Episode 14: Listening, Learning and Leading
Sanjay Shetty, MD, MBA, FACR
October 17, 2019

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Geoff: 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 am speaking with Dr. Sanjay Shetty, executive vice president for corporate and business development at the Steward Health Care System in Dallas Texas. Following completion of a radiology residency and musculoskeletal imaging fellowship at the Massachusetts General Hospital in 2006, Dr. Shetty served as assistant professor of radiology at Beth Israel Deaconess Hospital, while earning an MBA and graduating first in his class at the Wharton School of the University of Pennsylvania. Upon graduation, he left academia and became a management consultant with Bain & Company, advising on a breadth of topics from discount groceries to golf cart parts, all while moonlighting community radiology on the weekends. After just 2 years, in 2010, he accepted the position of chair of radiology at St. Elizabeth's, a hospital within the soon-to-be rapidly expanding Steward Health Care System in Boston. While serving in that role for three years, he became increasingly engaged in system-based roles, leading to his appointment in 2013 as president of the Steward Health Care Network, which is the second largest physician network in Massachusetts. And then 3 years after that, in 2016, he switched roles to become the president of the Steward Medical Group.

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Earlier this year, he pivoted into his current role as executive vice president for corporate and business development and a key member of the senior leadership team at the Steward Health Care System, which currently is the largest private taxpaying hospital operator in the United States, comprising 37 community hospitals across 9 states and the country of Malta and serving over 800 communities with more than 42,000 employees. In 2012, Sanjay was recognized by the "Boston Business Journal" as 1 of Boston's 40 under 40 for civic and business leadership, and in 2013, by Becker's Hospital and Health Care Review as 1 of 25 national health care executives designated as rising stars under 40.

Sanjay, welcome to "Taking the Lead."

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Dr. Shetty: Thank you, Geoff. Thanks for having me.

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Geoff: Let's start with your earliest days. Where were you born?

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Dr. Shetty: I was born in Long Island, New York. My folks were both physicians -- my dad, a practicing neurologist, my mom, a pathologist. So I grew up in New York until I went off to boarding school in 1989.

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Geoff: Terrific. And brothers and sisters?

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Dr. Shetty: I do. I have a younger sister, a urologist in Providence. So she's at Brown.

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Geoff: Lot of physicians in your family.

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Dr. Shetty: Sure thing. That's for sure.

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Geoff: And both your parents, were they practicing in private practice, community hospitals?

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Dr. Shetty: My mom never practiced here in the States, but my dad was a solo private practitioner in New York, working on the South Shore of Long Island for many years.

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Geoff: I see. And how would you describe your life growing up, with this very physician-oriented family and physicians to be?

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Dr. Shetty: It was a pretty typical second-generation childhood, I would say. Since my parents were immigrants to this country, they worked very hard for us, made sure we had basically everything we needed. So we're pretty blessed, I think, in terms of what my sister and I had access to, you know, had an opportunity. Even though they were new to this country, they figured out that they wanted to send us to a particular school and started us there when we were very young. So I think we are very, very lucky in a lot of ways.

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Geoff: Yeah. That seems like that they were extremely committed to you and your sister. You mentioned boarding school. Which school was that, and when did you begin?

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Dr. Shetty: Yeah. So I went off to New Hampshire, Phillips Exeter Academy as a sophomore and graduated from there three years later.

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Geoff: Got it. Prior to heading to Exeter, if you sort of think back to your family growing up, sitting around the dinner table, do you remember any particular dinner table conversations that were typical or interesting?

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Dr. Shetty: Huh, wow, that's a good question, Geoff. Wow, you know, I will tell you that there were probably not as many dinner table conversations as I might have liked, because my dad would often work pretty late into the evening, and my sister and I would often be eating by ourselves because we were trying to get to bed. But overall, I think some of them are interesting ones, we're really just hearing stories about my parents growing up and trying to understand what their lives were like in India. So those are some of the best stories, right, when you kinda learn about your parents as someone who's not just your parent, but as a little kid, as a student. And so it was really interesting to sort of hear those stories. I'm still kinda tickled by those stories today.

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Geoff: Any come to mind in particular?

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Dr. Shetty: No. Just some of them, it's just my, in particular, my mom, she was the youngest of eight kids in India. Often with lots of cousins roaming about the house as well who would stay with them, because they were more in the city. So a lot of cousins would be staying with them to go to school. So just a lot of really interesting stories of that many kids piled around the table, where her mom would always treat the cousins really well, and she would always be sort of at the very end of the receiving line for whatever meals prepared, and just sort of how busy and full their house must have been compared to our house, which was much more sort of typical two-kid family in New York.

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Geoff: Yeah. That does sound like a different world, a whole world away. Interesting, you mentioned your mom essentially being last in line for the food amongst all the kids. Her decision to not practice medicine when she came to this country, was that to commit her efforts to you and your sister principally or were there other reasons?

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Dr. Shetty: I think it was mostly that. I think I personally take some of the responsibility for this, because I remember very clearly, I think when she came, she had us right away, and then she sort of started studying for her exams. And I don't think, as little kids, we really let her study as much as she wanted to. So I don't think she ever got really comfortable that she would be ready, sort of having been away from it for a little bit and coming back to take, I think what at the time was called the easy FMG exams. I remember specifically a memory of being like three or four and going into her room, stealing her books, and hiding them in the house just so that she would pay more attention to us. And even when I was a little bit older, trying to read, obviously, very poorly pronounced names of bones and things, trying to tease her and say, "Oh, I'll help you study. You don't need to use the books." So I think I was directly responsible for her not being able to get all of that done.

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Geoff: What a rascal you were. How about your first job? I'm not talking about taking out the trash or doing the dishes, but outside the home. Did you have any jobs growing up?

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Dr. Shetty: Not until I went off to Exeter where I did some very basic stuff, like working in the computer lab and things like that. But not before then outside of the house. In college, I started by doing some tutoring. And I remember, in med school, I taught Kaplan MCAT courses. But those are a lot later. But yeah, really, it started when I went off to boarding school, where I was just looking for more pocket money.

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Geoff: Were there any lessons that you learned from those first jobs, that one, in particular, in the computer lab?

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Dr. Shetty: Really, it was just how to be sort of financially prudent. And you know, for whatever reason, my parents never believed in an allowance growing up. They really said, "If you need something, we'll buy it. If you don't need it, then we won't." And you have to justify every purchase along the way. But I think the concept of money and what money could buy never really clicked until I went away to school and I had an actual bank account and an ATM. That bank account is actually, crazily enough, through many generations of mergers and acquisitions, still my bank account today. And it's amazing that the first time where you start pulling money out and making money and realizing, "Wow, if I wanna eat out for dinner, that's equating it to three hours in the computer lab of working time before you kind of make the money that you need to eat out." And so, suddenly, the value of money came into fine focus for me, at least in this, I'm sure, later in life than most. But when you're off on your own, that's when it really starts to hit home.

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Geoff: Yeah. That's a terrific recollection. Looking back, what were some of your defining moments and influences? What do you recall being, perhaps, your first experience serving as a leader?

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Dr. Shetty: I would say, well, I have a couple of answers to that question. You know, the first in terms of leadership, one of the most defining experiences for me, as crazy as it is, was a summer camp that I went to after eighth grade. I went to a camp called CTY. It was sort of an academic summer camp at Franklin & Marshall College in Lancaster, Pennsylvania. And I think that was really probably one of the most important experiences I'd had. I was at a terrific school on Long Island, but really my world was pretty small, and that experience of seeing these incredibly talented kids from all over the country coming to this camp and realizing how big a world there was out there did a lot of things for me that one summer. And that's ultimately what motivated me to go out and go to boarding school and sort of push myself a lot harder than I ever had before.

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I think it was realizing what a big world out there, realizing how many sort of amazing talents and people there are, so on the one hand, pushing me to sort of try to do more, but on the other hand, also made myself a little bit more comfortable with the idea that you're never going to be the best at everything, right. You've got to be comfortable in your own skin. You've got to try to find and carve your own path. And I think that experience was really formative, and it kinda kept getting hammered home, you know, every stage of life, whether it was going away to boarding school, going off to college, going to med school, even meeting my residency class. Over and over again, opportunities to see what amazing people there are out there, and if you want to, you know, distinguish yourself, if you want to be in that mix, you've got to push yourself, but also, be comfortable with the fact that they're gonna do great things, and you can enjoy their success even as you're trying to have your own successes.

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Geoff: Yeah, well put. You are a Harvard man, earning a bachelor's degree in biochemical sciences, a master's in biology, an M.D. In fact, you earned your A.B. summa cum laude.

Clearly, you thrived as a student at Harvard. Was Harvard always the obvious choice, the obvious place for your education, or did you ever consider alternatives?

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Dr. Shetty: It's never an obvious place. I think I was happy when it worked out and I got in. But once I got the acceptance, I think that was the dream that I've had for a while, and I pursued it. I did drive my parents nuts right at the end, because I had an opportunity out on the West Coast as well and went to visit and threatened that I'd move across the country. And they were not too happy about that. So I think I did that more as a negotiating more than anything else, but I absolutely loved my experience there. I think it's the kind of place where -- and I tell this to kids now -- it is not a place where anybody's gonna hand you something on a platter, but if you're willing to go out and get it, the possibilities are endless. It was a place where, when you start out, you're in these huge classes and you may never see your professor. But by the end, you will be sitting in a small room with the key person, having conversations about science or about Shakespeare or whatever it is that you wanna study.

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I love the experience, but I recognize it's probably sort of because, by that point, I've been in so many environments where people weren't handing you anything, you know, and sort of bringing you to the experiences. But you had to go out and get it, and you had to sort of find your own path. And so that's why I love the place so much, because there was so many chances for us to pursue things in the classroom, but especially outside of the classroom, right. The chances to run organizations that had massive budgets with absolutely no adult supervision, you know, and you were just there, students, trying to do your best, and running some pretty neat things in the college community. So that's what I really loved about it.

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Geoff: Did you run an organization in particular?

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Dr. Shetty: Yeah. I mean, the one that I remember the most was I actually was what was called secretary-general of Harvard National Model UN. So it was running a conference for just over 2,000 college students from literally all over the world. I think we had every continent represented, other than Antarctica, attending our conference. We hosted the conference once a year in Boston, and I was the head of the organization. And I had a staff of 120 college students who are working in various capacities, running the committees, doing security, running the business. So in the end, I don't recall the exact budget, but you know, it was a budget of around $15 million. Again, no adult supervision, just a bunch of students running this entity, trying to make sure that we ran a successful conference, we're able to contribute to subsequent years, offer financial support for some schools that might not otherwise be able to do it. But that was really probably my first large leadership experience, where I had a team, where I had to delegate, where they had teams, and so there was actually a pretty big structure that I was working with, and where, you know, I had to earn my spot there after years of serving as a lower-level staff person, as a younger person in college.

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So that's probably one of my formative ones in terms of a sense of "I could do this thing that they call business," right? I'd never really done it before, never even thought about it, and that I had not, you know, had these opportunities to potentially consider, "Could I be a leader

in a different way than I might have otherwise thought, right?" At that point, I thought I would be a lab guy and maybe get an M.D., Ph.D. and work in a lab. And that experience really opened my eyes to the idea that it was fun to work on big teams and it was fun to have these leadership roles and have an impact on a pretty big scale.

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Geoff: Wow, that's fantastic. So it sounds like leadership was initially really introduced to you at Harvard. That's where the opportunities presented themselves, and that's where you were able to truly embrace them. Is that fair?

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Dr. Shetty: I think that's right, yeah. I mean, I've had a few things that I did in high school. So you know, I was captain of the debate team or head of the Indian society. So I did a few things in high school, but nothing at the scale of what I was able to do in college. And again, it was sort of these opportunities that were out there, you had to go find them and you had to pursue them. But I think college is really where I began to say, "Wow, I think I can do this." I will tell you that when I applied to med schools, most of my med school interviewers wanted to talk about that, because I talked about lab and talked about clinical rotations a lot. But this was something that felt a little different to them and was interesting for them to understand sort of "How does this work? What is this conference? And how is it that you're running this with absolutely no one else around to monitor you?" And I said, "It's because there'd been some great kids generations before me who built this organization, and I kinda got to slot in and be a leader of it for a year." But it was truly a formative experience for me in terms of having that chance to throw myself into a project of that scope.

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Geoff: Yeah. That sounds like a really astounding experience. So after medical school, you had a year of internship at the Lahey Clinic, and then you were back to the Harvard Family for residency and fellowship, followed by three years as an assistant professor at Beth Israel Deaconess. It's a lot of Harvard, and yet when you opted for an MBA after completing your musculoskeletal fellowship, you chose Wharton. What led you to break out of the Harvard mold for your MBA?

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Dr. Shetty: In terms of why I chose the MBA, actually, it was a couple of things. The first and most important was, at that point, I was working as a radiologist and I had a young kid, and the opportunity cost of going to a full-time program is just too much. Because you know, the idea of giving up a salary in radiology at that stage of my life was too hard to contemplate. So I really limited my search to executive MBA programs, where I'd have the opportunity to work during the week and then do the program on the side. And at the time, some of the best options for us were in New York or in Philadelphia, and either one of them would have required a pretty long commute. But I decided on the program at Wharton because I absolutely love the fact that they really take the program very seriously.

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Really, it's a full MBA, right. The course requirements, if anything, are the same, maybe even a little bit more than the regular MBA. The experience was as a cohort, so we joined as a class and we graduated as a class, and that part of the experience was really important to me. And so those elements of the program are really what drew me to the Wharton program.

And I know there have been a number of other radiologists who followed, because they also sort of prize that chance to say, "I'm part of a class, and I wanna graduate with a class and with friends and have that part of the business school experience along with another group of professionals."

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The other thing I loved about it was that it wasn't just a health care MBA. There was definitely health care opportunities within the MBA, but I majored in finance. And I did acquisitions and derivatives and all sorts of other things that I probably wouldn't have been able to do had I been doing a sort of healthcare-focused only MBA. And for me, that part of the experience is also really important. I learned a ton from my classmates who are outside of the health care industry, pushing me to sort of get the wheels turning about what I could be doing after graduation, but also to approach problems in a slightly different way. And that part of the experience was terrific as well.

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Geoff: That is an excellent articulation of the value proposition of committing to a full MBA program. Are there any other aspects of the Wharton MBA experience that you would highlight, perhaps for some of our listeners who are weighing the pros and cons of committing to an MBA program versus just sort of taking a few online classes here and there?

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Dr. Shetty: Yeah. I mean, I think I've had this conversation with a lot of folks along the way, because I think there's a growing cohort of those of us in radiology who have MBAs. And so I've thought a lot about this question. I think, for me, the MBA made a lot of sense, because I wanted to explore other opportunities. I wanted to see what else was out there, and choosing that full-time MBA did a couple of things. One, it really put a marker down on the idea that I was going to commit to studying. It's a huge investment of time and resources, and I wanted to sort of carve that out in my life to say, "This is what I'm going to do now." You don't do the MBA at that stage of your life just to get the credential, because the credential, on its own, means nothing like an M.D. does. It is really a set of skills, a set of approaches, a way to problem-solve, but it's not like having the credential MBA means you instantly get job X or job Y. You have to then use that and use your skills and follow the path that you wanna follow.

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So I think that program, for me, really helped me, one, carve out the time. It helped me focus on getting the work down and really pursuing a set of courses that, I think if I were doing it on my own in sort of piecemeal fashion, it would have dragged down for years and years and years. And I probably would never have given it the focus that it really deserves. It would have been something always on the side, always the last thing to do at the end of the night or the first thing to blow off if I had a choice. And so that sort of commitment really made me focus on trying to learn the material and trying to get the most out of my classes and the experience while I was doing it.

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Geoff: Those are marvelous insights. So you completed your MBA, again, first in your class, and you continued working as a musculoskeletal radiologist, assistant professor at Beth Israel

Deaconess. What else was going on for you professionally in those years? And in particular, after finishing Wharton, you must have been hungry to apply your leadership in management training. How did you pursue that?

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Dr. Shetty: Yeah. It was a process that I went through, actually, all the way through business school, because I think when I started the program, my assumption was that I would continue on the same path. I absolutely loved my time at Beth Israel Deaconess, met some terrific people, and I assumed that maybe there would be a path for me there or somewhere else where I could sort of pursue the management training that I learned maybe through committee assignments, maybe through some leadership roles down the road and as I was able to sort of grow, learn more about radiology, build on my academic credentials, but then also apply some of these management ideas. I think, during my MBA, what I realize was that, even though it was an executive program where many of the folks in the program were actually sponsored by the companies, a lot of people were starting to pivot. They were starting to...the wheels start turning when you're in a place like business school.

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You'll realize that there are a lot of opportunities out there, and people started making changes. They pivoted to new industries. They took on new roles at their current companies. They use the recruiting process at the Wharton School in order to apply to companies. And I began to say, "Maybe that is something I should be doing, right? I should at least look and see what's out there." I did consider lots of options, and the option that I ultimately settled on was what I jokingly referred to as my residency for my MBA, a chance to really apply it. And that was going into management consulting with Bain & Company. So I went through the process of recruiting with Bain in parallel to doing my MBA. And so by the time I graduated, I already knew that I was going to be leaving my position at Beth Israel Deaconess and moving over to Bain. I mean, it's a conversation that I had with folks, I think, pretty early on in my second year at BI, where I sort of started to talk about the idea that I might make this transition. So I did, and it was about six months after graduation that I actually made the move to Bain full time.

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Geoff: I see, full time. And can you tell us a little bit about what it was like working at Bain? What kind of projects did you take on?

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Dr. Shetty: Yeah. From what it was like, it was a completely different world. I know there are a lot of folks who've had these experiences, but since I was someone who had gone straight through, I'd never had a job quite like that where I was working at a desk but not looking at a monitor, at images, right. So it was a very different experience and a different culture. It's also an interesting place for a career, right, because I was so far out from college at that point, having done my med school and residency and everything else. So my cohort were the new freshly minted MBA grads, many of whom were maybe five or six, maybe seven years out of college. So I was significantly older, also in a different stage of life, because I had kids at that point. So it was interesting from just sort of dropping myself into that environment at a...on the one hand, considered an advanced degree person, because I had an M.D. and had done some other things in the industry, on the other hand, sort of back with folks that were significantly younger than me.

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In terms of the projects that I did, I threw myself into a bunch of different things. On the one hand, I certainly was interested in health care and did a couple of projects, one that had to do with imaging, actually. Can't speak about this particular client, but was working with them on how they marketed their products to their customers. Also, did health care with respect to devices. So I worked some in the cardiovascular space, electrophysiology, and interventional cardiology, working with a client on devices. But I also did projects completely outside of health care. I worked in what was known as the private equity group, which was the group that actually consulted with private equity firms who are about to make investments. And so in that part of my career at Bain, I worked on golf cart parts, I worked on discount groceries, I did kinda lots of crazy things, very quick projects trying to inform the investment thesis around certain potential investments, and learned a ton by doing those other industries.

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And sometimes, it would surprise the clients at the end of the engagement by saying...I remember once, I was doing the golf cart part project, and at the end, I was talking to the CEO, presenting some of the findings, and he mentioned some back pain, I said, "Oh, you should get an MRI." And he's like, "How do you know so much about this?" "I'm a doctor, too." And he had no idea, but I'd been working with them for weeks, and that I was a doctor in addition to being sort of the Bain consultant. And that actually made me really happy, the fact that I was able to sort of represent as a full-on MBA without having to rely on the fact that I was a doctor to sort of have, if you will, a crutch and actually perform pretty well in that environment. So that made me very happy when he was surprised at the end of the engagement that I was actually a doctor.

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Geoff: Yeah. You know, this part of the story is really kinda blowing me away. I mean, you grew up in a family of doctors, and you described how your dad was, you know, home late, taking care of patients and seeing folks in clinic. And yet, after all of this commitment for your medical education, you dove full-on into business, and that's really remarkable. What touchpoints did you maintain to your medical practice at that point? Were you still practicing radiology? And what might you describe as being the basis for compelling you into this new domain for which it sounds like, at least from a family perspective, there wasn't a lot of examples?

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Dr. Shetty: Right. Well, I tried to stay in touch with radiology as much as I could. Actually, a key person who has been an influencer for me for many years all the way back to...it was an internship, I did research with him, was Max Rosen, who at the time was at Beth Israel Deaconess, now is the chair at UMass. And Max was awesome. He was doing some community radiology projects with Beth Israel Deaconess and let me continue to moonlight on weekends while I was working at Bain. So I was continuing to do that all the way through my Bain experience by picking up occasional weekends at some of the community sites for BI.

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Also worked with an outpatient MRI company locally that allowed me to come in. They were desperate to have somebody who could do arthrograms for the athletes on the

weekends, but their radiologists weren't working at that time or weren't doing procedures. So I would literally come in on Saturdays and do 8 to 10 arthrograms and read those MRIs for them on the weekends, which was great for the athletes who didn't wanna miss school or miss work and wanted to come in and get that done on a weekend. So between those two experiences, I was able to do quite a bit of radiology and often had my Bain laptop open, you know, between cases, trying to catch up on work, because that was more of a full-time job as you can imagine.

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So I definitely tried to keep the radiology piece going, and it actually will tell you it helped me at Bain. The chief medical officer at the device company I was working with, when I would mention to him that I was tired because I was working at the hospital over the weekend or something, it definitely gave me an entree into talking to him as a colleague plus consultant in a way that my partners at Bain were surprised by. You know, "Who is this junior guy who's able to sort of be on the cellphone with the chief medical officer?" He'd call me up sometimes and sort of bypass the rest of the team, because he'd wanna run something by me, and I'd always have to go to a partner, "Okay, he called me up. I'm gonna run by you what I wanna tell him," but I'm gonna follow protocol and not bypass him. So that touchpoint with radiology was helpful.

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I will tell you, also, it helped me on some projects, because I had friends at BI who I've worked on a project in orthopedics. And often, what you do on these projects is you call experts, and you get their opinions on various vendors. And it's an expensive process, because you're paying people for expert opinions. I would often just call friends from med school, call friends from residency and from BI. And those connections, sort of maintaining them, were very helpful, because I could pull together a set of interviews in a day just by texting people, whereas for others, it would, you know, be a whole sort of engagement with an expert consulting firm in order to get all of that stuff. So those connections served me pretty well at Bain.

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But in terms of charting up a path and why I chose to go there, it really was sort of what I talked about. The wheels were turning in business school. I kind of realized that there was a really big world out there and that I wasn't sure what my path would be in academic medicine and how long it would take. And what I really wanted to do was the administration, was the business of medicine, and to be involved in thinking about populations at a bigger level. And so I wanted to try something different, and so I pushed myself out to do it. It wasn't necessarily the best financial choice immediately, because you know, radiologists make a really good living. But in the long run, I think it paid off, because it gave me that experience to really test what I'd learned at an MBA level, but also then give me some experiences that would serve me well sort of down the road.

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Geoff: Yes.

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Dr. Shetty: Yeah.

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Geoff: So you complete your MBA at Wharton, and then you have your time at Bain. And then an opportunity comes up to become chair of radiology at a community hospital, St. Elizabeth Medical Center in Boston. Tell us about your decision to transition from what sounds like an exciting time at Bain, a lot of interesting projects, to focusing on this new role.

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Dr. Shetty: Yeah. Couple of things, so I did get this opportunity, and after meeting a couple of key folks at my current company -- one is a radiologist, Dr. Mark Girard, who was running Steward Health Care Network at the time, another was a urologist, Dr. Mike Callum, who was running the medical group. So two key leaders, both folks who had done what I always dreamed of doing, you know, going from more clinical practice into more administrative roles. With this company, at the time, it was called Caritas Christi. They were the health care system for the Catholic hospitals in Boston, and what they began to talk about as they were recruiting me was that they were looking for young leaders. They were willing to sort of break the mold in terms of what would typically be a chairman of a department and rather go with folks that were really gonna understand sort of the business of the practice and understand what it meant to be managing a practice as opposed to sort of the more traditional path of, you know, putting in the time and maybe the more academic, etc. So they were really interested in getting to know me.

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Another part of what I sort of learned subsequently -- which I, you know, came to realize was gonna be really important in terms of the trajectory of the company -- was that Caritas Christi was in quite a bit of financial distress. And my current boss, Dr. Ralph de la Torre, who had become the CEO of Caritas Christi, recognized that that path that they were on was no longer sustainable. And so he decided to do something which, at the time, in Massachusetts, was really unthinkable and sought project funding for the system, and founded a new company, bought the assets of the hospitals from Caritas Christi, and founded what was known as Steward Health Care. And that funding came from a private equity firm. And so I think there was some interest in my background at Bain in terms of having folks that had some experience in the private equity world, even though mine was just on the consulting side.

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But regardless, having some experience in the business world and having physician leaders who could potentially play a role in a company that was transforming itself from...I think one of my Bain partners at the time who was advising me said, "Sanjay, how could you go there? That's the sick sister of Boston health care, right. That system is gonna be in trouble." And I said, "It seems like they're doing something different, and they're sort of being entrepreneurial in a way that I don't think I'll ever get to see in health care from a provider side in quite the same way." So I ended up making a jump.

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To be totally frank, you know, I went through my pros and cons at the time and, as I normally do, sort of really thought through, "Shall I leave Bain or shall I stay at Bain?" And I thought about that for a long time. But the part that I had really thought through, because my wife was bearing the brunt of it, was, you know, how hard it was from a travel perspective, especially with two young kids at home. And so ultimately, that's what swayed me to say,

"Look, this is an amazing opportunity." Bain would probably consider having me back down the road if it didn't work out. But in terms of an opportunity to be home more, to have a leadership role right away, it was kind of a dream come through. So that ultimately is what swayed me to the decision to give it a shot at this company, again, Caritas Christi, subsequently, Steward several months after I joined.

[00:32:54]
Geoff: Yeah. That sounds very well considered. But I guess it can't be lost that you were taking a certain degree of risk in making this move, and that was bold to do so. And it sounds like the role as department chair at one hospital, St. Elizabeth, was essentially a place for you to anchor initially with the company, but the intent from the start was that you would take on a larger role. Is that true, or were you really just sort of focusing in on the task at hand of this hospital's radiology department?

[00:33:32]
Dr. Shetty: No. I would say, first, that it was definitely a lot to learn. So the task at hand was trying to become a leader in radiology in St. Elizabeth's. At the time, I was also involved with the ACR and was working with the Mass Radiologic Society. I had a lot to learn about radiology and, frankly, a lot to learn about leadership. Because as you mentioned in the introduction, I was just a few years out of fellowship, now being asked to run a small department, a community-based department, but still with a lot of responsibilities for my physicians, a lot of responsibilities for the rest of the staff. And so that was really my only task at first. I did begin to sort of push myself a little bit more into a system-level role over time, but that came, I would say, a little bit later, mostly in the interest of trying to push some system-level thinking, system-level standardization among a group that was...my group happened to be employed at our hospital, and I was chairman of that department and working with our docs. But the rest of the docs in the system were various private practices. So I worked with a lot of those folks who've been terrific collaborators and colleagues to think about the system as a whole, even though we, as groups, were functioning separately.

[00:34:43]
Geoff: And you mentioned a lot of leadership lessons from those early, early days. Can you recount any?

[00:34:49]
Dr. Shetty: Yeah. I mean, one was...and again, this is something that...it's a little cliché, but I'll say it anyway, which is when I got there, I had a lot of ideas. But I will say the best thing that I could have done, especially as the junior kid in the room who's now coming in as the boss, was to listen a lot. I listen to the hospital president. I listen to all of our referring physicians. I listened a lot to my new team in the radiology department. And I did a lot of listening because I really wanted to understand, you know, what the problems were. I came in with certain assumptions about what the problems were. I discovered that some of the problems weren't as I thought, right.

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We needed to improve the perception of the department among the hospital. We need to improve certain core operating metrics. We needed to think carefully about financial performance and making sure that the group was sustainable. And I needed to think a lot about the people management and how do I make sure that, you know, we had a team that

loved to work together. And so those were some of the things that I dug into first, which changed a bit from sort of my thinking before I jumped into the role. And so the listening part was a really important lesson for me. I've had a couple of different stops along the path, as you mentioned, and often, what I have to do when I start is I do a lot of listening to really think about what are the problems that need to be solved before I start coming in with assumptions. So that's probably the first one.

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I think the second one is -- and I think this is true of anyone who's ever been in a leadership role, section leader, department chair -- you're often putting out fires. That is just the nature of the world that we're in, right, that there's gonna be a fire you didn't expect to deal with when you came in. And I think the two lessons are, one, try not to make that the only thing you do, try to have bigger level thoughts and set yourself goals that go beyond today's fire and today's crisis. And so that's something that I definitely would think a lot about as a chairman of radiology, which is I hear some bigger level projects that I wanna get done, and I'm gonna set myself timelines and goals on when I'm gonna get them done so that, no matter what's distracting me in the moment, I've got something that I'm trying to get to.

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But the other thing about those crises is that you have to, again, stop and listen and think carefully before you respond. Because I think some of the biggest mistakes are when you respond off the cuff or respond without really knowing what's going on, and you find yourself having to backtrack, you know, what you said originally as opposed to taking a moment, breathing, thinking through what is really happening, and then coming up with a measured and thoughtful response.

[00:37:13]
Geoff: This is tremendous advice. Thank you. Thank you for that. It sounds like it was a very formative experience for you. And your point about stopping and listening is not cliché. It's hard for people, particularly in such an action-oriented world that we're in, in Madison, you know, where oftentimes we're called upon to do something right away, because if we don't, the patient might suffer. And it's almost counterintuitive. So I really appreciate you're emphasizing that.

[00:37:45]
So you mentioned gradually taking on more system roles, and I see that you served as a medical director of radiology within Kindred Healthcare. Can you help us understand what was that role? And was that sort of your step towards systemness?

[00:38:02]
Geoff: Oh, no. That was a relatively smaller role, Geoff. That was just because our department was providing radiology services at this facility. And so as a result, as chairman, I would also take on the role of chairman over there. So that was a relatively smaller one. The real change in my role was when I officially became vice president of radiology for the system. That formalized my role of thinking about sort of how do we make the system work more as a system through policies, procedures, standardization of our protocols, etc. So that was really the first one. And then from there, the next pivot, which was an interesting and odd one, was when I was asked to take over also the employed pathology group. It was my first pivot outside the world of radiology, an opportunity to work with a really relatively

small group of employed pathologists who worked at a couple of facilities, but it was a really terrific opportunity to begin to think of myself as not just a radiology physician executive but a physician executive. And that was very helpful for me, because again, it gave me a chance to think about a completely different specialty.

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They have, in a lot of ways, a lot in common because of the fact that they're hospital-based and sort of tend to be receivers of volume, but also collaborators with physicians. So a lot in common, but then a lot that's very different from a business perspective and sort of what their coverage is, etc. So I learned a lot about just how do you manage physicians from a different specialty, how do you think about engaging with them, how do you learn about their world so that you can be a great contributor to what they're doing, and that was a great preparation for a couple of the other roles that would come subsequently in terms of thinking about leadership, not just as a radiologist, but as a physician executive, more generally.

[00:39:45]
Geoff: Yeah, terrific. I'd like to explore briefly your pivot into systemness, and particularly, if I am understanding you correctly, that when you started in your role at St. Elizabeth, that systemness wasn't clearly on the agenda and that you were able to establish those priorities and, presumably, to effectively communicate the value of having a more system-based approach to medical imaging for the broader system. Can you talk us through what sorts of steps were required to help to pivot the organization to embrace imaging from a more system wide perspective as opposed to the little pockets of groups associated with different delivery points?

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Dr. Shetty: Sure. It was an interesting role. In this, I had a lot of support from the chief medical officer of the system, Justine Carr, who had started to do this with a couple of specialties. And I had the opportunity to basically take the lead on imaging. And what was interesting about this was, again, at the time, we had employee group at one facility and private practices at the other facilities, and there was really nothing to tie them together. I think the process which I really enjoyed was actually the chance to engage with the leaders of the other departments and recognizing that I wasn't coming into it from a position of being able to say, "This is what we're going to do," but rather having to build collaboration among the group. And everyone came into it with a great attitude about, "Yes, there's a reason to do this. We're gonna have referring positions. We're going to get confused or frustrated if things don't work quite the same way from facility to facility, especially as the system as a whole is thinking more about systemness and retention of care within our integrated health care system."

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So the collaboration was terrific, but I think, for me, it became almost like a consulting project in a way. It was thinking about a project plan, really working on getting buy-in for the project, engaging with people, and then putting in a ton of work between meetings, basically to develop a straw-man for every one of these policies and procedures to say, "I've researched best practices. I've looked out there for what other institutions are doing. I've looked at what each of our institutions is doing," and come up with an idea, which takes a ton of work, right. But in the absence of that, it would have been a lot of swirling, a lot of talking around random details without actually getting to a finished product. So I think, ultimately,

those were the elements that led it to be reasonably successful in terms of implementing across a system pretty quick, because we had the buy-in, we had folks willing to commit their time to discussing these things, and they've put their time in to reviewing them, but then ultimately putting in a lot of work on my own to make sure that what we're ending up with was a high-quality product.

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Geoff: Sanjay, recalling your observation that is chair at St. Elizabeth's, you oversaw a department of employed physicians, but also worked with a number of private practices. What approach did you take to engaging those private practices and getting them to change in favor of standardization and a system-aware approach?

[00:43:00]
Dr. Shetty: Yeah. So I mean, the approach was really because I was not a boss per se, I wasn't direct reporting relationship with any of those folks, and they were, many of them, very long-standing, very well-respected folks at their own hospitals and as part of their own medical staffs. I was really coming from a place of collaboration. Ultimately, what it came down to was sort of developing a process that would allow us to collaborate together. We met on equal footing. We began to discuss the policies and procedures at a baseline, sort of setting priorities and understanding where we might wanna start. And as I mentioned earlier, I spent a lot of time really looking out at what was already in existence across the various hospitals, where were we already aligned, where could we get some quick wins, and where were some areas where we were a little further apart or where, you know, local politics might push us to sort of think creatively.

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So that was really the approach, was building a process and starting from a place of collaboration. And I think, ultimately, what was great is everyone in the room came in with all the right attitude, right, which was "Hey, there is probably a way we could standardize some of these elements, and that's probably to all of our benefit." Because having that standardization would yield consistency, make it a little more difficult to sort of argue with referring physicians or with others, because now, we were talking about something had really been adopted across a much broader base.

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Geoff: It's terrific that everybody started on the same page and also that you effectively leveraged the relationships you had established within the state medical society to kinda get the ball rolling. Were there no friction points at all in bringing people together?

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Dr. Shetty: No. I mean, honestly, the biggest friction point was just getting people's bandwidth. People are so busy in whatever practice, employed or private practice, that pulling people out to spend their time which was a huge commitment on their part, show up in person or participate in conference calls, to take the reading and review of these policies really seriously, knowing that they were then gonna be sort of owners of those policies. That was probably the biggest piece of friction, given that it was just one more additional piece of work on top of an already very busy schedule and clinical practice. But beyond that, no. I mean, there are probably worsened discussions or disagreements around specifics of the policies, but all things that we could work through, especially given that we had outside

references and other places to go to to kind of help arbiter any of those disputes or to ultimately come up with language that would allow some flexibility within the confines of best practice. And so it was much easier to sort of agree on the policies. It was a little harder to get everybody to work on it given, not that they weren't interested, but more just that they were so busy outside of this work.

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Geoff: Now, we also discussed what a turning point it was for you to begin leading pathologists as non-radiologists. What lessons did you learn from leading the pathologists that might help radiologists better understand their context within the health system?

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Dr. Shetty: Yeah. I mean, as I mentioned before, that discussion with the pathologists was fascinating. There's so much about them that is similar in terms of their practice and the way that they accept cases, they are consultants to other physicians, their providing of expert opinions. But then there are some specifics, and that I learned along the way in terms of how they do their billing, the nuances of all of that, etc. That was very helpful. So for me, the most important thing was, again, sort of what we talked about before, right, which is start by listening, start by trying to understand what their real concerns were at the time, and begin to prioritize what's important based on what you're hearing as well as what you know to be true based on your third-party review of financials or operations or opinions from other folks who are using the service, like hospital presidents or referring physicians. And so it's combining all that information to come up with how we were going to address things.

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I know one of the first challenges we had was it was thinking about expansion of this pathology group, as well as stuffing of the pathology group, and trying to be creative about how do you manage a group of pathologists working at multiple sites in a world that's a little more difficult than it is for us in radiology, where it's literally a click of a button to be able to see images from somewhere else. Pathology obviously involves a little bit more of the logistics and other things to get things to the right spot. But all things that we could work through once we were able to sort of have that conversation and agree upon what the vision would be for the group.

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Geoff: So take me through an initial meeting that you might have with a group of specialists that are non-radiologists for whom you are seeking to help them in a leadership role. You're seeking to gain their trust and help them feel comfortable that, as a radiologist, you're committed to understanding their world and can represent them in a larger system. How do you approach them?

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Dr. Shetty: It's a great question. And that conversation depends a lot on who it is you're speaking to. I will say, the first thing that obviously helps is having the title, having the role, and having the line responsibility for them. This was a slightly different situation than what we talked about before in terms of building a radiology enterprise, because in this case, I actually did have direct line responsibility for their P&L, for their income statement, for their financial performance, and you know, oversight responsibilities as an executive. So that obviously changes the dynamic a little bit as you walk into the room, because it's not a "Who

the heck are you," but "Oh, I hear you're the new boss, why are you here?" So the context is slightly different, but that doesn't mean you approach it, at least my opinion, doesn't mean you approach it any differently. It still is very much a "Hey, I'm gonna start by introducing myself." I'm gonna start by explaining that I do still practice, that I'm still taking call on the weekends, doing a lot of what they're doing every day, which I think grounds the conversation in a different spot. I also will talk a little bit about experiences that I had in other context, right, so give them a broader sense of my background on why me being in this particular role might make sense. And then, as I said, it's a lot of listening to try to understand where they're coming from, where their concerns might be, and building out a plan from there.

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Geoff: Now, when we were discussing your approach to building systemness, your perspective of working the task of building systemness as a consulting project is brilliant. As you perform the research and identify best practice, developing straw-man proposal, was that purely a solo act, or did you have some key teammates to support that effort?

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Dr. Shetty: At first, it was pretty much a solo act, again, because it wasn't a large enterprise. It's a relatively small enterprise without a whole lot of infrastructure. I will say that some of the collaborators around the table were also really helpful, right, in terms of picking up pieces and saying, "I'll run with this one," and then bring it back to the team. But it was started primarily as a solo act. I would say, obviously, as my scope has grown and roles have grown, the size of the teams have grown accordingly. And so, then, I'm completely dependent on collaborators and folks that work on my team in order to get those projects done, right, where they're really gonna delve into the weeds in terms of understanding best practice, whether it's, again, clinical best practice or business best practice or whatever, to become the experts who can then present to me and share with me sort of what they've learned and help us reach a decision together.

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Geoff: And what sort of approach do you take to team building in that circumstance today when you have the opportunity to construct a team to really delve in and to understand and study a project in advance of sort of rolling it out?

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Dr. Shetty: Well, a couple of things. I mean, first off, with selecting the members of the team to correctly get you to the right spot. I mean, this is a skill where I think probably the most important skill as a manager or executive that I still think I have to develop. I still wanna get better at this, which is going beyond sort of the surface interview and really understanding sort of what motivates people, really understanding who's gonna perform well, who has the background but also has the potential to do a great job in a role. So I will say, a lot of the more recent experiences have been because they are members, you know, hired in members of the team and employees. And sort of identifying them from the get-go is probably the single most important thing, that you put them on the team there for a reason.

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As you're assembling for a particular project, I think a big part of it is trying to lay out the scope in a way that's understandable. You may have a really good conception of what you

want, but sometimes you have to go through the formality of writing it down in order to articulate it well. And sometimes, that process of writing it down helps you really crystallize your thoughts in a way that helps everyone get on the same page. "This is where we wanna start the project. This is where we wanna end the project. Here's the project scope and charter," and then give everybody a chance to react to that, right. They may look at it and say, "Well, wow, that was a good idea theoretically, but you know, that's an impossible project. What if we did it this way," and sort of being willing to hear that feedback.

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So for a lot of these, I think it's trying to find the right people from the get-go, identifying and scoping out a project appropriately and making sure everyone's bought into that, and then constantly looking for feedback on how things are going to see what you need to adjust or modify along the way. I think the projects that haven't gone well or where...for all the right reasons, you're in a rush, you think it's obvious what you need to do, and you don't crystallize it that well, is oftentimes where you find that, six months later, you've been spinning your wheels and completely not getting to the right spot. And you kinda have to stop, sit back, reframe, and go again. And you may have lost some time, but probably a good investment to make at that moment. Otherwise, you're just gonna be one year in and realizing you haven't really made progress against the target.

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Geoff: Such a great point. Creating context is often something that difficulty, and when you've got an idea in your head and you see it so clearly, it's not always evident whether or not you've been able to successfully communicated to others. And I really appreciate you're emphasizing that as a first step in any group activity.

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Dr. Shetty: I try to lay that out as much as I can in advance, right. And sometimes it's plain disguise, sometimes it's crazy or too aggressive. And there'll be team members who push back saying, "Well, you know, that's not really how it works," or "This is how we've always done it." So I do think that process is also good, putting it on paper and committing to it. And then if your team pushes back, it doesn't always mean that you give in to what they're saying, just to be very clear. Sometimes it's "I hear you, but that doesn't mean that's the way we're gonna do it from now on," right, or that, you know, "This process that you're describing to me, how it's always worked has been broken, and which is why we're here talking about it right now. And we're gonna fix it." So I do think, sometimes, that process of writing it down also lets you be a little more aspirational than you might otherwise be if you try to articulate it verbally and then kinda negotiate in the context of a first meeting. Rather, you kinda play out a stake and you really force people to be aggressive about pulling you back from where you sort of set your initial goal.

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And I think, for me, that's something that I...well, sometimes, it gets caught up in, right. I sometimes learn too well into the weeds, where I start not being willing to challenge paradigms, not be willing to do things that are sort of more fundamental change as opposed to incremental change, and that's because I know too much about the weeds and I make assumptions that I don't have to. So sometimes that process can be good for that as well in terms of pushing yourself to think harder and then let the rest of the team really argue you back if they can.

[00:54:34]
Geoff: Superb. I'd like to spend some time discussing what you all have been building at Steward. Talk us through Steward's origins as an asset-heavy owner of acute care hospitals and its transition to an asset-light vertically integrated health care network.

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Dr. Shetty: Absolutely. This is really the brainchild of my boss, Dr. Ralph de la Torre, who founded this system. He, as I may have mentioned before, was CEO of the Catholic health system in Boston that was going through an incredible financial difficulty and made the pretty revolutionary decision at the time to say, "We need outside support," that we got in the form of a private equity company. The models continue to evolve. I think the big realization is that our strength came from being operators. Our strength was not because we owned the bricks-and-mortar in particular hospital facilities, but because we know how to operate hospitals, we know how to operate medical groups, and we know how to run a successful ACO in a world where we don't employ every single doctor that works with us. In fact, two-thirds or more than two-thirds of the doctors who work with Steward as part of our ACO are private practice. And so we had to get good at thinking about how do you align doctors of all different stripes toward a common goal of managing populations.

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None of that was dependent on actually owning the bricks-and-mortar that you are operating a hospital in. So the asset-light version was his brainchild and sort of came through thinking about how do you fund expansion, how do you fund growth in a world that traditionally would say, "A hospital is bricks. It's not the integrated health system around that that's there to manage a population." So that's been our evolution, and it's led to our sort of stabilizing some very difficult troubled hospitals in Massachusetts, and then pursuing a pretty aggressive growth plan through 2017, and continuing on a really good trajectory subsequent to that as a system that's really focused on delivering this health care model, and partnering with folks that are willing to take on the ownership piece in exchange for us being really good operators of an integrated system. Sometimes, buying a hospital and then building that integrated system around it where it didn't once exist.

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Geoff: And what sort of folks are those who want to take on the ownership of the physical assets that partner with Steward?

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Dr. Shetty: The biggest partner that we've had has been a company called Medical Properties Trust. They're a real estate investment trust or REIT. They're publicly traded as a company, and their reason for being is to invest in health care properties with excellent operators. Steward is a key part of their overall portfolio. So they've been a terrific partner to us in terms of seeing our vision, understanding our operating model, and being able to help us through this space of growth.

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Geoff: Great. Now, I can't help but sense that this model feels very similar to the one that exists in the hospitality industry, where major hotel chains lease properties focusing on operations and customer, or in the case of Steward, patient-centric enhancements. Is that a

fair characterization? And if so, then what lessons might you take from the hospitality industry to further pursue Steward's mission?

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Dr. Shetty: Yeah. It's an interesting comparison when we thought about a couple of different industries that have sort of those parallels in hospitalities in that mix. In some ways, it's similar, in some ways, it's a little different, right. Obviously, while the hospitality models really focused on the actual institution and sort of the traffic through that institution, we're also thinking about it as the hospital but as part of a larger integrated network of providers, both employed and private practice. And some stickiness, some glue between them, which are our value-based contracts, under which we try to manage populations. And so the ecosystem around each one of our sort of "hotels," to use the analogy, is a little bit broader in terms of how we're thinking about it, right. It would be almost like if every one of those hotels had a bunch of theater/management of managing hospitality more broadly, right, all the restaurants, all the other stuff around the hotel, that we're then also collaborating with the hotel to manage hospitality on a broader scale than just what's in the bricks-and-mortar of the hotel itself.

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So it's a little bit different in terms of how we think about it, because the hospital on its own is sort of just one cog in a much bigger machine. But in a lot of ways, it's similar, right, in that the actual facility itself is a key component. We have to invest in those facilities, we invest in collaboration as well as on our own in the facilities to make sure that they are state-of-the-art, that they're appealing to patients, that they're providing that very strong sense of patient experience that we're trying to deliver at our institutions, while also staying true to our community hospital roots and recognizing that we're gonna provide excellent high-value care in these communities to service the broad spectrum of needs but maybe not support every single need that might be necessary in a much larger scale, like for example, transplant, well, maybe an academic partner that we use, or trauma in some markets, where we use a trauma partner. So again, a hotel might think of itself as "We can provide all things," to what they need right now for hospitality, but perhaps are partnering for theaters or whatever else they're doing on the outside to provide hospitality on a broader scale. We think about it somewhat similarly to that. So some interesting parallels as you think about it, but in some ways in which I think it's kinda different.

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Geoff: Yeah, fantastic. Well, clearly, you've thought this through quite thoroughly. That was really insightful. Now, within the context of value-based care which is, as you've articulated, the model that Steward is pursuing, to what extent does Steward see value-based care provision needed to be standardized? Meaning, how value is created and for whom that value is created in order to have some control around what products are being developed across, you know, this vast network that you have. Or is it looked at more individually and, you know, based on circumstances in different markets?

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Dr. Shetty: Yeah. It's a great question. I mean, I think there is an underlying framework and foundation that is standardized that's absolutely crucial. And that's something that's been built over years and years in terms of investments in our underlying infrastructure of how we think about populations. So that investment is crucial, and because of our scale, in our growing

scale, we're able to leverage that standardization to drive results sort of more quickly. But that being said, I think there are a couple of things that I'm not really proud of in terms of how we do things, right.

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So one is the idea of how we manage populations. What's amazing about what's out there is that there are so many low-hanging fruit and so many opportunities to drive pretty big change without doing anything that is sort of crazy, right. You're just really doing things to say, "There's waste in the system." There are opportunities that we can take over, like reducing readmissions or changing how skilled nursing facilities are utilized or thinking better about just standardizing sort of fundamental gaps in care, screening, and other items that should be happening at a population level but just aren't. Those aren't big swings, those are pretty small ones, and yet, thinking about doing them on a population level where nobody's ever been incentivized to do them in quite the same way, is sort of interesting and cool in terms of how you're trying to manage a population. And so those are the elements that standardization can be very helpful for.

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All of that being said, you know, you still have to take a local approach. What works in Massachusetts still doesn't work in Texas or Florida. It's just fundamentally different, and that's because the physicians that you're dealing with are different, right. They're in a different spot with respect to how they think about managing populations. It's different with respect to the payers and the insurance companies who are often our partners in constructing these programs. You know, what's comfortable to our Blue Cross Blue Shield of Massachusetts is not quite the same as what we would see in other parts of the country. They'll likely get there, but again, they're in a different spot in their journey of achieving value-based care. And so you have to develop programs and collaboration that works for them, as well as works for us.

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And frankly, the patients, too, are in a different spot. What they're used to, how they're used to engaging with the health care system or with the health care provider are different, and so we have to move at different paces. And we're at a different spot in each of our local geographies. So that gets in the way of that standardization, but I think it's ultimately more appropriate for each of the geographies. Underlying all of that, obviously, is that state rules still are different in terms of how organizations are structured, etc. So we have to be thinking about that difference from state to state, region to region as well.

[01:03:02]
Geoff: Now, within the context of delivering population health, you mentioned screening as a relatively low-hanging fruit. And turning our conversation back toward radiology a little bit, I think radiologists are curious to see where imaging plays a role in population health. And perhaps, we might drill down on one potential poster child, which is lung cancer screening, which has great potential to have huge health impact but has had limited penetration in the marketplace, mostly owing to social and other cultural barriers, perhaps, limit access or awareness. And so I'm curious, how would you think about lung cancer screening, imaging from a population health perspective, from a low-hanging fruit characteristic?

[01:03:58]
Dr. Shetty: Yeah. No, it's a great question. And I will say, Steward has done some work -- and especially again in our Massachusetts market -- in pushing ahead lung cancer screening. I don't think it's taken off at our company in quite the way that I might have thought several years ago when some of this first work was coming out. And I do think, you know, there are some issues with screening in general, right, that make it difficult. So the biggest issue if you're gonna take a purely selfish view of the world, which unfortunately, you know, that's the world we live in, right, which is the insurance companies and employers, etc., screening has a potential for impact, but that impact is pretty far downstream, right. We're talking about years, not months, in terms of the impact that screening could have. In fact, initiating new screening can sometimes be an expensive proposition, because you're now gonna be finding things that you're dealing with, without any guarantee that that would have actually had a health impact within the current year or within the next two years.

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Unfortunately, most value-based programs, as they're currently structured, are really built around year-long engagements, right. Maybe employers think on slightly longer periods, because they know that their employees will be around for three to five years. But they may be not thinking that that employee is gonna be there for 20 years. And so everybody's making a little bit of that selfish calculation on, "Am I gonna have to pay the bill downstream if I don't screen, right?" As terrible as that sounds, it's just sort of a fundamental truth. And so in the absence of having that sort of clear return on investment in the timeframe on which you're gonna be responsible for the patient, you have to think about things a little bit differently. You have to create a guardrail that ensures good behavior in the period in which you're actually responsible.

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So one of the ways in which you can do that is to think about whether lung cancer screening rises to the level of a screening measure to which you can actually incentivize people more directly, say, "Hey, I know you're gonna manage sort of medical expenses for this population, but I also am gonna expect you to do these 20, 30 things for the entire population that I believe is the right thing to do, right." So mammography sits in that category, colonoscopy sits in that category, blood pressure screening, management of hemoglobin A1C in the context of a diabetic population. These are all things we know are the right thing to be doing right now, and we actually are incentivized directly against achieving those measures, both from a process perspective, "Did we check a particular thing," and also sometimes from an outcomes perspective, "Did we check the blood pressure," but also manage it really well.

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Again, we may not see the return in the current year if you were just purely thinking about managing total medical expense of that population. But because we've labeled them explicitly as a measure to be achieved, and we've put some dollars behind that to say, "If you make that investment, we will help make sure that it's worth it to you," then you can sort of drive the right behavior even though that particular party may not have a "return" on sort of improving health outcomes in a longer time window. So that's what's happened with a lot of our value-based contracts. So when we look at our contracts in the sort of array of quality measures that we're being held accountable to, it includes many things that will have a return many years out but which are absolutely crucial to driving better health outcomes, you know, for that population.

[01:06:59]
So the exceptions to that potentially are, for example, Medicare, right. So if Medicare knows that they are gonna own this patient from now till forever, they may have an incentive to say, "We're gonna now incorporate this into a set of quality measures, because we know that even though you provide our system, X may not have this patient in your ACO in a year. We know we're likely to have this patient in a year, two years, five years, therefore, we're gonna incorporate it into a set of standard measures that we're gonna hold every accountable care organization beholden to." The other would be in the case of, you know, in Europe or somewhere else in a single-payer system where they own those patients from cradle to grave. Those folks are also gonna be highly incentivized to be thinking about improving health outcomes from a longer-term basis.

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But it does also kinda go back to sort of the more fundamental question that, although lung cancer screening is a terrific technology in and of itself, we have to make the case as radiologists and as a specialty to prove that this is going to actually achieve the intended outcome, right. It's going to improve health outcomes. It is an excellent investment to be making right now. And that's why if you look more broadly in the world of the ACR that, and even health policy institutions, it's absolutely crucial, right. Having a group of folks thinking about this at a society level to say, "Here are things that we need to be investigating and sort of understanding better," is absolutely crucial. Because it can just be, "Hey, this is a cool Whiz-bang technology for right now. This is a technology that will actually yield better returns for us as a society and sort of the ACR being at the center of that." It's absolutely crucial.

[01:08:26]
Geoff: Yeah. No, I appreciate you're bringing that up. I mean, I think the evidence-based that we have unpacked over the last 20 years in this domain have been tremendously compelling. And the ACR has played a crucial role in helping to bring that forward. But I don't wanna have us spend too much time on this specific domain. It's a value one, and your perspectives are fantastic. But let me just ask one more question around radiology and population health. And that would be, do you see other ways in which radiology can take a strong supportive position in the interest of population health beyond screening for disease?

[01:09:11]
Dr. Shetty: Sure. This is one that I still haven't cracked in at on this one, to be totally honest. I wish I had. I'd probably be able to talk a lot about it. The story that I've told, I think even at some prior meetings, has been when I took over as head of the ACO, as president of Steward Health Care Network, I came charging in, and all I could think about was radiology, because that was literally my only experience as a leader and as a clinician. I quickly came to learn that that's not where the low-hanging fruit were right at that moment, right. For us, it was achieving gaps in care with respect to cardiovascular health, diabetes, mental health, things that are really driving up total medical expense. And so I haven't yet quite cracked where radiology fits into all of this. I think screening is one of the key ones.

[01:09:54]
But a point that I make all the time is...and again, I don't know how to monetize this, I don't know how to integrate it more fully, but radiology touches a lot of patients, but they

especially are touching patients who are in sort of high-cost episodes right in the moment, right. I think I once looked at our ACO data for a year, and I think the number was just over 50% of patients who were sort of utilizing health care resources were touched by radiology within 30 days. That's sort of the big dollar amount. I forget the exact statistic, but it was about 50% of patients who were touching radiology in the context of a very high-cost episode.

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And so clearly, radiologists are sort of at the nexus of a lot of these decisions that are happening that are either gonna drive down or drive up health care spending. And so, ultimately, the most important thing that radiology can do in this context is help make sure that we're doers of the resources that we're being charged to manage, that we're making high-value recommendations, that we're not just running up additional imaging or additional diagnostics broadly defined, and that we're not driving people to therapies that are unnecessary. How that ultimately gets evaluated, how that ultimately gets monetized or turns into value for radiology as a specialty, I still haven't quite figured out. I know there's been a lot of thought around sort of what happens before a test is ordered with respect to appropriateness criteria, etc. That also is sort of in different stages in different parts of the country, and probably a valuable effort.

[01:11:20]
But I think our role is much broader than that in terms of how we're directing care downstream from the imaging tests that are happening under our watch. And so it's that part that I still haven't quite figured out, where are we gonna play our role, and how are gonna insert ourselves into the bigger conversation? I think radiology runs a risk of getting carved out, especially as other specialties and others incorporate imaging into their day-to-day practice. And so we have to be very thoughtful about how we can be really high-value players in that enterprise.

[01:11:48]
Geoff: Yeah. I can't help but think about the gatekeeper role as you, you know, make that description.

[01:11:55]
Dr. Shetty: Yeah. But I mean, I think it's beyond sort of...I don't think we ever wanna be positioned of just saying no to imaging, right? Because sometimes, imaging is the best investment that can be made in a particular moment in time. And if all you're thinking about is the cost of the CT scan, but you're forgetting that that CT scan saves the surgery downstream, you're gonna end up spending a lot more. But it's how do you quantitatively or realistically think about the value being given by that particular interpretation, that particular study at that moment in time is a complicated business. This is why, you know, the health policy researchers are at it and why the Human Policy Institute exists. But I think that's the part where I think there's a potentially huge value for radiology as long as we can continue to be value creators.

[01:12:38]
Geoff: Yeah, no doubt. And it's parenthetically mentioned that gatekeepers both open as well as close gates.

[01:12:45]
Dr. Shetty: That's fair. Fair point.

[01:12:49]
Geoff: I'd like to turn back to you now and to continue on your journey. And thanks for giving us that orientation to very forward-thinking perspectives at Steward. Let's jump back to a point in time, about seven years after completing your fellowship, five years after completing your MBA, you become president of Steward Health Care Network, which I understand is essentially the ACO. This seems like an inflection point as your responsibilities really move to a broad system-wide basis. Can you help take us through, you know, what were your responsibilities at that time? And what was it like at that moment when you transitioned from mostly overseeing radiology?

[01:13:32]
Dr. Shetty: Yeah, sure. So I've had two different roles, as we may have mentioned, that have dealt with physicians outside of radiology. One was as president of Steward Health Care Network, which you mentioned, and then secondly, as president of Steward Medical Group, which was more direct oversight over our employed physicians, a group that, ultimately, by the time I stepped into my new role, was about 1,900 physicians across the country. So both of those, I think, were sort of key different types of roles. We suspect how you worked with physicians in the first and running the ACO. I was really charged with managing our system's performance on all of our value-based contracts, collaborating with both our employed and affiliated physicians in being successful in our contracts, both with respect to commercial as well as our governmental. First, to Pioneer and then the next-generation ACO, as well as bundled payment.

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And then subsequently, as head of Steward Medical Group, really thinking about all aspects of what it means to work with a group of employed physicians. They're hiring, they're contracting, they're in compensation, but also the day-to-day operations of the rest of the large multispecialty medical group covering 11 states, so all the back-office functions, revenue cycle, etc., so thinking about the business sort of wholly defined. So I would say that stepping into the role at Steward Health Care Network really was an inflection point, again, that real pivot to being a physician executive, and it was a really crazy transition for me, to be totally honest.

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The story behind it was my current boss, Dr. de la Torre, called me up when I was on vacation and said, "Hey, you know, Sanjay, I'm thinking of making you president of Steward Health Care Network." Man, you know, again, I was vice president of radiology and pathology at the time. And I thought he had the wrong number. I really didn't think he was calling the right person. I was like, "Do you know who I am? I don't think you're calling the right person." Because it was kind of completely unexpected. But I think it was as a result of some of the work that I'd done and some of the enterprise work, etc., as well as relationships that I had that kinda opened up that opportunity for me. And it was a pretty sudden transition, you know. When he asked, I said, "I'm on vacation. Can I start in a couple months?" He said, "Yeah, you can start as soon as you're back." And so that was the end of the negotiation right there.

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And it was a terrific opportunity. I really did, in that first few weeks, did what I said I've done many times in this conversation, which is I started by listening. I learned a lot from my predecessor, Dr. Mark Girard, who coincidentally is also a radiologist, who was in that role before, got his advice on how do you work with this broadly-defined group of physicians. I had had some experience with the network at that point, serving on the board of our local IPA that sort of became part of Steward Health Care Network. So I'd had some experience in the world of value-based contracts, but it was really almost brand new for me. First off, managing a completely different scope of staff, so I went from having my local radiologists to having a team of I think it was around 150 people working for me. I had a budget responsibility that was on a completely different scale.

[01:16:28]
I had a company responsibility sitting in the C-suite of a pretty large company for the first time and sort of being part of that conversation and in all the items that related to our strategic and financial performance. Completely new environment for me and, you know, literally went from office at the hospital to office at corporate and all of what that entails in terms of making a transition to a completely different way of thinking about my job. And so it was a number of different changes happening all at once, but again, I started by listening to everybody and started by understanding what my job was and what my job wasn't and tried to come in with a fresh set of eyes to think about what could I do to have an impact and build upon what was already a very successful organization and maybe add my own little twists to how things were running.

[01:17:15]
Geoff: Wow, what an amazing opportunity that was presented to you, and clearly, you knocked it out of the park. As you began to take this role on, surely in your mind, you were thinking, "Okay, you know, I'm gonna do a lot of listening, but what is my first engagement, or where do I engage? How do I decide, you know, where to start launching my leadership within this role?" Can you sort of take us through your thinking in that and how you got things started and gained your momentum?

[01:17:48]
Dr. Shetty: Yes. A couple of things. One was a lot of thinking around sort of what had been done, why was it done the way it was, and was there fundamentally different things that we could be doing, right? Were we doing things out of habit or were we doing it because that was the optimal choice? And I think just by virtue of how quickly things had grown, there were a few areas where I really felt like I could have an impact. One of them was on continuing to engage with our physician network. It was a pretty big network, something that we wanted to continue to grow. And they've been through wild growth in the early years of the company. But one of the areas where I realize was that engagement with individual doctors after the initial recruitment was something that we could continue to get better at.

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And so I thought a lot about how the entity was structured, how we were engaging with individual physicians from primary care and specialist side, how could we get better at sharing all the great work that was happening at Steward Health Care Network. And so that was definitely an area of focus as I began to have conversations and meet with people, realizing that what was so obvious when you're sitting at corporate wasn't as obvious when

you're dealing with it on the day-to-day and managing groups of patients, and understanding how much interesting work was actually happening, and how what they were doing wasn't so commonplace, right. What they were doing in thinking about populations was pretty special in getting that message out. So I think engagement with our physicians was really important to me.

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I think engagement with the staff was also really important. I was a new boss, somebody who'd never had a role of that scope. And so for me, there were some really fundamental things that I like to do. I literally would freak everybody out by walking around the office at random times. Just saying hi to people, trying to learn people's names, sort of very simple things that you do, but trying to really understand what everybody did. And that helped me understand the organization, right. It went from being an org chart to a team, and to begin to think about what people are working on and where's everything that they were working on really the highest value things that they could be. So that was a second area. So it was, you know, two-people things that I think, really, I dug in on at first.

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And the other one was trying to think about how we could get smarter about modeling our performance in more real-time and becoming even more disciplined. So I think they were already a very disciplined organization, but even becoming more disciplined about regular reporting, regular monitoring, understanding our performance so that we were never in a crisis. And that's a hard thing to do when you're managing populations over a one-year timeframe. It's very easy to say, "Well, we'll figure that out ones we're done," right, or you know, "The answer will come to us in December or January once the results are in." But you'll realize that if you're gonna manage at a scale and scope that we were managing, you had to be thinking about it from January of the year and saying, "What is our plan for the year? How are we gonna get out ahead of all the problems that are certainly gonna hit us and surprises that we're gonna meet by being more proactive?" And developing a proactive and thoughtful approach to all of the gaps and care that we have to meet, management of total medical expense, proactive partnerships, until I try to sort of rethink the way that we thought about our performance here with sort of getting out ahead of things, coming up with campaigns, etc., that we would be managing from the beginning of the year as opposed to fourth quarter pushes, which is the way you had to do things when you're always behind the Eight Ball and thinking about performance, you know, and always trying to just basically keep up.

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And so those are some of the things that I did initially in terms of basically, again, fresh eyes to a problem that when you're in the moment, it's sometimes hard to sit back and think big thoughts.

[01:21:14]
Geoff: Yeah. I have to observe that you are a very analytical thinker, and the way that you outlined constructing a strategy for doing exactly what you said department chairs need to do -- which is to not get stuck on the fires, but to have an underlying strategy so that you're able to achieve what you need to, and really taking the time, not only to study it, but to actually write down your plans and to share them -- I think it's a great example for folks to hear. So you kinda had two back-to-back presidencies at Steward. One of them was for the ACO, the

other one for the medical group, as you described. And then just earlier this year, having briefly, in 2016, held the position, you are now sort of refocused in a new role as executive vice president of corporate business and development for the Steward Health Care System. That's the title that I understand you hold today. And you know, one thing that I'm wondering if you can help us understand is that, in the two prior roles, it seems like a very clinically-focused role. You're helping, you know, with the network to manage populations of care, and then you're working with all the physicians to assure that they're effective and able to deliver on their job effectively. And now, corporate business and development. What is encompassed in that?

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Dr. Shetty: Sure, yes. The way that Steward is structured historically has been as three business units: Steward Health Care Network, Steward Medical Group, and the hospitals. And so in running two of those business units, really, you know, ultimately, my responsibility was as the head of the business unit and all of what that entails. So although there was definitely clinical aspects -- and part of the reason I love the job so much was the interactions that I would have on a regular basis with physicians -- my ultimate responsibility was towards, on the one hand, clinical excellence, but on the other hand, also, the business performance and operational performance. So those are very much business-focused roles, and I would say that my day-to-day was thinking about business and strategy for each of those two business units. And then the clinical was sort of the icing on the cake, if you will, in terms of having that ability to interact with physicians on a regular basis and play that role with each of those two organizations.

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So this role is, in some ways, an extension of those two. It is a little bit more heavily business-focused role. I work on, essentially, growth for the company, thinking about acquisitions, whether it's acquisitions of a single physician practice all the way up to acquisitions of hospitals, as well as other initiatives that are gonna help us drive towards longer-term growth targets for us as a company. It's been a really interesting position to be in. I did have a brief stint doing it before, but the nature of the company has changed fundamentally since the last time I did it. Whereas before, we were purely a Massachusetts company, now, we truly have a national footprint. And it's been really interesting to have an opportunity to understand how these transactions work as part of Steward Medical Group. I was working on a cadence with a terrific team to basically do an acquisition almost every week. We were acquiring practices all over the country to further support and build out our integrated health care system.

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This is an extension of that work. So while I continue to play a role with those physician acquisitions, I'm also thinking about acquisitions and other potential transactions and deals and collaborations that will help us see us towards the next stage in our growth evolution. So it's, for me, been a really eye-opening experience to learn about how these transactions work, all due diligence that's required in pulling up transactions that are of scale, as well as working with different types of folks, you know, both internal and external, on making the transactions successful. So it's been interesting for me, and again, a really cool opportunity for me personally, because whereas before, I wore the hat of Stewart Health Care Network or Steward Medical Group, I'm now truly wearing a corporate hat and kinda getting a chance to think about there may be opportunities that are great for one business unit, maybe not as

great for a different business unit, right. There's a tradeoff there. But overall, is there value to the company and value to Steward and, ultimately, value to, you know, the populations that we're serving? We can make decisions for all the right reasons. And so that's been a really interesting perspective as well.

[01:25:34]
Geoff: Sounds very interesting. And I think we could probably have a podcast dedicated almost every one of these roles and really unpacking all the things that you're doing. It's just so rich. Thank you for that. I wanna actually turn, in our remaining minutes, toward you a little more personally. Let me start by thinking back to your comment that spending time with your family contributed to your decision to leave Bain for what was Caritas Christi at the time. And family is clearly an important part of your life. And you just recently relocated your family from Boston to Dallas. How did that go, and how do you balance your family life with such a demanding professional life?

[01:26:19]
Dr. Shetty: Yeah. I mean, it's a great question. I think it's something that probably everybody who's listening to this podcast thinks a lot about, right, in terms of how do you make a balance between work and life. And because work is not life, despite what you might think from day to day, right. And so for me, it was a really interesting transition. As Steward grew, we made this decision to move our corporate headquarters to Dallas about a year ago now -- actually, more than a year ago -- because our footprint had expanded, right. Traveling from Boston, what was fundamentally a Boston company to now a national company was so difficult for us. Trips to Arizona, Utah, etc., was pretty brutal. And when we moved our corporate headquarters, you know, my wife and I made the decision that I would commute for a year, partly because we wanted to make sure our kids would land in great schools here locally. We didn't wanna interrupt the middle of a school year, but also partly because we wanted to sort of see how this was gonna work, right. Was the role really gonna be a Dallas role, or was there gonna be more flexibility?

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And what really became clear is it's so important to sort of be at the center of things. I mean, it's so important to be part of a corporate team to be present. Because so much of what's happening is not happening just in the scheduled meetings, it's happening by virtue of walking up and down the hallway and in sort of getting work done just by being where the company is. And so we made the decision to relocate this summer, and it's been a great transition so far. We love the city. I continue to be surprised by how much I like Dallas, given that I'm such a Boston boy at heart after 30 years of being there, that it's been a terrific city. And I think the family is settling in. My daughter started sixth grade. My son's decided actually to stay in New England as a boarding school student. And my wife has, you know, gone through the gauntlet of getting her Texas license and looking for her first opportunity in endocrinology right now. So we're excited, I think, to settle in. Although obviously, we miss Boston, and we'll continue to fly our Patriots and Red Sox flags in unfriendly territory for a while.

[01:28:12]
Geoff: Well, continued success in that transition, and at least the brisket is very good, unquestionably. Let me ask you, what role had mentors played in your leadership journey?

[01:28:25]
Dr. Shetty: You know, it's been interesting. I've had a few folks that I really have depended on. A lot of my mentorship has actually been here at Steward, because frankly, you know, the fact that I have gotten the roles that I'd gotten has been purely because of some amazing relationships that I built right here at Steward. The folks who interviewed me for my very first job, right, so Dr. Girard, Dr. Callum, some folks I mentioned earlier on have been just amazing in sort of helping me understand the company and sort of take on new roles. I think in an earlier stage, there had been some folks that had been just so amazing to me. Dr. Max Rosen, somebody I mentioned earlier, from then BI Deaconess, then subsequently UMass, was sort of always looking out for me and making sure that I had opportunities, and even being supportive in terms of finding me things. Like when I was working at Bain, being able to work clinically was really an amazing opportunity for me.

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I think mentorship's been important in terms of having people to bounce things off. I also have had a great mentor from my time at Bain, a guy named Chuck Farkas, whose piece of advice to me was amazing and something I followed through on as soon as we started talking about it when I started at Bain, which was, you know, have your council of advisers, right. These are people who you're not working with every day but who you can call and get advice on as you're thinking about the next job, thinking about making a transition, thinking about whatever. And build that council of advisers and make sure they're people that you feel comfortable calling. So Chuck has been one of those people that have always bounced thoughts off of and ideas off of and who can help making actions for me as I'm thinking about opportunities or thinking about ideas or need connection in a particular space.

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And so for me, mentorship is one piece of it, but in a sense, it's more of now to being my council of advisers, friends and other colleagues from the past who I just will feel free to call and just pick their brains. "Hey, I'm thinking about this," or "Tell me how stupid this sounds, and tell me why I'm wrong," right? Or they might say, "No, I think you're on the right track," or "You need to talk to this person."

[01:30:22]
Geoff: Terrific point. And having trusted advisers, so critical, regardless of where folks are in their professional careers and in their lives. It's great to have that outside perspective. How do you view the notion of giving back? Do you actively mentor would-be leaders outside of your organization?

[01:30:40]
Dr. Shetty: I do, and it's been a lot of fun to do it actually. So one of the ways I have been able to participate in a couple of events, for example, through the ACR's resident fellow section, and also just by virtue of the Mass Radiologic and other radiology societies. I often get phone calls or emails from folks who kinda make that connection through whatever vehicle, whether it's LinkedIn or indirectly through a friend or a friend of a friend. And so it's something that I take pretty seriously. When people have reached out along the way, I've always been able to find that time to chat with them or meet them for coffee or whatever it is that is sort of most useful to them. I can't say how helpful my advice has been, but I could certainly at least give one perspective, right, which is "Here's how I think about it. Here's

some people you could talk to." What can I do to be a facilitator for that person as they're sort of thinking about a particular stage in life?

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I think as I'm... I'm gonna click onto my calendar. I think next week, I actually have three of those phone calls scheduled. So people do reach out, and I'm always willing to sort of have that conversation, especially if there's something in common about our experience or something in common about what they're thinking about where I might be particularly useful to them. So it's been great, and luckily, there are other people that I know who are aware of that. So folks through my old business school who often will bring the MBA applicants to me, or folks through my radiology connections who will sort of make the connection, and it's been...frankly, it's a lot of fun for me, because once I have that conversation, it's sort of I get to take partial credit in that person's subsequent success, right, and I get to track what they're doing. And it's been really fun to sort of watch how people evolve and grow and sort of reaching out to paradigms that are completely different than what I would have thought was possible. So that's been fun to watch as well.

[01:32:23]
Geoff: Fantastic. What advice would you give to young radiologists who's inspired by your journey and would like to pursue leadership?

[01:32:33]
Dr. Shetty: I mean, I think the most important thing, one, is what we talked about just a second ago, right -- build your council of advisers, find people you trust. Sometimes, the formal "mentorship" program will yield a great person to talk to, but it may not be that person or people that you really are looking towards as an adviser. So it's finding that group of advisers. The second is never say no when you're given an opportunity. You can always say no eventually, but at first, you've got to at least explore it. You've got to at least think about whether or not somebody asking you to take something on is worth it. It may be unpaid, it may be a lot of time, but it's gonna give you a great experience. You're gonna have a story to tell, and you've always got to be thinking about the story that you're gonna tell. And so some of these things that seem like a big burden may actually be a blessing in disguise.

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So you've gotta say yes, at least at first, to learn more about it. I've seen so many people who just say no out of hand and don't realize. So they're passing up. The first opportunity is that unpaid opportunity, the next one is the new job that is the life-changer or the game-changer. I mean, I would say that's probably been the lesson that has gotten me the furthest, which is I tend to be the "Yes, what can I do?" And then you find out that that was actually the test or that was actually the experience where they wanted to see how you would do and then turn into something much bigger and grander just because you said yes the first time. So those are probably my two biggest pieces of advice, is say yes and get those people that you're willing to bounce ideas off of in a completely unfiltered and confidential way.

[01:34:01]
Geoff: Fantastic. And for a mid-career radiologist, for example, that is seeking to take on a broader role within a health care organization, do you have any advice for that person?

[01:34:14]
Dr. Shetty: Yes. I think it can get harder and harder almost the further along you get. I think what you have to do if you're trying to take a broader role in the organization is start to think about, "How do you make that pivot," right, from being a physician, or from a radiology executive to a physician executive, or a radiologist to a, you know, physician, broadly speaking, physician leader. I think the best things that you can be doing is thinking about the health system at large and where you could be involved, right. Network beyond your department, network with the other physicians, other physician leaders, understand what opportunities, committees, medical staff, leadership, so many different pathways that people can take to really broaden their scope and broaden their perspective. It may start as small as a committee assignment. It may be as big as, you know, running for office in the medical staff, and becoming medical staff president.

[01:35:02]
But those are all different ways in which you can begin to think of yourself on a broader scale, and I think that's where I think people...I at least have seen people have the most success is they get involved, do a really good job, and then, you know, broaden their experience from there, get picked up for jobs even beyond the pill as a result of just a great volunteer opportunity or a great, you know, raising your hand when they're looking for some help. And even, again, if there's not something eminent about what that role is, it at least will give you a great experience and a great network that you can leverage down the road.

[01:35:33]
Geoff: Super. Well, Sanjay Shetty, thank you so much for sharing your journey with us today. You are a humble man who has accomplished so much. And as I consider the journey that you've described for us, the roles that you have fulfilled in such a short period of time, it's amazing to think what is yet ahead for you. But we look forward to hearing about your future successes. And again, just thank you very much for taking the time to share them with us today.

[01:36:07]
Dr. Shetty: Thanks so much, Geoff. It was very a lot of fun.

[01:36:18]
Geoff: Okay. That's it for this time. Thank you for listening. If you've enjoyed this podcast, I invite you to do three easy things. Subscribe to the series so you can never miss an episode. Share the link so your peers can listen, too. And like or rate every episode so more people will discover it.

[01:36:39]
Please join me next month when I speak with Dr. Valerie Jackson, executive director of the American Board of Radiology and president of the Radiological Society of North America. Following completion of a bachelor's degree, a medical degree, and radiology residency at Indiana University, Valerie joined the IU faculty in 1981, rising to professor in 1990, receiving an in-depth professorship in 1994, and becoming chair of the department of radiology in 2004, a role in which she served for 10 years. Val rose to prominence in radiology as an expert on breast imaging and education. She has served numerous leadership

roles within national organizations, including president of the American College of Radiology, the Society of Breast Imaging, the Society of Chairs of Academic Radiology Departments, and her current role as president of the RSNA. Val was an active volunteer of the American Board of Radiology for 20 consecutive years, including 9 as ABR trustee, before retiring from academia in 2014 to become the ABR executive director. Within this role, Val oversees over 100 ABR staff, who support more than 1,300 professional volunteers that oversee the certification of diagnostic radiologists, interventional radiologists, radiation oncologists, and medical physicists.

[01:38:10]
"Taking the Lead" is a production of the Radiology Leadership Institute and the American College of Radiology. Special thanks go to Anne Marie Pascoe, senior director of the RLI and co-producer of this podcast, to Peg Helminski for production support, Linda Sowers for our marketing, Bryan Russell for technical 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 Duke University. We welcome your feedback, questions, and ideas for future conversations. You can reach me on Twitter, @GeoffRubin, or the RLI, @RLI_ACR. Alternatively, send us an email at rli@acr.org. I look forward to you joining me next time on "Taking the Lead."