Episode 35: Leaving Things Better
Brent Wagner, MD, MBA

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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.

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Today, I'm speaking with Brent Wagner, executive director of the American Board of Radiology. After starting his career in the Air Force and a key role as head of Genitourinary Radiology and program director at the Armed Forces Institute of Pathology, Dr. Wagner went into private practice in Reading, Pennsylvania, where he served as president of his group for 12 years and Chairman of the Board of Directors of the Reading Health System and Tower Health for 4 years. He has been a longtime volunteer for the American Board of Radiology, serving as trustee for GU Radiology for five years and ABR President for two years.

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While serving as ABR president and Reading Health System Board Chair, Dr. Wagner earned a Master's in Business Administration from the Carey Business School at Johns Hopkins University. Last summer, he left his radiology practice of 22 years to assume the role of ABR executive director, taking on this demanding leadership role through the unprecedented challenges of the COVID 19 pandemic.

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Brent, welcome.

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Brent: Thanks very much. I'm really glad to be here.

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Geoff: We're delighted to have you today. Our listeners love to hear about our guests' upbringing. Where were you born?

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Brent: I'm born in Southeastern Pennsylvania, outside of Philadelphia. And I grew up basically in the extended suburbs of Philadelphia.

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Geoff: And what did your parents do for a living?

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Brent: My mom was a homemaker. My dad was an entrepreneur. In retrospect, I guess, long before it was fashionable, but he was involved in several business ventures over the course of my growing up in diverse businesses. And in fact, it occurred to me that when I would run into his business partners, their advice all along was don't go into business. Because I think there were stresses associated with running, you know, what we'd call a startup today.

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It did occur to me quite recently that that was one of the reasons that I kind of gravitated toward medicine because my father's colleagues and my father, to some degree too, just said stay in school. Neither one of my parents finished college. And I think they saw that as an important goal as well.

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But it was an interesting framing of the question for me, which was that one way or the other, apparently, I was gonna stay in school for a long time. And the other advice from my father was keep your options open. So those two things I've carried with me throughout the years.

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Geoff: Yeah. So you experienced the impact of uncertainty and stress in your father through those years?

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Brent: Yeah, that was part of it. The other part of it, just in the neighborhood, beyond my father's small business ventures in the area where I grew up, the space program hit its peak and then its rapid decline after the moon landing. And what I saw was a lot of people who had been involved in the industry behind the space program found themselves out of work as that sort of mini crash. And at least where I grew up, that was impactful as well was seeing that

people were...again, keep your options open, stay in school, and don't rely on something that... Who would have guessed the space program as rapidly growing as it was in the mid-'60s, by the early '70s, when I was 11 years old, would have declined so dramatically?

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So, perhaps, that also had an impact. My father's two best friends from high school were both physicians. We didn't have any physicians in the family. But to some degree, they were role models as well, in terms of the opportunities to sort of always be learning and the opportunity, as we all know, to be in a position to help people in a very direct way.

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Geoff: How about brothers and sisters? Did you have any of them?

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Brent: I have a sister. She took a different path. She actually did not love schooling that I did, and she lives nearby where I used to live in Southeast Pennsylvania. Now, of course, I have relocated to Tucson, but the family is still in Southeastern Pennsylvania. And so, I still think, consider that to be home in some way. I like my new home in Southern Arizona as well.

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Geoff: Excellent. Yeah, that's terrific. When you were growing up, would you have dinner together as you sort of, can you visualize any conversations that you might have had around the dinner table and give us a sense of what that was like?

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Brent: Well, it's interesting you said that. You know, my father, as a businessman, he wasn't home for dinner very much. And it's ironic that I think as a practicing physician, although they were called duties, of course, and there were some evenings that we didn't get home necessarily at 5:00 or 6:00, the realities for, and I'm sure people see it in their friends and family too, when you're involved in these sort of perennial startups, you know, it was almost rare for my father to be home.

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I will admit he was home every weekend because he'd take home and all the business world was shut down at that point. But a lot of those conversations, you know, were around these same kinds of themes as, you know, work hard, do a good job, show up when you need to, and be accountable for your actions. And those were the conversations we would have.

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Although, again, it kind of reinforced that there are downsides to being in this sort of entrepreneurial world of business. And certainly, that may have been part of what made my family push me toward medicine. But I felt it was an easy push, I guess. It's all good.

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Geoff: Yeah. Sounds like important lessons to have learned.

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Brent: Yes, absolutely.

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Geoff: What was your first job outside the house?

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Brent: This is not very glamorous. I was a mechanic, basically, in a small business that refurbished equipment. A lot of it was used in gas stations, gas pumps. And some of it was used in ancillary businesses that related to petroleum. But it was not, as I say, not a very glamorous job. We basically took equipment that was broken, we fixed it up, and then resold it.

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The idea today, it just kind of seems like it's very timely today, you know, reuse, right? That was again, reuse, recycle pattern. We didn't see it that way. We saw it as kind of dirty, uncomfortable work. But it did. And again, in retrospect, we were problem solving all the time. It was not assembly line work because you know, assembly line, you're just putting together pieces that you know we're gonna work. In some ways, we were experimenting. Will this part work well? Can we make this rig up something that that makes the piece perform the way it's supposed to and reliably?

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And I hadn't thought about that quite recently that, in effect, we were problem solvers. One time, someone brought in a piece of equipment, the foreman. I looked at it, I said, "I've never seen anything like that." He goes, "Yeah, I don't even know what it does. But the customer wants it fixed." I said, "Well, where do we start?" And he said, "Well, the customer kind of said that was our problem not his." And I said okay. So, we took it on. And then a week later, we had it working and learned some lessons along the way.

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Geoff: What was it? What did it do?

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Brent: Well, it turns out, it was a piece of equipment that painted large pieces of metal like a ship. I mean, it was not something for spray painting a car, it was, multiply that by 10. And somewhat ironically, the solution laid in the O-rings. And 10 years later, of course, we would learn that O-rings were critical in the function of the space shuttle and the associated tragedy.

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But ironically, when I was doing it, we were kind of looking at, "Okay, we're going to solve the said problems." And it turned out it was get the right O-rings so that this thing could go back to painting whatever huge pieces of metal it was designed to paint.

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Geoff: It seems like a pretty special purpose piece of equipment. Do you enjoy working with your hands?

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Brett: You know, since then, you know, I don't have hobbies that really relate to that. Some of my hobbies now are sort of things I do with family: reading, a little bit of golf (and I am truly terrible), and then skiing. And I suppose those are kind of the extent of the holidays. As you know living in Tucson, we have the opportunity to hike a lot, which is something new that I've kind of stumbled upon, and I really enjoy as well.

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Geoff: Yeah, yeah, it's beautiful here. Do you recall what your first leadership experience was growing up?

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Brett: You know, those grew somewhat slowly, I was in a fraternity in college. And that was probably the first time that I was given the opportunity to lead. I was sort of the second in command. We had the fraternity president, and I would help him, and we'd kind of run the group because it was a combination of, of course, a boarding house and a meal plan. And we had responsibilities for budget and that kind of thing.

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And I did much the same thing, actually in college, although we call it a fraternity which really was just a boarding house of about 15 or 20 people. But it wasn't, I suppose, until sort of the chief resident function in the Air Force when I was in Radiology residency that I suppose it took to on that next level.

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Geoff: Yeah. Let's get there in a moment. So, I see that you attained a Bachelor of Arts in Chemistry from Lafayette College. What led you to go to Lafayette?

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Brett: Well, it was in that part of the country, and it sort of kind of long story. But my parents wanted me to go to private school. They felt that the public school where we're at, which I think in retrospect was pretty good. It was one of these well, every opportunity, you know, again, because they didn't complete college. So the idea was, "Well, let's do what you need to do."

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And in asking around, it turns out, you can go to college at almost at any age. And it was close enough, but far enough away. So, I chose to live at Lafayette, but it was only an hour and a half from home because I did it when I was a little less than 16 and a half years old. And that was something like the compromise my parents and I reached because I didn't want to go away to a private school somewhere. Instead, they said, "Would you go to college?" And I said, "Yeah, the I could do that."

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So, I wound up there almost by default because I said, "Okay. It's a good school. It's small. It's close by, but I can still live there." I'll just say I wouldn't

recommend that to anybody. I think being a kid as long as you can be a kid is a great thing. But it worked out okay for me. So, that's quite a long ago.

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Geoff: How did you come to enter college at 16 and a half?

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Brent: Well, like I say, you know, it turns out colleges really don't...you don't need a high school diploma. And I didn't have one. But you take the SAT. And they were convinced that I didn't need somebody standing over my shoulder to tell me to do my homework. As I say, I wouldn't necessarily recommend it. I think there's a lot of growing that happens that last couple of years of high school. But like I say, it worked out.

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But that's how I wound up at that particular school, a great school. I mean, I'm not even sure I could get into it today. But it's probably more competitive than it was.

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Geoff: Yeah, I see that there were only about 600 students enrolled in the incoming class recently. Is that about the size of the classes when you attended?

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Brent: It was even smaller. It was we were 2000, almost exactly 2000, so 500 students a class? Yeah, it's gotten a little bit bigger.

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Geoff: I mean, I can imagine that even being only a year and a half younger than most of the incoming freshmen that that's, you know, a pretty big gap. I mean, was it difficult socially through college to, you know, build relationships and to, you know, engage in the typical collegiate activities?

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Brett: Yeah, I think the size of the school probably helped, so you ramp up pretty quickly. But you're right. I mean, and that was, I suppose part of the challenge, which, again, may be part of why I wouldn't recommend it. But it worked out. I mean, it was a few years in, and you're the same as everybody else. And it was fine.

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Yeah, I'll admit, I was a bit of a nerd. So an awful lot of what I was doing there was just studying. Again, I wasn't the party guy overall anyway. There were plenty times to have fun, that was great, and then socialized. But at the same time, you know what it's like. You're premed, you're trying to get good grades, and you spend awful long time in the library.

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Geoff: So, you knew you were premed at that point? Did you enter college thinking I'm going into medicine?

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Brent: Pretty much. Yeah, in fact, I started out biology and switched to chemistry just because I was better at chemistry. So, it was almost a default. Like I just went in, yeah, thinking it was going to be things that would prepare me for medical school. We didn't have a premed major per se.

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In retrospect, I would have taken philosophy and then just take in the requisites in science. But I was pretty good at science, not as good, I suppose, in the liberal arts. So that was, again, by default, you know, go with your [crosstalk 00:13:06].

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Geoff: You went for chemistry because of your aptitude as opposed to some burning underlying interest in the molecular nature of things.

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Brent: Yeah, I suppose. I mean, I still find it interesting. Actually, I think back to the stoichiometry. I used to do it. It was kind of those are fascinating puzzles. And so there was that part of it. But at the same time, today, given a choice between reading about biology or reading about chemistry, I'd probably reread biology. And as they say or Shakespeare or philosophy, or something far removed from the sciences.

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Geoff: The fields have changed a lot since those days.

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Brent: Indeed.

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Geoff: How about any formal extracurricular activities at Lafayette or athletics?

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Brent: No. I'm probably the least athletic person I know so not much of that. And I was involved a little bit in the school paper. And, like I say, in the fraternity, you know, we were a social organization as well as sort of the idea of a place to live. So, that was probably the extent of the hobby was whatever minor leadership role I had there.

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Geoff: And then you went on to Thomas Jefferson for medical school. What led you to choose Thomas Jefferson? Was it a circumstance where you're considering many different schools, or you were really trying to stay relatively local?

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Brent: Yeah, that's interesting. In retrospect, I guess, the schools I looked at were basically local. I mean, there was this, back then, when I think of two colleagues of mine, who were also interested in medical school I was in class with at Lafayette, most of us were applying regionally. In fact, an awful lot of my classmates wound up at Jefferson.

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But, you know, they had a good reputation. It was a solid school. And I didn't know much about schools outside of the region. That was probably the biggest reason. So, I shouldn't say it opened doors in any way that other medical schools wouldn't have, but at the same time, it had had a good balance between its research endeavors and the quality of education you get as it relates to community clinical care.

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In fact, that latter part was a big emphasis. And at the time I went into medical school, I was thinking family medicine. And Jefferson was more than, for example, University of Pennsylvania, a great school, but Jefferson seemed to emphasize the sort of the clinical care, especially in nonurban areas in Pennsylvania. So, that may have been what tipped the scales to that direction.

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Geoff: And then what led you to radiology?

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Brent: It's just a little embarrassing. But when I started third year medical school, I started in OB GYN, and I thought it was absolutely terrific. So, I'm doing a rotation, first exposure, clinical medicine and I said, "Oh, this is great, I'm gonna do this." And then, my next rotation was peds. And when I got to pediatrics, I said, "Oh, never mind, OB GYN is out. Ped is where it is. I'm going to be pediatrician." And you can see where this is going. The third rotation was internal medicine, I thought, "This is great."

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You know, so that that went on for the entire third year of medical school. And then it carried over a little bit in fourth year of medical school. The thing I was doing at the time, "Well, this was what I could see myself doing now." I owe the Air Force some time. So in some way, I did have to make a decision right out of medical school because I was going to do an internship and wind up, you know, serving the Air Force to make up for my scholarship.

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But the last rotation I did in medical school was radiology. And it was in an Air Force hospital and just great mentors, and I got to see that each case is kind of like a detective story. And the relationships that you have with clinicians are different from a lot of other specialties. So, the short answer is it was the last thing I did. Therefore, it was the thing I really, really wanted to do at that time. So, somewhat ironic. I think if my last rotation had been something other than radiology, I would have wound up in that thing, whatever it was. So, it worked out.

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Geoff: Yeah, I mean, it's good to see the good parts of anything. And we're fortunate that radiology came last.

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Brent: Well, I certainly feel fortunate that way. Yes.

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Geoff: So, you mentioned that you spent time with the U.S. Air Force and indicated that, at the time, you were in medical school, you had some time to pay back. Tell us, how did you get into the Air Force? What was the entrée and maybe take us through that decision process?

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Brent: Kind of an embarrassing story too. I got to my last year of college and I was sort of out of money, you know, private school. And I kind of said, "Gee, I've tapped out my loans. And, you know, my parents were destitute, but they kind of said, "Well, you know, what are your plans here?"

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And there was a brochure, literally a paper brochure, in my mailbox. And at the end of my third year of college, it was the Air Force ROTC program, meaning you can get in, it turns out, you didn't have to get in at the very start as a freshman, you could actually join it along the way. And there was a special scholarship that transitioned into a health professional scholarship.

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So, it's okay, this is great. So, essentially, I joined ROTC for my last year of college and that transitioned into the scholarship for medical school, which was important to do, because there again, you know, as many of your listeners know that you have to figure out a way to pay for it. So, I had no military, really, in my family. My father was too young for Korea, too old for Vietnam. And, you know, that was true of a lot of the contemporaries, you know, the parents of people I went to school with.

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So, I went over the Air Force because a brochure that showed up in my mailbox. And, say, 10 years. So, again, it worked out really, really well. But it was, if I looked at that brochure and threw in the trash, I would not have wound up in the Air Force.

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Geoff: Yeah, very timely. And certainly nothing embarrassing about, you know, needing to be resourceful in finding a way to pay for your education. What led you to choose the Air Force over other branches? Was it just that was the brochure in the mailbox?

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Brent: Exactly. That's exactly right. If it would have been a Navy brochure, I would have been a Navy physician. No, that's exactly it. The short answer is that's who happened to... You know, I'm sure they just went and they put in thousands of these into the student mailboxes. Picture the old days when it wasn't email, and it wasn't internet. And in fact, you know, I went to the Student Union, and that's where I was recruited in the Air Force, a hole about four-by-four inches, that one piece of mail, and it was that brochure.

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Geoff: So I see that you spent two years as a general practitioner on Carswell Air Force Base in Texas before beginning your residency at Wilford Hall. Was it your choice to go spend some time as a GP or was that the Air Force's choice?

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Brent: That was the Air Force's choice, I mean, to go straight into a radiology residency. For example, at that time, and I remember I went into medical school thinking family medicine and left medical school thinking radiology had a slight edge over family medicine. But at least for radiology, there was not the option, and so, I basically applied only for transitional year internships during fall of senior year. So I was gonna do a PGI as a transitional and then decide whether or not you know then complete a family medicine residency in the future or, as it turns out, radiology.

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Either way, the Air Force was going to get a general medical officer out of me. And in effect, your family practice, no peds, but everything else, you know, everything from young recruits to retired Air Force and Navy veterans. So, that was what I did for two years. And ironically, the Air Force convinced me to do my radiology because, although the medicine in general in the military is wonderful, the care that people receive is great, it's not optimal for physicians because, of course, the resources aren't there.

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So I would learn in later years, you know, this idea of physicians doing physician work, which was one of my mantras when I was leading the radiology group, was not part of the military mindset. And as a result, in some

ways, I credit the Air Force for kind of saying, "You know, you were on the fence about family medicine and radiology."

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Well, you know, it became radiology because I told myself I can't do family medicine. I can't see 30 patients a day, and sort of keep up with the record keeping and everything else. It's probably worse today, actually, for a lot of our family medicine colleagues, I'm sure it's even worse than that.

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Geoff: It is demanding, no doubt. Are there any lessons that you carry with you today from your time as a GP?

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Brent: You know, I will admit, it's been quite a few years. I think an awful lot of what we did was you become very resourceful in the way that you take care of people. You learn to prioritize what's important and what isn't. And so managing that abnormal blood sugar or blood pressure, the diastolic in Room 5, you know, becomes a lot more important than, "You've had that back pain off and on for five years and what can I do about it?"

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So, you start to triage those things for yourself because you have to. But beyond that, it was a great practice, just I think challenged in the way that we found ourselves with limited resources. I mean, the whole idea was, you know, don't burden the taxpayer and make sure that you're providing good care. So, in that respect, I suppose that's where the lessons came in.

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Geoff: Near the conclusion of your time as a GP, you took a course in aerospace medicine, what led you to pursue that, and what was that program like?

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Brent: Yeah, that was almost, I shouldn't say an administrative error by but Air Force, but I was interested. What it is, is really training to be a flight surgeon. So, training to take care of pilots. And you start looking at the physiology of dealing with g-force and dealing with things what seems like minor as inner ear problems and obviously what it takes to keep a pilot flying.

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So, it was interesting to me, because knowing that I wasn't going to be getting out of the Air Force anytime really soon because I was on my way to, as you said, to radiology residency, it was a way to learn about the Air Force. It really was. So, for me, that's what it became a little bit about the physiology of flight, and a little bit about the mission of the Air Force. So, in that sense, and I did it right before I went on to the radiology residency, so I never really got to apply those skills.

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And that's where the administrative error kind of comes in. You know, they had an opening, I was qualified, I went off and did it. And I suppose if I said, after a year radiology, I didn't want to do this anymore, then I could say, "Well, I'm a flight surgeon, so put me in charge of taking care of pilots." But as it was, as I said, it was really just a glimpse into the non-medical side of the Air Force, if you will, about the truly the line that was referred to, you know, what happens on the line as opposed to the hospital.

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Geoff: Yeah. You know, the adage that which doesn't kill us makes us stronger comes to mind.

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Brent: True, yeah.

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Geoff: Yeah. Did it make you want to fly? Did any fighter pilot say, "Let's go up, Doc" and give you a ride?

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Brent: Well, we did get a couple of, during that course and I got a couple in ROTC to where you're in a fighter, a jet trainer, basically, a two-seater jet. And I always loved it. I mean, it was terrific, you know, stressful. A lot of people got sick. I was fortunate enough that I didn't get airsick. But flying upside down and that kind of thing, it was a lot of fun. And they were almost motivational. They were considered incentives that you could do this.

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And of course, flight surgeons do have to fly. So, yeah, I love that. But, by then, you know, you've already committed to medical school and actually you're starting to age out. Believe it or not, by the time you're done medical school and a transitional year and two years as general practitioner, you'd be a really old student pilot by Air Force standards because most of those, of course, are right out of college.

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Geoff: Yeah. So, after a couple of years, you started your residency at Wilford Hall. And ultimately, it seems you developed a passion for genitourinary radiology. How did that develop? Did it develop during your residency?

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Brent: Yeah, I suppose so. I love the modalities. You know, at that time, body MRI, which was coming into kind of popularity, I suppose. And we were doing a lot of CT and I was doing a lot of ultrasounds. So, I was, during my course as an attending, I was chief of the ultrasound, and that by design then, you know, pushes you into female pelvic imaging, etc. that really would emphasize the GU part, GI part, I suppose.

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But we were doing images, we did we did everything. The real push toward genitourinary was that the AFIP had an opportunity in that. You know and they were still very separate in terms of GI and GU. And the opening was GU, so I was able to do that.

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But the person doing the hiring at the time at AFIP read one of my MRI reports, and I guess I was having a good day because it was a report on endometriosis, a patient with multifocal endometriosis. And he basically saw that report and said that I want to hire a person like that. And we wound up on the phone and one thing led to another.

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So, I suppose it was an interested...at one level, on the other hand, we were body imagers. But I was more on the ultrasound side, which meant female pelvis and...

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Geoff: It makes me wonder, you know, what was in that report?

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Brent: Right. Well, I'm not sure I've ever dictated a report that long before because he showed it to me then after I got the job. And he said, "Well, this is it." He told the story from his perspective. And I said, "Yeah, I don't dictate that way anymore." I must have a lot of time on my hands.

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Geoff: I see. You were quoting references...

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Brent: Yeah, stuff like that. It was very detailed. It sounded very articulate. And, you know, of course, that was before voice recognition software. So, it was probably a lot longer than reports I would have done once I was established in practice.

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Geoff: Bravo. So, right off the bat, out of residency, you took on a leadership role as chief of ultrasound, as you mentioned. You're also the Assistant Residency Program Director at Wilford Hall. How did you come to assume those leadership roles straight out of residency?

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Brent: You know, they're assigned for the most part. So, it's military, right? So, someone above you assigns that. And in regard, remember, I want to qualify, you know, chief of ultrasound, it just meant, you know, we only had a faculty of 20 people, everyone was the chief of something, I suppose, in some ways.

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So, just to be fair, you know, it's not as if I jumped over people more senior because the one good thing about the military residency, there are a lot of good things, but one of the good things was that you always have freshly trained, fresh minds coming along, whether they were from outside of residency or from within.

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I think the Assistant Program Director, and back then it was a lot easier than being a program director today, but that role was, you know, I think, because I

had come out of the program as chief resident. And I think they just saw that I could be a bridge between the trainees and the faculty.

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And I suppose I had an interest more than anything else. I'm not sure I had the aptitude. But I definitely had the interest in doing it. So, when that opportunity came up, and they asked and I said, "Of course, that's terrific."

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So, in some ways, I can't say it was a competitive position that I won out over other people. Instead, you kind of get tapped on the shoulder by the senior person in the department, Colonel, who was not clinically active, but his job was to find somebody who could do this and it seemed like a good fit.

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Geoff: Yeah, excellent. Now, after two years on staff at Wilford Hall, you then went back east to the Uniformed Services University of Health Sciences in Bethesda for another 2 years to complete your 10-year military career. I'm guessing that USU was a pretty competitive assignment. Was the AFIP assignment something that was already connected to getting you to USU or...?

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Brent: Exactly. Yeah, they were connected. Basically, the way the funding was set up is that USU was the funding source, but my office was AFIP. So, in effect, when I wasn't active at AFIP with the resident corps, I was teaching medical students over at USU.

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Geoff: So, going straight from Wilford Hall then, essentially, to AFIP as a director, was that a common pathway? That also seems pretty impressive at an early stage.

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Brent: You know, it wasn't unheard of. I think there were some people who got to that point at a more senior level. In this case, you know, like with a lot of things, timing was everything. That opening existed and prior to that there hadn't been a dedicated GU person.

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Actually, Alan Davidson, one of my mentors, was the civilian in that role. But of course, at that stage he had published books and he knew everything that was to know with the kidney and urinary tract. But when it came to the ovary, uterus, the kinds of things or even adrenal imaging with MRI, that was not his strength. So, we overlapped in that sense of it.

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So, in some ways, there was an opening there. There is a willingness on the part of Wilford Hall to say, "Yeah, we can backfill that position." And the opening was not only at AFIP but, as I say, simultaneously, the funding source at USU. So, as much as anything else, it's a coincidence, you know. So, I was in my early 30s, and kind of just fell into this dream job. As I said, maybe less on aptitude than interest and timing.

[00:30:15]

Geoff: Yeah. It was a fantastic opportunity. It's great that you were able to capitalize on it. You know, I want to just sort of, you know, back up a moment. You know, we're talking about the AFIP. But the AFIP doesn't exist and hasn't existed for at least 10 years or so under that name. And for our listeners that might be under their mid-40s, would you mind giving a little explanation of what is the AFIP? What was it? What is it today?

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Brent: Well, yeah, the AFIP was established in the late '40s as a... Well, it becomes a little complicated. I guess, there was a nonprofit, nongovernment organization that occupied that same space in some way. So, there's this overlap between the ability to have the ARP, American Registry of Pathology, overlap with AIRP.

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But where it became important to radiology, of course, is that it developed the Resident Course, that I attended as a resident in 1990. You know, it was one of a kind course, in many ways, it still is, even though it's changed its name and its focus a little bit. But at the time, when I was on staff there, we consulted with pathologists on almost daily basis, getting at this kind of route, radiologic-pathologic correlation.

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And then, at the course, of course, we hosted over 95% of U.S. residents over the years. Many international residents, those developed in the '90s still goes on today. And then it evolved to, as the government started to cut back on funding and around, I believe it was 2011, is when it was turned over to College of Radiology that now administers the American Institute of Radiologic Pathology.

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But, in effect, it has the same teaching mission that it had before. The difference is the underpinnings in that building where you had pathologist working, you know, a floor above you, and you interact with them every day, I think that's presented some challenges for the Institute. But it continues to, of course, provide excellent education in this sphere of radiologic-pathologic correlation.

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Geoff: Yeah, I mean, it must have been an incredible experience to be working with pathologists, seeing some of the most interesting cases in the country on a daily basis. Yeah, I was there, I want to say, it was probably around 1991 or even potentially getting into '92. But I remember them telling us that the AFIP was formed by Lincoln during the Civil War as a, you know, place for all of the amputations that were performed during battlefield medical procedures to sort of bring them back and to learn about battlefield medicine.

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Brent: That's right. It was an offshoot of the Civil War Medical Museum. And, in fact, and I don't know the status of it today, but when I was on that campus, the museum was on the floor just below us. And I just walked through there once while. It was free and it was a very unusual museum because there was no National Medical Museum at the time elsewhere, that was the only one. And they actually had Lincoln's cervical spine specimen there with a probe, in it where the bullet tragically injured cervical spine, so and a whole bunch of other exhibits.

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So, in that sense, that tradition lived physically in the same building. You know, the building was unusual, Geoff. I don't know if you remembered it, it was a bomb shelter in the Eisenhower era. It was obviously about the time it was completed because it could not withstand...bombs were getting better, faster than the buildings were. So, I had to go through a glass door to get to work

every morning. Or my car and I will walk through just heavy glass doors that was almost like in bank vault. We were in a concrete bunker basically, two stories or three stories below ground.

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But a great place to work. It was almost like this cloistered environment, I suppose, in some way that once you were down there, there were no windows to distract you. There was no noise, you know, it's just the work.

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Geoff: It was an iconic place, no doubt. Now your role as staff radiologist there, prior to becoming ultimately the chief of GU radiology and course director, what specifically was your day to day?

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Brent: Well, two days a week, I was still clinical. I thought that was important. And, again, I was assigned to USU, which meant that I work a day a week at Walter Reed, the old Walter Reed in Washington proper, and then over at the Bethesda Naval Medical Center. So, that was two days a week.

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The other three days a week, we took class cases that came in, process them, and reviewed them for selecting images that could then be used in future lectures. And as I said, we met without a pathologist going over the imaging, going over the pathology as part of the formal archiving process within the AFIP.

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The days became very full very quickly. And looking back on it, I can remember, with one or two exceptions, if you went in on a Saturday, you were going to run into a colleague. You know, in theory, this was not a 9 to 5 job, and your work spilled over into a weekend. They were long days, which seems odd, because we weren't rendering direct clinical care. But the projects just became kind of overwhelming.

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And, in fact, my successor, when she took the job, I called her, my old office number about a year later, and we were friends. And she picked up the phone and I was not surprised at 2:00 in the afternoon on a Sunday, she's sitting in the

office because that was the kind of job that was the... The work was so much fun and so interesting that I think an awful lot of us took on project after project. And it grew into, you know, this, you go in for a few hours every weekend, just to kind of get caught up for the following week. It was a blast.

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Geoff: It sounds like really an invigorating environment. You know, before we leave the military, a couple of other questions. I saw that the Air Force recognized you with a couple of commendation medals. What did you do to earn those?

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Brent: Well, that's interesting. You know, for the people who've been in the military, an awful lot of those medals are, I used to call them, "the I've been moved medal" because basically, you're almost assigned those because you completed an assignment and, I guess, didn't kill anybody. Although, in the military, that sounds odd too.

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So, it just wanted to say, you didn't mess anything up and you did your job, and you brought credit to the unit. And effectively, that's what it is. It's credit to the Air Force and to the organization you were serving.

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So, I got to admit, none of those medals were because I threw myself on a grenade. We didn't have any grenades in the hospital, I guess that's part of the problem. But, you know, we wound up...an awful lot of those commendations are kind of built into that.

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My last one, I gotta admit, I'm not big on ceremony. And the last one I got was at my new assignment at USU. And I told the colonel who's in charge, who administered, kind of my direct report, she said, "Well, you're going to get this medal." And she was, "Do you want the ceremony?" And I said, "Can we just make it very informal, just hand it to me?"

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And so, a week later, I showed up and there was the certificate there with the yellow sticky on it. And she goes, "Congratulations." And there was a little star

and that was it. So she did what I wanted, which is, I don't need the ceremony part of this. But, yeah, those commendations for me were, you know, they're nice.

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But I felt, in some way, they minimized, you know, the true commendations that were like people who were in the field and really making sacrifices, and sometimes physical sacrifices, for the mission. So, not to demean what we did but, at the same time, there were a lot of people who sacrificed a lot more than I did as part of their military service.

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Geoff: What leadership lessons do you take from your time in the military that you rely on today?

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Brent: You know, probably the biggest one is that there was sometimes inherent in military leadership, there was ironically sometimes a lack of accountability. And I know that sounds odd. And it struck me as odd at the time.

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But the reality is the organization was so bureaucratic that one could easily get...and this just didn't really apply to medicine very much, but you could get lost in the enormity of the organization. And I think there was this tendency where a poorly done... I mean, you can't get fired really in the strictest sense. And if you learn how to work the system, you can succeed without truly being accountable to the people you serve.

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And when we think about, I know in your organization, you know, complex organizations in any large hospital, there are these relationships that are based on what service you provide and what value do you provide to the others around you? And that was, in some ways, I think, it was inherent in certain elements in the in the military structure, especially on the medical side, in other areas, perhaps not so much.

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And I know that's a vague way to basically say I think accountability actually, ironically, had its very strength in the military at the same time was one of its

weaknesses. Because for certain jobs and certain functions, a very, very large organization that is so structured in its leadership becomes problematic in that way.

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Geoff: Yeah, interesting observation. You know, it seems like you were just really getting rolling in Bethesda and then you pivoted to private practice at West Reading Radiology Associates in Reading, Pennsylvania, what led to that transition?

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Brent: At the time, there was an opportunity to get back directly into teaching. And West Reading was back, closer to home, close colleague was on the staff there. And at the time, they had a residency. So, it was a community practice that had a decade's old residency. And this was a chance to sort of get back into practice, the clinical care. I alluded to, and I hate to use a word of mouth in this context, but AFIP was...perhaps, it was my inability to say no to extra projects and things. And it was, ironically, going into a private practice would mean, I'd probably get to spend more time with my family.

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There was another very practical concern, and that was that I'd been in for 10 years, I'd never been overseas. And, in fact, when I wanted to go, those opportunities weren't available to me, someone else either. You know, I was in training or it's AFIP or whatever it might be. So, when I got out of the military, it was for that reason. And then, a couple years later, I just said, you know, I'd like to get back into a practice environment. So that's where I wound up.

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Ironically, of course, I got there in 1998. And in May and June, we were told the residency was history, it was going away a month later. So, all those good things I talked about how my timing worked out, my favor this one, did not. You know, the simple reason was money owed. Remember, in the late '90s, GME dollars had really started to dry up and that had a direct impact on the hospital's radiology residency.

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So, we trained people for a couple more years, and then there hasn't been a residency in that environment since. So, ironically, I love the practice. It was a

great opportunity over 22 years. But I wouldn't have gone there if it didn't have the radiology residency. And about the same time I was unpacking my office equipment into the new practice, they told me, "Well, yeah, we're not gonna have a residency."

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Geoff: Yeah, it's all too common a story where we, you know, start things off with certain expectations and the world changes. So, I'm sure there's other examples we'll come to as we get further into the conversation.

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Brent: So, you know, you mentioned as a pivot, and that became a personal pivot then too, because, you know, it's then, my mindset changes, "Okay, what am I going to do in this in this new environment that I really didn't anticipate?" As you say, we can touch on that more. But it became, you know, you pivot for a set of reasons that then change rapidly, and you pivot again.

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Geoff: Yeah, well, you know, elaborate. What's on your mind?

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Brent: Well, for me, it became, you know, it was all about the clinical care at that time. We were a group at that time of about 15 or 16 radiologists but growing rapidly, you remember that around 2000, late '90s, early 2000s. And every group was growing quickly.

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And, you know, I fell into sort of the idea of I enjoy doing ultrasound, I enjoy doing the body imaging, but we took call on everything. So, it's a very busy emergency room at one time, currently the largest in the state of Pennsylvania. And we were serving that with 135,000 visits to the emergency room.

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So for me, it became, "Okay, well, let's build a practice. Let's do it better than we had done in the past." as we're going. So, I found myself, I got there at '98, I guess, it was 2002, when there was an opportunity, there was a change in leadership, and there's an opportunity to become group president.

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And, you know, people say, "So, well, how do you do that?" Well, remember, I started late, right? I didn't get there till I was in my late 30s, where I was really out of training. So I'd done the 10 years in the Air Force.

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But the other thing is, and that it's really true and I'm sure you can attest this, and I'm paraphrasing Woody Allen, and I'm not even sure this quote should be directly attributed to him. But, you know, "80% of success is showing up." And it really is. All it is, is being there.

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A lot of us can do that. And I could do that. And I found myself volunteering for the little things. You know, I like this example, just because it's true. And it still would be important today. When people ask me, "How did you ascend to these levels that were president and board chairman and things nice?" "You know, it started out in the CME committee." Nobody wanted to do. There's nothing glamorous about the CME committee.

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I personally, again, I'm a nerd, you know. So, for me, it was glamorous. But for most people that wouldn't be viewed as something glamorous. And you go there because you get to meet people from all different departments. You know, you're doing good work, you're doing important work that is supporting a CME committee of medical staff almost 1000 people. But it's not glamorous. It's not something you'd be talking about in a cocktail party. At the same time, that's where it starts.

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And then when the next opportunity comes along with something a little bigger. And as long as you showed up and read the materials in advance, and you did what you're expected to do it. And you know this from your own life experience. This is where success comes. It comes from the little things early on that then build into bigger things. And they come from showing up and doing what's expected of you or a little more.

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Geoff: Yeah. I know. I mean, I think that that is such an important point to emphasize. I can't say how many times I heard in my early years from folks you need to learn to say no. Sometimes, when your instincts say to say yes, then that

is the right instinct to pursue. And obviously, you don't want to burn yourself out, you need to try to achieve balance as best as possible. But, you know, a lot of these roles as you described, you know, can be very empowering.

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And I know you spent time as the chief of the medical staff and, you know, myself in a very similar role. It was really fantastic to get to know a broad scope of physicians that, you know, in many respects, touched radiology. But getting to sort of enter their world and hear the issues that they were concerned about, I found, you know, particularly interesting and empowering.

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Brent: Yeah, and you're right. Actually, I think that importance of saying no becomes even more relevant being further along in my career that I got. And even friends, you know, sort of the same point in our careers would say, "You know, you got to only say yes to things where it's an enthusiastic yes." Meaning if you have to talk yourself into it, you're probably have to be saying no. But that time, again, you get far enough along your career.

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But for me, it was, just as you said, you know, it was the ability, did you want to be involved in making something and doing something interesting? I mean, that's really what it came down to for me. So, the role in the medical staff came along with the idea to run for medical staff president. And ultimately, it was knowing your commitment, actually, because you do three years as vice president, three as president, three as past president. You know, why would you want to do that?

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And for me, it became, you know, how can I help? How can I do this? And for me, it was that servant leader element, and I found it interesting. It was just interesting to me. And I would be approached by younger people, and the motives are important. Because if the motive is, "Well, I'd like to be there when those conversations are had because I want to know what's going on?" Yeah, I kind of understand that. But at the same time, it has to be, you know, how can I help, not what's in it for me?

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In fact, a colleague, it's probably about four or five years ago, who was talking about forming a task force that would look at a certain question in a very preliminary way. And, you know, the question was, how can I get in on that? And the question really should be, how can I be of help?

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So I found myself, during my time on the hospital board, there'll be meetings that someone was going to sit down and have a conversation around something, and I never said I want to be involved. What I said instead was, let me know if I can help. And to me, that's a huge difference is that sort of, that's certainly an attitude that I think comes more easily to some than others. But it can't be about the glory. You're just gonna be disappointed.

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It can't be about the "power" because there really isn't much. You know, the power comes because people give it to you and not because you choose to take it. So, I think this is true. This overlaps with your experience in a lot of ways, too. It's really what I can do to help not how can I be in a position to call the shots? Because the reality is, you don't call the shots very often.

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Geoff: Yeah. No, it's such a great point that you took the time to articulate. I really appreciate that you did. When you think back to your years as the president of the group, the leadership positions that you had in the hospital, what comes to as your proudest moments?

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Brent: That's a great question. And there are actually two separate things. As with the group, the proudest moments revolved around reassuring radiologist who... And this is common to everyone, everyone in the new job, you know, they start to have self-doubt, "You know, did I make the right call? Am I good enough for this? Am I gonna do a good job?"

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You know, we all want to do the job, right? So, in small doses, I can't say it was universal, but it was, I hope, with most of the people that we brought on at that time, I can remember saying many times, "Don't sell yourself short. We've not given up on you. Don't give up on yourself." And this is the rough patches that happen with any new job. You know, you're three months in, four months in,

and even to the point of, we'd have some who were frightened off by procedures.

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For example, only to say, "I'm not comfortable doing lumbar punctures." I say, "That's all right. We can be uncomfortable with this, or we can sit down, and we can make you so you're comfortable. Because, you know, you'll see one, do one, do another, do another. And we'll make sure that, you know, when it comes up 2:00 in the morning, you could do a lumbar puncture when we're asking you to, and not be afraid of that and not be some negative in your work."

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So, to the point where that particular individual stands out in that regard. And five years later, was like, you know, it wasn't a question of, "Can I get out of this procedure during the day?" And instead was jumping on the opportunity to do these procedures. Well, you know, so I take that as kind of accomplishments that would relate to personnel and the groups.

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The other big one, actually, as group president. I think our relationship with the medical staff improved significantly during my tenure. I'd like to say that I had a lot to do with that. I'm not sure that's true. I think it was about creating for everyone, because I'm only one person out of, at that time, over 20. I can be the nicest guy in the world, that's not going to help.

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What we need is a culture that says, "We understand that our placement in the medical staff is to provide value to the clinicians." And then do that. And so, those two fit in the group president, right? The idea of making sure that new people to the group, we'd have a long ramp up to call, we'd have to make sure that they felt that they were part of the organization. It didn't work every time. But I think for the most part it did.

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Now, the second thing, you talked about president of the medical staff. The crowning achievement actually was to change the leadership, the governance structure. And what we did was we downsized the Medical Executive Committee.

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Now it sounds odd, but it actually fits with a whole bunch of recent publications, some of it in the JACR, but that pop up everywhere in the business world, etc. It's that large groups, while they are representational, don't make good decisions. Another way to say it, it's not quite the same thing, is they don't make decisions well. And that's true of things but, and you know this. But at the same time, we had at the Medical Executive Committee of 27 people. And it was, you know, and great people, smart, hard workers, dedicated to the mission.

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And it was dysfunctional because there were 27 people in the room. But it was representational, every time we added... We added the trauma service. Okay, the chief of the trauma is now on group executive committee. We had the positions that became almost slotted positions, which was kind of a bad word [inaudible 00:51:35] because the goal of the Medical Executive Committee is not to serve the interests, as a radiologist, let's say, as the chair of Radiology. I'm not there to serve Radiology. I'm there to serve the mission of the hospital or the medical staff, more or less in that sync.

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So, my biggest role was, I'd say, in the medical executive committee, with the help of a consulting attorney. And it was an iterative process. We went from just out and out, "No, we're not gonna let this happen." Because remember those 27 people, some of them had to give up their status, if you will, their role in this, but they're involved.

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But we got it down to 15. The lawyer wanted 12. I told her we can get it to 15. It was a bloodbath. And we got it to 15. And the irony, and that you'll appreciate this too, is that they went into effect the same day that I was no longer president of the medical staff. So, I never got the benefit of being able to run a conversation among 12 people instead of 27.

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But I think, you know, and it's difficult. It's a difficult, it's counterintuitive, isn't it? You think in a room like that you would want lots of representation. You want to hear from the trauma service, you want to hear from infectious disease,

you know, you want all these people there. We had a seat for the chief medical information officer.

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The problem is that when it comes to making decisions, we really want to call in people like that to advise, to inform, but not necessarily to deliberate and come to decisions. And you can argue that 15 was still too large. We should have gotten it down closer to 10 or 12. Because, as you know, and many of your listeners will know this too, you know, the most effective meetings are when you have 5 to 7 people, not when you have 25.

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So, that was my sort of single biggest accomplishment. But interestingly, of course, it's not viewed as an accomplishment to some of those 27 people who were no longer in the room. But at the same time, years later, I would hear from the people who were involved as saying, "What we would we have done if we hadn't done this? If we hadn't kind of had this wake-up call?" And just appreciated just how important it was, by-laws, we defined the governance of an organization with 1000-plus members of medical staff.

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Geoff: Yeah. Yeah, it's a heavy lift. And you very nicely articulated the challenges of getting the organization to a better place. And you're right, sometimes, you do all that work for the next ones to follow, to get the benefit. But it does sound like it was a terrific initiative.

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Brent: You know, it's funny, it brings back, you know, my father used to say, I didn't realize he was paraphrasing the Boy Scouts because the scouting was not a big part of me growing up, and I don't think it was for him either but, "Leave a place better than you found it." This fit into that mold as something, you know, again my dad had, he must have told me a hundred times when I was growing up.

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Geoff: I mean, and it's really a nice example of sort of activist leadership. I mean, it's easy to get into those positions and just sort of leave things alone, status quo. But, you know, making the decision to shake things up, you know, getting lawyers involved. You're practicing radiology at that point. You know,

I'm sure that at some level, this wasn't something you needed entering your life. But clearly, you know, you felt the responsibility of the role and you seized the moment.

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Brent: Well, ironically, that particular conversation where we had a few advocates, and this was an example of, you know, change management, which would be a whole different topic for us today. But one of the tools is, you know, you have to convince people that there's a problem, right, there's something we have to address. And that took a while because it's difficult to explain this. That the structure itself is counterproductive.

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And so, one of my allies in this who was actually more senior than I was, we left one of these discussions where we laughed. And he had said, "If you ever needed an example of why you need to downsize this group, it was that conversation we just had." So, the irony is that the very thing that you're trying to fix is sometimes the impediment to get there, gets that activism you were talking about

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Geoff: Thirteen years after leaving the AFIP, you became the genitourinary imaging trustee for the ABR. I think that's pretty cool that you were able to walk in, in formal GU radiology role after such a long break. What was your role as trustee?

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Brent: Well, the trustee primarily is responsible... I'll break it into two categories. One is to staff committees that develop content for the exams and that would include, at the time I joined, we were still doing oral exams for diagnostic radiology. So, I was assigned to the genitourinary segment of the content and the administration of those exams. In the sense that you have recruit examiners for the diagnostic radiology oral, and develop the test content for our various exams, whether it be what we now call the core exam or the certifying exam. And now, of course, we have Online Longitudinal Assessment. So, all that would be, fall to the trustee.

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The other role in our governance split in 2015, within the ABR, but the trustees of that time also had a role in the decision making. So the hiring of the chief executive officer, the decisions around major financial transactions, for example, extended lease arrangements, etc. So the trustees also did that.

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They did what a governing body would do for a nonprofit, basically, just had those fiducial responsibilities that you're well aware of, you know, the duties and the obligations to the mission. And one of those, of course, is financial.

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So, in some ways, the trustee function at the ABR, at that time, was an amalgam of those two things. On the one hand, these fiducial responsibilities, and the other hand, that the idea of developing content and they made sure committees were well served by around 1000 volunteers that served the ABR.

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Now those rules have been split apart. But I should mention that the way I wound up there, it relates almost to that CME committee example I gave when I first started at Reading Hospital. I was just an item writer that I think grew out of an item in question. It was the same thing at ABR. So, I was writing items for the exams. And I think I sort of stumbled into that because I had been in AFIP at some point. I am still lecturing there, in fact, right up until...I'm still lecturing there so they thought I could contribute content in that regard. And I did.

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But it gets back to, you know, if you do the work and you show up, even in private practice, I was approached to be a trustee, you know, by my mentor, at the time. I said, "I'm not academic enough for that role." "So, no, we're trying to make sure that we have people for private practice, sort of, diversify."

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I told myself at the beginning, I said, this will probably never happen. It was certainly, in some ways, it was a compliment. But, at the same time, I said, you know, they're 20 other people more qualified than I am to do this. And then I told myself that this will probably never happen. But I said, "Sure, I'd like to be considered for that."

[00:59:01]

And it grew out of, I believe, more than anything else is the ability to run a small group [inaudible 00:59;07] and do it with the same skills that you bring, probably, to your job every day and do it in some small way. And then, I wound up in that role.

[00:59:17]

Geoff: Yeah, yeah. Now, during your time as ABR trustee, you became chair of the Board of Directors of Reading Health System and Tower Health, a position that you held for four years. How did you ascend to that leadership role?

[00:59:31]

Brent: You know what? I hate to sound repetitive. It was the same idea. You know, it's the same. We were, at the time... And so that board got downsized at the same time, much of the way the Medical Executive Committee had done, in an unrelated fashion, although, ironically, to about the same numbers. And I was involved in both, although my role was as almost a spectator for that second one as we downsize.

[00:59:53]

But as we downsized, the governance model was sort of shaken at the roots in the sense that this representational role had been part of the health system, meaning the chief of Medicine, the chief of Surgery, the chief of Obstetrics and Gynecology, these were all board positions, but they were slotted positions. And that's just not a good model for board governance because you really should be obligated to those fiducial responsibilities. Remember those same things that you bring to the board. And now you're not there to represent the medical staff or other doctors or the department of Surgery.

[01:00:29]

And as we shift away from that, I think, again, maybe it's a matter of, you gonna know when to listen, and you know when to talk. And they kind of took me aside and said, "Would you be willing to, you know, be considered for this role?" And at first, you know, I said, "Yeah, what can I do to help you?" It really became that.

[01:00:49]

I think, honestly, that was probably the biggest thing that gets you to a role. At the time, I was doing, I was toward the end of it, I was the only physician on the board. Those are generally not made up of physicians. They're actually or, I should say, health system boards are almost never physician heavy. They're actually made up of local leaders of industry, right? They're made up of attorneys and accountants and people who are...unity, they form a united way, you know, people like that on our board.

[01:01:19]

And I think what, at least prompted them to at least look at me as a candidate for that was because at every step along the way, I probably was more interested on how can I help than, you know, I need to be involved.

[01:01:32]

Geoff: Serving as board chair, did you ever find yourself at odds with the interests of your practice?

[01:01:39]

Brent: Well, we were very careful that when direct conversations came up regarding the practice that I would recuse myself. So, that was not really an issue. We had a contract with the hospital, but it was a large enough organization that that conflict was...you know, we disclosed it.

[01:01:57]

The biggest conflict in my practice was that when I was sitting through a day-long board meeting, I wasn't reading CT scans. And I understand that, and certainly, that means someone else had to read the CT scans.

[01:02:08]

And, in fact, when I had the opportunity, I would make sure to share that with the board and just say, "You know, I'm grateful to my group because without them, I couldn't do this. I couldn't come up with enough time off to really be part of that." So probably the biggest problem was not in a contracting relationship we had, etc. because the lawyers at the board then make sure that was clearer than it needed to be even. The biggest friction really was, you know, the whole...

[01:02:32]

I'd go away for a one-hour meeting that would turn into a three-hour meeting, and I had to call back and say someone needs to cover for me till I get back. And it's tough. And I understand. I mean, I get it. I think that the group was willing to support it. And it certainly did. I think where it became problematic is the actual real-life impact, which is, "Okay, someone else has to do a thorough biopsy because I'm still in a meeting that ran over like that."

[01:03:00]

Geoff: Yeah. No, it's a great point. I mean, the adage that it takes a village, you do rely on your colleagues, your partners to help allow you to do the roles that you have, that you need to do.

[01:03:13]

So, now, just two years ago, you graduated from the Carey School of Business at Johns Hopkins University. What led you to seek an MBA after having had so much leadership and management experience under your belt already?

[01:03:28]

Brent: Well, I guess it was two things. One is I still felt that, on the finance side, even though, you know, the business model for private practice is not very complicated, when you get right down to it. Yeah, we were successful because it's a hard business model to fail at, honestly. Or at least it was. Maybe, it's more challenging today, and I think it probably is a little bit more challenging.

[01:03:48]

But the other side of it was, and honestly, I credit the RLI. When I was at the first summit, I'm gonna get the year wrong, it might have been 2012. And Geoff, I think you were at that, if not the first one, the second one or where I kind of went up at one of these. And I went, I think, eight of them in sequence, or seven of them in sequence. And, as you know, those are business faculty that are teaching us during those summits. I thought they were phenomenal.

[01:04:16]

Businesspeople think differently. And, if we can borrow from them... And I don't think they...it's not that they bring less emotion to the practice. That's not really the issue. It's really about a very analytical, you know, things that I think complements what we do as physicians. It's not in conflict with it. But it does allow us to assess a problem in a very different way.

[01:04:41]

Because, as you know, this is a task oriented that is largely done by individuals, right? I mean, there's been a lot written about, maybe it shouldn't be as by individuals, but it certainly is task oriented. Whereas the ability to see the large picture, I think, is intrinsically part of any successful business, right?

[01:05:02]

So, if you're only looking at the next week's worth of production of anything, you can't run a business. But I can look at that next hour labs they have to do and say, "Okay, I got a thorough biopsy to get done, I've got to do it extremely well. I gotta make sure the patients happy. And that we don't have a complication." But that's a very episodic thing as opposed to the way businesspeople think. So, I credit the RLI of kind of pushing me.

[01:05:24]

And I did it for interest's sake. You know, obviously, it wasn't going to...in fact, you'll appreciate this. Of course you did your MBA as well. One of the exercises we had, when we were assessing sort of the employment arrangement that somebody might have is, it was a test question on one of the exams, it says, is it worth it for a 57-year-old individual to get his MBA? And you had to plot out the additional earnings over time, their expected career, what it cost them in opportunity cost and true financial cost? And the answer was no.

[01:05:52]

And here I was 57 years old, and I'm taking this exam. And I don't think the professor did that on purpose. But, basically, the answer to the exam question was I never should have done my... So, the irony was not lost on me. And I, as I say, I don't think he did that on purpose. But I did it for interest. I did it because I found it fascinating the way businesspeople think. It was terrific. And then on top of that, I think, you know, a better understanding of accounting and finance.

[01:06:19]

Geoff: Yeah, I mean, I wouldn't be so sure that that wasn't on purpose to offer that question. But the flip side is that, you know, the adage, you know, feed your head, trust your gut. There's two sides to, you know, any business and management question, the quantitative and the sort of the poetry side. And so, I would ask you, you know, based upon whatever modeling that one pursued about whether it was worth it at age 57, to you, was it worth it?

[01:06:52]

Brent: Oh, absolutely.

[01:06:53]

Geoff: There you go.

[01:06:54]

Brent: It was terrific. You know, I learned things and delved into things I never would have thought about and in a different way. You know, the rough spot for me was, I was older than the parents of my classmates. That's gonna happen. So, it's okay. Or, I found, I'd state it another way, I had classmates who were younger than my children.

[01:07:16]

Geoff: It's a privilege to be able to learn at that stage and to bring the basket of experiences with you. I found epiphanies occurring to me in the classroom and my reanalyzing occurrences that had happened, maybe, you know, 8 or 10 years ago within the construct of these new tools. I just thought that was invaluable. Yeah, fantastic. What about you? What would have been some of your greatest epiphanies from the MBA program?

[01:07:49]

Brent: You know, I think there were also more little epiphanies, I guess, let's say, in different way. You know, a lot of the understanding around...and these were things I knew. They were things that I think were brought into sharp relief, you know, when they would talk about the time value of money, what motivates people, a little bit of the change management stuff, and...

[01:08:09]

But I think the biggest single thing was value. You know, that's become, you know, of course, out of Porter's work, as you know him. You know, there's this idea that ultimately, we have stakeholders to them, and then that's going to be true, whether it's the department radiology, a health system.

[01:08:29]

And I suppose the second piece is that taking the long view of what success looks like and what that path is going to be in getting to success. So, if there were big ones, it would those. There are a whole bunch of little ones.

[01:08:45]

Ironically, one of the things, one of the courses I liked the most just because it made me think even outside of this box of radiology and the ABR, etc., was a course on world trade, which we can argue has nothing to do with anything that I do day to day. It never did. But we start out with sustainable goals and the way, you know, our nation looks at developing countries. And, you know, a fascinating elective, it was it was only about two weeks long, including a week spent in Peru.

[01:09:12]

I mean, that's one of the more memorable things. It has nothing to do with what I bring to work every day. But the kinds of things you learn along the way and truly a big picture, right? That's the biggest picture thing is when you start talking about sustainable goals. That was a wonderful experience.

[01:09:29]

Geoff: Last year, you left Pennsylvania and your practice of 22 years relocating to Tucson and becoming the executive director of the ABR. How would you describe your roles and responsibilities within this current position?

[01:09:42]

Brent: Well, you know, it's twofold I suppose. One is running the organization itself. We are right around 100 employees and on a budget of about $80 million. These are public numbers. So, you know, we have an organization to run that is providing the things that we do, mission-oriented things regarding board certification.

[01:10:01]

I think that takes up, because a lot of that can be sort of delegated, if you will, I mean, the staff, I have here is excellent. You know, that takes up probably less than half of the time. The rest of time is getting back to that value question for stakeholders. And whether it's permanent record, the candidates, the diplomates, ultimately, you know, the public and that's our mission sits there.

[01:10:26]

And I only record the public very much, right? I mean, I don't, you know, we don't hear from that, because there's this presumption among the public that we indirectly serve that radiologist or any physician would want to pursue

excellence. It's probably the briefest way to say it. And so, they take what we do for granted in some way. We, as a profession, not we the ABR.

[01:10:47]

But they count on something like the ABR to be there to do it. So, I guess if I had to try and quantify it, I'd probably say that half to a little more of what I do is on that side of things, which is how do we relate to stakeholders? And how do we continue to represent value to those stakeholder groups?

[01:11:05]

And I didn't include all that wasn't intended to be a comprehensive list, but they're the big ones, right? How do we relate to candidates, diplomates, the public? And then, I suppose, I'd put program directors in that same...

[01:11:15]

But at the same time that the job is, you know, we're also approving budgets and hiring personnel for IT initiatives that we have to do in order to keep current. I'm talking to attorneys about how do we deal with the practical things of having a nonprofit, which is the audit and the business, the business law functions that go into a lot of other things that we encounter day to day.

[01:11:38]

Geoff: The COVID 19 pandemic has undoubtedly disrupted the cadence of your first year on the job. Can you tell us a bit about how the pandemic affected the ABR and your role as executive director?

[01:11:50]

Brent: Yeah, it's interesting. I never got a chance to get used to the old cadence. So I don't know what it was like because I arrived about four months after the pandemic kind of took hold.

[01:11:59]

Our focus, since I arrived on July 1 of last year, has really been around providing remote exams. And it was really based on something that I ran across, quite recently, by Yuval Harari, where basically he said the risks of doing nothing amidst something like a pandemic, he was actually talking specifically about the pandemic, but the risk of doing nothing, meaning failing to innovate were greater than the risk of innovation.

[01:12:27]

So, we took on innovations that were challenging over such a short-time period. I mean, if we had decided to do this, this would have been a three-year project, not an eight-month project. But we didn't have a choice.

[01:12:39]

So staff and I have been just sort of consumed by getting these exams out, because these reflect really in a very real way to thousands of individuals' lives. Right, the timing of this process isn't...and we realized we were not going to be able to wait out the pandemic, nobody could, for most of what they're doing.

[01:12:58]

That's really what we've been doing is focusing on, okay, for now, for this year, now, I would say, well, we get through the quarter. Next month, it will be a year into this process. But actually, we complete, as of tomorrow, you know, the exams. And that catch up, which only started the first week of January, and again, gave us only about six months and change to get it developed, really has been the challenge.

[01:13:23]

And here's the good news is that these innovations that we've developed, I think are sustainable. I think we'll be able to do it. This was not a short-term fix. If it works, we'll continue doing it.

[01:13:34]

Geoff: That's great. I was gonna ask you, you know, what you anticipate will be the lasting changes brought about by the needs of social distancing during the pandemic?

[01:13:44]

Brent: Yeah, well, of course, those needs, we've seen in just the last 10 days, you know, decreasing. This idea, you know, how much distance do we need? Do we need masks, etc.? It still clocks, but we would argue on the downward side of the curve. But I think it really gets back to then the secondary things, unrelated to the pandemic. Why should the individual have to travel for an exam if we can create an exam that can be done without travel?

[01:14:07]

And it's kind of interesting, we got a lot of criticism for why did you do this three years ago? And the reality was, there are downsides to this process. There are small security risks. There is what it looks like as credible [inaudible 01:14:21] to internal stakeholders, other physician groups, other subspecialty boards.

[01:14:29]

So, well, it's not all perfect. It's just that I think moving forward, we've kind of proven with this somewhat risky experiment that we can make it work, and we're going to continue to make it better. But the long-term plan is that, yeah, this thing prompted by the pandemic, likely will be our revised model.

[01:14:50]

Geoff: Yeah, that's excellent. Do you look back and see your business school education as contributing to your ability to navigate these past nine months or so?

[01:15:03]

Brent: Yes, the short answer is yes. The only problem is that I'm not sure I recognize them specifically when they happen. But sometimes, I'll look back and say, "Yeah, that's something I never would have thought of or at least all of in that way without having gone through some of the courses in business school."

[01:15:18]

An awful lot of it, as you say, you know, an awful lot of what I dealt with would have been things that I would have dealt with over the 20 years in private practice on the hospital, Medical Staff Executive Committee, and the board chairman, etc. So, it's difficult to parse those out. Right. And you know, I think would be different if I had been 20 years younger, when I did the business school, then maybe those would have been more directly related to that.

[01:15:42]

But as it was, absolutely, there are times I find myself, in fact I'd be sitting with staff and something will click, and I'm thinking back to something we read or something that was a major point in change management or crisis management. You know, I know, of course, in your jobs, you dealt with that as well. You know, how do we communicate when and to what degree. These things were all, I think, reinforced if not new ideas in the business world.

[01:16:09]

Geoff: Yeah, absolutely. Recently, the ABR rebranded maintenance of certification to continuing certification, why that change?

[01:16:17]

Brent: Yeah, that's a great question. I wish I knew the answer to that one. I'll tell you, it's continuing certification. And that became, I think, a slow evolution at the ABMS, which of course our organization [inaudible 01:16:31]. But yeah, you know, ABMS's standard across all the member boards. And there was this evolution from maintenance of certification and continuing certification. For the exact reasons, I'm not sure, I think both terms have been used sort of interchangeably, although MOC was the more conspicuous term. So, nothing really changed about the program. And I think that's important to emphasize.

[01:16:52]

We're going to be using both terms, I think in the short term, just to try to diminish any confusion and ultimately wind up with continuing certification because that was the, I think, that was more understandable to the public during the Vision Commission, the testimony phase back in 2019 to 2020.

[01:17:13]

So, I would just reinforce for the listeners, it's not a real change in the program as much as a change in terminology that we hope is more intuitive, not only to practitioners, but also to the public that might look at, "Okay, what do a certification entail?" Does that make sense? I mean, unless I don't know if you've seen any...certainly no differences in the programmatic offering.

[01:17:36]

Geoff: Yeah, no, it does. I mean, you know, I really appreciate your articulating that. I mean, one might wonder if it was a concerted effort to rebrand a program that in some spheres was losing popularity.

[01:17:50]

Brent: Oh, that's interesting. That was not the intent. The intent was merely to, I think, continuing certifications, is probably grammatically closer to what this really is. And perhaps maintenance of certification was... You know, back in 2003, when I think John Madewell delivered [inaudible 01:18:08] or whatever,

on maintenance of certification as it would reflect for radiologists. You know, radiologists relate to this way of thinking.

[01:18:14]

And I think it was borrowed at that time from other boards. And as a result, it's just evolved to continuing certification. But at some point, you just have to change what to call it in the communications. So, like I said, we'll probably use both terms, parenthetically, and then move forward to continuing certification. But it was not at a conscious effort because the maintenance of certification was bad and continuing certification is good. But rather, I think that the continuing certification is just a little bit better.

[01:18:42]

Geoff: Yeah, understood. Recently, you shared the news in the monthly newsletter that fee reductions might be coming for ABR services. What is motivating those changes?

[01:18:52]

Brent: Well, you know, we have a very public financial record. And with the growth in our reserves, it's really not because we're charging more in fees that we spend in cost, but rather, because the market has done extremely well, as you found out, over the last decade. We found ourselves, we don't need to maintain reserves at quite that level, can we basically look at ways to control fees so that...? You know, we're not trying to get rich? We're not trying to build a huge stockpile.

[01:19:27]

We need a certain level of reserves, to withstand, for example, downturns, because it's, you know, it's a portfolio that represents the investment reserves. But at the same time, we're not trying to grow that infinitely nor are we comfortable, even a multiplier of two or three, we want even less than that.

[01:19:48]

So that's part of it. The challenge right now, and I do anticipate some level of fee reduction probably to small groups. We've targeted groups that I looked at and that I said, "You know, we're charging more than this cost us to administer for specific programs." I don't want to presume or comment on behalf of the board, I think these fee reductions for 2022 will likely be targeted to small groups, but there'll be significant decreases in what those fees will be.

[01:20:14]

The more global groups like the initial certification for diagnostic radiology, which impacts 1300 candidates or more per year, is a little tougher because any increment then has that same reflection in the operating sort of based on our operating revenue. So, we just need to be a little careful.

[01:20:33]

I've been pushing this since before I took on this job as board president saying, "You know, we need to cover costs, but at the same time, what can we do to reduce our costs and hence reduce our fees?" And we'll be looking at that very carefully. And that's a couple years.

[01:20:48]

The caution is we haven't hit steady state with the new exam models yet. And my staff reminded me of that we're still trying to improve. So, we're not at a steady-run race, and you think we would be. After COVID, we might be. So, I would anticipate some rate reductions in 20...

[01:21:07]

Geoff: Yeah, I mean, the initiative is really laudable. And particularly, you know, when thinking about the typical business school curriculum around pricing where one wouldn't even necessarily be sensitive to costs when setting pricing more related to what the market will bear and in terms of revenue generation. But, you know, just sort of filtering through some of the key points you've made in identifying the creation of value for key stakeholders, then revenue generation is not necessarily completely aligned with the principle of creating value to the shareholders.

[01:21:48]

Brent: Well, I think the critical thing is, as you said, we're not interested in charging what the market will bear. We're interested in covering our costs. And I think we have that obligation that, again, that fiduciary obligation back to the people who pay the fees.

[01:22:04]

I share the story once or twice with larger groups. My son is an R3 in radiology. And he called me on my 60th birthday last year. And he said, "Happy birthday, Dad. What are you going to do about fees?" in one breath. And I'm very

conscious of it. I think we realize that we have an obligation to keep fees at the lowest possible level.

[01:22:24]

And we'll never do that. The only caveat is people think this is a simple thing to do. And it's actually very complicated to do it well. And it's expensive. Today's day and age, by the time you're covering insurance for employees, by the time, you know... And we are very conscious of keeping with sort of market value, if you will. You know, we don't overpay, we provide reasonable benefits, but we're trying to balance things between what we want to do to maintain a good workplace and a good work environment at the same time, realizing that ultimately, I have a responsibility to candidates and diplomates to keep fees as low as possible.

[01:23:05]

Geoff: You mentioned that as a nonprofit organization, the ABRs tax filings are public. In the most recently available filings from 2019, before the pandemic, there was a change in net assets from $40.7 to $47 million. With $47 million in net assets, what are your perspectives on the role of those assets and how to best put them to work?

[01:23:27]

Brent: Yeah, so as you know, using reserves to fund operations is sort of a no, no. You just don't do that. I would argue the ABR and I have argued this with the board. And they agree, quite recently, we're different, meaning, we should be willing to spend down the assets that... Because that growth was not because we took in more money than we spent, but instead, it's because the market did extremely well. And we can't count on them forever. Nobody does.

[01:23:57]

But at the same time, there's a point at which, I think spending on the reserve in order to have fee abatements, is an important measure. Challenge is that as much as... We hate to increase fees, right? That's a very unpopular thing to do. So, you start to ride this roller coaster. So, we just want to be very thoughtful and intentional around fee reduction so that we can make them stick. And the problem is we'd be making them stick not based on revenue, we'd be making them stick based on a portfolio.

[01:24:31]

But your point is well made. I think that growth is a result of the equity market more than anything else. And you've all seen it, your listeners have seen it. But at the same time, we don't need to maintain reserves at that level. And that's where we hope to at least implement some fee reductions, basically, drawing off of those reserves. At the same time, we just have to be mindful that the reserves are there for a reason that is to support unanticipated infrastructure needs there might be in the future.

[01:25:00]

So, I hope that's certainly the way the board is, as candid as I can be. The way the board is looking at it, we know we're different. We're not... Yeah, we have to be. We have an obligation, I think, and that's how I word it to the board. And they agree, we have an obligation to maintain fees at the lowest possible level. And to watch... You know, it's an embarrassment in some way to you know, that it's great. The markets doing well, everybody's happy about that. But at the same time, we need to be reasonable on how much reserve we maintain going forward.

[01:25:28]

Geoff: Yeah, absolutely. I mean, having assets is a blessing. And it is an opportunity to invest in the organization in any number of ways. One of them is just to return value to the stakeholders, namely, through reduced fees. Another one is to engage in R&D. And I'm curious the extent to which the ABR has engaged in R&D over the recent years. And what are your thoughts about budgeting for R&D going forward?

[01:25:55]

Brent: Well, that's a great point. And that has been a topic recently. You may remember that the division commission report and the current draft standards that just came out, I guess, last month, for a month through the beginning of July. It talked about the board using dollars to do research. We actually have the ABR foundation as well, much smaller purpose, right around a million dollars, I believe. And we have informally made that available to people. And what we're gonna do is formalize that.

[01:26:21]

And I believe, look, to do that. I'm reluctant to say to people paying fees that our intention is to grow a Research Fund. But at the same time, this may be an opportunity, because that growth, of course, was not based on fees that growth

is based on the equity market or in more general... And that was brought up actually, Vince Mathews of the communication we just do in the last 10 days said we need to be looking at ways to do research into what board certification means.

[01:26:51]

That particular research is very hard to do. It's very hard to have a control group. It's very hard to basically take the variables out that you would need to do it otherwise. So, I'm not surprised that people have struggled, I think to do that research. We would actually fund it. We probably wouldn't do it. I think it needs to be independent.

[01:27:09]

I think, you know, but we are willing to have considerations around funding for individuals who might say, "Hey, I have this great idea that would examine the role of board certification, especially continuing certification actually, in what value it brings." Our role, you know, we see as supporting that, but not as really doing it because I think it would have more credibility as independent activity.

[01:27:33]

Geoff: Yeah, I mean, you know, research in the interest of providing a better product and better services to your stakeholders, I think is really well aligned with the organization. It's not just necessarily the value of continuing certification, but how does one implement the testing procedure? And you know, what's relevant, what's not relevant? And as you mentioned, it's hard work. So, and probably the NIH isn't gonna fund it.

[01:28:00.531]

Brent: I wouldn't count on that. No.

[01:28:02.044]

Geoff: Yeah. Why not? Okay, excellent. No, thank you. Thank you for indulging me in those questions. Let's turn to your family for a moment. One of the concerns that I hear amongst radiology leaders is achieving a good work-life balance in particular, as it pertains to nurturing family life. Can you share some details of that journey with us?

[01:28:22]

Brent: Yeah, I have three kids. They're all grown now. I guess their age is 28, 22, you know, they have their own lives now. But as they were growing up, I intentionally didn't... I put off the graduate school thing, the MBA for a while for that reason.

[01:28:37]

You know, I think I look back on this sort of an idyllic kind of thing that kids were involved in sports and school activities. And you know, that was a blast. In fact, it did hit home quite recently, we're talking about academic productivity levels, you know, among radiologists and writing that next paper. And a colleague of mine years ago said, "You're not going to judge your life based on how many papers you wrote. That's not what's going to define you as an individual."

[01:29:07]

And she wasn't actually talking specifically about me, she was talking about all of us really. Are we really going to look back and say, "I wish I'd written one more paper, one more book after, etc.?" I mean, those are important activities to be sure. It's just that, you know, I look back on and I say, "Oh, it was more about the kids."

[01:29:24]

And right now, they're in, I've got them in all in the Eastern time zone. And, of course, you know, you and I are both in Mountain Standard time. But I'll be heading back next week, and it's an opportunity to see the grandkids and do the fun stuff, honestly. So, I don't regret not writing more papers, personally.

[01:29:42]

But I think, you know, that balance is challenging sometimes. And I know that there were times when I missed school activities. I'll tell you a short story. When I was elected president of the medical staff. I missed, my son played wonderful in high school, and he currently a radiology resident, at the time, he was a high school football player. He had a game that was an hour away, you know. So, normally I would have gone and I said, "I'm going to skip this game." It was a big deal. It was a regional game that mattered.

[01:30:12]

And I said, "I expect, you know, this vote happens tonight for present medical staff." And what he didn't understand, it was unopposed, you know? And

because after the thing, he called me from the thing, he said, "We won the game." And he said, "How do you do in the election?" I said, "Well, I won, but it's one of these, you know, sort of structure ballots." You know, so I was always embarrassed to say, I missed a game for an election I was going to win anyway. I just felt that I needed to be there, which I think actually is a true statement, I needed to be there.

[01:30:37]

So, you know that those things, of course, those trade-offs came up from time to time. But in general, you know, one of the advantages of radiology for many of us is even though there's a lot of off-hours work, and a lot of weekends you have to work, it's a little more predictable than some of our colleagues. So it all worked out.

[01:30:55]

Geoff: Yeah, well stated. When thinking about our profession, what keeps you up at night?

[01:31:03]

Brent: Well, the profession at large, I think, you know, when we look at these larger and larger organizations that are becoming this conglomerate technologist. I think, in some ways, for lack of better word, the world of technology. And I know that's, that's not maybe even the most accurate way to say it, but it's kind of the way people think about it.

[01:31:27]

I think it starts to distance us from why we went into the field, which was.... And it also takes away the local feel of, you know, in my group that I left last year, you know, of 23 to 26 people, where you kind of pull it together because my concern becomes really about widgets [SP]. And I know it's gonna play out differently in different locations and different practices. But that would be, I think, as I would look at it, again, I had a kind of an idyllic practice too because we were growing collegial, you know, we had our rough spots but for the most part, as a group, we got together, we came to the right decisions, and we got along.

[01:32:10]

And I'm worried that the larger and larger these organizations get, the more we're taken like cogs in a wheel and us like practitioners working toward those

relationships that are all local, right? I mean, you know, there's a limit to how much teleradiology you can do and actually know the person at the other end. And I know it's done. And it's not impossible, it's difficult doing that.

[01:32:34]

I won't talk about AI, because that's going to get [inaudible 01:32:35]. So I think I probably in that camp that says that, probably middle of the road, that AI is going to change things, but it's not going to make radiologists obsolete in any widespread way. But I don't claim to have any particular authority in that. But that first thing I do have some authority and just that having witnessed the relationships and how important they are in generating a successful and they're moving practice. I'm moving less and less, sort of an automatic, as we go to larger and larger practice organizations.

[01:33:08]

Geoff: Yeah. And ending on a positive note, what excites you most about radiology?

[01:33:16]

Brent: You know, this is almost embarrassing to say. When I was going to work every day in private practice, I look forward to coming to work. It was fun. I knew I was going to be doing interesting things that were important. I still feel that way about my new job. Even though I'm not going to hospital every day, I feel like I'm doing important work. It's a lot of fun.

[01:33:33]

You know, I think the future for the profession is just amazing, provided we keep as an organization or as an industry, we keep our focus on the things that matter. We talked about a lot of them today. And I really, I think is why as I'm driving into work every day, it's like, this is as good as it gets. Honestly, not perfect, but really good.

[01:33:56]

Geoff: That's excellent. Well, Dr. Brent Wagner, I can't thank you enough for sharing your thoughts today. Your journey, a truly fascinating one and one that I think many of our listeners will find inspiring. Profound appreciation, thank you.

[01:34:14]

Brent: Thank you very much. It was a lot of fun to have this chat and I hope it was useful to some of your listeners.

[01:34:28]

Geoff: Please join me next month when I speak with Reed Omary, the Carrol D. & Henry P. Pendergrass Professor and Chair of the Department of Radiology and Radiological Sciences, Professor of Biomedical Engineering at Vanderbilt University Medical Center and School of Medicine in Nashville, Tennessee. An interventional radiologist who has pioneered image-guided therapies for hepatocellular carcinoma, Dr. Omary serves on the board of directors for the society of chairs of Academic Radiology Departments, and is president elect of the Association of University Radiologists. He founded and directs the Vanderbilt University School of Medicine's Medical Innovators Development Program, and co-leads the Medical Center's strategic planning efforts.

[01:35:10]

As host of his podcast, "Innovation Activists: Designing Health Care's Future" and through an active presence on social media, Dr. Omary is a passionate proponent of healthcare innovation and fostering the next generation of radiologists and healthcare leaders to inspirational and supportive leadership.

[01:35:28]

"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 coproducer of this podcast, to Port City Films for production support, Linda Sowers, Meghan Swope, and Debbie Kakol for our marketing and social media, Bryan Russell, Jen Pendo, and Crystal McIntosh for technical and web support, and Shane Yoder for our theme music.

[01:35:55]

Finally, thank you, our audience, for listening and for your interest in radiology leadership. I'm your host, Geoff Rubin from the University of Arizona College of Medicine in Tucson. We welcome your feedback, questions, and ideas for future conversations. You can reach me on Twitter @GeoffRubin or using the #RLITakingTheLead. Alternatively, send us an email at rli@acr.org. I look forward to you joining me next time on "Taking the Lead."

[01:36:26]

[Music]

[01:36:49]