potentially a pediatrics elective. And so that's what I was able to do. So that was kind of a fun and interesting opportunity as well.

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Dr. Rubin: Sounds like it. Where did you go?

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Dr. Smetherman: Belize.

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Dr. Rubin: Belize. Wow. Oh, phenomenal. And you mentioned that your MPH has influenced your career subsequently. What would you say are some of your biggest takeaways from the...

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Dr. Smetherman: I think for me eventually winding up in breast imaging, I think breast imaging is really an area in radiology where there is probably maybe the most overlap between the actual practice of radiology and public health. I've always been a very ardent supporter of screening mammography. I was fortunate enough to come into my residency and then staying at Oschner and having the opportunity to see our screening programs grow. Also partnering with my primary care colleagues and kind of developing our network of screening sites. I was also fortunate enough to be in the American College of Radiology screening leadership program. So yeah, I really do feel like my public health background has served me well as a breast imager. I will also say that it has made watching the pandemic unfold particularly interesting. So.

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Dr. Rubin: Yeah. Yeah. I imagine you mentioned the ACR screening leadership program. What was that?

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Dr. Smetherman: So I think it was in 2013, the ACR leadership, Dr. Geraldine McGinty, Dr. [Inaudible 00:23:15] and Dr. Debbie Monticciollo could see that kind of the generation of pioneers, you know, Dan Colepans and people of that ilk were getting a little more senior and they really wanted to have a group of people who were in the next generation to carry the torch. And so they put together a program and they invited, I think, it was about 20 us from all different institutions across the country to go through this really prolonged boot camp. I mean, it was about half a year. And you had to get permission from your department and the commitment that you would be able to go to this onsite media training and everything. And so we had weekly webinars and we would have reading that we would have to do, we'd have to write mock letters to the editor and then we wound up having to write real letters to the editor as various things would come out in the literature that tried to undermine screening mammography beginning at age 40.

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So it was a pretty intense experience. And then at that year at the Society of Breast Imaging Meeting, they did mock interviews for each of us and we had to go and it was as though we were being interviewed on various different screening subjects by a reporter, potentially a not-friendly reporter. So there was that simulation. And then since then, you know, we have all been very involved in all the different screening efforts, whether it was again writing

letters to the editor, writing journal articles about screening, teaching other people about screening, really trying to make sure that we all really understood the underlying science of it.

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Dr. Rubin: What a terrific initiative. It sounds like it was very impactful.

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Dr. Smetherman: It really, really was. Definitely had a big impact on my career. And I'm really grateful that, you know, they gave me that opportunity because, yes, it just was a phenomenal experience. And they've actually had additional cohorts of radiologists who were invited to join. And I actually had the chance to be one of the instructors for some of the subsequent cohorts. And we still meet, like it is still a regular ongoing program. So.

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Dr. Rubin: That's excellent. Excellent. Yeah. I mean, there's no question that breast imaging represents the front door to many health systems and is such a critical element to the care of a real major public health challenge, which is breast cancer. And so it's great that you're so engaged and at the ACR supported a program like that.

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Dr. Smetherman: Absolutely.

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Dr. Rubin: Now, your post-graduate path was an interesting one. You did a year of internal medicine at the Oschner Clinic in New Orleans and then a year of neurology at Yale, as you mentioned, and then you went back to Oschner for radiology residency. Take us through the decisions that led you on that pathway, both from a medical specialty and a geographic standpoint.

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Dr. Smetherman: Sure. So... And probably this was because, you know, we talked about that I didn't have a lot of physicians in my family. So when I went through medical school, as I went through the different specialties, I thought that probably the thing I should do was to pursue a career in the area that I found the most intellectually interesting and stimulating. And I love it reading about neurology. I really enjoyed trying to figure out what was wrong with the patient and there was a whole lot of puzzles and solving the problem. But so, you know, I was all set. You do an internal medicine internship for that and then I was at Yale doing neurology. And, fortunately, they really took a very holistic approach to what your practice was gonna be like as a neurologist. And I was probably in the last generation of medical students who had a really, really strong focus on inpatient care.

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And we did not have a whole lot of really practical outpatient training. And so what I realized is that we were incredibly good interns, but when I got to Yale and I spent a lot of time in the outpatient arena all of a sudden I realized, you know, as much as I love learning about this, and as much as I love like in the acute setting, figuring out what's going on, my personality was probably not the greatest fit for what was gonna be most of what you do, which is outpatient medicine. So at that time, there were not a whole lot of treatment options and oftentimes what the patients really needed was better social services. They needed better access to physical therapy, occupational therapy, you know, support to be able to pay for their medications. And really, you know, back at that time, there wasn't a gun great system to help them.

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Dr. Smetherman: And so it was actually... And I found myself becoming frustrated by that. And I still, you know, I think everyone around me was really surprised when in the middle of that year I was like, "I am just not sure this is the right choice for me." And they're like, "What? You're doing great." You know, I was like, maybe on the outside it seems like I'm, you know, doing just fine, but on the inside, I could just see that this was not gonna make me happy. And that was a really hard conclusion to come to. That involved a whole lot of me looking at myself in the mirror and being like, "I know that you thought in this idealized Marcus Welby version of, you know, who you were going to be, that you were gonna be in there and taking care of patients every day and, you know, impacting them and making their lives better and helping them to get better and you might be able to do that with a facade, but on the inside, this is really frustrating you.

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And so that was a lot of soul searching and that was pretty hard. And then, of course, you know, you've invested all this money you have all these student loans, you really can't start back from scratch. Nor did I want to because there were many things that I still enjoyed, but so I really kind of went back and it was like, "Well, what do you really enjoy about medicine? What do you enjoy about healthcare and where could you find a path?" And I realized that what I really enjoyed was solving the problem, figuring out what was wrong with the patient, and really that diagnosis piece. And so as I looked at other specialties, I realized that that radiology really filled the bill. Now, what's interesting, I did still love hospital medicine, but hospital medicine didn't actually exist as a specialty at that time. I think if it had, I might've done that because I really did enjoy that, seeing a patient and working with them and figuring out what was wrong with them, but that didn't exist. But I've loved radiology. So radiology was certainly the right choice for me. But it's just interesting when I think back to that time, I think if that had been an available path, I might've pursued that. So.

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Dr. Rubin: As you were pursuing your residency, which included a year as chief resident, what were your thoughts on your post-training career? Were you thinking, "I wanna be in community practice, academics," what was your sort of perspective there?

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Dr. Smetherman: I... And actually, Ochsner turned out to be the perfect place. I really wanted the middle road. I wanted to have the opportunity to be involved in academics, but I wasn't really sure having been at Yale for a year that I wanted to be in a real hardcore university-type setting, but I didn't think I really wanted to be in private practice either. And so I was lucky enough to be able to finish up my training and stay there. And it has really turned out to be a wonderful place to work and definitely a very rewarding experience and fit for me. So I don't think I went into it thinking that, but as I just kept going along further and further in my career and looked at other options I was, you know, I was delighted when they found a place for me to stay and obviously it's worked out pretty well because here we are a few decades later, still at the same institution.

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Dr. Rubin: Yeah. It's fantastic. Yeah. Truly. And you have maintained an affiliation with Tulane while being at Ochsner. What is the relationship between the two organizations? Is it formalized in any way?

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Dr. Smetherman: It's really not. We have some shared residencies, but there are a lot of us who have a clinical, you know, appointment there, which is what I have and have had for a while. And it's interesting, sometimes we spend less time with that. Sometimes we spend more, kind of depending on their needs. And we, of course, have had Tulane medical students and LSU medical students who come to us and do clinical rotations. Ochsner has an affiliation with the University of Queensland in Australia and we have American students who do their first two years in Australia and then they do their clinical years with us and actually have a clinical instructor appointment with the University of Queensland as well.

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Dr. Rubin: Nice. Now, coming out of your residency and joining the staff at Ochsner, were you identified? Did you identify yourself as a breast imager at that stage or is that something...

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Dr. Smetherman: Yes. And I was really truly fortunate to have a mentor in a physician named Gunnar Cedarbam, who was Swedish. And if you know anything about kind of the history of mammography, Sweden really had a pioneering program in mammography and screening and all of those things. And so we were so lucky to have someone who had learned mammography in Sweden come and head our department and was just instrumental in my training. I mean, even, you know, when I first joined the staff, being able to train alongside him was just phenomenal. So I mostly did breast imaging from the beginning and then a fair amount of ultrasound as well. Oschner was a big ultrasound program, always had been, still is. And I loved ultrasound too. I loved the hands-on aspect of ultrasound, and it's a big part of breast imaging. So that's what I've done most of my career, those two things.

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Dr. Rubin: And then within five years of completing your training, you became the chief of breast imaging at Ochsner. What led to that opportunity? How did that opportunity come about?

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Dr. Rubin: Well, it was about time for Dr. Cedar Bom to at least kind of step back. He went part-time and they needed someone to do it. So they asked me, I was very honored. And as often the case, as soon as I took over, we uncovered this big computer problem, and so I had to dive in and help clean up all that, you know, really early in my career, learning that, you know, you have to make sure that you're always auditing everything that a computer does. And so in some ways when you look back, it's almost at the time it did not seem like a fortunate thing, but if you, you know, right in the beginning of taking over a new leadership position, if you have to jump in and fix a big crisis, I think it does give you a little bit of street cred.

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And, again, I would never have chosen to have to do that, but, you know, it is probably a good way to establish, nope, you're the new leader, you're the one in charge of this. And then if you're able to successfully get it cleaned up, then that's also, you know, I do think that, that in the term, kind of smooth that transition a little bit. And, you know, we were fortunate, Dr. Cedar Rom[SP] continued to work for another 15 years after that. We have tremendous longevity in our department and many of our retirees are retired. Physicians stay and work PRN as he did. So he was still around and was still a tremendous mentor. But I was really the one that had to jump in and fix this problem that arose.

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Dr. Rubin: It's interesting that you relay the notion of how a crisis can help cement your role in a new leadership position. Have you ever considered manufacturing a crisis in order to...

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Dr. Smetherman: No. Absolutely not. Although, you know, it just sort of turns out that, you know, crises always come around, whether it's Hurricane Katrina or the pandemic, or whatever, but I think at least, you know, knowing too how to marshal the resources, how to get everybody on the same page, how to, you know, come up with a solution. I always had that problem-solving kind of part of my personality. But yeah, no, absolutely not. Trust me, I would have avoided every single crisis along the way if I could have.

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Dr. Rubin: Just had to ask.

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Dr. Smetherman: Good question, but yeah, no way.

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Dr. Rubin: Now, starting in that leadership position, you know, even in an advance of realizing that there was this computer crisis to manage, did you have certain aspirations or things that you sought to accomplish, stepping into the role of being chief of breast imaging?

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Dr. Smetherman: You know, I don't think so. I think at that time I was just really focused on making sure that I was able to take that mantle and continue with the excellent care that we were providing, but we had another thing that happened in the next, you know, like in short order after I took over and that was, we made the decision at the institution to invest and open a freestanding breast center that was across the street. And so there was a tremendous number of opportunities that arose with that. So it was a multidisciplinary breast center, we had the breast surgeons there, oncologists, radiation oncologists. And so that was all of a sudden a really big change as well. And so that really did provide a lot of opportunities to put new processes in place, to really form these really strong multidisciplinary relationships.

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And we were all already working together, but kind of being separate, being unto ourselves and working as a unit, I really do think that, you know, as I think about kind of the leadership journey, having to take on those challenges also was a really good opportunity for me to grow. And so we did all of a sudden start a whole lot of different programs. We put in place things like radiology, really owning that process of not only reading the screening but of navigating the patient from screening to recall from the diagnostic mammogram to the biopsy, we were the ones telling the patients that you needed a biopsy, we are the ones scheduling those biopsies. We were the ones, you know, working with our surgical colleagues to communicate the results, to get them to, you know, the next step in that process, you know, seeing the surgeon, seeing the oncologists.

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So we made a lot of changes that turned out... You know, we were ahead of a lot of other places, but we're really forward-thinking. And so I think kind of putting us all over there and being like, okay, you guys, you're working as a team, really, it turned out fantastically, but I think it did present a lot of like really quick opportunities to have to start making changes, doing process improvement. I became much more interested in quality improvement because, you know, I realized, "Oh, my gosh, we have all of these things that we need to do and we need to make sure that there aren't any patients who slip through the cracks. We need to make sure we're documenting everything that we're doing" So I had another challenge. That was more of a plant challenge, not really a crisis that gave me a lot of opportunities to kind of develop my leadership skills.

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Dr. Rubin: Yeah. It sounds like a really dynamic time. Now, you added the role of associate program director to your responsibilities in 2005, just a few months after hurricane Katrina devastated New Orleans. What was the impact of Katrina on your hospital and clinical practice?

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Dr. Smetherman: Unprecedented. I actually was on teammate. So I was there when Hurricane Katrina came. The way that we handle our hurricane call in our department at Oschner is if you are on the team that's working the weekend, then you're gonna be team A. You're what we call essential personnel. And then if you are the next weekend, then your team B, and it basically goes Friday 5:00 p.m. to the following Friday at 8:00 a.m. The reason that we do that is, number one, we know with the skill mix of people that we have on call, that we'll be able to cover all of the different modalities and studies that will be done. But also, everybody has...when it's the real thing, everybody's got some family situation that would make it difficult for them to be there. And I've always felt like we shouldn't be in the business of trying to make value judgments of whose personal situation takes priority, right?

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And so at the time of hurricane Katrina, I have twins, they were four, but I knew it was my turn. I made arrangements for them to evacuate with my family. And, again, and that doesn't mean that people don't occasionally switch, but you know it's your job. And candidly, when we interview people, we tell them, you know, hurricane coverage, you know, if you're gonna be working with us, is gonna be part of your job because it happens too frequently. So I was there. We were fortunate in that, although we got down to one generator, and at that time we just had our tertiary care hospital. That was our one hospital. But what that meant from a practical standpoint was that the red plugs still worked. So that meant the ventilators could still be plugged in the ICU pumps still worked, so you could basically have the most critical services.

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If we needed to do an ultrasound or a CT, we could do it. That we had to do things when we realized that we were losing power, like we stationed portable X-ray machines. And at that time they were see our X-ray machines with plates, but we stationed them in ICU and they had consolidated the ICU's, consolidated the PIC, and NICU. And so we'd have to actually, they'd go and take the radiographs and we'd have to run the plates down to the radiology department. We originally were handwriting our interpretations and then we were able to hook up to one foam that we could do dictations. And we all worked as a team again. It was myself and two other radiologists who were there on team A. And, you know, we had to get there in advance.

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The first morning, there was a fire actually in the institution. So they had to get the fire, turned out, water did start coming in our department, but I'm very proud to say we did not lose any equipment to flooding. We quickly, as a team went, unplugged things, covered them with, you know, plastic wrap. Two days later when the levees were breaking and water was coming in and we didn't have air conditioning, the temperature did get too high in the MRIs, so we did have to quench two of the MRIs. Although we were able to eventually get them back up, you know, several weeks later, but that was really quite an experience. We were fortunate enough that we're close to the levy, so we're on high ground and we did not flood.

Although we had water come in, we didn't have water rise up. It came very close, but it didn't flood.

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And as I said, we lost a lot of the lights, but we had the emergency lights. We did still have the red pumps. And then Oschner was prescient enough to put in a well. And so the water was not drinkable, but we were able to run the water and flush the toilets on the first three floors. And I will just say, let us never underestimate the power of indoor plumbing. And that was a huge... That might sound like a small thing. And we really were isolated. Like we were really under ourselves. They had enough food for three days. So we then had to make a deal with Walmart. There was a Walmart down the street and drove trucks and basically said, "These are the things we're taking, you know, we will pay you." And they were fantastic.

And I will say, if you had to be in New Orleans during hurricane Katrina, Oschner was the place you wanted to be. We never closed. We were able to continue to provide services the entire time. We had learned a lot from our previous hurricane, so we didn't have extra people. That's why my children weren't there, for instance. You know, it was supposed to be you and then that was it. Because when it's really the real thing, the more people that you have to take care, of in addition to just your patients and the staff that you need, the more resources you need. And so yeah, that was quite an experience. Definitely a life-altering experience. We were there.

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Another thing no one ever envisioned was that people wouldn't be able to get back to us, but, of course, they couldn't. And so we were there from Sunday morning to Friday evening. So I always tell the story, I had not ever been on the hurricane team before, but the ultrasound supervisor who was there had done a couple. And so I remember Saturday night calling her and saying, you know, "Hey, I'm packing up. You know, should I bring like what, two, three pairs of underwear, two, three pairs of slacks?" And she was like, "I'd bring five." And I was really, really glad that I followed that advice because although my house was fine, we had one broken window pane, but our neighbor's tree fell on our electrical box. So hurricane Katrina hit on August 29th and we couldn't move back into our house until the week before Thanksgiving.

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Dr. Rubin: Oh, my gosh. Wow.

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Dr. Smetherman: So anyway. So we were able to eventually get in and get like, you know, changes of clothes and things, but yeah.

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Dr. Rubin: Yeah. I imagine just navigating between your house and the hospital was
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Dr. Smetherman: We couldn't get there for days and days. I actually left Oschner and went to meet my family in Lafayette, Louisiana on that Friday night, which is about two and a half hours west of New Orleans. I didn't get to go back into my house for many, many more weeks before things were just cleaned up, and then we could go in with flashlights and get, you know, more of our clothes and things. So.

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Dr. Rubin: Yeah. I know that a number of residents in the city of New Orleans were permanently displaced from Tulane, I think, and also from LSU, perhaps?

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Dr. Smetherman: We did take a few of those residents into our program, particularly LSU. Tulane had a partnership. I think they were able to keep their residents at least in their program, but LSU's program actually had to disband. And so we took a few of their residents. We actually hired one of the LSU staff, a thoracic radiologist who came to work with us. But, yeah.

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Dr. Rubin: Yeah. So you were in a role of associate program director at that point, so you were tasked in part with sorting all that out?

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Dr. Smetherman: So, yes. So the program director and my colleague Dr. Jim Milburn, his family, his wife is from Puerto Rico, so his family actually wound up living in Puerto Rico for six months. And so that's why they asked me to be... They had not had an associate program director, but that's why they asked me to step up and do it because I was going to be around and he was basically going to Puerto Rico every other week for months. And so they needed somebody. So I only did that job for a brief period of time, but I was glad to be able to help. We certainly needed to have continuity and we wanted to make sure that since we were, you know, our training program was not disrupted and I will tell you that the clinical volumes dropped off for a brief period of time but because there were so many places that were no longer open, they exploded because everybody came to us.

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And so we needed the residents, we needed all of the attendings, we needed everybody back pretty quickly. There was a short period of time, maybe about a month where we were sort of in teams and so we'd have one group of radiologists and the next group of radiologists. And so I think we had teams A, B, C, or A, B, C, and D and then I was back, it was team A again. So I was out for like 15 days and then I was back and we never... After, you know, maybe one or two more, I think it was within six weeks, they basically needed everybody back because we were just so busy. So strong clinical volumes again.

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Dr. Rubin: Yeah. I mean, seems to follow the pattern of a leader was needed and you should happen to be there to step up.

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Dr. Smetherman: I did transition out of that once his family moved back. But yeah, I was there. I was, again, my New Orleans family, my sister's house was not damaged although many other family members' houses were damaged on both my husband's side and my side, but I was able to find couches to sleep on and stuff. So I was around in New Orleans.

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Dr. Rubin: Yeah. Yeah. Resilience, clearly. A few years after Katrina, you became the vice chair for clinical affairs in the department of radiology. What did that role entail?

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Dr. Smetherman: Yeah. So as we were growing, we acquired three of the tenant hospitals shortly after hurricane Katrina, about a year later. And our then chair, still chair of the service line, Dr. Dennis Kay, was like, you know, "We're just managing too many places. You know, I really need..." So the program director, Jim Milburn, became the vice chair for education and academics and I became the vice-chair for clinical affairs. And so in that role, I was tasked with a lot of the operations. If we were starting at a new hospital, I would help them standardize their protocols. Sometimes that went really smoothly, sometimes that was kind of a challenge. I also became really involved in quality improvement in that role which was a natural segue with breast imaging, but I really kind of jumped in with both feet and tried to really educate myself on that and learned a lot about PTSA cycles and ran tons of quality improvement projects for the department. And I loved all that. I really enjoy doing all of those things. And so, yeah, so I did that for several years, you know, many, many years, and continued to grow in that role as the service line, continued to grow and grow and our department continued to grow and grow.

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Dr. Rubin: Yeah. Now, when you refer to the Ochsner health system at this point, what is the scope of the health system?

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Dr. Smetherman: Okay. Well, today it's 40-owned and managed hospitals. We went from one to four, you know, and just gradually over time with lots of different... And, you know, it hasn't been that long really, you know, we... And we did all different kinds of things. There were some hospitals that we acquired. There were some that we did clinical integration and partnerships. There were some that we did joint ventures. There was our most recent, really kind of big merger was a joint asset merger with Lafayette General, which is now Oschner Lafayette general and Lafayette. that's a seven-hospital health systems. So today our hospitals go all the way from the Louisiana, Texas border and Lake Charles all the way over into the Gulf Coast of Mississippi and actually into kind of the middle of Mississippi with rush health system.

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Wow. What was motivating all that growth?

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Dr. Smetherman: Well, I think multiple different things, you know, and we have a partnership with LSU Shreveport. I think we had success in a lot of our early partnerships, both improving quality, but also a lot of these smaller hospitals have had a lot of financial challenges, and our executive leadership team really kind of developed a reputation for being able to go in and partner and help turn around some of these smaller facilities. Some of them are like service district hospitals as well. And so oftentimes it would be the partner coming to us and saying, you know, "Do you think you can come in and help us clinically and from an operation standpoint?" So yeah, just a... And, you know, I mean, it is not an economically easy place to succeed in healthcare in, you know, Southeast Louisiana and the Gulf Coast. Our economy has a lot of challenges, you know, our education level isn't that great. So, as I said, mostly it's been people who needed help would come to us by all different kinds of channels.

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Yeah. Now, you yourself have active medical licenses in six states, which in addition to Louisiana, including Virginia, Alabama, North Carolina, California, and Texas, are these required to fulfill your Austrian health system role or?

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Dr. Smetherman: No, although I am in the process of getting a Mississippi license. And that will be part of my role at Oschner, but so no. If you are aware, there's a 10-year rule in a lot of states, or there used to be. And so if you think about the timing, I finished my residency in 1996 and I was not in a CAQ, you know, fellowship. So Katrina hit in 2005. And although we made a bet that we were gonna stay, my husband and I in New Orleans, I think there were a lot of question marks there. And we weren't sure were gonna work out. I mean, you know, they didn't for a lot of people. And so it just made sense for me to get several other medical licenses at that time because had I not, it would have involved, you know, could've potentially been a lot more complicated situation. And if you know, you know, anything about kind of the board and all that stuff, they were just developing the maintenance of certification, you know, that was really just coming around. I am in that program now, but at the time, there was a lot of uncertainty about what that was gonna be, and it was just okay, if I wait another year, this is gonna be a whole lot harder. Let's get them all right now. Wound up not really having to use them, but yeah. So it was not really related. It was like, okay, if this doesn't all work out and Oschner doesn't make it, we wanna have a few more choices of where we might wanna go.

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Dr. Rubin: Yeah. That's sort of remarkable display of proactivity.

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Dr. Smetherman: Well, you know, I think we were... That was a hope for the best plan for the worst situation.

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Dr. Rubin: Now, shortly after you were in a more system roles for the service line, I see that you started business school at LSU in Shreveport. With all that you had going on, what led you to pursue an MBA?

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Dr. Smetherman: So that's a great question. And trust me, if somebody had told me when I was in medical school that I was going to get an MBA I would have said, "I cannot envision a future where I would do that." If I wanted to do that, you know, I wouldn't have gone into medicine in the first place, but a couple of things happened along the way. The first was really that I was pointed to the Oschner health system board at this really critical time in our history when we were undergoing this massive growth. And around the same time, I happened to sit next to Dr. Geraldine McGinty at a meeting. And I had already had a little bit of interest in medical economics, just, you know, along the way. But those two things kind of coincided and I was like, "You know, I really am interested in healthcare economics."

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And so I started being active in the ACR's economics commission. I had been very active in my state chapter and had gone through the ranks and was the president of the state chapter and had been a counselor for Louisiana. So I started kind of interested in the background, but then they really needed somebody who was a breast radiologist involved with the CPT advisors for the ACR and the economics commission. And so through Dr. Mcginty, I wound up becoming a part of that team, which I'm still a part of that team, and I really just enjoy working with those people so much. So I started looking at learning more about CPT codes, and reimbursement, and then I went, got on the Ochsner health system board. And again, there was a lot of talk about budgets, and proformas, and future directions. And I was like, "You know, I'm really interested in this. I don't know where it might take me, but, you know, I'd really like to explore this more."

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And so I did some self-education, went to some courses, you know, took a few courses through the RLI and then the ARLLM, which was another leadership group in radiology. And I was like, "You know, I really feel like I want a little more than this." And so I started looking at some of the business schools that had either online or hybrid programs. And so I knew that there were several things that it had to satisfy. I wanted something actually that was really online because my children were by that time kind of in late middle school, about to start high school, kind of seventh to eighth grade and then I'm like, "I don't want more time away from them. But they're studying a lot anyway, so if I'm studying too, you know, it's not that different." I wanted something where... There was obviously an accredited school, you know, a real school. I wanted something that if I had to stop for a period of time, that I'd be able to pick it back up pretty easily. There are some MBA programs and some executive MBA programs where it's like a cohort and you do it in this order and it's like an

18-month cycle and if you have to stop, and I knew that my job was, you know, my day job was pretty busy and so if I had to stop for maybe a semester or half a semester, I didn't wanna have to wait 18 months until I could get back into the cycle.

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So I had looked at several different places. I was actually in the...going through the application project for UMass Amherst. And I found out that LSU Shreveport had just started about a year before, a master's in healthcare administration program at MHA and an MBA. And with my MPH, there's some crossover with an MHA and I was like, "Well, that's not gonna really be...you know, that's not gonna really be that different." And so I looked into their MBA program. The curriculum is pretty standardized. It wasn't all that different. And if you were an in-state student, the tuition was only $1,000 a course. So even with having to take like the remedial accounting and economics, the whole degree was $12,000, which was about a third of the next least expensive program. And so I remember, you know, looking at this and doing the application and thinking, "If I can't make this one work, then I can't make this work." You know, this has everything that I wanted. I remember talking on the phone to them. And so anyway, so I wound up doing that.

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There was actually one semester where things became very busy. I had a colleague who had to go out on kind of an extended maternity leave. And so I did have to drop out. So that was actually a good thing, but I was there. Their program is big enough that you can just go right back into, you know, the next semester and pick it up where you left off. I wound up... And I've never used it, but I just did it because it was so fun and so interesting. I actually sort of like had a concentration in entrepreneurship. Now, I can't really imagine myself starting a business, but I just found those courses so enjoyable. And so you take like an extra course or two, or, you know, put your electives into that and loved that. It was really fun. And I will tell you that, again, you always gain benefits from things that are not would you ever envisioned going into them, but I learned a whole lot about virtual education.

Like the last time I had gone to school, it was books, and highlighters, and lots of written notes. And this was... I learned about Zoom and lectures on Zoom. I learned about group me. I learned about, you know, lots of different communication tools. We had, you know, digital textbooks and highlighting digital textbooks and actually typing notes, having the textbook on half the screen, and having a word document on the other side, working on projects with people who were all over the country. I had one class where the professor was in Germany and there was somebody in Las Vegas. There was someone who was a legislative aide who was working from DC. There was someone in Texas. And we did other fun things. Like they had some simulations that we did, developing a company and, you know, you'd get this market data and adjusting it and doing that in a virtual group.

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So those skills actually turned out to be advantageous with COVID and trying to navigate that. But anyway, so I thoroughly enjoyed, was really glad that I did it. I did not go into it thinking, "And this is gonna be another rung-on a career ladder." But it has really enriched my career. It's enriched my involvement in healthcare economics. Certainly, I think made me

a much better-informed board member, whether it was on the Oschner health board or now on the ACR board of chancellors. So, yeah. It was thoroughly enjoyable. I'm so glad that I did it. And I would recommend other people who are, you know, maybe, you know, getting along to the middle part of their career. Don't let it hold you back. You know, you can find a way to do it, try new things, do something different, learn about something new.

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Dr. Rubin: That's awesome. Yeah. I mean, I think you did a beautiful job of articulating, you know, many great aspects of taking a little time from the middle of your career to go to business school. And, you know, a lot of those things I can relate to. The diversity of the students that you work with and, you know, such different industries and backgrounds that they come from, it's all a fantastic. It sounded like you just had a terrific experience.

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Dr. Rubin: And, you know, in articulating that you would recommend business school for anyone who is thinking about it, who would you see as an ideal candidate amongst practicing radiologists to go to business school?

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Dr. Smetherman: You know, I do think that people who are looking to advance in their career, who would like to become involved in administration, I do think some things, even not just the hardcore business accounting things, but also organizational behavior, you know, there are the whole lot that you learn in that. I will also say, you know, at Ochsner, and I would venture-guess in a lot of other institutions more and more. And you see the graphs that the number of healthcare administrators has increased exponentially and the number of physicians is pretty flat. I found that there was almost a language and a set of expectations that some of my nonclinical administrative colleagues had that I had never heard. And so I do think that being able to speak that language has been very helpful. You know, we are very much advocates of the dyad model at Oschner and more and more, our administrative colleagues do not have a clinical background.

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Years ago, in radiology, for instance, you often would have a tech who was a superstar would become the supervisor and then the manager, and they had that clinical background, but more and more, I was finding and continue to find that my administrative colleagues do not have a clinical background. And so I do think that it has been helpful to me to really know more about their background, be able to work kind of just a little better on projects where they don't feel like they've got to bring me up-to-speed, maybe quite as much as if I had not done that MBA.

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Dr. Rubin: Yeah. Exactly. So since finishing business school, and for the past three years, you've been serving in the role of department chair of radiology and associate medical director for medical specialties at Ochsner. Tell us about the roles and how do they mesh with one another?

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Dr. Smetherman: Fantastic question. So, and I was a little unusual that I took them on both at the same time. A lot of people might be in the chair role first and then take on the associate medical director role. So I am the chair at our flagship hospital, which is our academic hospital. And, you know, we have about 50 or 60 radiologists who work there. That's where our residency program is. For that same campus, I have seven other departments that report to me, and that includes infectious diseases, rheumatology, GI, endocrinology, emergency medicine, hospital medicine, and pulmonary critical care. So the way that our organizational structure is because we're not a medical school, is that we obviously have department chairs and then those department chairs report to associate medical directors, and then we have four associate medical directors at Osher in New Orleans, and then we have a regional medical director.

And so they're different regions. We're in the New Orleans region. Obviously, we have Baton Rouge, we have, you know, the north shore. So, yeah. So almost... I think everybody who is an associate medical director is also a chair because you really do need to have that frontline operations experience. And then in my role as the associate medical director, that role is really more about guiding the chairs who report to me, but also, I think, finding the synergies, finding the ways that all those departments work together, which has really been critical in the pandemic. In fact, my monthly meeting with those chairs was today and we are seeing, you know, another surge in COVID here with the Delta variant probably have close to 900 patients in our hospital system again, unfortunately, and mostly un-vaccinated, but we need to quickly expand our physician core to take care of those COVID patients in the hospital.

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And so, you know, today during the chairs meeting, I had the hospital medicine chair talk about the different models that they are using and because just strictly, the hospitalists can only cover a certain amount. So they have a model now. And I can't take credit for these. These were, you know, they developed, but they have a model in there where you can bring your whole team. So you can bring an endocrinologist and perhaps in an APP who works in endocrinology and maybe your nurse and bring them to work as a hospital medicine team, not on COVID patients, but then working with a liaison who's a hospital medicine physician. We also have a model that they're calling the dinosaur model. And I said, "Couldn't we call it the classic model or the vintage model or something like that?" But basically, what that is we have a group of residents who are internal medicine residents plus a chief resident on that service with one of the medical specialty attending.

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So my chair for rheumatology volunteered for that this morning after the meeting. And so anyway, but it's about really finding those connections about, you know, quickly for us working with the ED, making sure we've got good access, do we need to add another CT? Okay. If we put the CT here, we're gonna have to move our X-ray, and how does all that work and how do we make sure we've gotten good-through button? How do we leverage the electronic health record so that our techs don't try to go get the CT patient until they're ready?

You know, just all those different things. How do we ease the transition from, you know, the emergency department to the floors? So all of those different things, how do we all work together?

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Dr. Rubin: Yeah. Super interesting, the aggregation of departments that you have under you and, you know, you mentioned about organizational behavior, organizational design, you know, when I think about medical specialties like endocrinology, infectious disease, rheumatology, hospital medicine, you know, usually those are divisions as part of a department of internal medicine and a chair of internal medicine, overseeing those divisions. And oftentimes medical imaging or radiology would be mixed in with anesthesia and pathology and perhaps emergency medicine, but this is a completely different. It's all kind of, you know, really any insights into how it is that it's organized that way?

[01:09:46]

Dr. Smetherman: So I think it is intentional and I think it is to try to decrease the silos, honestly. You know, the multi-specialty group practice model which is our model is really all about teams and collaboration and I think finding the synergies, finding the ways that everybody works together. And I, you know, had done a tremendous amount of that when I was at the breast center and we started our own breast center, we had these multi-disciplinary teams, found ways to succeed together, find the win-wins for everybody and not be like you're always at odds with other departments to try to get resources. How do we get the resources that we all need? Now, I mean, it's not always, you know, kittens and rainbows and everybody gets along, I mean, but I do think having this kind of structure does at least facilitate that and facilitate those conversations.

[01:10:41]

After the meeting this morning at 7:00, the emergency medicine department was having their department meeting and that chair was like, "You know, my colleagues are working really hard and I know they're really exhausted, but I think they would really benefit from hearing all of the innovative things that hospital medicine is doing to try to help us get through this pandemic." So she was like, you know, "Do you, meaning me or the hospital medicine chair, could one of you or both of you come and just present for 5 or 10 minutes just so that our emergency medicine colleagues have some perspective about what's going on." And so we were able to make that happen this afternoon. And it was great because again, you don't feel like you're all by yourself fighting this battle alone. So, yeah.

[01:11:27]

Dr. Rubin: That's fantastic. Have you ever found the roles of department chair and associate medical director being in conflict?

[01:11:36]

Dr. Smetherman: You know, I thought I might, but for the most part, I have not. I think I have been... You know, and I've been there for a long time, so I know these people all pretty well. Perhaps if you didn't have all of those relationships, it might be harder, but actually, I

think it's made it easier because, you know, you have a lot of social and political capital, you've worked with these people before. The pulmonary medicine chair and I went onto the Ochsner health system board together. So our terms, they're at the same time. And so I think it just lets us work together better. So at least, for me, I have not really found that to be the case. You know, again, I don't know if you were a new person coming into it ND didn't have all of those ties, It might not happen quite so organically. And I'm knocking on wood here big time, but no, it hat has really not turned out to be the case. I could see there could be potential and you would love to say, "Oh, it's just because I'm doing such a great job as a leader," but it might just be good luck, right? The thing that's gonna cause that conflict may just not have arisen so well, s.o.

[01:12:48]

Dr. Rubin: Well, but as you articulated relationships matter and being able to cultivate those relationships, build that social capital, as you mentioned, is really fundamental.

[01:12:58]

Dr. Smetherman: It definitely is critical, I think, to success.

[01:13:04]

Dr. Rubin: I wonder if we could spend a moment talking about the pandemic and how it has been for you to manage through it in New Orleans. Perhaps you could take us through some of the key challenges that you've faced as a leader and how you've dealt with them at various stages of the pandemic.

[01:13:21]

Dr. Smetherman: Sure. As I think most people know, in March 20, 22 weeks after Mardi Gras, we had our first case of COVID and nobody knew it at the time, but it was basically a massive super spreader event. And we went from having our first case on like March 12th and by April 1st, we had 900 patients in our hospitals. If there was ever a time where the lack of siloed behavior was critical to success, that was it. But, again, I think those relationships really helped and people rose to the occasion, you know, immediately were redeployed and tried to find innovative ways to take care of the patients and each other. We did have, as many others did, we did have to make the very difficult decision early on to really, really cut back on non-emergency services, including things like screening mammography.

[01:14:14]

You know, if you remember at that time, we knew so little and I think there was a real risk to patients, to our employees, all of those things and then, of course, there was a shortage of PPE, and so you had to be a really responsible steward of those resources. But we have said it again and again at Oschner that we really do feel like our group practice model is what enabled us to succeed. And candidly, we had a lot of experience with disaster management. So, you know, we knew how to put together an incident command center in a day, we have a large project management office and all of those people immediately got redeployed to COVID to help us build things quickly like respiratory evaluation units in the ED and making negative pressure rooms.

[01:14:59]

You know, the distribution of PPE was a challenge. We had to be responsible stewards. So they basically kept that centrally, but we realized that even though people knew if they needed PPE, they could get it like having those channels to go through, you know, it made people uncomfortable and uneasy. And, again, I give credit to my hospital medicine chair, she was like, "Let's do this. Let's give everybody one of those little drawstring backpacks and every day we'll fill that with their PPE for the day and they can... And we're just gonna give it to them every day. They don't have to ask for it, they don't have to go looking for it, and they'll turn it in at the end of the day, the dressing, and we'll just give them another one." And so, again, I think solutions like that kept it from ever feeling like it was out of control. And I remember going up on those COVID wards during that first surge and feeling almost a sense of relief, honestly, because you would see all of these terrible stories in other places, people using trash bags as, you know, their gowns and whatever, and we never got to that point.

[01:16:04]

We worked together. And when I was up there, I remember it being just a very business-like environment, you know, very professional, taking care of all the patients. We were also lucky now that we're such a big organization, that we already had things like an office of professional wellbeing. And so we could immediately...our chief wellness officer and, you know, some of the psychologists basically just started rounding with those teams every day. So, anyway, so that got us through the first wave. And then, of course, like everybody else, we'd had subsequent waves and now we're to this fourth surge which has presented different challenges, I have to be absolutely candid. Having a very low vaccination rate and a lot of vaccine hesitancy for lots of different reasons, I really think has made this surge particularly challenging to the morale of the different departments.

[01:17:03]

You know, the degree to which it's preventable. You know, as we look at our patients, as I said, we have around 8000, 900 patients. And recently, you know, we were in a meeting with our CEO and he put up that graph and he was like, "If our vaccination rates, you know, were better, if these people were vaccinated, we would have 80 of them instead of 800 of them." You know, and our statistics are pretty consistent with everybody else. You know, hospitalized patients, about 10% are fully vaccinated and the other 90% are not. In the ICU's, it's about 95% are unvaccinated. I'm knocking on wood here. We have not yet had a death in our fully vaccinated patient. Although we have had some deaths, unfortunately, in unvaccinated patients. But, again, our chief wellness officer was there and, you know, as they... And, you know, and we'd have crisis lines for people again, and we have throughout the entire situation, but now it's more like validating people's anger, but saying that's really not productive, right?

[01:18:07]

And there are other diseases that we have to treat, whether it's lung cancer or, you know, obesity-related diseases that are also technically self-inflicted, if you think about it, at least in part. And so trying to deal with those different emotions has been a lot of what I've been doing it and, you know, and people are just tired. And I really do understand that. And so

now, you know, on our meeting this morning, the pulmonary critical care chair, when he spoke to our colleagues who have largely outpatient departments like endocrinology, like rheumatology, said, "The most important thing that you can do is the patients that you have a relationship right now, if they're not vaccinated, we need to do everything we can do to get them vaccinated." And so that was one of the big to-dos that came out of that meeting for me, was we have to do whatever we can to get those vaccinations. Like if we have those patients in our hands, no matter what reason they're there, we need to have ready access to how to get them in and get vaccinated and strike while they aren't as hot. So, yeah. You know, you know, the whole pandemic has been an absolutely fascinating experience, lots of different leadership challenges, not all victories, right? You know, there are some things that we've done a great job and some things that, you know, you're like, "Oh, gosh, you know, I feel like I could have done a better job of handling that."

[01:19:33]

It's interesting, kind of to bring this all back, and this is just a little story, so I'm gonna take you on a little detour here. We mentioned early on that, you know, all of my grandparents and great-grandparents who lived in Louisiana and my grandfather, the one who was born in Cherrington, his father was the only other medical person in my family. So he, like me, went to Tulane. He graduated from medical school in 1908. I have his diploma, I have his Louisiana medical license because since I was the only other medical person, I was the one who wound up with these things when my grandparents died. I have his graduation picture which actually has some really famous people who are on the medical school faculty like Rudolph Mattis, the father of vascular surgery. So, anyway, I have a picture of my great grandparents, my great grandmother, my great grandfather, and my grandfather who was a little baby, their insurance, and he's wearing his white coat. I still have his microscope, but I never knew him. I never came close to knowing him because he actually died in 1918 because he caught the Spanish flu from a patient.

[01:20:45]

And so this has been like a big part of our family lore, like your whole family legends. So they were there, he was a prominent doctor. He was the town doctor. And then after he died, his widow and their three children had to move back to New Orleans and she had to go back to living with her family and all of a sudden they were like the poor relatives that had to depend on the rest of the family for place to live. And so she wound up doing things like worked as a truant officer. And so, anyway. So I've always had this kind of little bit of fascination just with pandemics in general. So to be living through one has really been interesting. I have thought more about him in the past year and a half than I probably had in the preceding two decades, so.

[01:21:36]

Dr. Rubin: Yeah. Understandable. I mean, did your great-grandfather's pathway make you think differently about your own involvement through the pandemic? Did you ever think about your own mortality? And...

[01:21:54]

Dr. Smetherman: Yeah. I did, actually. I mean, I think that's natural. I think we all did, right? But I was like, "Oh my, gosh, you know, what would be the irony here." You know, if I were to wind up succumbing to this, you know, I bet there would be nobody else in the family that would ever go into a healthcare career again. It's like, "This is not working out well for us." But, fortunately, nothing like that happened. I did not get COVID, but yeah, I will have to say that I really hadn't thought about him in a long time. I read the great influenza. And so obviously I thought about him then, but yeah. You know, I hadn't really thought about it much at all, but it's been obviously top of mind at times. And I will have to say also thinking about things that despite, you know, 100-plus years of incredible medical advancements, we still had to rely on some of, exactly the same defensive mechanisms, like masks and quarantines, right?

[01:22:54]

Dr. Rubin: Yeah. Yeah. Well, at least we didn't have to wear those masks with the lung noses that we would stuff with...

[01:23:00]

Dr. Smetherman: Exactly. Like for the plague in Italy, I have one, actually. Not a real one from the middle ages, but my husband and I in our travels have collected masks. And so in Italy, we've got one of those that we actually have them displayed. We have a solarium. So yeah, I have one of those. I think the ones we have to wear a better than that.

[01:23:24]

Yeah. Yeah, no doubt. Well, I mean, that was a marvelous articulation of the so many complex issues and the evolution that we're all facing in this pandemic and it truly is remarkable. And, you know, we participated together in a town hall event about a year ago or a little more than a year ago and, you know, when I think back to the conversation and what we were dealing with, the notion that today we would be talking about the challenges of vaccine hesitancy is just remarkable, you know, where would have come in a year?

[01:24:00]

Dr. Smetherman: And, you know, really disappointing, right? Had we known then that we were going to have a vaccine by the end of the year and that it would be able to be available to the vast majority of the public in less than a year, I think we would have thought that was miraculous. I will tell you that I anticipated, we would have effective treatments before we would have a vaccine.

[01:24:28]

Dr. Rubin: It is miraculous. It is truly miraculous. And when we were in late December, early January and, you know, clamoring for those early doses and getting people vaccinated, if someone were to say to me, "Oh, but just you wait. Six months from now, there's gonna be large portions of population that won't expose themselves to those vaccines and they're going to have substantially greater risk as the virus becomes more infectious and any evolves," would have never imagined.

[01:25:00]

Dr. Smetherman: I would never have believed in it. And much as I would not have believed when we spoke about a year ago, that we would have a vaccine before year's end, an effective approved vaccine again, I agree with you. I don't know which one would have seemed less likely to me, but I didn't contemplate the possibility of either as a feasible reality. I could not agree with you more.

[01:25:28]

Dr. Rubin: I mean, it makes me say what's next? You know, I mean, at every stage of this pandemic, we haven't really had a clear vision of the future. And I mean, at some point, you know, we will slide right into some form of normalcy, but it's an interesting time. And it's, you know, embracing how challenging it is to truly predict what's around the corner. It is a very interesting circumstance.

[01:25:57]

Dr. Smetherman: Yes. Many times I have said that this is going to be a fascinating thing for people to read about in the future. It's unfortunate that we have to live through it, but you do wonder too, things like what's happening right now with the outbreaks in the areas that are less vaccinated, how is history gonna view that? Are they gonna view that like the labor day parade that happened in Philadelphia during the Spanish flu, and, you know, then they wound up having massive cases. You really do wonder.

[01:26:32]

Dr. Rubin: Yeah. Well, I mean, how does history treat the prioritization of personal liberty relative to public health?

[01:26:40]

Dr. Smetherman: Yes. You know, it is so interesting too, I think, that this pandemic has shown us both how interconnected we all are to one another globally but also how separate we are and how much that conflict of self-interest, and public health, and the greater good, how pronounced that is. And it is really interesting, like, you know, vaccine hesitancy, it's not just one set of beliefs, you know, it does... In fact, my husband says, it's almost like the one issue that goes all the way around 360 degrees of the political spectrum and meets. You know, the people who are on the very, very, very far right and the people are on the very, very, very far left, actually have that in common on the Venn diagram. It is interesting. And trying to understand that, because there's no way you're gonna make progress on that until you really understand what is underlying it and it's not the same for all people. And some of it, I don't think we're gonna crack. And so what we basically have to do is just, everybody that's at all persuadable or who, you know, there's some weakness in their, you know, notions about why they don't wanna get a vaccine, the people who just wanna...kind of the ones who want it to wait, I think that's our opportunity and I think my colleague this morning who was talking about if you've got a relationship and there's somebody who's maybe on the fence, we've got to get to those people on the fence.

[01:28:39]

Dr. Rubin: Yeah. Before we leave the top of the pandemic, I wanna turn to a different dimension of it, and that is how it is affecting our professional lives. And, in particular, I'm really curious about your perspectives on remote versus onsite practice of radiology. You know, I think that we were at a period last summer where we were applauding the miraculous, rapid evolution of platforms like Zoom that enabled us to have telepresence and that enabled us to practice remotely and readout residents remotely, and all of these sorts of things. But, you know, as we've come to this stage, you know, how do you view this question about truly hybrid work versus the value of people being in the same place, delivering healthcare?

[01:29:33]

Dr. Smetherman: Yeah. I have thought about this a great deal and I think first and foremost, it's here to stay. It's here to stay in every industry. So I think that maybe there will be some places where you're able to bring your entire workforce back. I think that may turn out to be the exception. So I will tell you that in our department, you know, we are in the situation that we continue to have a growing market share. Ochsner was very public-facing during the pandemic and so we have actually seen... We already had a large market share. We're actually seeing that grow. So the needs of our community and their reliance on us to provide that just continues to increase. And candidly, it can be a challenge to recruit enough people to take care of that population. And so although I would never have envisioned this two years ago, I think it is quite likely that we will have a hybrid physician workforce. And we already are having a hybrid physician workforce. Believe it or not, not everybody is dying to move to Southeast Louisiana. So what I have found is that in a few really key specialties where it's a challenge to recruit, we are looking at a combination and have already recruited a combination of people who will work onsite and who will, you know, will never work in Louisiana probably. We may bring them in once or twice a year, just so that we can establish those relationships, but we've had some excellent candidates come our way who are interested in working for us remotely and, you know, I got together multiple different groups of stakeholders at the end of the day, you know, who got to the go-no-go and they were like, "We would be foolish to pass up the opportunity to hire this person.

[01:31:24]

So I think, therefore, it is incumbent upon us to make this work. I think that superlative communication is going to be key. I think that referring providers should not be able to sense a difference. You need to be every bit as available to them if you're working remotely as if you are there. I do think that there are ways to incorporate remote physicians into your academic practice as well. I do think using tools like Microsoft teams really do facilitate that. I think we can now give effective lectures remotely. I think you can participate in multidisciplinary conferences remotely. And, in fact, for us, we've actually seen attendance in multidisciplinary conferences go up because it is more convenient. I don't think we could ever have a fully remote section. We will always have to have people on-site, but I do think that at least for our department, that is gonna be a part of our future. And we may have talked about this the last time, but certainly, it's a topic that I've spent a lot of time thinking about in the past year. Things are going to be different when this is all over. We are going to be a changed world. And I think it would be foolish to think that we're gonna go back to January

1st, 2020, and to try to... I think it's a waste of time to reconstruct what the workplace look like that, what people's expectations of their lives look like.

[01:32:55]

What I am finding in my colleagues is they want flexibility and even the people in my department... So it was very interesting. I had floated the concept of having homework stations for everyone, actually, when I first took over as chair, it was not well received. Not at all. Our value was being there, and how are the referring doctors gonna find us. Now, obviously, when COVID hit, a lot of people's view of that changed pretty quickly. But what we have found is a lot of our colleagues really enjoy that. They really want us to find rotations where they can work from home. Now, they may not wanna work from home, and this is the people who are local every day, but they really do treasure those days where they're able to have that option. So, again, I think we have to find, if you want to keep your workforce satisfied, it's almost incumbent upon you to find a way to make it work.

[01:33:51]

In fact, two my two of my biggest projects for the second half of this year, which has gotten a little bit delayed because we had this fourth surge, but one is communication and leveraging our electronic health records to facilitate all of those communications, whether it's with each other, whether it's with technologists, whether it's with referring providers and just to make it easy, and simple, and intuitive for people to find us. I wanna find out who's reading neuro-radiology from the Westbank Hospital. I want it to be as close to one-click as it can be. So that's one big project that I'm working on to get that. And then the other is we're putting a task force together. We haven't started yet, but...and I need some physician champions to optimize our remote resident education. You know, there is I think an understandable sense that how can you ever make that as good as being right next to the resident? It's certainly easier to be right next to the resident, but again, as I look at filling the needs that we have clinically and on our, you know, in our academic mission, I have to be open to the possibility of having some of those people work in other areas geographically. And so we need to find ways to make it work, not spend a whole lot of time saying why it won't work.

[01:35:11]

I also was lucky enough and we're participating again to participate in the ACR's virtual visiting professor program in breast imaging where partner institutions got put together and it was a chance for your junior faculty to be visiting professors. And it was great. It was great for resident education. It was a nice opportunity for some of the junior members of our staff to get in front of a little bit different audience. And we have started the second year of that. So the first year, we were fortunate enough to be paired with Sloan Kettering. This year we're paired with Weill Cornell. So really looking forward to that opportunity. I have a couple of new members of our breast imaging section, and so they're gonna be given lectures this year as well.

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So I think things like that. We also, you know, our program director, Jim Milburn, who I've mentioned several times, also did a really nice job, particularly through. He's an interventional neuroradiologist and through his societies, did a really nice job of putting together educational programs, you know, CME, and resident training, and town halls, and all different kinds of things and panels, and, you know, really kind of use this as an opportunity to almost rethink how we do education. So it's definitely gonna be a hybrid. It will never be 100%, but yeah, those are my thoughts in a nutshell. And we'll see, you know, we'll talk in a year and we'll see where we are. Maybe six months.

[01:36:42]

Dr. Rubin: Fantastic. Yeah. You have had many roles outside of your institution on behalf of organized radiology and getting into all the details of those is gonna be a little bit beyond what we're gonna be able to do today, but I wanna just touch upon one thing, and it is your current role on the board of chancellors of the ACR. You've already served on a number of committees within the board of chancellors, you're now the secretary-treasurer for the ACR. As your engagement has increased with the ACR at the highest levels, what are your aspirations for the ACR and what do you seek for the ACR to accomplish in the next few years?

[01:37:30]

Dr. Smetherman: So that's a fantastic question. And I actually had the privilege earlier this week of being at the...participating in the planning committee meeting for the new strategic plan. So these things are very much top of mind. So I would love for the ACR to really continue to be and to grow as the organization that is really the convener of radiology. Obviously, economics and advocacy are incredibly important to the ACR's mission and that is really an arena in which we are the leaders in radiology. And I cannot imagine that we aren't going to have to double down on that and not only continue what we're doing, but become even more involved. And so definitely that. I also think the new health equity coalition is incredibly inspiring. I think many people might have thought in a legacy fashion that's not in, radiology's wheelhouse.

[01:38:40]

You guys sit in dark rooms, you never see the patient. You don't even know anything about that, but I think we will have unique opportunities, and particular because of our involvement in screening to promote health equity. And so I think obviously we're gonna have to partner with lots of different people, primary care and population health and multiple different specialties, but I do think the pandemic has laid bare so many of these health equity challenges that I think we all were aware of but now it's just right in all of our faces. And so I do think that's gonna be another really exciting direction for the ACR, that we can really have just a tremendous impact in ways we might have never even thought of ourselves.

[01:39:28]

Dr. Rubin: Terrific. I'd like to turn a moment to family life. And you mentioned that you have twins and it's fantastic. I love it when I meet radiology leaders with multiples. Reed Omary was a guest this last month and he has twins.

[01:39:43]

Dr. Smetehrman: Oh yeah. There are a lot of us.

[01:39:45]

Dr. Rubin: Yeah. Yup. Yup. Fathered triplets. I have two.

[01:39:48]

Dr. Smetherman: Oh, really? Oh, wow. Are those your only children, the triplets?

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Dr. Rubin: No. but...

[01:39:54]

Dr. Smetherman: You're busy then. I can't imagine. Twins kept us really busy, so.

[01:39:59]

Dr. Rubin: Yeah. Well, so, you know, one of the concerns that I hear expressed amongst radiology leaders is work-life balance and particularly as it pertains to raising a family. Can you share some details of that journey with us?

[01:40:12]

Dr. Smetherman: Sure. So when our children were born, my husband was the managing partner of his family business. His family owned a large independent catering company which had been in existence for 30 years. My mother-in-law had founded it and then her children were then running it, my husband and his two sisters. And we managed to make that work for a few years. It was challenging with a lot of help, family, and nannies, and all of these different things. So our children were born in 2001, and then honestly, it was after Hurricane Katrina. So after hurricane Katrina, it was quite obvious that Ochsner and my work was going to become much more. You know, acquiring those hospitals and being the only place that was open, it became painfully apparent. And at that point in time, our children were four.

[01:41:09]

They were just starting like real school, pre-K. And my husband's business was going to be very, very time-consuming to re-establish. There was, again, a big labor shortage, particularly for jobs on which catering companies rely, things like dishwashers, and cooks, and drivers, and all of these other things. And so my husband made the decision.... His sisters did reopen the company on a much smaller scale, but he made the decision to step back from that and he became really the primary caregiver, I guess, for our children. He was the one who was the room parent. He brought them to school. You know, did a lot of the parent-teacher conferences. I came when I could. But that's how we made it work. I think everybody makes choices and I applaud everybody who figures out how to make it work.

[01:42:02]

It is a challenge. It is an ongoing challenge. I think you have to be very thoughtful and you have to really, again, just like when I talked about having to look yourself in the mirror, when I made the decision that neurology was not gonna be the right path for me, and again, I think this is true. You know, you look down and you're like, "Okay. How do we get this done? What works?" I was lucky to have a spouse who had worked in a family business that was a catering company and so he could cook, and so I didn't have to do those things. And so, anyway, and so that's honestly how I've made it work. And I, you know, often quote Sheryl Sandberg who says that the most important career decision you make is the choice of who your partner is going to be. And so I will say that it has worked out fantastically for me, but everybody figures it out for themselves. It was always nice if one of my children was sick, for instance, that we really didn't have to stress about that. It had been a stressor when they were younger. And so that's what we did. And so my husband wound up pretty much retiring. He has a real estate license. He, you know, does still dabble in that. But anyway, so... And I will tell you that it has made my ability to really focus on my career and do what needed to be done and just much more doable.

[01:43:15]

Dr. Rubin: Yeah. Yeah. I mean, I think back to how you were recounting your days in high school and in college and the dance recitals and the drama, the theater, the singing, do you get to pursue any of that? I mean, how do you unwind and what types of hobbies are you able to pursue?

[01:43:38]

Dr. Smetherman: Yeah. So I did keep up with singing for many years actually until my children were born. I took voice lessons. I sang for four years with the New Orleans Symphony Chorus. Really enjoyed all of that. I did sort of have to take a break from that for the past 15, 20 years. Our children are 20 now, but I will tell you that particularly since the pandemic, but I make an effort to exercise every day, particularly if I can do it outside. So on the weekends, whether it's in the park here or...we have a little beach house that's just an hour from here that we go to frequently and go just, you know, being able to wake up in the morning on a Saturday morning and go walking on the beach. It just really clears your mind. So, yeah, so that's kind of my stress relief. It is funny, we were looking forward to kind of redeveloping our hobbies when our children went to college in the fall of 2019, but then they wound up back in the spring of 2020. So yeah, we were empty nesters for about six months, so.

[01:44:51]

Dr. Rubin: Wow. Well, Dana Smetherman, you are just such a phenomenal example of a diverse and effective radiology leader. I am so enthralled by your journey and what you have accomplished and just how articulate you are in describing your pathway, your vision, and in your proactivity. I can't thank you enough for joining us today on "Taking the Lead.

[01:45:19]

Dr. Smetherman: Well, thank you so much. That is, you know, high praise indeed. I know that you have interviewed many, many, many radiology leaders. I've listened to some of

those podcasts and really enjoying them. So thank you for the compliment. It's absolutely my pleasure, and just thanks for giving me the chance to chat with you.

[01:45:48]

Dr. Rubin: Please join me next month when I speak with Howard Fleishon, associate professor at the Emory School of Medicine and chair of the board of chancellors of the American College of Radiology. An Arizonan for most of his professional career, Dr. Fleishon was a partner in Valley Radiologists Limited and North Mountain Radiology Group, serving on the medical staff of several community hospitals in the Phoenix metropolitan area over a 20-year span. He held a number of leadership positions, including group presidents, medical director, and vice-chair. An active member of the Arizona Radiological Society, Dr. Fleishon held a number of leadership positions, including chapter president. His leadership at the state level was an entree to many national roles with the American College of Radiology, including a five-year term on the council steering committee and 12 years of continuous service on the board of chancellors culminating in his current role as chair beginning in 2020. Six years ago, Dr. Fleishon brought his experience and expertise in community radiology practice to Emory University, joining the radiology department as division director for community radiology specialists.

[01:46:56]

"Taking the Lead" is a production of the radiology leadership Institute and the American College of Radiology. Special. Thanks go to Anne Marie Pasco, senior director of the RLI and co-producer of this podcast, to Port City Films for production support, Linda Sours, Megan Swope, and Debbie Kokal for our marketing and social media. Brian Russell, Jen Pendo, and Krystal Macintosh for technical and web support, and Shane Yoder, for our theme music. Finally, thank you, our audience, for listening and for your interest in radiology leadership. I'm your host, Geoff Rubin from the University of Arizona College of medicine in Tucson. We welcome your feedback, questions, and ideas for future conversations. You can reach me on Twitter at G-E-O-F-F-R-U-B-I-N, or using the hashtag, RLI Taking the Lead. Alternatively, send us an email at rli@acr.org. I look forward to you joining me next time on taking the time on "Taking the Lead."