ACR Resident and Fellow Section

New State Chapter Resource Handbook

Version 1.0

Compiled by the Membership Committee

March 27, 2005

Welcome to the American College of Radiology (ACR) Resident and Fellow Section (RFS) resource handbook for new state chapter development. The purpose of this handbook is to provide a single resource guide for residents and fellows interested in starting a resident and fellow section within their state. This handbook also has resources that will assist newly formed state chapter resident and fellow sections with continuing recruitment and tips for strengthening their membership.

The membership committee was formed within the RFS in 2004 to address the increasing interest in RFS development at the state level and expanding ACR RFS participation at the national level. The culmination of the committees first year of existence has been publication of this handbook. Prior to the committee's existence, the ACR Committee on Resident and Young Physician Activities composed a resource guide, which has been available on the RFS ACR website (www.acr.org). The current handbook updates much of the information available in that resource guide and includes new presentation outlines on ACR organizational structure, state chapters, and current issues facing the ACR RFS. In addition, it includes articles published in the JACR and E-bulletin on RFS state chapters. Lastly, it includes an update on the Aunt Minnie Discussion forum project headed by committee member Dan Entrikin, M.D.

This handbook is a project in evolution. Currently only 13 state RFS chapters are in existence. As more state chapters are formed, the ACR RFS membership committee will continue to update this handbook and add additional focus on maintaining membership within the state chapter.

We hope that this handbook will be useful to residents interested in starting RFS chapters within their state. We welcome any feedback for improvement of the handbook and encourage all those interested to get involved in the ACR RFS at any level, but particularly those interested in state involvement to express an interest in the membership committee.

Thank you for your interest in the ACR RFS.

Dan Entrikin, MD
Greg Galdino, MD
Jo-Anne Lacey, MD
Joshua Rosebrook, MD
Ajay Sood, MD
Aradhana Venkatesan, MD.

ACR RFS Membership Committee Members

HANDBOOK FOR STATE CHAPTER DEVELOPMENT

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HISTORY

The American College of Radiology has long recognized the importance of leadership development within the State Chapters. In 1988, the ACR Council adopted a resolution formally recognizing the need for State Chapters to establish Resident Physician Sections (RPS). The ACR Committee on Resident and Young Physician Activities then developed a set of guidelines to help State Chapters develop and implement state chapter Resident Section Programs. Between 1988 and 2004, resident and fellow participation grew steadily. Several state chapters were established. (The experiences of the Illinois and Virginia chapters are contained within the handbook).

In 2004, the name of the Resident and Physician section was officially changed to Resident and Fellow section (RFS) to recognize the important contribution of fellows as part of the RPS. At the annual meeting in 2004, the RFS also experienced a record number of resident and fellow attendees from all over the country. Several new state chapter RFS sections were formed to foster increased resident and fellow participation at the state levels. As of 2004, 13 state chapters were officially established. Also in 2004, the RFS executive committee formed the membership committee to assist the development of state chapter RFS sections and to continue to support recruitment for existing state chapters.

The culmination of the work of the membership committee is published in this handbook entitled The Handbook for State Chapter Development. The handbook incorporates and updates much of the information in the previously published Resource Guide and includes additional resources and references for state chapter development. With the rising number of residents and fellows participating in ACR activities, state chapter development becomes increasingly more important to address the needs of residents and fellows within their state.

ACR Governance

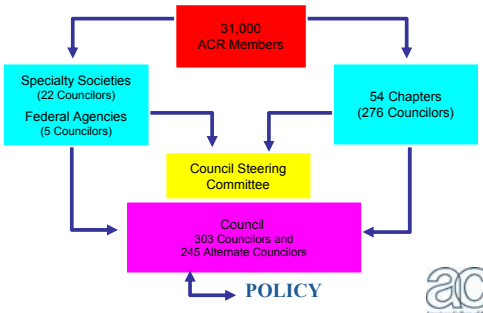
An Overview for the
Resident Physician Section
May 2004

ACR Mission

The ACR is a nonprofit professional society whose primary purposes are to:

- improve service to the patient
- advance the science of radiology
- study the socioeconomic aspects of the practice of radiology
- encourage continuing education

Policy Development



ACR Councilors

- 303 councilors
- 1/100 ACR chapter members (min. = 1, max. = 23)
- Military (3), VA, PHS, 1/military branch
- 25 specialty societies, 1/society
- Councilors -at-large – rad. onc. (0), med. phy. (6), other (3)
- 3 year terms, limit =2

ACR Alternate councilors

- 231 alternate councilors, possible to have up to the total number of councilors
- Vote only when councilors unable
- 1 year term, no limit

The Role of the Council

- Establish overall policies of College
- Councilors/alt councilors act as liaisons between local or specialty societies and the College
- "Legislative branch" of ACR

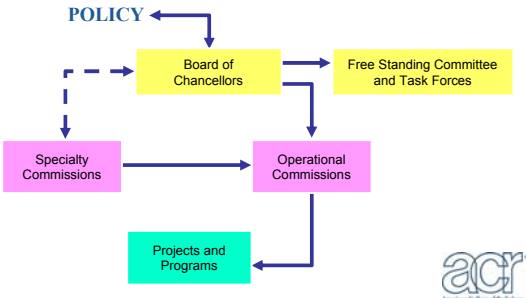
Council Steering Committee Members

- **Speaker, Vice-speaker**
  - Preside over annual meeting
  - Elected, 1 year term (max = 2)
- **14-17 members**
  - 6 elected by Council for 2 year term
  - Others appointed for 1 year term, renewable

Council Steering Committee Role

- **Liaison to Board of Chancellors from Council**
- **Liaison to Council from Board of Chancellors**
- **Ex-officio members of Commissions**

Policy Implementation



Board of Chancellors Role

- **"Executive branch" of ACR**
- **Day-to day operations of the ACR**
- **Serve as Chairs of Commissions**
  - >1000 members of the ACR serve on Committees

Board of Chancellors Members

- **< 25 members**
  - 5 appointed by chair, 1 year term (max 6)
  - Others elected by Council, 3 year term (max 2)
  - Pres, VP, sec-treas
  - Includes reps from ARRS, RSNA, ASTRO

Board of Chancellors Operational Commissions

- **Communication**
- **Economics**
- **Education**
- **Government relations**
- **Human resources**
- **Quality and safety**
- **Research and technology assessment**

Board of Chancellors Specialty Commissions

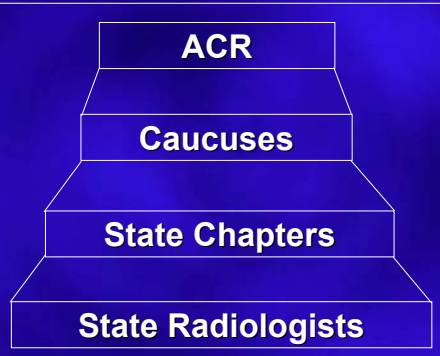
- General and pediatrics
- Interventional and CV
- Molecular imaging
- Nuclear medicine
- Neuroradiology and MRI
- Medical Physics
- Radiation oncology
- Small and/or rural practice
- Ultrasound

ACR RPS
Role of State Chapters

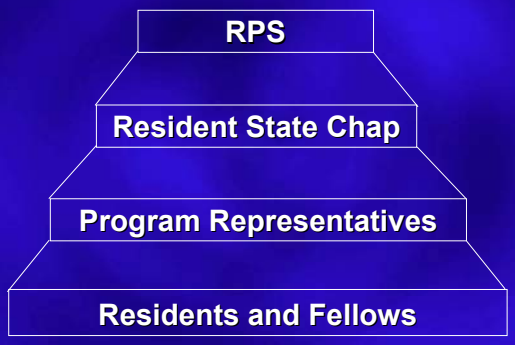
Greg M. Galdino, M.D.
A3CR2 Representative
RPS Executive Council

California Radiological Society
UCSF

State Chapters



State Chapters



State Chapters

- Resident State Chapters
  - Communication (Disseminate Info)
  - Discussion Forum
  - Political Activities
  - Social Interaction
  - Networking

State Chapters

- State Issues
  - Unique Legislation State to State
  - Geographic Differences
    - Practice Environment
    - Scope of Practice
  - Variable Reimbursement
  - Mini ACR Structure
    - Lobby State Legislature

State Chapters Demographics

- Resident Chapters
  - 12 State Chapters
    - NY, NJ, MA, TX, FL, PA, WA, IN, IL, CT, CA, MN
- Delegates
  - 5,332 residents in ACR
  - 90 residents
  - 37 States (typically 30-40)

State Chapters

- Programs (Diag Rad and Rad Onc)
  - 65 Programs represented at ACR

Annual State Meeting

- Resident Section Forum
  - Resident related issues
    - Political Topics
    - Program Specific
    - Education
    - Career Related
- Network
- Educational Program (CME)
- Practice Related Program / Business

Organizing a Chapter

- Contact State Chapter
  - President, Executive Council
  - Identify Programs (ACGME)
  - Resident Contact information (ACR)
    - Kelly Foster
  - Program Contacts
    - Program Coordinator
    - Program Director
    - Program Chair
    - Chief Residents

Organizing a Chapter

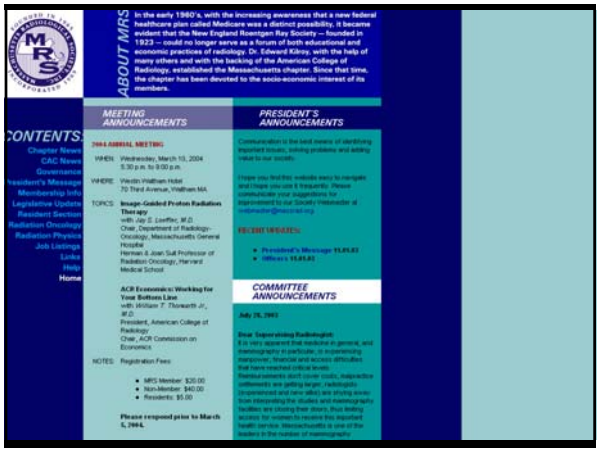
- Priorities
  - Email Introduction Letter
  - Program Representatives
  - Establish a Council
  - Conference Call
  - Regular Communication (Email)
  - Quarterly Newsletter

State Chapter Websites

- MA: www.massrad.org/rfs
- NY: www.informatic.sunysb.edu/nysrs
- TX: www.txrad.org
- FL: www.flrad.org
- NJ: www.rsnj.org
- CA: www.calrad.org

Web Site

- Calendar
- Contact Information
- By-laws
- Chat Room
- Job / Fellowship (State Specific)
- Education


ABOUT MRS
In the early 1960's, with the increasing awareness that a new federal healthcare plan called Medicare was a distinct possibility, it became evident that the New England Roentgen Ray Society -- founded in 1923 -- could no longer serve as a forum of both educational and economic practices of radiology. Dr. Edward Kilroy, with the help of many others and with the backing of the American College of Radiology, established the Massachusetts chapter. Since that time, the chapter has been devoted to the socio-economic interest of its members.
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CAC News
Governance
President's Message
Membership Info
Legislative Update
Resident Section
Radiation Oncology
Radiation Physics
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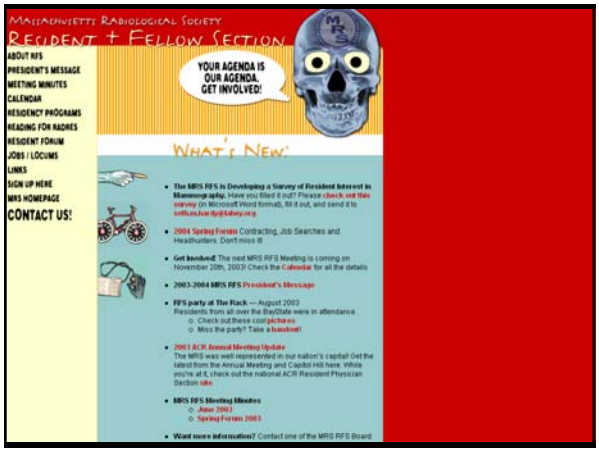
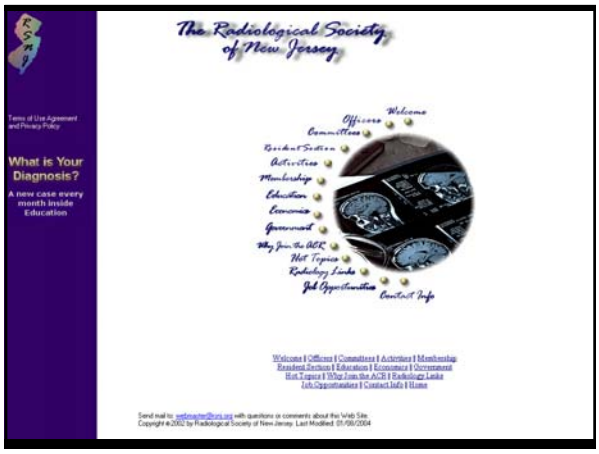
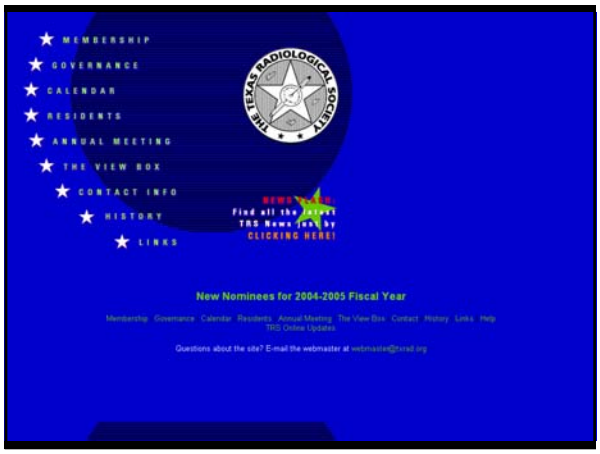
MEETING ANNOUNCEMENTS
PRESIDENT'S ANNOUNCEMENTS
COMMITTEE ANNOUNCEMENTS


Massachusetts Radiological Society
Resident + Fellow Section
YOUR AGENDA IS OUR AGENDA, GET INVOLVED!
ABOUT RFS
PRESIDENT'S MESSAGE
MEETING MINUTES
CALENDAR
RESIDENCY PROGRAMS
READING FOR RADRES
RESIDENT FORUM
JOBS / LOCUMS
LINKS
SIGN UP HERE
MRS HOMEPAGE
CONTACT US!
WHAT'S NEW:


The Radiological Society of New Jersey
What is Your Diagnosis?
A new case every month inside Education
Welcome
Officers
Committees
Resident Section
Activities
Membership
Education
Economics
Government
Why Join the ACR
Hot Topics
Radiology Links
Job Opportunities
Contact Info

Radiological Society of New Jersey
Resident and Fellow Section
RFS Home
What's New
Leadership
Residency Programs
Surveys / Forums
Committee Reports
Meeting Minutes
Education
Activities
By-Laws
Job Listings
RSNJ Home
GET INVOLVED!
Dear Colleague,
Check the web site early and often as we make a strong foundation for the RFS!


MEMBERSHIP
GOVERNANCE
CALENDAR
RESIDENTS
ANNUAL MEETING
THE VIEW BOX
CONTACT INFO
HISTORY
LINKS
THE TEXAS RADIOLOGICAL SOCIETY
CLICKING HERE!
New Nominees for 2004-2005 Fiscal Year

RESIDENTS
HOME
Resident Section Bylaws
Resident Section Officers
Resident Physician Committee
Accredited Radiology Programs in Texas
Radiology Practices in Texas
Resident Participation Program
Resident Poster Program
MEMBERSHIP
GOVERNANCE
CALENDAR
RESIDENTS
ANNUAL MEETING
THE VIEW BOX
CONTACT INFO
HISTORY
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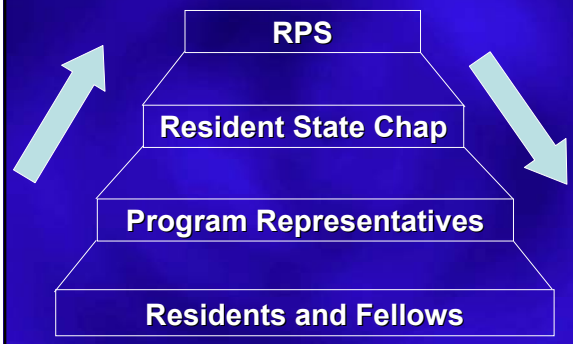
Resident Section Officers
Resident Physician Committee

Lines of Communication



Get Involved

- Resident Chapters
  - 12 State Chapters
    - NY, NJ, MA, TX, FL, CA, WA, IN, IL, CT, PA, MN
- Delegates
  - 5,332 residents in ACR
  - 90 residents
  - 37 States (typically 30-40)

Resources

- Ajay Sood (New Jersey)
- Ravi Prasad (New Jersey)
- Greg Russo (Connecticut)
- Greg Galdino (California)
  - gmgaldino@yahoo.com

American College of Radiology Resident and Fellow Section

Report from the 2004 Annual Meeting

What is the American College of Radiology?

- Represents Radiology and Radiation Oncology
- The ACR is OUR Voice
  - Socioeconomics
  - Politics
- Without it, we would have NO representation
  - The Government, Medicare, Insurance Companies, Organized Medicine, other Specialties certainly aren't looking out for us!
  - We have a unique perspective towards imaging – we have to speak up

ACR Mission

The ACR is a nonprofit professional society whose primary purposes are to:

- improve service to the patient
- advance the science of radiology
- study the socioeconomic aspects of the practice of radiology
- encourage continuing education

ACR Membership

Over 32,000 members

- Radiology
- Radiation Oncology
- Radiation Physics

What is the Resident and Fellows Section (RFS)?

- *All residents* are Members-In-Training of the ACR
- Over 5,000 Residents are therefore members of the ACR
- The RFS represents these residents within the College

Why have a Resident and Fellows Section (RFS)?

Residents have a unique voice within the ACR:

- Long-term stakeholders in decisions
  - We have our whole careers ahead of us
  - We represent the future of the specialty, voicing concerns for current trainees and those yet to enter the field
- Strong focus on education
- Multi-disciplinary
- Multi-institutional
- Optimistic, at times idealistic

The RFS today

- Residents are taking positions throughout the college
  - Increasing influence in the ACR
  - Many opportunities to get involved
- The RFS represents Radiology and Radiation Oncology residents to many other organizations
  - Including the Program Directors (APDR), Chairmen (SCARD), Residency Review Committee (ACGME/RRC), the American Board of Radiology (ABR).
- Activities organized through
  - The national ACR RFS Executive Committee (5 Members)
  - The ACR State Chapter Resident and Fellow Sections

Why should *YOU* get involved?

- Residents *must* have a voice – it's *your* future career at stake!
- Understanding the issues is *critical*

- Potential Threats to the practice of radiology:
  - Self-Referral / Turf Battles
  - Medical Liability Reform
  - International Teleradiology
  - Physician Extenders / Radiologist Assistants
  - Diminished Reimbursement

We will discuss each of these in detail…

ACR Annual Meeting & Chapter Leaders Conference

- May 8th - May 13th in Washington, DC
- ACR Leadership
- Councilors representing state chapters and specialty societies

- Over 90 Residents, from all over the country

Resident Fellow Section

- Leadership Seminar
- Meetings with ACR Leaders
- An opportunity to share problems and solutions from across the country
- Setting the Agenda for the coming year

ISSUES DISCUSSED:

✓ Impact of turf battles on education
✓ Self-referral
✓ The Public Perception of Radiology
✓ Physician Extenders

ACR Council

- Composed of the Councilors from State Delegations and Specialty Societies
- Discusses and votes on **Resolutions**, which set the policy of the ACR

- Residents discussed the Resolutions at the RFS meeting, reaching consensus on the *RFS position*
- Residents had a ***huge*** impact this year, leading to changes in policies on:
  - Physician Extenders
  - Emergency Ultrasound
  - Location of the ACR Annual Meeting
  - Establishment of State Chapter Resident Sections

Capitol Hill Visits

- The ACR Visit to Capitol Hill is now a central component of the meeting
- Most attendees spend the entire day on the Hill, meeting with the Members of Congress and their legislative aides
- Residents participate as part of their State Delegation

- Our visits ***DO*** matter…
  - We are constituents
  - We speak for our patients and our specialty
  - We are a large presence on the Hill – people know that we are coming
  - We have **ACR Government Relations** and **RADPAC**!

ACR Government Relations

- The ACR Government Relations section engages in lobbying efforts through the year
- Offices at 1701 Pennsylvania Avenue give us a powerful presence
- Unified voice on the Hill

RADPAC

- RADPAC is the non-partisan political action committee that supports "radiology-friendly" candidates
- Founded in 1999
- Has raised over a half million dollars to date

- Over $100,000 raised at the 2004 Annual Meeting!
- ***More and more residents are supporting RADPAC…***

Health Professional PACs: Top Contributors
2003 – 2004 Election Cycle

Rank	Organization	Amount	Dems	Repubs
1	American Dental Assn	$541,200	41%	59%
2	American Society of Anesthesiologists	$307,000	33%	65%
3	American Physical Therapy Assn	$249,001	43%	57%
4	American Medical Assn	$248,027	33%	67%
5	**American College of Radiology Assn**	**$238,500**	**47%**	**53%**
6	American Optometric Assn	$229,750	45%	55%
7	[illegible]	[illegible]	[illegible]	[illegible]
8	[illegible]	[illegible]	[illegible]	[illegible]
9	[illegible]	[illegible]	[illegible]	[illegible]
10	American Assn of Orthopaedic Surgeons	$154,500	35%	65%

RADPAC is growing – we continue to move up the list of Health Professional PACs

Slide Courtesy of Dr. E. Stephen Amis

Capitol Hill Visits

- Recent victories:
  - Medicare Modernization Act (2003)
    - Increased reimbursement for outpatient Mammography
    - Temporary Patch for the Medicare Conversion Factor for 2004 and 2005… *more on that later*
    - ***We lobbied for these changes at the ACR 2003 meeting!***

ACR 2004 Capitol Hill Issues

1 **Self-Referral**

2 **Medical Liability Reform**

3 **Medicare Conversion Factor**

WE DISCUSSED EACH OF THESE ISSUES ON CAPITOL HILL

The Major Issues: *Potential Future Threats*

- It is important to understand the issues
- How does each affect ***residents***, ***resident education***, our ***future careers***?

- Self-Referral / Turf Battles
- Medical Liability Reform
- International Teleradiology
- Physician Extenders / Radiologist Assistants
- Reimbursement Issues

Self-Referral

- The practice of non-radiologists referring patients for studies to imaging equipment in which they have a financial stake
- Creates an economic incentive to refer patients for more studies
- Studies are often interpreted by non-radiologists or "farmed out" to a radiologist
- As residents, we usually don't see this directly
- Examples:
  - Extremity MRI Magnets in Orthopedics
  - Brain MR / CT in Neurology / Neurosurgery
  - PET in Oncology

Self-Referral

- **One Problem:**
  - Excludes Radiology, threatening future of the specialty
- **More Problems:**
  - Increasing utilization creates a huge strain on an overburdened health care system
  - Increasing costs of imaging might make universal decreases in reimbursement a possibility
  - Studies are often low quality and performed without quality control
  - Leads to unncessary studies or duplicated studies
  - Skims the best insured patients away from Community Hospitals and Academic Centers

Self-Referral

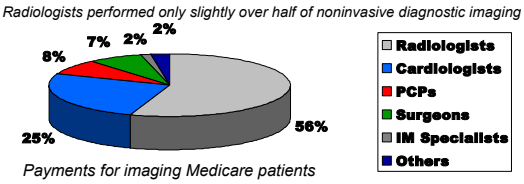
- How do we approach the problem?
- Imaging is Expensive!
  - Diagnostic imaging approaching $100-billion-a-year business
  - Imaging is the fastest growing component of physician services in Medicare program
    - Spending up 50% over past five years vs 30% rise for overall cost of Medicare

But these numbers don't tell the whole story!

Self-Referral

Radiologists perform only a portion of imaging:

2001: Radiologists performed only slightly over half of noninvasive diagnostic imaging



Payments for imaging Medicare patients

Courtesy of Dr. E. Stephen Amis

Self-Referral

Non-radiologist imaging costs are a major driver of increasing overall imaging spending

- RVU rate per 1000 Medicare beneficiaries from 1993-1999:
  - Radiologists: 7% increase
  - Nonradiologists: 32% increase
- Billings for imaging services 1998-2002:
  - Family practice: 75% increase
  - Cardiologists: **100% increase**

Courtesy of Dr. E. Stephen Amis

Self-Referral

Evidence indicates that physicians who own their own imaging equipment are more likely to self-refer for imaging studies than other physicians who have refer to others

- Hillman Studies (1990,1992)
  - Self-referring physicians 2-8X as likely to order imaging studies as those who referred to radiologist
- U.S. General Accounting Office (GAO) (1994)
  - Study of physicians in Florida, based on Medicare data
  - Confirmed Hillman study (2-5X as likely)

Courtesy of Dr. E. Stephen Amis

Self-Referral

So, economic incentives can change practice patterns and drive up health care costs

The Government has recognized this in the past with self-referral legislation:

- **Stark I (1989):** prohibited physicians from referring Medicare patients to clinical laboratories in which they had fiscal interest
- **Stark II (1993):** added prohibitions on referring patients for imaging to any practice where fiscal interest existed
  - ***Loophole: Any physician still allowed to own and operate imaging equipment in their own offices***

Courtesy of Dr. E. Stephen Amis

Self-Referral

The "In-Office Exemption" Loophole is growing larger, particularly with the advent of cheaper MR, CT, and PET technology

The ACR estimates that Medicare could save at least **$6-8 billion** by blocking self-referral!

Other insurance companies could also save considerable money by blocking self-referral

Self-Referral

ACR Leadership Develops Action Plan on Self-Referral

On April 13, the ACR Government Relations Commission, College leaders, staff and outside consultants gathered at ACR headquarters united in the mission to develop a clear plan of action for the College on the issue of self-referral.

During the 5-hour comprehensive session, the group discussed and evaluated a number of strategies and tactics for the College to spearhead, including exploring a variety of legislative strategies both at the federal and state level to deal with abuses of nonradiologists who provide imaging services in their offices. To ensure that the full spectrum of the membership's interests and concerns are addressed, a special work group comprised of representatives from general diagnostic radiology, nuclear medicine, interventional radiology, radiation oncology and other areas was appointed by commission members and leadership.

The meeting featured the presentation and discussion of two important bodies of work, the first being a comprehensive white paper titled *Financial Incentives and Physician Referrals: Self-Referral Across Two Decades*. Written by Rachel Kramer, director of the ACR Economics and Health Policy Department, the paper will be provided to all College members once it is published. Also discussed was the in-depth analysis completed by one of the ACR's retained economic consultants on the universe of costs associated with imaging within the [illegible] program.

Among the outcomes [illegible] will be spent educating policymakers [illegible] also were specific actions [illegible]

- examining [illegible] determined to be most at risk
- looking [illegible]
- undertaking [illegible] by nonradiologists

This issue is at the top of the ACR agenda!

"ACR staff and leadership know what the members want," said E. Stephen Amis Jr., M.D., chairman of the ACR Board of Chancellors, at the meeting. "We're responding in force to explore every appropriate channel for making our collective voices heard. When the College policy has been thoroughly defined, the membership will be enlisted to become lobbyists on this issue and the effort will be orchestrated to coincide with state and federal timelines to ensure the best possible outcome."

Contact the ACR webmaster at [illegible]
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Revised: 16 April, 2004

Self-Referral

Plans:

- Legislative Efforts: National and State
- Research

Potential Allies:

- Government
- Employers
- Insurance Companies
- Hospitals
- Our Patients / Taxpayers

Self-Referral

The Capitol Hill Visits were very successful:

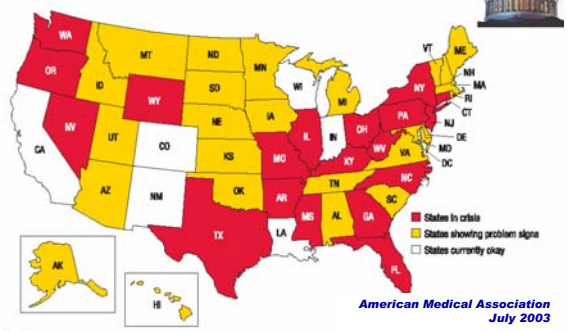
- The Members of Congress and their staffs were not familiar with the issue… the Capitol Hill Visits put it on the radar!
- They were interested when they heard about the huge potential savings to Medicare.
- They were interested in learning more.
- Most couldn't believe that Doctors were proposing to spend less on health care.

STAY TUNED ON THIS ISSUE…
The ACR White Paper is forthcoming

Medical Liability Reform

- Worsening National Medical Liability Crisis
  - Escalating Jury Awards
  - Increasing costs of defending against lawsuits, even frivolous lawsuits
  - Physicians are increasingly unable to find or afford medical liability insurance
    - Premiums have increased 25-400% over two years
  - Huge implications for Patient Access
    - Mammography, ER, OB, Surgery and the Surgical Subspecialties
    - Physicians leave their practices due to worsening liability situation, leaving patients without care

Medical Liability Reform



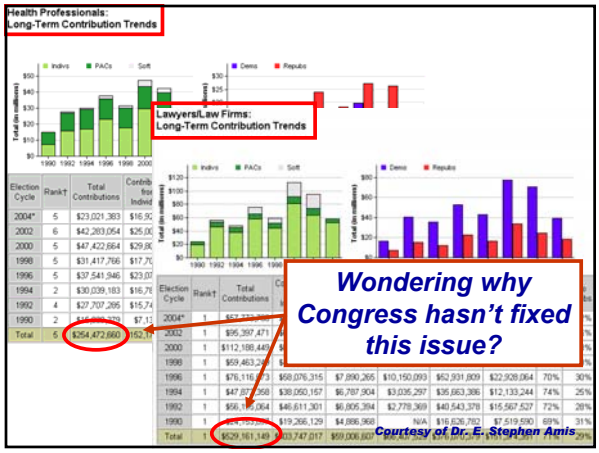
American Medical Association
July 2003

Medical Liability Reform

- The Department of Health and Human Services:
  - "The cost of the excesses of the litigation system are reflected in the rapid increases in the cost of malpractice insurance coverage… the litigation system is threatening health care quality for all Americans, as well as raising the costs of health care for all Americans."
- ***Reforms work!***
  - Individual states have enacted reforms / caps
  - California's MICRA (1975) ($250K cap on non-economic damages) has slowed the growth of insurance premiums, increasing 182% since 1976, compared with 569% nationally.
  - Reforms can lower overall healthcare spending, increase patient access, and speed the liability process

Medical Liability Reform

- The ACR supports legislation that caps noneconomic damages at a rate that significantly reduces medical liability premiums.
- Overall indemnification for breast cancer malpractice litigation averaged $438K in 2002, up 45% from 1995
- Americans support Liability Reform:
  - 84% fear that skyrocketing medical liability costs could limit access
  - 72% support limiting the amount that patients can be awarded for "pain and suffering (Gallup)
- Opponents argue:
  - Insurance companies are at fault for premiums
  - Possible savings won't be passed on to Physicians
  - Physicians needs to police themselves better
  - Patient's have a right to sue
  - Caps don't protect the interests of women and children



Courtesy of Dr. E. Stephen Amis

Medical Liability Reform

There have been recent successes in the House:

- ✓ HR. 5: Help Efficient Accessible, Low-Cost, Timely Health Care (HEALTH) Act of 2003
  - Passed 229-196 on 3/13/2003
- ✓ HR. 4280: Help Efficient Accessible, Low-Cost, Timely Health Care (HEALTH) Act of 2004
  - Almost identical to HR 5
  - Passed 229-197 on 5/12/2004
  - *Passed the day after the ACR Capitol Hill Visit!*
  - Modeled after California MICRA
  - May be used as a campaign issue

Medical Liability Reform

But nothing has made it out of the Senate:

- ☹ S. 11: Patients First Act of 2003
  - Modeled after successful House legislation
- ☹ S. 2061: Healthy Mothers and Healthy Babies Access to Care Act of 2003
  - Targeted OB Care only
- ☹ S. 2207: Pregnancy and Trauma Care Access Protection Act of 2004
  - Targeted OB and Trauma Care only

All failed in the Senate due to a Procedural Vote – the Senate could not achieve the 60 votes required to overcome a Filibuster

Medical Liability Reform

What next?

- The ACR is supporting the AMA's efforts to on Medical Liability Reform, including developing a Grassroots Patient Action Network to let patients tell their ***OWN*** story of reduced access
  - The ACR approved a $50,000 donation to this effort
  - Radiology is among the largest contributors to the overall AMA campain on Liability Reform
- Public Awareness
- Continued Legislative Pressure
- The Capitol Hill Visits helped to increase visibility on Capitol Hill, particularly in the day before voting on HR. 4280

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Spotlight on Issues
Medical Liability Reform Is AMA's No. 1 Legislative Priority
What the New Medicare Law Means to You
AMA Welcomes Increase in Medicare Payments

An excellent resource:

www.ama-assn.org

Courtesy of Dr. E. Stephen Amis

Reimbursement

- The ACR is a leader among specialty organizations in issues of reimbursement
- ***Nothing*** in reimbursement is automatic
  - Every new procedure needs a CPT code in order to get reimbursement
  - Every new CPT code must be valued by the Relative Value Update Committee (RUC)
  - Every change in coverage from Medicare and each local carrier must be monitored and fixed – it can make a huge difference to a practice!
  - Each step is a fight, since every specialty is fighting for pieces of the same "pie"

Reimbursement

- The Medicare Physician Conversion Factor (CF) is a separate piece of the reimbursement process
- The CF helps to determine how much physicians are reimbursed by Medicare
- The CF is determined by some simple formulas:

Calculation of the Conversion Factor

CY 2004 Physician Fee Schedule Update and Conversion Factor

The physician fee schedule update, as specified in section 1848(d)(3) of the Social Security Act, must be annually adjusted by the Update (or Performance) Adjustment Factor (UAF), which compares "actual" expenditures in Medicare to targeted (or allowed) expenditures for that year. The UAF equation seems to be the source of most controversy and where most topics of discussion originate, including issues related to self-referrals in imaging technology.

The performance adjustment factor for a given year is determined by the statutory formula shown below[4]:

$$UAF_{20} = \left[\frac{(t_{20} - a_{20})}{a_{20}}\right] * 75\% + \left[\frac{(t_{96-02} - a_{96-02})}{a_{20}\,(1 + SGR_{20})}\right] * 33\%$$

Where:
t_{20} = estimated target, or targeted, expenditure for calendar year 2003 $(t_{20} = t_{20}(1 + SGR_{20}))$
a_{20} = estimated actual expenditure for calendar year 2003
t_{96-02} = estimated cumulative allowed expenditure from 4/1/96 to 12/31/02
a_{96-02} = estimated cumulative actual expenditure from 4/1/96 to 12/31/02
SGR_{20} = Sustainable Growth Rate for the calendar year 2003

Number of Beneficiaries
An increase in the number of beneficiaries requires an increase in the SGR. Higher SGR will results in higher "target" expenditures for the year in which the update is being calculated.

Changes in Laws and Regulations
Accounts for the percentage change in expenditures for physicians' services caused by updates in law and regulation from the year before.

$$SGR = f\left(\text{Percent change in 'fees for physicians' services, including drugs}, \text{Percent change of the average number of fee-for-service beneficiaries}, GDP, \text{Change in expenditures due to change in law and regulation}\right)$$

Physician Services
Medicare's sustainable growth depends on the percent increase or decrease of fees for physicians' services and captures the growth in utilization of physician-administered drugs.

GDP
Acts as a limit by which utilization of services are allowed to increase. If the GDP is strong (high) the SGR will be high

Huh?

OK – Its not that simple…

Courtesy of Dr. E. Stephen Amis

Reimbursement

- The key is that Medicare reduces payments to physicians when program expenditures for their services exceed a set target, or SGR (sustainable growth rate)
- The SGR is not an appropriate target for growth, since it is tied to GDP and does not include many key components that factor into health care costs

- Physicians are therefore unfairly targeted for reductions in reimbursement

Reimbursement

- Congress has bailed us out before:
  - The formula would have required a 4.2% cut in reimburesement for 2004
  - The Medicare Modernization Act created a temporary fix for 2004 and 2005, instituting a 1.5% increase in reimbursement
  - The ACR lobbied for this fix at the 2003 Annual meeting!

- Current projections indicate a 5% annual cut beginning in 2006, continuing every year to 2012 or 2014.
- The combined cuts would result in a 40% drop in physician reimbursement in 2014 compared to 2005

- *The ACR supports legislation to revise and stabilize the Medicare Conversion Factor update formula*

Reimbursement

The Capitol Hill Visits were somewhat successful:

- We raised an important issue: Physicians may stop participating in Medicare if reimbursement is too low:
  - This will reduce access to health care for the Elderly
  - The population is increasing rapidly, so we need full participation by doctors

- This is a long-standing issue, and most Members of Congress are very aware of the problem
- Most agreed that the current situation is not ideal
- Fewer were willing to commit to any changes because of the money involved and current economic realities

International Teleradiology

- Clearly a hot-button issue
- Residents have to make their voices known:
  - We have a unique perspective: we care about the future of the specialty for the next several decades
  - Many practicing radiologists and hospitals are desparate for manpower and don't see beyond their own immediate needs
  - We need to speak up for patient safety, patient privacy, and quality radiology
- There are many facets to the issue that are still undecided:
  - Licensing Requirements
  - Reimbursement Issues
  - Patient Privacy Issues
  - Medicolegal Issues: Jurisdiction
  - Ethical issues ("Ghost-signing" reports)

Money&Business

Section 3

Who's Reading Your X-Ray?

Jobs in Medical Care, Too, Can Be Outsourced Overseas

By ANDREW POLLACK

Feelings Are Not Mutual In 401(k)'s

By CARLA FRIED and DIANA B. HENRIQUES

The issue has made national headlines

Courtesy of Dr. E. Stephen Amis

THE STATEMENT IS STRONG AND SPECIFIC:

•**Certification by the American Board of Radiology** is the **best** means for the health care consumer to judge the qualifications of the radiologist.

•**Be licensed** to practice medicine **in the state** where the imaging examination is originally obtained, as well as possess any medical or other licensure required within the jurisdiction of the interpretation site;

•**Be credentialed** as a provider and maintain appropriate privileges in the health facility or hospital in the United States where the examination was obtained;

•Have appropriate **medical liability coverage for the state** in which the

The ACR Resident and Fellow Section will continue to monitor developments to make sure that our perspective is represented

Physician Extenders

- A broad group of Allied Health Professionals that may help in the practice of Radiology in the future
  - Radiologist Assistant (RA):
    - Initial proposal passed as ACR Resolution at the 2003 Meeting
    - A joint program developed by the ACR, ASRT, and ARRT to create an advancement pathway for technologists
    - First school opened at Loma Linda in Fall 2003
    - Designed so that RA must function under the supervision of a radiologist. Specifically prohibits providing any interpretation at all (preliminary or final). Would probably be involved in simple procedures or fluoroscopy only.
    - Created to preempt efforts of the Radiology Practice Assistant (RPA) program (Weber State), which was trying to give trainees independent practice rights (including interpetation!)
    - The RPA program is NOT recognized by the ACR but trainees may someday be included under RA if they agree to all rules and provisions
    - The ACR will draft legislation to define scope of practice

Physician Extenders

- A broad group of Allied Health Professionals that may help in the practice of Radiology in the future
  - Physician Assistants (PA) and Nurse Practitioners (NP):
    - Still preliminary discussions, but there are people in these areas who might seek to help in Radiology in some capacity, like simple procedures or fluoroscopy
    - The ACR and the ACR RFS feel strongly that these individuals should have strictly defined scope of practice and should function only under the supervision of a Radiologist
    - A Resolution at the 2004 Annual Meeting allows the ACR to begin to negotiate with these groups to set up program and examinations
    - The RFS was ***instrumental*** in making sure that the ACR cannot negotiate with or approve any program unless it is clearly stated that the assistant can provide "no interpretation, preliminary or final."

Are you Fired Up Yet?

Self-Referral / Turf Battles

Medical Liability Reform

International Teleradiology

Physician Extenders

Reimbursement Issues

Do you see why Residents and Fellows have to get involved in the ACR?

CURRENT PROJECTS

ACR Resident and Fellow Section

MR Education

- The ACR RFS conducted a survey in 2002-2003 to evaluate the resident experience in MR education.
  - Recently published in the JACR
- A large majority of residents are not satisfied with the quantity and focus of current MR training.
- Residents therefore feel inadequately prepared to cope with the increasing number of MR examinations performed.
- Over 90% of 300 respondents to our survey reported that an MR minimal training requirement should be sought.

Wald, C. *et al.* Residents' Perceptions of MRI Training in the United States. **Journal of the American College of Radiology** 2004;1:331-337.

MR Education

- The RFS is now acting on the results…
  - Shared concerns with the Residency Review Committee
  - Presented the results to the Program Directors (APDR) and the ACR
  - Working with the ACR Commission on Education and national experts in MR to develop a comprehensive MR teaching resource, to be made available online, that will help increase exposure of residents to different types of examinations, particularly in Body MR

Call Survey

- Based on discussions at the 2003 Annual Meeting, Joshua McDonald (Resident, University of Iowa) surveyed Program Directors and Chief Residents in Spring 2004
- Preliminary results presented at 2004 Annual Meeting
- The RFS hopes to use the results to advocate for residents:
  - Are programs increasing resident call to compensate for increasing volume?
  - Beyond the number of hours on call, is call *INTENSITY* too great?
  - Is education being sacrificed?
  - Are residents being used for Teleradiology?

Discussions with the ABR

ACR ≠ ABR

- First, the American College of Radiology is ***NOT*** the American Board of Radiology. *They are 2 separate groups!*
- In fact, the ACR RFS has represented residents on issues related to the ABR:
  - We were instrumental in preventing the move of the Oral Boards to one year post-residency
  - We challenged the recent Boards Fees Increases, demanding an explanation and a receiving a promise to provide justification and warnings about fees and possible increases in the future
  - We will continue to monitor the development of the Maintenance of Certification examinations (10 year exams)

Upcoming Issues

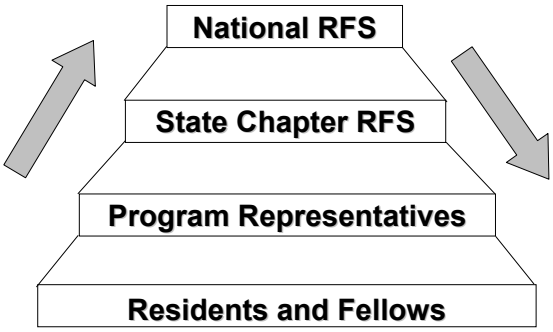
- MR Education
- Fellowship Survey
  - We will survey all members of the Class of 2005 to find out about Fellowship plans and experiences with the NRMP Radiology Fellowship Match
- Impact of Turf on Education
  - A survey of all residents will attempt to clarify the current state of affairs in radiology education, particularly in Angiography, OB Ultrasound, and Cardiac Imaging

PLEASE HELP WITH THESE SURVEYS… WE CAN'T REPRESENT RESIDENTS IF WE DON'T KNOW WHAT YOU WANT

How Can I Get Involved?

- **State Chapter Resident and Fellow Sections**
  - Some state ACR chapters already have an RFS
  - Or, start a new one!
  - There is a committee of residents who can help you get your State Chapter RFS started or organized…
- **ACR National Resident and Fellow Section**
  - ACR Commissions and Committees
  - We are always looking for people to volunteer to get involved
- **Annual Meeting**
  - State will pay for at least two residents, but anyone can go
  - Get your department to sponsor you!
- **ACR Internships** – Fantastic opportunity
  - Government Relations – Rutherford Internship
  - Economics and Health Policy – Moorfield Internship
  - Education – Jackson Internship

The ACR RFS: Lines of Communication



Courtesy of Dr. Greg Galdino

How Can I Find Out More?

- ACR Website
- RFS e-Newsletter

Check out the ACR website

www.acr.org

Look for the

ACR RFS e-Newsletter

Via e-mail!

By the way…

It's not all work…
It's a lot of fun too…

Meet residents from your area and from all over the country

Make friends with the people with whom you will work for the rest of your life

ACR-RFS Executive Committee 2004-2005

Jesse Davila, M.D.	Chair
Sanjay Shetty, M.D.	Vice Chair
Gregory Galdino, M.D.	Secretary
Aradhana Venkatesan, M.D.	A^3CR^2 Rep
Tara Lawrimore, M.D.	AMA Rep

CONTACT US!

Benefits to State Chapters of a Resident Fellow Section

The ACR, in conjunction with many state chapters, often financially sponsors a resident from the state to attend the annual ACR and chapter leadership meeting. The resident serves as a liaison from his/her state to address issues particular to residents in that state and to participate discussions on issues facing the ACR and ACR RFS as a whole.

Parent State Chapters, in return for supporting an RFS in its early growth stage, stands to gain from its investment in several ways:

1**. Increased Membership** – an organized and well-run section attracts new members. Resident and fellow physicians represent over 5000 ACR members-in-training and will respond to the unique opportunity that access to policy development offers. In addition, many residents and fellows are introduced to policy making and issues facing the ACR and profession of radiology through the state chapter meetings and communications that they would not be exposed to in their training programs. Increased awareness of issues is important for recruitment into new members into organized medicine.

2. **Continued Membership** - The earlier physicians can be attracted into organized medicine, the better the chance that membership will remain important in their professional lives. This is particularly true of residents and fellows that plan to practice within their state of training.

3. **Leadership Growth and Development**- Leadership qualities are developed during medical school, refined during residency, practiced by radiologists and applied in your chapter and the ACRCouncil. A state chapter RFS enables fosters leadership at an early stage. These leaders are important to the future of the parent state chapter. Involvement at this early state allows residents and fellows to influence and learn from organized medicine.

4. **A Broadened Membership Base**- RFS members may have more diversified perspectives and input to state chapter discussions than available in the existing membership. In addition, RFS members are the ones with the most vested interest in their specialty as they are at the beginning of their career.

Benefits to residents and fellows of a State Resident Fellow Section

There are also many benefits that residents and fellows within a state can reap with by establishing a state RFS. Some are highlighted below.

1. **Communication** – The RFS serves as a means to disseminate information that is important to residents and fellows, both relevant to their future career and particular issues facing members in training. In addition, it serves as a means to communicate issues and experiences particular to the state RFS to the national RFS. Having a well organized state RFS keeps the communication lines open and established. This is particularly true for larger states that are unable to meet regularly due to geographic separation. In addition, the ACR RFS has regular communication (Enews: Quarterly) that addresses issues specific to residents and fellows distributed via email. Many state RFS also have regular publications (i.e. newletters) or discussion forums online that permit regular communication between RFS members. Fellow members often may serve as excellent resources to find out "how things are done" at different institutions.

2. **Socialization with Peers** – Radiology, while being one of the larger medicine specialties, is still a relatively small community. The RFS gives the opportunity to meet and socialize with other members-in-training to share experiences and friendship outside of the training institution.

3. **Involvement in organized medicine** – Involvement in a state RFS is usually one of the first introductions to organized medicine within Radiology for many state RFS members. It is comforting to realize that organizations such as the ACR are lobbying on behalf of radiologists and promoting the field of radiology.

4. **Awareness of political, economic, and governmental issues** – Often issues facing practicing radiologists are not recognized by members-in-training because of the "protected environment" of academic institutions and training centers. A state RFS allows exposure to issues that radiologists face in practice and that will ultimately shape the field of radiology for members-in-training; this is particularly true of issues facing individual states, which may be different than those facing the ACR on a national level. In addition, it allows exposure to the policy making body of radiology, including how policies are created and implemented.

5. **Education** – Educational programs are often incorporated into state chapter meetings. Equally important are issues related to employment, business, and legalities of practicing radiology that are not taught in training programs. Understanding issues such as employment contracts, liability, and practice structure are vital finding employment after training. Many state RFS programs offer educational opportunities to increase awareness for residents and fellows on these issues.

6. **Contacts / Networking** – Getting involved in the ACR at both the national and state levels fosters relationships with ACR members that may create opportunities in the future for employment, education, or friendship.

Steps to Develop a State Chapter RFS

The next section will outline suggested steps that may be helpful when starting a state chapter. These are simply guidelines and are open to modification as each chapter may face different hurdles compared to others. Guidelines are broken down into four categories: (1) Establishing a new RFS outlines early steps to lay groundwork for chapter formation; (2) Implementation deals with organizing the chapter, formally establishing chapter leadership, and recruiting RFS members; (3) Promotion outlines the next steps for getting a chapter active; (4) Financing provides some suggestions for securing additional funding resources for social events, educational activities, etc.

The following section then presents experiences from several state chapters outlining successes and suggestions for forming a state chapter.

The end of the section then presents two articles highlighting state chapter development.

Establishing a New Resident Fellow Section

The initial steps may vary widely according to the geographic size of the state and number of programs within the state. Initial steps may include:

Approach the State Radiological Society with idea of establishing an RFS

It is extremely important to have the moral support of the existing state chapter members behind the idea of establishing am RFS. They often may provide administrative support and in some cases financial support for developing an RFS. Present to them the benefits of having an RFS section within the State (pgs 20-21).

Determine the Training Programs within the State of interest

- Contact the ACR to obtain a list of residents registered in training programs within your state. The ACR staff that assist the RFS are Kelly Foster (KellyF@acr.org) and Trina Madison (TrinaM@acr.org).
- Use the American Medical Association Fellowship and Residency Electronic Interactive Database (FREIDA:) which provides a list of accredited resident training programs in diagnostic radiology and radiation oncology, including contact information for program chairpersons or directors. This is particularly helpful for larger states which have multiple programs with significant geographic separation. Be wary that some of the contact information may be outdated, but it is a good starting place to identify training programs. (http://www.ama-assn.org/ama/pub/category/2997.html)
- The Accreditation Council for Graduate Medical Education also lists residency and fellowship training programs that are accredited by the ACGME, available at http://www.acgme.org/adspublic/

Find a contact person at each training institution

Once the programs within the state are identified, find a contact person at each training institution to notify about the plan to establish a state RFS. Contact persons may include Department Chairman, Program Residency Directors, Residency coordinators, chief residents, or any residents and fellows within the program.

- As mentioned above, the ACR can provide a list of residents at each training institution. Email residents directly at the program to recruit members.
- The Internet is an extremely valuable tool for finding current contact information within specific programs at the individual training institution sites. Use a search engine, such as Google (www.google.com) to search for specific institutions and locate home pages for the individual departments.
- Utilize resources within the State Chapter Radiological Society to establish contacts and promote the idea of forming an RFS.

Make initial contact through introduction letter

Send a letter outlining the intent to develop an RFS section to contact person(s) at the programs within the state. A shotgun approach is often helpful. The letter may include highlighting certain issues within the ACR RFS. Wait for responses and follow-up as needed.

Implementation

The next steps will focus on chapter organization including developing routes of communication, forming RFS leadership, and recruiting new members.

Identify and recruit interested members to the RFS

Once individuals are identified that are interested in getting involved and forming the RFS, it is important to recruit representatives to help form the RFS. Some state chapters, especially those with geographic separation and multiple training programs, are organized by representatives at each institution. It is helpful to solicit two residents, one more senior and one more junior, with leadership qualities and interest in ACR issues to be the representatives at the respective institutions. This ensures continuity once the senior representative graduates.

Develop Chapter Leadership and an Executive Committee

It is important to encourage active participation from interested members and recruit leadership positions for the RFS. Getting a small group of motivated individuals will make the group more successful than trying to single handedly organize the RFS chapter alone. Delegate tasks and responsibility. It is very important to have the assistance of a senior chapter member (State Chapter RFS Liaison) to give advice and assistance during the early formation of the RFS. Ask the state chapter leadership to suggest one interested member that can assist in conference calls and include them in email communication. It would be beneficial to have one of the state chapter executive committee members as the liaison to provide feedback to the state chapter membership and executive committee. Establish an RFS executive committee, including designated offices such as President/Chairman, Vice-President, Secretary, and others as needed. Assign specific tasks to each office to divide responsibility. (Guidelines for offices can be found in the Model Bylaws under the appendices).

Establish regular routes of communication

Set up regular (but not too often to be burdensome) communication routes between the executive committee and program representatives. This may be in the form of conference calls (often the state chapter can assist with the formalities of setting up conference calls. If geographically possible, face to face meetings are the best way to accomplish things early in the chapter formation. Alternatively, regular email communication and distribution lists (with all representatives emails) can be used and are very effective.

Plan for an Annual Meeting to coincide with the State Chapter Annual meeting

The culmination of the RFS chapter formation should be a meeting that coincides with the state chapter annual meeting. There is no substitute for face to face meeting which may include educational programs, discussion and open forum time to address resident issues, and RFS business related issues, such as elections. In addition, it is important to discuss issues facing the ACR and ACR RFS to foster discussion among attendees. Prior to the meeting, representatives should try and recruit residents and fellows from their programs to attend the meeting and become new members.

Promoting a New Resident Fellow Section

Once there is organization, governance, representation, and communication established, it is time to promote the RFS and recruit new members.

Regular communication

As mentioned under implementation, regular communication via conference calls, emails, or periodic newsletter is effective to discuss topics of interest to residents, including ACR issues, educational issues, and resident related issues, such as call, residents benefits (i.e. educational funds, etc) that may vary from program to program. Meeting minutes should be regularly recorded by the Secretary and posted on the web site (see below) for all RFS members to review.

Plan the Annual Meeting

One of the most effective ways of ensuring attendance is to provide a program that is interesting to residents and fellows and one that may not be part of the regular radiology curriculum. Some ideas may include a session on job opportunities (private practice vs. academics), issues related to private practice employment such as contracts and how to evaluate potential employers, and a forum on legal liability. Make sure to incorporate an open discussion forum and facilitate discussion with important issues facing residents and fellows. It may be helpful to poll attendees prior to the meeting through a questionnaire than targets issues of interest which can serve as discussion topics, such as self-referral, call-issues, moonlighting, and radiological education. A successful annual meeting will ensure regular annual attendance and assist in recruiting new members.

Encourage Attendance to the ACR Annual Meeting and Chapter Leadership Conference

One of the aims of the state chapter RFS is to have as many delegates as possible attend the ACR annual meeting and chapter leadership conference (typically held in Washington DC in the spring). This meeting often provides ideas and examples as a basis for the state annual meeting. Ideally, one representative from each program in the state should attend the annual meeting, however funding for resident attendance may be an issue. Some states have been successful in petitioning the individual programs to support a resident financially to attend. The State Chapter may assist in petitioning department chairman to financially support resident and fellow attendance.

Plan other activities to recruit new members

Social or educational outside of the annual meeting are a good way to promote the state RFS and recruit new members. Additional financial support may be necessary for these activities (see next page: Financing an RFS).

Develop a web site

A web site for the RFS is also an effective way to promote the RFS and recruit new members. The site can be part of the State Chapter web site, or can be independent. In addition, some states have incorporated a discussion forum specific to state issues (similar in nature to Aunt Minnie).

Financing a Resident Fellow Section

Organization and implementation of a Resident Fellow Section does not require a financial commitment from the State Chapter, however it is often helpful to have financial support from the chapter if possible. Funding may be necessary for the annual meeting or other social or educational activities.

Costs associated to the RFS may include but are not limited to the following:

- Staff support services and office supplies
- Regular meetings (including conference calls) of the RFS membership and Executive Committee
- Sponsorship or stipend allowance for resident or fellows to attend state annual chapter meetings
- Sponsorship of a Chapter Resident Fellow Section delegate to the ACR Annual Meeting
- Production and distribution of newsletters and publications
- Conferences, local organizational meetings
- Resident workshops

Residents should be aware of all expenditures by the Chapter on behalf of the RFS. Specific information regarding the costs associated with various activities such as meetings, newsletters, mailing brochures, etc. should be made available to the RFS. The RFS should have the opportunity to advise on the allocation of funds and the implementation of an appropriate dues structure.

Potential funding sources include (but are not limited to)

- State Chapter funding
- Outside sources such as radiological equipment suppliers
- ACR
- Dues
- Training programs

The following page is one financial account of the Connecticut RFS formation provided by Greg Russo, one of the membership committee members.

Connecticut RFS Formation Financial History

This is basically a log of how I obtained financing for the new Connecticut RFS last year.

After supporting and officially recognizing the new CT-RFS(The Resident and Fellow Section of the Connecticut Radiological Society), the CTRS(Connecticut Radiologiccal Society) agreed to pay for our first " election dinner meeting " in January 2004.

We did not have an official budget from the CTRS until November of 2004 which was set at $1500.00, but more was available if needed. Some members of the CTRS were willing to give me up to $5000.00, but I think they wanted to have more control of how the money was spent. They have tentatively agreed to fund a weekend symposium for Residents and Fellows this summer which would be above and beyond the $1500.00 base budget.

In 2004 we did not have official funding so for our first major event we had to seek outside funding. The event required rental of a place for a meeting, food, bar, and funding for the speakers. I personally called all of the local reps for private vendors in the area. All were very helpful and receptive, especially when I told them it was for Residents and Fellows. I could not get complete funding from one source which ended up being about $25000.00 for the entire event. I was able to secure partial funding from GE, Kodak, and Berlex to cover the entire cost. The event was successful with about 50 Residents and Fellows attending from all 7 programs in Connecticut.

Josh Cooper from the ACR spoke at the event. I found out that the ACR provides funding every year for each state section to have a speaker from the ACR travel and speak at an event in their respective state. The average price is $1500.00. The CTRS was not using that funding in 2004, so the CTRS President wrote a letter to the ACR, approving of our event, and the ACR readily funded Josh to come to speak. Dr. Alan Kaye spoke at the event as well, but is local and did not require or request funding.

Another important, non-financial step was securing a place on the Executive Committee of the CTRS. As President, I now attend all of the Executive Committee meetings and represent all of the Residents in the state. I and future CT-RFS Presidents will have direct communication with the CTRS EC and will be able to influence their decisions regarding our section. It is also important to see first-hand what local issues they are dealing with and how they are dealing with them.

I am optimistic that the second year of the CT-RFS will be more successful with an official budget and support from the CTRS.

I hope the information provided is adequate. If more is needed, please let me know.

Greg Russo

CT RFS Founder and president

Chapter Resident Physician Section Formation
SAMPLE

The Chicago Radiological Society (CRS) established the first radiological Resident Physician (RPS) in 1983. The CRS began the development of the first RPS by forming ad Ad Hoc Committee on Membership for Residents. The following list of recommendations came out of this committee:

1. Radiology residents were included as members-in-training of the Chicago Radiological Society (CRS), a division of the Illinois Radiological Society (IRS). (ACR bylaws, Article III, Section 10.)

2. An organization of resident physician members known as the Resident Physician Section (RPS) was established for the express purpose of:

   a. Appointing members to serve on committees of the CRS;
   b. Determining the policy of the RPS;
   c. Providing a forum for any issues that the membership of the RPS might care to raise concerning problems unique to the members-in-training of the society.

3. The RPS table of organization was patterned after a similar section of the Illinois State Medical Society including an elected officership and a governing council.

4. Resident physician members were accorded all rights and privileges as full members of the Chicago Radiological Society with the exception of holding office. (ACR bylaws, Article III, Section 10.)

5. A resident physician member was appointed to serve on each committee of the CRS, including the Executive Committee, with full voting privileges.

6. A meeting place was provided for the RPS Annual Meeting and for the RPS Executive Committee meetings (usually immediately preceding the Chicago Radiological Society's six (6) regular meetings).

7. An RPS delegate was sent to the ACR Annual Council meeting as an observer.

8. Program Directors were encouraged to promote attendance at RPS meetings by providing time off for residents to participate.

9. Funds for the support of the Resident Physician Section and its activities were obtained by a capitation assessment of each training center.

10. The Chicago Radiological Society Resident Physician Section members were encouraged to join the Chicago Medical Society, the Illinois State Medical Society, the Medical Society of Cook County and its RPS.

These recommendations were drafted in the form of motions and were passed by the Executive Committee of the Chicago Radiological Society.

POTENTIAL GUIDELINES FOR ESTABLISHING RESIDENT PHYSICIAN SECTIONS

VIRGINIA ACR RESIDENT PHYSICIAN SECTION
By: Scott W. Wise, M.D.

INTRODUCTION

The following are the primary steps I took in organizing the radiology residents in the state of Virginia. Although I no longer live in Virginia, the annual meeting of the three residency programs and discussion of resident relevant issues continues unabated. The key question to be answered in forming a resident physician section is what format will work for the residents in your state or region? For example, in larger states such as Virginia it is not practical for residents to meet frequently (such as a monthly basis). Additionally, the structure of the resident section must have a mechanism to propagate the section from year to year. Potential leaders from the early portion of residency should be encouraged to get involved and continue planned activities. This narrative describes how I approached these issues in Virginia.

POTENTIAL GUIDELINE STEPS

1. In September 1992, I attended my first meeting of the American College of Radiology. During this meeting, I learned a great deal about the importance of this organization in our specialty. Some of the residents discussed how they had established resident physician sections in their regions. At that time, we did not have a resident physician section in Virginia, but it seemed to be a good idea. I discussed the possibility with my mentor and some of the representatives from the Virginia Chapter of the ACR. They encouraged me to speak to the Virginia Chapter at the next meeting concerning the possibility of resident activities.

2. At the Spring 1993 Virginia Chapter meeting, I spoke on the issue. The Virginia Chapter was supportive of the idea and committed to some of the financial responsibility.

3. I spoke to the Chairman of MCV at the time, Dr. Anthony Proto, and he supported the idea as well. I think that it is important to have the support of your Chapter of the ACR, your chairman and your program director. Lack of support by these individuals could make it extremely difficult to institute the resident physician section.

4. I then had to decide when and where the first meeting should occur. As Richmond is centrally located in Virginia, this seemed to be a logical location for the event. The timing of the event was dependent upon how long it took to establish a format and other details. In addition, the date had to be removed from the written or oral ABR examinations to eliminate this possible reason for poor resident attendance. I settled on a November date as it was after the written ABR but before the holidays and the start of studying for the oral phase of the ABR.

5. At this point, I contacted the chief residents at the Eastern Virginia Medical School (EVMS) and University of Virginia (UVA) residency programs. I solicited their help in organizing the event and had them speak to residents in their programs to insure that the format of the event would be universally considered "worthwhile." This is extremely important. The last thing I wanted to do was spend a tremendous amount to time, effort and money putting together a function that was poorly attended by the residents. By getting the chief residents at the other programs involved, I had people to help me with the work and security in knowing that they would make sure that residents in their programs would not back out at the last minute.

6. The chief residents from the other programs then discussed the meeting with the residents in their programs as well as their respective chairs and program directors. The purpose of the meeting was emphasized in all discussions (greater participation of the residents in organized radiology, i.e. ACR, discussion of issues of common concern to the residents and greater sense of camaraderie among the residents in the state of Virginia).

7. I suggested to the other programs that one portion of the meeting agenda be a film panel session similar to the format for meetings of the A^3CR^2. We devised a plan that each of the four classes at each program would send an unknown case to the same level class at one of the other programs. Each class would then work on deducing the diagnosis as a group with assistance as necessary from faculty. Several weeks prior to the meeting, the sending residents would contact the receiving residents to make sure they were on the right track with their diagnosis. This was to be a fun and educational process and the purpose of the contact was to make sure no one was embarrassed by a grossly incorrect diagnosis at the meeting. A secondary purpose of the film panel session was to insure that all the residents at each program had some level of activity in preparation for the meeting. Additionally, representatives for the sent and received cases had to speak at the podium during the meeting. This would again insure attendance at the meeting, at least by a few presenters in each of the classes.

It was difficult to find a consensus for the remainder of the meeting format. The residents from one of the programs wanted a social gathering (like a party), whereas one of the other programs suggested a format of scientific presentations. We finally found an agreement on the following speakers, Melanie Young from ACR Government Relations to address topics of concern to the residents, David DiSantis, M.D. to discuss what the ACR has to offer all members (job placement, government relations, etc.) and Bruce Hillman, M.D. to address the future of radiology research. In addition, during the discussion at the meeting, very good input was made by my chairman, Anthony Proto, M.D., about issues in academic radiology and about private practice issues by Bruce Hauser, M.D. The input from the ACR was one of the primary goals I had for the meeting to increase the residents' familiarity and hopefully degree of participation in the ACR. The individual speakers and topics, however, required multiple phone conversations until consensus was reached.

A cocktail reception and dinner were also included as part of the meeting. These portions of the function promoted interaction among the residents of the three programs. In addition, I made table assignments for the dinner that would insure residents from every program would have the opportunity to interact with residents from the other programs at the same level of training. I wanted to avoid residents sitting together by program (MCV, EVMS, UVA).

8. A facility had to be selected to have the meeting. A good restaurant in downtown Richmond was chosen. The facility was excellent because it had a meeting room to listen to the speakers, a separate room for the cocktail reception and a third room for the dinner and film panel session.

9. I then had to find complete financial support for the meeting. The Virginia Chapter of the ACR would provide financial support but wanted to supplement what I could not obtain from other sources. Subsequently, I contacted representatives from various companies that do business with radiology departments soliciting support. I was successful in this effort with approximately $3300 coming from corporate sponsorship and approximately $200 from the Virginia Chapter. To recognize the corporate sponsorship at the meeting, I had small signs of the sponsors at the check-in desk (registration desk), word slides recognizing the companies and representatives during my address at the meeting and an invitation to all the sponsoring representatives to attend the meeting. During my solicitation of corporate sponsorship, I made it known to the sales representatives that the chairs and program directors from the three programs were to attend the meeting. This may have helped me in the fund raising effort.

10. A Saturday was chosen for the event as time off from work did not seem possible for a weekday meeting. The time of the day for the meeting was also important for the residents having to travel (EVMS about 2 hours and UVA about 1 hour). I selected 3:00 P.M. for the start of the function and 8:00 P.M. for the conclusion as to avoid people having to drive late at night.

11. I sent information about the meeting including an agenda and directions to each of the residents a few weeks prior to the meeting.

12. The chief residents then sent me a list of names of each resident in their program that would commit to attending the meeting. For the residents in my own program (MCV), I contacted each resident personally to decrease the chance of having residents RSVP through the departmental mail and then now show up.

13. Besides the chairs, program directors and speakers, no additional faculty were invited to the function. There was insufficient finances for more people, the space was limited and this was an event organized by the residents for the residents.

14. Bob Braden and Terri Stillwagoner at the ACR were extremely helpful in obtaining nametags for each person attending the meeting. I also had extra (blank) nametags for late additions.

15. During the initial portion of the meeting, a chief resident was the introducer and moderator for the speakers. Following the speakers, the cocktail reception and then the dinner took place. After dinner, I addressed the meeting by recognizing everyone who helped with the organization, the sponsors and re-emphasized the purpose of our meeting. Subsequently, Bruce Hillman, M.D. gave his presentation and this was followed by the film panel session. The moderator of the film panel session was the co-chief resident at MCV. The final function of the event was lead by the chief resident at EVMS. This was the solicitation of a committee to organize the meeting and agenda for the following year. This was important to insure continuity of the resident section.

16. After the meeting, I sent thank you letters to each of the speakers and sponsors. In addition, I organized all the relevant paper work related to planning the event. This packet of information, along with a detailed description of my challenges and solutions, was intended to help the following year's committee in the planning process.

CONCLUSION SUMMARY

Overall, the first meeting of the Virginia Radiology Resident Physician Section was a tremendous success. It was very well attended with 65 residents present. This represented in the range of 80% to 90% of the Virginia radiology residents. I was very pleased with this attendance and the satisfaction that each of the residents expressed about the event. The organization committees have also maintained the continuity of the section over the past three years. The steps I took and decisions I made may or may not work for you in your state. However, I would suggest that you carefully analyze the demographics in your state or region and try a format that has a high likelihood of generating resident interest and participation. Regardless of your particular solution, you will be doing good by our specialty to start a resident physician section. If we as radiologists cannot get together to discuss current issues, it will be difficult for our relatively small specialty to fend off outside threats. It is up to us to maintain the future of radiology in the best interests of our patients. I wish you the best of luck in your resident physician section.

Starting, Maintaining and Growing a Resident and Fellow Section

Max P. Rosen, MD MPH
Joshua Lee Rosebrook MD
Maryellen Sun, MD

In Massachusetts we are fortunate to have many Radiology residency and fellowship training programs. Since 1999 the Massachusetts Radiological Society (MRS) has supported a Resident and Fellow Section (RFS) which has grown increasing active and popular each year. The factors influencing the development of an RFS in each state will vary depending on the number of training programs, the financial and mentoring support of the state chapter leaders, and the interest and motivation of the residents and fellows. In our experience in Massachusetts we have found that a three pronged approach to creating, developing, and maintaining interest in the RFS has been especially productive. Our "formula" centers around an initial social event, a yearly leadership dinner, and a spring forum.

- **Social Event:** A resident social event timed at the beginning of the academic year is designed to provide a brief introduction to the MRS and also to build a database of interested/receptive residents. The event is usually held at a restaurant/bar that provides opportunity for "social interaction" such as billiards. The event is underwritten completely by the MRS with an average cost of $2,000 - $2,500 for a private room, dinner and drinks. Usually 30-40 residents/fellows attend, representing all of the training programs in the metropolitan Boston area. Residents/fellows are invited by e-mail, from a contact list developed by a representative from each program.

- **Leadership Dinner:** A yearly leadership dinner is held each winter (usually in February) as a follow up to the fall social event. Attendees are generally individuals who have become involved in the chapter since the fall social event, or who had been involved during the prior year. Residents who are already active in the RFS are encouraged personally invite residents in their programs who they believe would be interested in making a future contribution to the RFS. Leaders of the MRS chapter attend and speak with the residents about current issues facing the MRS and the annual ACR meeting. The dinner is designed to promote interest among the residents/fellows in moving into leadership positions within the RFS. The dinner is underwritten by the MRS, with a budget of $1,000 - $1,500.

- **Spring Forum:** The Spring Forum is a yearly educational forum which includes a featured speaker and panel discussion. It is organized by the RFS, and attendance is open to any resident in the area. Recent topics have included the impact of digital imaging on the practice of radiology, negotiating your first job, and the timing of the oral boards. This year's forum will focus on Cardiovascular Imaging and Turf Battles. RFS elections are also held at this meeting.

In addition, the MRS sponsors two residents or fellows to attend the ACR annual meeting. A recent article published in JACR by Drs. Shetty and Galdino entitled *"ACR chapter residents sections: getting involved locally"* nicely summarizes the experience in Massachusetts and California and is included for discussion. Additional information can be found on the MRS RFS web site at: www.massrad.org/rfs .

ACR Chapter Resident Sections: Getting Involved Locally

Sanjay K. Shetty, MD[a], Gregory M. Galdino, MD[b]

INTRODUCTION

Although radiologists and radiation oncologists have a powerful national voice in the ACR, each of us is also represented by a network of individual radiologic societies that have a vital role in representing physicians in economic and governmental issues that arise locally. Although most residents are members of these local societies by default, only a handful take advantage of the many resources and opportunities that they can provide.

Thirteen chapters have formalized resident involvement through the establishment of resident and fellow sections (RFS); these sections promote increased interaction between residents at different programs and provide a formal mechanism for residents to get involved in local activities. In this article, we describe positive experiences with one of the oldest chapter resident sections, the Massachusetts Radiological Society (MRS) RFS, discussing some of the ways that a chapter RFS can benefit residents both individually and as a group. We also describe recent experiences of creating vibrant new resident sections, providing a framework for others to do the same.

The big question: why should any resident with an already busy schedule, one already crammed with family and work obligations and the ever looming threat of the boards, devote his or her time to a chapter resident section? There are many answers, drawn from our experience as well as those who came before us. Socialization with peers: it's an opportunity to meet other residents in your local area, and to discuss residents issues, such as on-call and educational experiences, that may differ from program to program. Networking: it's a chance to interact with leaders in radiology from throughout your area; in particular, with the dedicated involvement of practicing radiologists working in both academic and private practice settings, this can be an excellent resource for future employment opportunities, whatever your personal career goals may be. Education: perhaps most important, it is a prime opportunity to learn about the economic and governmental forces that shape the environment in which we practice and to build the tools that you will need to influence and protect your specialty in the future.

THE MRS RFS

The MRS RFS was founded in 1999 [1] as an initiative to increase residents' awareness of and participation in the local radiologic society. Thanks to the strong interest and financial support of the MRS Executive Committee, as well as previous residents who gave generously of their time, the section has been extremely active since its inception. The RFS benefits from the participation of an increasing number of residents from throughout the state; in fact, the most recent Executive Committee includes representatives from six different programs. The RFS has focused much of its effort toward organizing events that are open to all residents. An annual social event opens the academic year, allowing new radiology residents to meet each other while introducing them to the MRS and the ACR. Our series of annual forums has addressed topics such as contracting, the timing of the oral boards, the job hunt, and strategies for passing the boards. The topics for these sessions are selected because of active interest on the part of current residents and often serve as springboards for general discussions of resident issues. A dinner sponsored by the MRS Executive Committee in the late winter offers another opportunity for residents to learn about the ACR and the MRS. The event provides a more informal opportunity for residents to directly interact with the leaders of the MRS, gaining a unique perspective from practicing radiologists who regularly devote their time and effort to the issues facing our specialty. Finally, the RFS serves as a conduit for residents to participate in the ACR's annual meeting and chapter leaders conference, now held annually in Washington, DC. Residents are sponsored by their chapter and the ACR to participate in this vital annual activity, affording them the opportunity to meet residents from across the country, lobby on Capitol Hill, and learn about the issues that face the specialty as a whole.

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0091-2182/04/$30.00 • DOI 10.1016/j.jacr.2004.05.015

Central to the success of the Massachusetts RFS has been the establishment of strong communication between residents. We have an active e-mail list and also maintain an up-to-date RFS Web site with an events calendar, contact information, and minutes from previous meetings [2]. We also hold regular meetings of the RFS Executive Committee, allowing a face-to-face opportunity to discuss resident issues and plan future events. The importance of communication cannot be underestimated. Not only does a good network increase participation in the events and strengthen the profile of the section, but many good friendships have arisen among residents at different programs thanks to involvement in the RFS. Our ability to stay in touch has been enhanced by an accident of local geography, the close proximity of numerous programs within eastern Massachusetts. Of the 10 programs located within the state, 7 are located within the greater Boston area, making our regular meetings and special events very accessible for most residents.

The RFS has become firmly entrenched as a vital part of the society as a whole. Residents routinely participate in the monthly MRS Executive Committee meetings, offering their perspectives on current issues within the state and creating a conduit for the dissemination of information to residents. This regular interaction has also helped demonstrate the importance of an active RFS to the leadership of the society. We have always been fortunate as a section to receive unwavering support for our activities, including generous financial backing of our events and Web site. We are also welcomed warmly as part of the chapter delegation at the ACR's annual meeting.

ESTABLISHED RESIDENT SECTIONS

The Massachusetts RFS is only one model for a successful chapter RFS. A handful of active chapter RSFs exist throughout the country, including in New York, Texas, New Jersey, Florida, Pennsylvania, Indiana, Minnesota, and Michigan. State chapter resident and fellow sections have been established more recently in California and Connecticut. However, the total number of chapter sections (13) is surprisingly low. This represents an excellent opportunity for interested residents to found sections within their own localities.

STARTING A NEW CHAPTER RFS: THE CALIFORNIA EXPERIENCE

Recognizing the void that existed in California, residents created a new resident and fellow section within the past year. Given the size of California, the large number of programs across the state, and the geographic separation of these programs, the task differed in some respects from that confronting the MRS RFS and other resident sections; however, other resident sections and their leaders served as an invaluable model and resource.

An important first step is to approach the leadership of the ACR chapter for use of the resources of the chapter executive office (if one exists); this will help generate interest among practicing radiologists in the chapter and facilitate future support. Next, identify how many programs exist in your area, because some smaller programs may be less well recognized but no less important. One of the initial challenges for California was to identify contact residents or faculty members at individual programs to facilitate communication. The American Medical Association directory (FREIDA) [3] provides a list of accredited resident training programs in diagnostic radiology and radiation oncology, including contact information for program chairpersons or directors. Some of this information, however, was outdated because of faculty or administrative turnover, and university or hospital Web sites were very helpful adjuncts. In addition, the ACR provided contact information for registered residents.

Once programs and a contact person (a faculty member or resident) were identified, we sent an e-mail describing the ACR and the California Radiological Society, explaining why resident involvement is important, and outlining our goal of organizing a resident and fellow section within our state. Many residents responded enthusiastically to the idea, and many attended our chapter annual meeting, which served as a prime opportunity to generate interest and recruit the leadership for the section. Through continued correspondence by e-mail, we identified a resident to act as the program representative at each institution and participated in a conference call to discuss the elections of executive officers, bylaws, and our next annual chapter meeting. The more established chapters have resources to help create RFS bylaws, generate ideas for events, and provide a template for an RFS Web site [4]. As with more established sections, creating a communications network via e-mail, conference calls, or a Web site is vital to keeping the section organized and moving forward. We are now planning for our next annual meeting in conjunction with the California Radiological Society, including a program

dedicated specifically to residents with a forum to discuss resident issues and career development.

Residents in Connecticut also recently organized a chapter. These newly formed chapters are infused with energy and momentum thanks to the initiative of a single individual who recognized the benefits and importance of a strong state RFS. Helping create a chapter represents an extremely valuable contribution to the ACR and organized radiology, and the process of watching your idea blossom into a self-perpetuating organization can be extremely gratifying.

FUTURE DIRECTIONS

The leadership of the national ACR RFS recognizes the importance of the state chapters to the ongoing strength of the resident voice within the ACR. To this end, the new national RFS Subcommittee on Membership and State Chapters will bring together leaders from chapters across the country, including residents from both long-established and newly formed groups. This will hopefully serve as a resource to individuals who are interested in starting their own RFS chapters.

The national ACR RFS is also exploring ways to increase resident participation at the annual meeting in Washington. We have observed that the opportunity to participate in the national meeting has inspired many residents to get involved in the ACR, thanks to the excitement generated by the resident meeting, discussion of crucial issues, and the visit to Capitol Hill. The ACR and the chapters currently contribute money to sponsor two residents from each chapter with a training program to attend the annual meeting. Several chapters, including Missouri's, have taken the initiative to increase residents' participation by sending a resident from each program. We are also exploring creative ways to send more residents to the meeting, including establishing foundations within the member's chapter and soliciting sponsorship from industry groups or individual departments (in responses to a gauntlet thrown by Bill Bradley, MD, of the University of California, San Diego, at the 2004 ACR annual meeting, when he challenged all programs in California to sponsor residents in the future). Increasing residents' participation at the annual meeting is vital to the health of the chapter RFS. By creating a core of people with the knowledge and enthusiasm necessary to promote the section at their home institutions and contribute to a strong chapter-level RFS, residents' involvement will ensure continuing leadership within our specialty for many years to come.

REFERENCES

1. Wald C. Evolution of an ACR state chapter resident section: the Massachusetts Radiological Society Resident and Fellow Section. ACR Bull 2000.
2. Massachusetts Radiological Society Resident and Fellow Section. Home page. Available at: http://www.massrad.org/rfs/.
3. American Medical Association. FREIDA online. Available at: http://www.ama-assn.org/ama/pub/category/2997.html.
4. Radiological Society of New Jersey. Home page. Available at: http://www.rsnj.org/.

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ACR Bulletin, March 2003:

Radiological Society of New Jersey Resident and Fellow Section Has a Bright Future

Radiological Society of New Jersey
Resident and Fellow Section Officers
President: Ajay Sood, M.D.
Vice president: Sunil Gujrathi, M.D.
Secretary-treasurer: Ravi Prasad, M.D

"I have some great news for all current and future radiology residents and fellows in the state of New Jersey." So began an October 2002 announcement from Ajay Sood, M.D., about the formation of the Radiological Society of New Jersey Resident and Fellow Section (RSNJ RFS).

It was indeed a welcome announcement. New Jersey has eight residency programs, a few fellowship programs and more than 100 radiology residents and fellows, reasons enough to improve service and representation for residents and fellows in the state. As the future of the specialty, the RSNJ and the ACR, radiology residents and fellows have always been an important priority to the RSNJ. The formation of the new RSNJ RFS is an acknowledgment that residents and fellows deserve a forum in which to voice their needs and concerns. "There are a lot of issues unique to residents as a group, and a well-functioning resident section should be able to address them with the support of the state radiological society," says Sood, resident representative to the RSNJ.

It was with this goal in mind that Sood took it upon himself to pursue the idea of forming an RFS last spring. He initiated a conversation with the executive committee of the RSNJ to discuss the importance and feasibility of doing so. Together with Mark DiMarcangelo, D.O., past president; Albert Tedeschi, M.D., president; and Resident Section Liaisons Judith Amorosa, M.D., and Robert Graziano, M.D., he formulated a 3-part development plan.

One part of the plan was to establish a database of all residents and fellows in New Jersey. The RSNJ automatically recognizes anyone in training in the state as a complimentary member of the society, so there was no need to have residents and fellows fill out applications. Since the ACR follows the same policy and also collects information on residents and fellows from all training programs annually, it was able to provide the RSNJ with information about the residents and fellows in New Jersey.

The second part of the plan was to improve the resident section of the RSNJ Web site, www.rsnj.org/residents. It now includes information about the section, upcoming meetings and New Jersey training programs as well as links to educational resources such as the RSNJ Web-based "Case of the Month."

The third part was to spread the word about the formation of the RSNJ RFS and generate interest. Sood understood that it would take the support of all residency programs in the state to

make the RSNJ RFS successful. With this in mind, he began by eliciting support at his own training program at Cooper Hospital/University Hospital Center in Camden, N.J. Conversations with colleagues produced favorable responses, as did early informal conversations with radiology residents across the state. Sood expanded his efforts last fall, contacting every program director and chief resident in the state to promote the initiative. At that time he asked each program to nominate one resident to serve as a liaison to the RFS. Every program agreed to participate, and Sood was then ready to move on to the challenges of planning the first meeting, electing a governing committee and developing bylaws.

Hoping to incorporate into the RSNJ RFS the features of successful resident sections around the country, Sood took a careful look at the resident sections in states such as Massachusetts, New York, Michigan and Florida. While attending the 2002 annual meeting of the ACR RPS as a delegate from New Jersey, he talked to other leaders of chapter resident sections. He also referred to How to Establish an ACR Chapter Resident Physician Section, a resource guide available on the resident section of the ACR Web site. The model bylaws outlined there served as a model for those developed for the RSNJ RPS. Armed with this information and encouragement, plans began for the first meeting of the RSNJ RFS.

The meeting took place on Jan. 14, 2003, in New Brunswick. In attendance were resident representatives from six training programs as well as three program directors. Participants ratified bylaws, elected a governing committee and began developing an agenda. According to Sood, an initial project is to survey the residents and fellows to determine their needs and interests. The governing committee will then use the survey results to develop resources and programs that best meet the needs of New Jersey residents and fellows. The RSNJ RFS also plans to coordinate efforts with other regional and state resident and fellow sections to share ideas and expand opportunities for everyone involved.

For more information about the RSNJ RFS, visit its Web site at www.rsnj.org/residents.

Discussion Group Collaboration With Aunt Minnie:

Reasons for collaboration with Aunt Minnie –

- Few radiology residents are fully aware of the many issues facing our profession.
- Resident participation with the ACR has room for improvement. Few residents fully understand the depth of commitment that the ACR has made towards improving and protecting our future.
- Most radiology residents do not frequent the ACR website, whereas, a majority radiology residents utilize the auntminnie.com on a regular basis.

Goals of project –

- Increase radiology resident and fellow awareness of:
    - Active political and economic issues affecting radiology
    - Global issues facing radiology
    - Practical aspects of radiology (i.e., day-to-day issues facing private practices)
- Increase resident awareness of and participation in the ACR by utilizing an already highly utilized and effective tool: auntminnie.com.

Tentative plans for collaboration with auntminnie.com –

- Every 4-6 weeks a member of the ACR or the ACR RFS will write an article on a topic (political, economic, global and/or practical issue in radiology). The format of each article should be instructional and convey information in a "resident-friendly" format such that the relevance of each topic to our future is made clearly evident.
- This article will be posted as a "Special Feature" under the Resident Digital Community section on the Aunt Minnie website.
- There will be a hyperlink associated with the article that will connect the reader to a discussion group on the Aunt Minnie website, which will serve to promote resident and fellow discussions on the topic.
- The author of the article and the RFS delegate in charge of each particular discussion group will intermittently monitor and participate in the discussion group to ensure that correct and up to date information is conveyed to the readers, and to answer any questions spawned during discussion.
- This discussion will continue for ~4-6 weeks, after which time a new article will run and the cycle will start over again.
- After each article runs and the discussions are completed, the original article and any relevant summary of the discussion could be added to a database on the ACR website to serve as a continuous resource for future radiology residents.

Action items –

- Discuss project at the ACR annual meeting, and seek out volunteers (established ACR members as well as knowledgeable residents/fellows) to be contributing authors in the discussion groups.
- Get resident volunteers from ACR RFS to head up each of the discussion groups. Each person would be responsible for obtaining (from the above volunteers) or writing an original article every 4-6 weeks, and submitting it to Aunt Minnie to be posted on the website in order to initiate the next round of discussions.

APPENDICIES

APPENDIX A

MODEL RESOLUTION FOR THE FORMATION

OF A CHAPTER RESIDENT FELLOW SECTION

WHEREAS, Radiology Residents in __(STATE)__ have a genuine interest in the activities of organized medicine within this state and the nation, and

WHEREAS, the need for solidarity within the medical profession is ever increasing, and

WHEREAS, The American College of Radiology has determined that active participation by Residents at the chapter level is vital to the future of the College and the continued excellence of radiological practice, and

WHEREAS, Delegates from the Resident Fellow Section of state chapters are invited to attend the ACR Annual Council Meeting, and

WHEREAS, One of their member delegates will be elected by them as their ACR Resident Fellow Section Councilor and Alternate Councilor to the ACR Council; therefore

BE IT RESOLVED,
that the __(STATE)__ Radiological Society form a Resident Fellow Section to provide a forum with the __(STATE)__ Radiological Society for the exchange of information among young radiologists in training and their more senior colleagues, and

BE IT FURTHER RESOLVED,
that the __(STATE)__ Radiological Society will include radiology residents in the decision or policy making process affecting all radiologists in the State, and

BE IT FURTHER RESOLVED,
that the __(STATE)__ Radiological Society will support a resident delegate from the RPS to attend the ACR Annual Council Meeting.

Guidelines for RFS Section

_____ Radiological Society Resident Fellow Section

Preliminary

ARTICLE 1: NAME

The name of the organization shall be the Resident Fellow Section (RFS) of the _____ Radiological Society.

ARTICLE 2: PURPOSE

1. To provide a unified voice for radiology residents in (State);

2. To promote the interchange of information and opinion between resident physicians and fellows in training programs in Diagnostic Radiology, Radiation Oncology, and their subspecialties throughout the State of _____;

3. To assist in maintaining consistency in standards for radiological residency and fellowship training programs throughout the State of _____ as set by various regulatory organizations;

4. To provide a forum for the education of residents and fellows in the ethical and socioeconomic aspects of the practice of radiology; and

5. To provide a mechanism for input and involvement by residents and fellows in the educational, socioeconomic, and policy-making functions of the Radiological Society of _____.

ARTICLE 3: MEMBERSHIP

All members-in-training (interns, residents and fellows) in the state of _____ shall be members of the RFS.

ARTICLE 4: RESPONSIBILITIES

(The ____ RFS will function as a section within the ____, as determined by the existing bylaws of the ____.)

(The ____ RFS will function as an independent organization governed by the bylaws contained herein.)

The ___ RFS shall be responsible for electing its officers from members of the RFS. All active members are eligible for officer positions which are described under Article 7.

The ___ RFS, through its officers and governing body, shall be responsible for the conduct of all pertinent matters to come before the section, including the scheduling and agenda of ____ RFS meetings and conference calls.

ARTICLE 5: FINANCES AND BUDGET

The activities of the ____ RFS will be financed in accordance with the policies established by the (parent organization) (Executive Committee of the ____) as described in the (parent organization bylaws) (____ RFS guidelines).

(Should the ____ RFS elect to assess dues then the secretary-treasurer should submit a budget for approval by the Executive Committee of the ____ upon recommendation of the secretary-treasurer of that organization. The Executive Committee of the ____ RFS or of any funds generated by assessment of the state chapters for the support of the activities of the ____ RFS.)

ARTICLE 6: GOVERNING COUNCIL

The Governing Council of the ____ RFS shall consist of two delegates (preferably one senior and one junior resident) from each accredited radiology training program within the State of _____. These delegates shall be elected or appointed by that training program at their discretion.

Additionally, the Governing Council of the ____ RFS will consist of the offices of the president, vice president (president-elect), secretary-treasurer, communications, social / annual meeting chairperson and member advisor (parent organization) liaison to the ____ RFS.

Two ____ RFS officers (president and vice president) will act as representatives to the ____ Executive Council as described by the ____ bylaws. Two ____ officers (president and vice president) will act as representatives to the ACR RFS.

ARTICLE 7: OFFICERS AND ELECTIONS

The officers of the ____ RFS will be a president, vice president (president-elect), secretary-treasurer, communications, and social / annual meeting chairperson. These officers will be members of the Executive Committee of the RFS Governing Council (in addition to the ____ member advisor / liaison) and will implement policy and attend to the day-to-day activities of the RFS. Elections of officers will be by majority vote of the Governing Council. Nominations for Governing Council positions will be taken at the annual meeting. Elections will take place via email or conference call by ____. All of the above shall serve a term of one year beginning ____ following their election.

ARTICLE 8: DUTIES

Section 1: President.
The president shall preside over the meetings of the Executive Committee, Governing Council and meetings of the general membership of the ____ RFS. He/she shall serve as a ____ RFS representative to the ____ Executive Committee. He/she shall be an ex-officio member of all standing committees of the ____ RFS Section. The president, together with his/her officers, shall execute the policies of the membership and the Executive Committee of the ____ RFS. The president will also act as representative to the ACR RFS. If the office is terminated or resigned prior to completion of the term, the vice president will assume the role of the president immediately. The president should attend the annual ACR meeting, annual meeting of the state chapter, and any other major meeting of the state chapter as deemed necessary by the ____ RFS.

Section 2: Vice President (President-Elect).
The vice president shall preside over meetings in the absence of the president. The vice-president will serve as president following the one year term as vice-president. If the office is terminated or resigned prior to completion of term, a temporary officer may be appointed by the president until another member can be elected by ad-hoc election. He/she shall serve as the second ____ RFS representative to the ____ Executive Committee. He/she shall be an ex-officio member of all standing committees of the ____ RFS Section. The president will also act as a second representative to the ACR RFS. The vice-president *should try* to attend the annual ACR meeting, annual meeting of the state chapter, and any other major meeting of the state chapter as deemed necessary by the ____ RFS.

Section 3: Secretary-Treasurer.
This officer shall be responsible for notifying the membership and the Executive Committee of all meetings, recording and distributing minutes retaining all records of the membership. The fiscal duties of this officer shall include the maintenance of all financial records of the section, the collection of dues, if any are to be assessed, and the deposition and disbursement of all funds. The secretary-treasurer will report any and all financial matters to the secretary-treasurer of the ____. He/she will preside at those meetings which the president and vice president are unable to attend. If the office of secretary-treasurer is terminated or resigned prior to completion of the term, a temporary officer may be appointed by the president until another member can be elected by ad-hoc election.

Section 4: Communications
This officer shall be responsible for monitoring the ____ RFS website and message board. He/she will act as ____ RFS liaison to the ____ website administrator. The officer will also be responsible for any regular

communications to the governing body (RFS members) if such communications exist, but will not be more frequent than quarterly. The officer will also organize conference calls through ____, which will not occur more frequently than quarterly, unless decided upon by the Governing Council. He/she will preside at those meetings which the president, vice president, secretary-treasurer are unable to attend. If the office of communications is terminated or resigned prior to completion of the term, a temporary officer may be appointed by the president until another member can be elected by ad-hoc election.

Section 5: Social / Annual Meeting Chairperson
This officer shall be responsible for conducting any social activities within the RFS. In addition, he/she will coordinate the program of the annual meeting. If the office of social / annual meeting chairperson is terminated or resigned prior to completion of the term, a temporary officer may be appointed by the president until another member can be elected by ad-hoc election.

Section 6: Representatives.
The representatives to the ____ Executive Committee and to the American College of Radiology Council will constitute the only authorized delegates from the RFS to the above councils and will be the president and president-elect. Alternate delegates may be appointed to the ACR by the respective offices of the president and vice president. Their privileges while attending these council and committee meetings (i.e. category of seating, privileges of the floor and voting rights) will be in accordance with the bylaws of the pertinent society. They will carry out the directives of the ____ RFS as determined by the membership and the Governing Council concerning the policies of the section and its position on matters under consideration.

Section 6: ____ Member Liaison
This member will act as advisor to the ____ RFS membership, Governing Council, and Executive Committee. The member must be an active member of the ____ and will be elected by a majority vote by the Governing Council of the ____ RFS. The member will be invited to participate in any and all meetings of the ____ RFS and is expected to advise the ____ RFS in their best interests.

ARTICLE 9: RECALL

Any officer of the ____ RFS may be recalled by three-fourths (3/4) vote of members at any annual meeting of the membership.

ARTICLE 10: COMMITTEES

The president shall appoint such committees as are necessary for the proper functioning of the ____ RFS.

ARTICLE 11: SEMIANNUAL MEETINGS

The Annual meeting of the ____ RFS will be held in conjunction with the (parent state chapter) if possible, but at the discretion of the RFS. A semiannual meeting will be held at the annual ACR meeting, usually occurring in the spring, but at the discretion of the ACR.

ARTICLE 12: AMENDMENTS

These (guidelines / bylaws) may be amended at any semiannual meeting of the ____ RFS by a majority of those present and voting.

Joshua L. Rosebrook

February 5th, 2005

Dr. _____,

My name is Josh Rosebrook and as President of the Massachusetts Radiology Society Resident and Fellow Section (MRS-RFS), I am writing on behalf of over 200 residents and fellows in Massachusetts to ask for your support in funding residents from your department to attend the American College of Radiology (ACR) Annual Meeting this April 9-14th, 2005 in Washington DC.

In the past, the ACR and the MRS have sponsored 2 residents from the entire state to attend this important meeting. Over the past 3 years, there has been a significant growth in both resident interest and the importance of the issues facing radiology. Between the turf battles, the medical liability crisis, and inappropriate imaging utilization, Radiology is coming to a crossroads of vital decisions and actions that will define the future of our specialty. We need our future leaders to become involved today and additional funding from supportive departments like yours will provide your best residents with the knowledge necessary to become experts in these issues and the leadership training necessary to do something about them. In addition, having someone in your department with this up-to-date knowledge and experience makes them a valuable resource for departmental education and planning.

As in years past, the 2005 ACR meeting will involve intense resident leadership training, interactive sessions with leaders in education and academics like Dr. Richard Gunderman, discussion of new and old ACR policy initiatives, and participation in lobbying for the ACR to Massachusetts Congressmen on Capital Hill. Activities usually run 8AM to 6PM and begin Saturday April 9th with a Cardiovascular Imaging Categorical Course. Capital Hill visits scheduled for Tuesday, April 12th. The meeting is free for residents and typical budgets for an average stay run between $1000-1500. Sending two residents who can stay in the same room is a great way to maximize participation and a department's resources and exposure. Programs in the states of California and Ohio have already committed to supporting a resident from each program and I know the high quality programs in the great state of Massachusetts will support their resident's and Radiology's future by doing the same.

Thank you for your time and efforts in this important matter. Please feel free to contact me at any time with questions.

Sincerest Regards,

Joshua L. Rosebrook, M.D.
President, MRS-RFS
jrosebrook@partners.org

Max P. Rosen, M.D., MPH
President, MRS
mrosen2@caregroup.harvard.edu

Dear Fellow Resident,

My name is Greg Galdino, and I am the resident California representative to the American College of Radiology (ACR). I am writing you to let you know that we are in the process of forming a stronger, more cohesive resident voice in the California Radiological Society (CRS) by establishing a resident section of the CRS. The CRS, in addition to addressing concerns of practicing radiologists specific to California, serves as the California chapter to the ACR. The ACR currently has a very active and vocal resident physician section. In addition, many other states have already established a resident physician section in their respective state chapters. These resident organizations aim to address concerns specific to residents and fellows within radiology, but also aim to educate residents and fellows about issues facing our field.

Our goal is to have one resident representative at each training program within California to act as a liaison to the CRS and represent their institution. One of our main purposes this year is to establish a fully functional resident section within the CRS. The role of the resident representative will be to represent the concerns of their respective institution and to disseminate information from the CRS to their fellow residents and fellows. Involvement will likely include participation in a few conference calls during the year and attendance at the annual CRS meeting would be encouraged.

This years annual CRS meeting is rapidly approaching, scheduled for Sept 20-21 in Newport Beach. Topics will include a mini-symposium on the acute care of stroke and practice management topics as well as national and state updates. In addition, the residents will meet to discuss formally establishing the resident section. Additional information about the meeting can be found on the CRS website at http://www.calrad.org/index.htm and residents and fellows are encouraged to attend.

I would like to ask that at least one resident from your institution that may be interested in the CRS (and particular being the resident representative) contact me. I would also encourage any interested residents to attend the upcoming CRS meeting. Residents from several programs are currently planning on attending, and it should be a very productive meeting. If you or any of your fellow residents are currently planning on attending, please also contact me so that we may organize an agenda for the resident section at the meeting.

My sincerest thanks,

Greg Galdino
UCSF Radiology

Dear Department Chairman,

We are writing this letter on behalf of our support for resident and fellow involvement in the Resident and Fellow Section (RFS) of the American College of Radiology (ACR) and the California Radiological Society (CRS). As you are aware, the ACR is the political voice of radiology and continually strives to improve our field. The ACR is also dedicated to educating residents, fellows, and new graduates in all aspects of radiology, as these groups represent the future of our field.

The visibility and importance of residents was particularly notable at this year's annual ACR meeting in Washington DC. The RFS participated in many discussions and voiced their concerns in regards to many issues facing radiologists today, such as radiology extenders, self referral, and continuous coverage. Their presence had a significant impact during our visit to Capitol Hill.

The main purpose of this letter is to encourage your support of resident's and fellow's participation in the ACR and CRS by sponsoring attendance of at least one resident from your program to the annual meetings. At this year's ACR meeting, it became apparent that many states have significant resident representation. In addition, states such as Missouri and North Carolina have pledged to have all programs in their state represented. As one of the largest and most innovative states in the United States, California should not be underrepresented in the ACR. As program chairmen, we have pledged to financially support one resident representative from each of our programs to attend the ACR meeting annually. As a challenge to other states, we encourage all department chairmen in California to also support a resident from their program to attend the ACR meeting and ensure the future of our field and California's strong voice within radiology.

As you may or may not know, the CRS is California's state society and state representative to the ACR. The CRS has also recently established a RFS and has a representative at nearly every program in California. The CRS has their annual meeting October 2-3 (Saturday, Sunday) in Newport Beach. This year's educational program on Dynamic Imaging would be beneficial to residents and fellows. In addition, this year's program has a dedicated agenda for the RFS, which will include a discussion forum on issues facing residents (e.g. MRI education) and radiologists (e.g. Self-referral) as well as a career forum. We ask that you encourage your residents to attend this year's meeting and help make the RFS of the CRS one of the strongest in the country.

Sincerely,

Ronald L. Arenson, MD
Professor and Chairman
Department of Radiology
UCSF

William G. Bradley, Jr, MD, PhD
Professor and Chairman
Department of Radiology
UCSD

David Hinshaw, MD
Professor and Chairman
Department of Radiology
Loma Linda University

Perspective

Seven Leadership Fallacies and How to Correct Them

Richard B. Gunderman[1]

The future of radiology and the welfare of the patients it serves hinge on the quality of people who lead it. Radiology leaders are like ships' captains. Poor leadership threatens to sink radiology organizations. Mediocre leadership may leave us merely treading water. Only good leadership will enable us to sail successfully to our destinations.

As radiologists contemplate the future of the field, one of the most promising investments we can make is to cultivate the knowledge and skills of radiology's future leaders, preparing them to meet the challenges and opportunities that lie ahead. Yet many capable medical students, residents, and newly minted radiologists pay leadership little heed. Arrested leadership development may be traced in part to widely prevalent misconceptions or fallacies about leadership. In an effort to unlock more of this leadership potential, this article describes seven of the most debilitating of these leadership fallacies and what can be done about them.

Irrelevance

The first leadership fallacy concerns the relevance of leadership. Some very intelligent, highly skilled, and dedicated people believe that leadership has little or nothing to do with us. We see ourselves as future clinicians, or scientists, or educators, but not as leaders. We have spent hundreds or even thousands of hours studying anatomy, pathology, imaging technology, lesion detection, differential diagnosis, and diagnostic reasoning. We see ourselves as experts in these areas and continue to study such subjects throughout our careers in an effort to remain on top of our field.

Many of us enjoyed little or no opportunity during medical school, residency, and continuing education to study leadership. We tend to see leadership as the province of business school graduates and politicians. To many of us, leadership is a black box. Leaders seem to us like the Wizard of Oz, mysteriously manipulating their organizations' levers from behind a curtain.

Viewing leadership as a mystery creates problems for our departments, institutions, and profession. If many of the best junior people in a field such as radiology regard leadership as a black box, who will be prepared to play leadership roles? In some cases, it is inevitable that future leaders will be drawn from the ranks of the less qualified.

More likely, leadership of hospitals and health care organizations will devolve to people such as business school graduates who have received training in leadership. In many such cases, these business school graduates will be people with little or no experience in patient care, medical research, and educating the next generation of health professionals.

In this scenario, the people who make decisions about what equipment to purchase, or whom to hire, or how the budget will be allocated, or how the strategic priorities of the organization will be formulated may be people who do not think like physicians and radiologists. This may affect the field in ways that undermine the effectiveness and career satisfaction of radiologists and compromise the achievement of our core missions.

Leadership is not an esoteric topic relevant to only a select few, but a ubiquitous feature of daily life for every radiologist. Every clinician is a leader of a team of colleagues composed of technologists, nurses, and secretarial staff. Every educator is a leader of medical students, radiologic technology students, or residents. Every parent is a leader of children.

Every person who bears any responsibility for any area or function within an organization is a leader, at least insofar as we must influence others to ensure that the work gets done properly. Even those of us who think of ourselves as followers are leaders. People in positions of greater formal authority depend on us for an understanding of what is happening in the organization. In shaping the perceptions of leaders, we function as leaders ourselves.

In many organizations, the people with the greatest formal authority do not necessarily exert the greatest influence. In meetings, for example, it is not always the person who presides that shapes the opinions of others to the greatest degree. Even a very junior person may wield a great deal of influence by ex-

Received May 19, 2004; accepted after revision September 22, 2004.

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AJR 2005;184:1065–1068 0361–803X/05/1844–1065 © American Roentgen Ray Society

pressing important ideas in a powerful fashion. In short, leaders are not so rare as we sometimes suppose. Far rarer, in fact, are individuals who enjoy no opportunity to lead.

Disqualification

Another disabling fallacy concerns the lack of leadership qualifications. Many of us who are otherwise capable people fear that we simply lack what it takes to be a leader. As a result, when opportunities to lead present themselves, we duck and cover, hoping that someone else will step forward to shoulder the responsibility.

This is a venerable theme in Western culture. In the Bible, God recruits Moses to go to Pharaoh and tell him to release the people of Israel from bondage [1]. The reluctant Moses responds, "Who am I to go to Pharaoh, and that I should bring the children of Israel out of Egypt?" Later, as God tells him how this will be accomplished, Moses expresses doubts about his ability to convince the Israelites to follow him: "But suppose they will not believe me or listen to my voice?" A bit later, Moses again resists, saying, "I am not eloquent, neither before nor since you have spoken to your servant; I am slow of speech and slow of tongue." Finally, Moses reluctantly agrees to serve as God's spokesperson, but only with the stipulation that his silver-tongued brother, Aaron, will speak to the people for him.

Many of us operate with the mistaken notion that leaders are born and not made. Having known few successful leadership experiences in our lives and recognizing that people do not seem to turn to us in times of crisis, we suppose that we are missing a crucial set of genes that makes some people innately effective leaders. In meetings, we are not the first to speak up. We do not feel compelled to ensure that our will always prevails. We are not the life of every cocktail party, and groups of people do not necessarily coalesce around us in social settings. Perhaps we may have been disappointed by the few formal leadership opportunities that came our way, or we may have found the experience baffling, or unrewarding, or even a failure.

In fact, however, effective leaders need not be the tallest, or best looking, or most naturally congenial people. They are not necessarily the best conversationalists, nor would they necessarily be voted the most popular. Many effective leaders, such as Abraham Lincoln, have been rather private, shy, and even self-conscious people [2].

Leadership is more an art than an ability. People are born with abilities, including abilities in different arts. For example, some people have a knack for musicianship, others for art, others for mathematics, and still others for simple congeniality. Yet even more important than sheer ability are factors such as how hard we work at cultivating our innate talents, how strongly we wish to excel at what we do, and above all, how much we care about the people with whom we work.

Even people with many natural gifts for leadership may fail. We fail because we do not understand what the organization should be trying to do. Plato once wrote that power should be entrusted only to people who are not in love with it [3]. Why? Because people who are in love with power may not care about what happens to other people in the organization, or about achieving the organization's missions. Instead, they simply want to be in charge.

There is something reassuring about Moses' attitude. He did not set out to lead. Instead, he doubted that he was qualified for the job. It was only as he came to understand the importance of the goal for which leadership was needed that he became a great leader. For Moses, knowledge of the good came before the desire to lead. With time and experience, he grew into a role he was not initially prepared to play. So, too, those of us who recognize opportunities to lead should spend less time worrying about our lack of qualifications and more time trying to understand where our organizations need to go.

Tyranny

Another leadership fallacy concerns the nature of leadership. Many people suppose that the most important measure of leaders is the ability to get other people to do what we want. The further we can move others from where they want to go, the more effective we are as leaders. Leadership, in other words, is conceptualized in terms of influence.

What means could leaders use to exert influence? One approach would be persuasion, using reasoned argument to try to convince people that it is in everyone's interest to pursue a different goal. Yet other less noble approaches might work too. For example, withholding information, or even outright deception, might help to change people's minds. Similarly, bribing people might change their priorities. So too might the use of coercion, threatening people with the loss of their jobs.

As these examples indicate, leadership is not about getting people to do what we want. When we bully others, we are not acting as a leader but merely imposing our will on others. Instead, leadership is about helping people to see what we ought to want, because it is best for us, or best for our organization, or best for the people the organization serves. Merely getting people to do what we want is the definition of tyranny.

How do tyrants think about the needs and aspirations of others? In most cases, they see others as tools for the satisfaction of their own desires. They regard them as buttons and levers they need to manipulate to get what they want. When people fail to follow orders, tyrants are quite prepared to do away with them because tyrants are not interested in people. They could not care less with whom they work, so long as they get what they want.

True leaders, by contrast, really care about the people we work with and want to see them happy and fulfilled in the work they do. Really caring about other people as people, and not merely as cogs in a machine, means refraining from shouting at them like a tyrant, and instead talking with them and, above all, listening to them. True leaders are not mere talkers. We should be listeners too. We should recognize that a two-way flow of information is vital if we are to understand our organization and the people who make it up. True leaders are not so much dictators as learners, always seeking to understand our colleagues and putting that understanding to work in the life of the organization.

Technique

Is leadership a matter of technique? From a technician's point of view, what matters most about leadership is how you lead. Should you be open with people or secretive? Should you be readily available to meet with people on a moment's notice, or be difficult to get hold of? Should you deal with people through intermediaries, or face to face? Should you delegate most of your authority, or attempt to do as much as possible yourself? These are the questions that preoccupy a leadership technician.

There is no doubt that some approaches to leadership are more likely to succeed than others. Yet the role of technique tends to be overemphasized. Whether we are traveling by air, sea, rail, or road, it is more important to understand where we are headed than how we are getting there. To know how to travel, we must first define our destination.

Knowing how to lead requires knowing where the organization should be headed.

Merely moving quickly and efficiently is no advantage if we are moving in the wrong direction. In other words, leadership techniques need to be adapted to the challenges and opportunities at hand. The approach that works best when things are going well may not be well suited to a crisis. So, too, different leadership approaches are called for depending on the colleagues with whom responsibility can be shared. Good leaders focus on the goals first and the technique second.

Courses on leadership tend to focus too much on technique, in part because techniques are relatively easy to teach. For example, we can easily teach participants different techniques for brainstorming, or ranking priorities, or delivering bad news. Harder but much more important is educating people to better define what our priorities should be. To do that, it is not sufficient merely to master a technique. Our need for leadership techniques is far exceeded by our need to understand ourselves, our colleagues, our organizations, and the changing environments in which we are situated.

It would be unfortunate if people could seize power in an organization simply by mastering techniques learned at a weekend seminar. Like most important things in life, earning the prerogative of leadership and excelling as a leader require serious effort. There are no short cuts to understanding what an organization should strive to become.

Vanity

One of the most seductive features of leadership is the prestige associated with it. There is a natural tendency to suppose that people in positions of leadership are the best. We look at the higher compensation, larger offices, special privileges, greater authority, and enhanced access to information leaders enjoy and suppose that being placed in a leadership position instantly makes a person a big shot.

Nothing could be further from the truth. Often people who get the corner office do not last long. In some cases, the fault lies not with the newly appointed leader, but with the impossibility of the situations into which we have been placed. Moreover, the prestige associated with leadership can undermine relationships with colleagues, rendering them shallow and even artificial. Prestige can also be a distraction, so entrancing us with the trappings of the office that we lose track of the legitimate reasons we wanted to lead in the first place.

Good leaders do not spend much time looking in the mirror. There is no room for selfishness. Placed in a position of authority, selfish people regard the organization as a springboard for their own success. As far as they are concerned, the people they work with exist to provide them the means to advance their own careers, in power, wealth, and prestige.

By contrast, truly great leaders regard their own knowledge, skill, and experience as tools with which to serve. Our first commitment should be not to ourselves, but to the mission of the organization we lead. If we seek authority, it should not be to make ourselves look bigger, but to make a contribution. Our goal should be to make a difference in the life of the organization and the people who work in it. We want to know that the organization would suffer if we were not there. We want to play an important role in forming teams, helping teams succeed, and enabling our colleagues to perform at their best.

The desire for authority is not a bad thing. So long as we intend to use it for the appropriate purposes, it is a good thing. It would spell trouble for organizations if no one cared enough about us to want to serve.

Ease

Really good leaders can make leadership look easy. Faced with a difficult situation, the best seem to know instinctively what to do to diffuse tension, or cut through the fog, or jump-start a stalling project. In fact, however, effective leadership is not easy. It is like practicing radiology. A medical student watching a radiologist interpret cross-sectional imaging studies might conclude that radiology takes little effort, because the radiologist can form an accurate diagnostic impression after studying the images for only a few seconds. In fact, however, the radiologist has invested years or even decades of effort to be able to make such rapid and apparently effortless assessments.

To become a good leader requires a great deal of effort to get to know the organization, the people in it, and the environment in which it operates. What seems like a spur-of-the-moment, instinctive stroke of brilliance in fact requires long study of the organization's priorities and its style of operation. Only people who really care about their organizations and work hard to learn as much as they can about them will be in a position to succeed.

A famous example of a leader who made it look easy is Sir Winston Churchill, one of the most important political leaders of the 20th century and a Nobel Laureate in Literature for his mammoth *History of the English-Speaking Peoples*. Churchill was also known as one of the greatest orators of the 20th century, achieving worldwide fame for such memorable utterances as, "Never in the field of human conflict was so much owed by so many to so few," "We shall draw from the heart of suffering itself the means of inspiration and survival," and "Let us therefore brace ourselves to our duty, and so bear ourselves that, if the British Empire and its Commonwealth lasts for a thousand years, men will still say, 'This was their finest hour' " [4].

Listening to Churchill's famous radio broadcasts during the Second World War or witnessing his speeches in person, many people had the impression that he spoke extemporaneously and was simply an extraordinarily gifted speaker. However, we know from Churchill's own writings and those of others close to him that he worked for hours, sometimes days, to formulate what he would say, and practiced his speeches many times over. In fact, Churchill was a stutterer, and he struggled with a speech impediment his entire life.

Sacrifice

Perhaps the greatest leadership fallacy of all is the notion that accepting formal leadership responsibility means sacrificing the other things in life we really care about. Must great leaders give up all pretense of maintaining a happy family life? Must leaders set aside personal ambitions for such areas as clinical work, research, and education to such a degree that we lose ourselves in our organizations? Must those of us who aspire to formal leadership positions be prepared to relinquish even our own moral scruples for the good of our organization?

These are very dangerous misconceptions, in part because they inevitably turn gifted people away from leadership. If playing a formal leadership role means wrecking our personal life, abandoning the professional challenges that attracted us to radiology in the first place, or even being forced to do things that trouble our conscience, then who wants it?

Far from diminishing a person, however, leadership provides wonderful opportunities for personal development through service. Excelling as a leader requires a person to develop many of the most important human virtues, such as courage, self-control, compassion, justice, moral discernment, and wisdom. To become a great leader requires sustained personal growth and satisfies the human need to serve a purpose larger than oneself.

Instead of abandoning what we care most about, leadership invites us to pursue it to an even greater extent. We should try to make our organizations places where people can flourish both personally and professionally. Ideally, everyone, including leaders, should feel fully engaged in what the organization does. There is no reason that even chairpersons should not continue to devote some time and energy to former professional pursuits. Continued clinical work and scholarly activity helps leaders remain more in touch with the life of the faculty and become better acquainted with the day-to-day activities of the department.

Above all, prospective leaders should not assume that we must check our moral and religious convictions at the portal of leadership. It is simply not the case that only Machiavellian types need apply. One of the hallmarks of great leaders is a moral vision for the organization, one that places integrity and commitment to high principles at the core of organizational life. No matter how clever, urbane, and politically adroit we might be, great leadership is not possible absent that moral vision.

Conclusion

It is vital that radiologists at every stage of professional development pause from time to time to reflect on leadership. Talented people who never saw ourselves as leadership material need to discover the hidden leader within us. People who already aspire to formal leadership need to acquire a deeper understanding of what it means to be a leader, and what leaders need to do well to promote the success of our organizations.

People who occupy leadership positions need to reexamine our leadership performance and seek out opportunities to perform even better. Departments and national professional organizations need to recognize the importance of fostering future leaders, and to continue to develop and refine leadership development programs. Even people who think of ourselves primarily as followers need to reexamine what we expect from our leaders and consider what we might contribute to make leaders more effective. Above all, we need to recognize, study, and effectively respond to the fallacies that lead leaders and potential leaders astray.

References

1. Exodus 3:1–4:16
2. Donald DH. *Lincoln*. New York, NY: Simon and Schuster, 1995
3. Plato. *The republic*. Translated from the Greek by A Bloom. New York, NY: Basic Books, 1991
4. Jenkins R. *Churchill: a biography*. New York: Farrar Straus and Giroux, 2001

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