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Bulletin

About Time

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Breast MR with Guided Biopsy	January 28–29	**Cardiac MR**	March 15–17
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OUR MISSION: The *ACR Bulletin* supports the American College of Radiology's Core Purpose by covering topics relevant to the practice of radiology and by connecting the College with members, the wider specialty, and others. By empowering members to advance the practice, science, and professions of radiological care, the *Bulletin* aims to support high-quality patient-centered healthcare.

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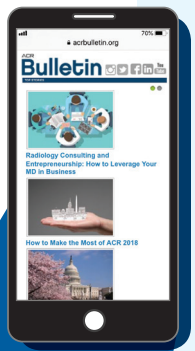
QUESTIONS? COMMENTS? Contact us at bulletin@acr.org
Archives of past issues are available at ACRBULLETIN.ORG



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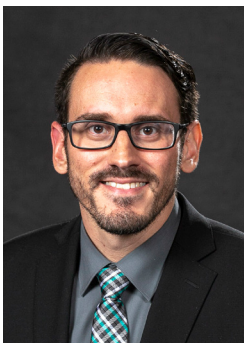


Daniel Ortiz, MD,
ACR RFS Chair
Guest Columnist

The Times They Are a-Changin'

Recent developments could have a substantial impact on radiologists — particularly junior ones.

The practice of radiology is drastically different than it was 30 years ago and will continue to evolve. A major trend has been practice consolidation, buyouts, and commercialization. The drivers of this trend include increased regulatory burden, including that associated with the MACRA legislation. Smaller private practices may struggle to build the infrastructure to meet these requirements and to compete as penalties start to ramp up in the coming years.

Many graduating radiologists seek to join private practices with the goal of becoming equity partners. Opportunities to do so may be impacted by the trends toward corporatization described above. During a recent discussion with a senior radiologist, I was told that our generation of radiologists should just give up on this model because we are going to become "just like the cardiologists," who have seen a similar migration to an "employed" model. Whether or not I agree with my colleague, I would articulate my generation's aspiration to enjoy the wide variety of opportunities and autonomy afforded to our predecessors and to ask that practices be transparent when interviewing us about their plans for the future.

Another topic that weighs on the minds of the RFS community is student loan debt. Over the last decade or so, the cost of undergraduate and graduate programs has skyrocketed, as have the interest rates on student loans. Student loan debt undoubtedly contributes to burnout, another hot topic in radiology. Studies show burnout is increasing within our specialty, with radiology now the 7th highest specialty for burnout (previously 20th highest in 2017 and 10th highest in 2016).[1] Other causes include rising volumes, decreasing reimbursements, and increasing difficulty to achieve work-life balance.

And then there's AI, which will certainly impact our generation of radiologists in the years to come. Instead of being anxious and hesitant, we must learn to embrace it and use this incredible set of tools to make us more efficient at what we do — both from a workflow and a patient diagnosis perspective. The true test will be how to not only integrate, but maintain such technology, regardless of practice type — a focal point of the ACR Data Science Institute™. As the landscape changes to offer packages to improve practice efficiencies, there is the potential for a perception that fewer radiologists and groups will be needed. However, rather than limit opportunities for radiologists, we will have to shift our roles to focus more on high-level interpretations, informatics, and patient/referrer relationships, as has been advocated for by the ACR Commission on Patient- and Family-Centered Care. If we pair the responsible, ethical use of AI for our menial, time-consuming tasks with a focus on the ideals of the Imaging 3.0® initiative, our specialty will be able to flourish and sustain all those who rise through the ranks. As a community, we should support algorithm developers who work with radiologists to provide tools that support us in the care of our patients. We should be wary of developers who seek to work around us.

We look forward to seeing continued transformation of radiology leadership. ACR BOC Chair Geraldine B. McGinty, MD, MBA, FACR, the first female chair in the College's history, is making a concerted effort to ensure that qualified women are equally represented in leadership roles, particularly at the national level, where we are seeing female leadership on committees, commissions, and the BOC. This year, the ACR RFS and YPS Executive Committees have at least equal numbers of elected male and female officials. The RSNA RFC has also achieved gender parity due to the efforts of its chair Courtney M. Tomblinson, MD. In addition, the Pipeline Initiative for Enrichment of Radiology program, founded by the ACR Commission for Women and Diversity, is also working to increase minority medical student exposure and preparation for radiology postgraduate training. This diversity of thought and action will be crucial as we work together to ensure we thrive as a profession and effectively serve our patients.

Even with the changing landscape of radiology, it is important to never lose sight of the strong foundation of our specialty, to remain optimistic in times of uncertainty, and, above all, to ensure that our ultimate focus is our patients. B

Dr. Ortiz would like to acknowledge the role of Amy K. Patel, MD, medical director of women's imaging at Liberty Hospital, clinical assistant professor at the University of Missouri-Kansas City School of Medicine, and RFS liaison for the ACR YPS, in the development of this column.

ENDNOTE

1. Kaplan, DA. Stop Burnout in Radiology Before It Starts. *Diagnostic Imaging*. Feb. 27, 2018. Available at bit.ly/BurnountinRad. Accessed Oct. 15, 2018.

Learn more about managing expectations and staving off burnout on page 15.

White House Leadership Fellowship Awarded to Radiologist

Michelle L. Dorsey, MD, chief of radiology at the Phoenix Veterans Affairs (VA) Health System, has been named a recipient of the White House Leadership Fellowship. Dorsey, the first VA physician fellow, will spend a year in Washington, D.C., working in the White House Office of Management and Budget to provide programmatic leadership for the federal government's customer experience cross-agency priority goal. According to Dorsey, "This fellowship will prepare me to develop transformative, collaborative programs that can make a genuine difference in the lives of veterans. In particular, I anticipate that my work in 'customer experience' will translate into actionable initiatives here in Phoenix to enhance veterans' satisfaction with the delivery of care."

To read more, visit acr.org/WHLF_Rad.

PHOTO: ROBERT HANKINSON

Michelle L. Dorsey, MD, is pictured in the Eisenhower Executive Office Building with Richard Skokowski, a White House Leadership Development Program Fellow.

Wellness Visits Linked to Other Preventive Health Services

According to a new Harvey L. Neiman Health Policy Institute® study published online in *Preventive Medicine*, annual wellness visits increase a Medicare patient's likelihood of receiving eight key preventive health services, including mammography. "Promoting preventive care among the Medicare population is essential to enable the elderly to stay healthy, avoid or delay the onset of disease, and live productive lives," said Danny R. Hughes, PhD, executive director of the Neiman Institute. "Given recent efforts to trim covered healthcare benefits as a mechanism to control rising costs, it's clear that the annual wellness visit is an important benefit that provides real value to patients, providers, and payers by effectively facilitating preventive care to this population."

Read the full study at bit.ly/AWV_NHPI.

Tell Us How Patients Make Your Day

Do you have a patient who has touched your heart or motivated you to make a change? The ACR is proud to offer our members a new platform to share stories. Tell us how ACR has helped you provide your patients with quality care. Visit acr.org/WeAreACR, upload a photo (it can be a headshot, a case — with identifiers removed, or a photo with you and your patient) and your written story or a brief video, and we'll do the rest. We also welcome patient and patient advocate stories.

For more information, contact WeAreACR@acr.org.

Showcase Your Chapter: Award Submissions Due Jan. 15, 2019

The ACR Chapter Recognition Program, created in 2003, recognizes successes, innovative ideas, and work to facilitate the sharing of ideas among chapters. Chapters can earn awards in four categories: Government Relations, Meetings & Education, Membership, and Quality & Safety. Chapters that have demonstrated excellence in all four categories can earn the Overall Excellence Award. The submission process has been revamped to better meet the goals of the program and to streamline the process for applicants. The 2018 Chapter Recognition Awards submissions are due Jan. 15, 2019.

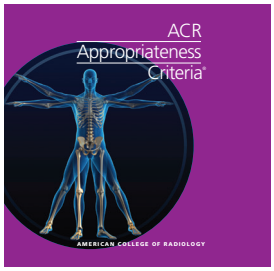
Learn more at acr.org/CRA2018.

> **As radiologists, we have to demystify the mammography discussion for women and their providers by replacing this confusion with facts. The ACR and Society of Breast Imaging have created tools to help us do that.**
>
> **— Debra L. Monticciolo, MD, FACR, at bit.ly/VOR_DemystifyingMammo**

ACR DSI Releases First Use Cases to Guide AI Development

The ACR Data Science Institute™ (DSI) has publicly released more than 50 use cases in a TOUCH-AI Directory as the first step in creating a framework that enables the efficient creation, implementation, and ongoing improvement of AI tools in medical imaging and radiological sciences. The freely available use cases in ten subspecialty areas will help ensure that algorithms are created to address relevant clinical questions, can be implemented across multiple electronic workflow systems, enable ongoing quality assessment, and comply with applicable legal, regulatory, and ethical requirements. According to DSI Chief Medical Officer Bibb Allen Jr., MD, FACR, "It's important for the medical imaging community to work with AI developers on solving healthcare problems in a comprehensive way. The TOUCH-AI Directory presents a vital pathway to help turn promising AI concepts into safe and effective AI tools to help radiologists provide better care." The use cases in the TOUCH-AI Directory are open for public comment for 60 days after release.

Visit acrdsi.org to view cases, comment, or submit a new use case concept.



ACR Appropriateness Criteria Releases New and Revised Topics

The College has released an update to the ACR Appropriateness Criteria®, a bank of 179 diagnostic imaging and IR topics that are meant to provide the most comprehensive evidence-based guidelines for diagnostic imaging selection and image-guided IR procedures. The update includes three new and nine revised topics, as well as a revamped, easier-to-use online feedback portal. "These evidence-based guidelines, created and updated by an expert panel of radiologists and multispecialty teams, are recognized across the medical field as a national standard," said Frank J. Rybicki, MD, PhD, FACR, chair of the ACR Committee on Appropriateness Criteria. "They provide the backbone to support the College's commitment to ensure that our patients get the right care for their medical conditions and that our patients avoid unnecessary care."

For more information and to view the new and revised topics, visit acr.org/ac.

IMAGING3.0®

Imaging 3.0 Case Study: Battling Blind Spots

As part of its efforts to make diversity and inclusion intentional, the radiology department at Vanderbilt University Medical Center (VUMC) has implemented ongoing unconscious bias training — achieving 100 percent participation thanks in part to offering CME credit and tapping into the variable compensation plan. The medical center recruited radiology leaders to participate in its efforts to train all faculty, residents, and staff to recognize and respond to unconscious bias. Now radiology leaders will lead a series of workshops over the next several years to help staff across VUMC recognize and respond to unconscious bias.

Read the case study at acr.org/battling-blindspots.

Chat With the Chair

ACR BOC Chair Geraldine B. McGinty, MD, MBA, FACR, invites you to attend the annual Chapter Town Hall meeting online on Wednesday, Jan. 9, from 8:00 to 9:00 p.m. EST, to receive an update on the state of the College, the challenges the specialty is facing, and plans for meeting these challenges while continuing to grow and prosper. The Chapter Town Hall will provide opportunities for member participation and questions.

For more information and to register, visit bit.ly/ChapterTownHall.

New 2018 DMQC Manual Now Available

The ACR has published the 2018 Digital Mammography Quality Control (DMQC) Manual, which now includes quality control (QC) materials for digital breast tomosynthesis (DBT). Using the new edition will promote uniformity throughout quality control processes and enable facilities to use a single manual for 2D imaging and DBT QC, regardless of system manufacturer or model. The ACR will provide all accredited mammography facilities a link to download a free PDF of the manual.

ACR Accreditation Launches "We Are Patients" Campaign

The new "We Are Patients" campaign presents diverse patient perspectives on various health issues and positive patient-care experiences at ACR-accredited facilities. The campaign offers a toolkit with downloadable customized ads and videos that ACR chapters and members can share via their newsletters and websites.

Visit acraccreditation.org to access the materials.

Here's What You Missed

The *Bulletin* website is home to a wealth of content not featured in print. You'll find blog posts, extra articles, and other updated multimedia content at **acrbulletin.org.**

Resources for Young Radiologists

The 2018 Valerie P. Jackson Fellow discusses how her fellowship afforded her the opportunity to explore educational content generation, design, and implementation. Read more about her experience at **bit.ly/2018VPJ_Fellowship.**

The Future of Medical Imaging

Top quality and data science experts convened to share the latest tools and insights on how AI can be used to optimize business efficiencies and high-level patient care at the 2018 ACR Conference on Quality and Safety. Read more at **bit.ly/QandS_10thAnnualConference.**

The Spirit of Collaboration

A radiology resident shares her learnings from the 2018 Radiology Leadership Institute® Summit — and why her focus as a leader has shifted from an emphasis on results to relationship building. Read more at **bit.ly/RFS_RLI2018.**

"Not only would LDCT cut older current and former smokers' risk of dying from lung cancer nearly in half, but it also leads more people to stop smoking — which could save more lives."

— Ella A. Kazerooni, MD, FACR, at bit.ly/Lifesaving_Impact.

CALENDAR

December

7–9 Coronary CT Angiography, ACR Education Center, *Reston, Va.*

10–12 Neuroradiology, ACR Education Center, *Reston, Va.*

January

10–11 CT Colonography, ACR Education Center, *Reston, Va.*

11–13 ACR/RBMA Practice Leaders' Forum, Hyatt Regency, *Houston*

11–13 Emergency Radiology, ACR Education Center-University of Arizona Cancer Center, *Tucson*

14–16 Abdominal Imaging, ACR Education Center-University of Arizona Cancer Center, *Tucson*

17–19 Body and Pelvic MR, ACR Education Center-University of Arizona Cancer Center, *Tucson*

24–26 Breast Imaging Boot Camp With Tomosynthesis, ACR Education Center, *Reston, Va.*

28–29 Breast MR With Guided Biopsy, ACR Education Center, *Reston, Va.*

February

4–6 ACR-Dartmouth PET/CT, ACR Education Center, *Reston, Va.*

8–10 Musculoskeletal MR of Commonly Imaged Joints, ACR Education Center, *Reston, Va.*

11–13 High-Resolution CT of the Chest, ACR Education Center, *Reston, Va.*

25–27 Coronary CT Angiography, ACR Education Center, *Reston, Va.*

28–March 1 Transcatheter Aortic Valve Replacement, ACR Education Center, *Reston, Va.*

JACR ROUND UP

Price Transparency: It Pays to Be Clear

According to a new study published in the *JACR*®, inaccurate or confusing pricing information leads to patient dissatisfaction as well as lost revenue. Authors found that "some charges and fees associated with complaints citing 'unexpected' charges and noncovered services result in the waiving of such fees or charges and hence in revenue losses by the department." However, when given accurate estimates of out-of-pocket costs prior to imaging, "cost estimates at our institution resulted in fewer billing-related complaints, decreased revenue losses, and increased overall patient satisfaction," according to authors.

To read the study, visit bit.ly/JACR_Cost-Transparency.

JACR Launches New Quality and Safety Collection

The *JACR*® has developed a new collection of journal articles specifically geared towards quality and safety. The collection, curated by Sara K. Meibom, MD, and Nadja Kadom, MD, addresses the growing need for the establishment of safe healthcare systems which, according to the curators, "requires a multifactorial approach including a culture focused on safety, the ability to recognize and address human error and system failures, the ability to identify root causes, and tools for improving the status quo." Within this collection, readers will find information on imaging appropriateness, structured reporting, peer learning, waste, and patient outreach. There are also subcollections surrounding the six aims for quality healthcare from the Institute of Medicine.

To access the collection, visit jacr.org/quality-safety.

> **As we continue to focus our attention on improving the quality of care we provide, we must not forget about the care of the provider, the so-called fourth aim of healthcare.**
>
> **— Jonathan B. Kruskal, MD, PhD, FACR, at bit.ly/JACR_Burnout**

Study Finds Breast Density Reporting Laws Help Patients

The *JACR*® and non-profits Are You Dense, Inc. and Are You Dense Advocacy, Inc., recently teamed up to conduct a study on breast density reporting laws and how they impact women's awareness levels and conversations with providers about risks associated with breast density. Despite support from patient advocates, the laws have been criticized for their readability levels and "potential for additional costs and overdiagnosis, physician unpreparedness, and patient and provider confusion." Study results showed, however, that state-level density reporting laws are associated with increased breast density awareness and increased likelihood of conversations between women and their providers regarding supplemental screening.

"Women and their physicians should talk about the woman's breast density and its impact on breast cancer screening and diagnosis," said Dana H. Smetherman, MD, MPH, FACR, chair of the ACR Commission on Breast Imaging. "At the ACR's urging, inclusion of breast density information in mammography reports to physicians began long ago based on the ACR's BI-RADS® classification system. In states without legislation, women may not automatically receive density information but should be aware that it is generally available in the mammography report. This information is helpful for both radiologists and referring providers as they discuss density status with their patients."

Visit acr.org/JACR_BreastDensity for more information.

By Ezequiel Silva III, MD, FACR, Chair

Evaluation and Management Codes Are Relevant to Radiology

Recent CMS changes could have primary and secondary consequences for the specialty.

CMS has proposed a significant change to the evaluation and management (E/M) code set. This code set represents the highest volume/highest expenditure current procedural terminology (CPT®) code set in the Medicare Physician Fee Schedule (MPFS) — totaling more than $47 billion in spending in 2017, which was approximately half of all MPFS spending. At first glance, this may seem relatively insignificant to the ACR, since clinical encounter codes are not necessarily at the core of what we do. But understanding the changes to the E/M code set may be germane to radiology at two levels:

1) The specialty, particularly radiation oncology and IR members, bills E/M frequently.
2) The secondary effects and precedent of this policy change are relevant.

Earlier this year, in accordance with the president's executive order directing federal agencies to reduce regulatory burden, CMS presented its "Patients Over Paperwork" initiative.[1] The policy changes resulting from this initiative have been far-reaching, predicted to reduce an astonishing 6,000 years of burden for healthcare stakeholders over the next three years.

The E/M code changes are a product of this initiative, and CMS is only proposing changes to the physician office-based E/M codes. The codes are differentiated by place of service (inpatient versus outpatient), nature of the encounter (new versus established patient), and level of complexity (on a scale of 1 through 5). The level of complexity is based on a combination of elements associated with medical history, examination, and decision-making. Keeping track of all the associated reporting requirements is burdensome, resulting in billing and documentation challenges for physicians.

Basically, the CMS proposal collapses the E/M codes into two levels by making no payment differential or reporting requirements distinction between levels 2 through 5. Therefore, the reporting requirements are lower, and the payments for more complex services also decrease. As a result, the proposal has received criticism, especially from specialties that see more complicated patients. In response, the AMA has formed a combined CPT/RVS Update Committee workgroup to modernize the E/M code set. The group's goals include reducing the administrative burden of documentation, including unnecessary documentation for patient care. In other words, it aims to simplify documentation, coding, and compliance.[2]

So what do these E/M code changes mean for radiology? We will need to monitor and contribute to the potential code changes, ensuring that the new codes capture what our members provide. These changes may present us with opportunities. For instance, greater E/M reporting would capture activities related to imaging-directed consultations, pre-procedure planning, and post-procedure follow-up. And from a diagnostic imaging perspective, we want to ensure that the value of diagnostic imaging to E/M-related patient care is recognized and valued.

Secondary impacts and consequences are worth considering. If the E/M codes receive an increase in total payment, a budgetary adjustment to the rest of the fee schedule is possible. In other words, if E/M payments go up, radiology payments could go down. There are potential implications to the technical component payments (which translate to practice expense) due to shifts in a variable called the Indirect Practice Cost Index. There may not be much we can do about these secondary consequences, but we will monitor them so that policymakers are aware of downstream consequences. Also, if CMS proves willing to simplify the coding, reporting, and payment structure of the largest, most reported code set in the MPFS, the same could be undertaken for other codes, such as those in radiology.

At first glance, the changes to the E/M code sets may seem inconsequential to radiologists. However, as the new E/M coding and documentation requirements change under the proposed rule, the primary and secondary consequences will matter to our specialty. B

ENDNOTES

1. CMS Proposes to Lift Unnecessary Regulations and Ease Burden on Providers [news release]. Washington, D.C.: CMS News and Media Group; Sept. 17, 2018. Available at bit.ly/Patient_Over_Paper. Accessed Oct. 17, 2018.
2. 170 Groups Send Letter on Proposed Changes to Physician Payment Rule. Available at bit.ly/AMA_Letter. Accessed Nov. 2, 2018.

Just In

The day before this column went to press, the Medicare Physician Fee Schedule Final Rule updated the regulations as follows: the changes are delayed until 2021, at which time the first four levels of the E/M code set will be collapsed into one, and the fifth, most complex, level will be preserved.

Get Certified in Hospice and Palliative Medicine

Candidates who are certified in radiation oncology, general radiology, diagnostic radiology, or IR are eligible to be certified in hospice and palliative medicine. New candidates must complete a one-year fellowship program before taking the exam. For more information, visit the ABR website at bit.ly/Hospice_Cert.

About Time

Radiologists are entering the conversation on end-of-life care to support patient decision-making at a difficult time.

After David Bowie lost his 18-month battle with liver cancer in 2016, Dr. Mark Taubert, a palliative care physician at Cardiff University School of Medicine in Wales, U.K., penned a post-mortem thank you letter to the music icon. The unusual correspondence expressed Taubert's thanks not only for Bowie's musical contributions, but also for his advanced care planning and his use of palliative care and pain management professionals. Taubert suggested to Bowie in the letter that if he "ever were to return (as Lazarus did), you would be a firm advocate for good palliative care training."[1]

End-of-life care is often associated with cancer treatment, yet it encompasses a host of diseases, from liver or heart failure to advanced COPD and Alzheimer's. It is critical that end-of-life-care teams — oncologists, body imagers, neuroradiologists, radiation oncologists, and others — communicate with patients, their families, and one another to limit patient anxiety, pain, and unnecessary procedures, including unproductive imaging.

"When patients and their families are making these types of difficult choices — whether or not to continue to pursue care or to change treatment — it's important that they have the information they need presented in a way that they can easily consume," says ACR BOC Chair Geraldine B. McGinty, MD, MBA, FACR. "This goes to the heart of what we do, because oftentimes decisions are being made based on imaging."

End-of-life care focuses on giving patients the best quality of life — providing comfort and pain management — while ultimately helping them die with dignity. Palliative care is used to treat patients who have a serious illness, for which a cure or a complete reversal of the disease is not possible.[2] Hospice care focuses on maintaining quality of life for terminally ill patients receiving palliative care relief.

When a physician believes that treatment is unlikely to achieve the desired goal of care, treatment is considered futile.[3] "The results of imaging studies help determine whether further treatment will be advantageous to the patient or provide no benefit, being essentially futile," says James A. Junker, MD, FACR, chief medical officer at Mercy Hospital Jefferson in Crystal City, Mo.

Radiologists should gauge end-of-life care situations by pairing their expertise with the comfort level of patients and their families and the findings of other physicians providing care, Junker suggests. "If the patient's primary physician, palliative physician, and the family want the radiologist to get involved in the discussion to assist with understanding an imaging study, there's no reason not to play that invaluable role and help with decision-making," he says.

Training for Empathy

According to Junker, radiologists can better contribute to end-of-life care if they have a desire to get involved and some training in how to communicate unfavorable news (learn more about communicating with patients and families on page 13). This can involve formal training or experience gained through participation. Radiologists who seize opportunities to work with palliative care physicians and hospice directors gain valuable insight, Junker says. His hospital holds meetings to discuss complex cases related to end-of-life care. Attendees include physician specialists, nursing staff, and often patients' family members to discuss appropriate treatment or palliative care and hospice options.

"Radiologists can serve on or even start up these committees," Junker says. "It can be time-consuming (and not all of the cases will be about specific radiological studies), but the knowledge gained from being a part of these interactions could be really beneficial to a radiologist when he or she is called to communicate results to family members."

When radiologists are asked to speak with a patient or family member, a little empathy — even if it is learned — can go a long way. Personal encounters with life or death situations are especially powerful.

Junker, earlier in his career, had a close family member diagnosed with a near-fatal malignancy. The experience changed his perspective and he started getting more involved with oncology patients. "I had always been involved on some level," he

says, "but that experience changed my intensity level. I now feel like I have more knowledge of the pain and suffering that patients and their families go through."

Starting New Conversations

Starting down a path to empathy can begin with an open conversation about end-of-life goals and palliative treatment — ideally before seeing a patient in grave condition. "It's best to introduce the conversation in an outpatient setting when the patient isn't feeling threatened or emotionally distressed," says Alphonse H. Harding, MD, medical director of IR at Elkhart General Hospital in Indiana. It's acceptable to ask patients if they have thought about such a situation, he says, and whether they have a plan in place.

These conversations should start with the young and the healthy, Harding insists. "We need to change the culture of communication in our country to empower people to have honest, open talks with their loved ones and their physicians," Harding says. "IRs, for example, deal regularly with very difficult situations in which families have not thought things through. Patients find themselves making decisions in an acute setting rather than having dealt with it months or years before."

Physicians, including radiologists, can practice a forward-thinking dialogue with those closest to them — their own families, colleagues, and other staff at work. "Start with your own family," Harding says. "Ask them if they have advanced directives in place or if they've talked to their spouses if the worst happens." Then you can approach nurses and physicians in your work setting, "Tell them you've had the conversation with your own family and suggest they do the same," Harding says.

> "We shouldn't be wishy washy in our reports if there is clear deterioration of a patient's condition based on the imaging. It is appropriate today – given that palliative care is now a dedicated specialty – to suggest a palliative consult in your report."
>
> – Alphonse H. Harding, MD

Providing Clear Interpretations

Broaching the subject of planning ahead won't stop patients from getting sick. When the worst happens, the caregiving team must be committed to unambiguous and straightforward communication, providing the highest level of comfort and making ethical treatment recommendations.

"We shouldn't be wishy washy in our reports if there is clear deterioration of a patient's condition based on the imaging," Harding says. "It is appropriate today — given that palliative care is now a dedicated specialty — to suggest a palliative consult in your report." Radiologists who want to drive process improvements related to quality of life must be clear in what they present, he says.

It's important that all caregivers involved help patients and their families understand their goals — and help them reach those goals within the realm of what's realistic, says Seth A. Rosenthal, MD, FACR, chair of the ACR Commission on Radiation Oncology. Sharing imaging studies could foster a better understanding of the illness, he says, and possibly lead to a more constructive discussion between the patient, family, and the physician team.

"Sometimes a picture is worth a thousand words," Rosenthal says. "And sometimes a picture may not truly capture the story and may be a distraction from the overall message of the care." Guiding palliative care patients is ongoing for radiation oncologists, he notes, and sharing imaging studies should be based on the patient's wishes, he says. "For some people it may be very important to see the images, and for others not. You have to read the patient and family to determine if they want you to interpret their studies to further the discussion of treatment options."

Committing to the Process

According to Harding, helping patients come to terms with realistic goals is just as important as treatment. "If you see a patient in a palliative state that has no hope for recovery, you may have to raise treatment questions with the intensive care doctors and with the family," Harding says.

You may decide to drain fluid from a patient's chest so he or she can breathe more easily, Harding offers as an example. "But if the patient is in a coma and has multi-organ failure and you're being asked to put in a gastronomy tube or dialysis catheter, it's your role as a consulting specialist to ask the family, 'Is this really what you want?'"

continued on page 21

The Power of Communication

ACR's new curriculum for radiology residents is an experiential exercise in patient- and family-centered care.

Learn more about the Radiology Resident Communications Curriculum at acr.org/CommunicationEd.

As value-based care becomes the new standard in today's shifting healthcare environment, the role of communication in radiology is expanding. Effective communication is vital in demonstrating radiology's value, particularly to patients, who oftentimes are not aware of the role radiologists play in their care.[1] That's why the ACR Commission on Patient- and Family-Centered Care recently launched the Radiology Resident Communications Curriculum, a free resource designed to teach residents effective interpersonal skills and help residency programs comply with communication requirements.

"From a business perspective, it makes sense for us to start communicating more," says David S. Sarkany, MD, program director of radiology residency at Staten Island University Hospital. "So patients understand that the name at the end of the report is a person, a specialist."

This newfound emphasis on communication, however, is not a natural transition for many radiologists, who are often referred to as the "doctor's doctor" due to their seemingly exclusive interaction with other physicians and healthcare providers. "Historically, radiologists have not had as much face-to-face interaction with patients, so they're sometimes out of practice," says Carolynn M. DeBenedectis, MD, associate professor of radiology and residency program director at the University of Massachusetts. "However, now there's a huge push for more face-to-face interaction, so they'll have to communicate with patients more."

With the professional stakes so high and experience levels often low, providing additional training in communication for radiologists should be in place. And yet, formal communication training is almost non-existent in national radiology residency programs.[2]

To fill this gap, the curriculum was developed. The intensive program, which launched in August 2018, includes module-based learning, patient-doctor simulations, skills assessments, and sample case studies in communication.

The curriculum's purpose is twofold: 1) it provides residents with a skill necessary for their future success, and 2) it provides residency program directors with assessment tools to show compliance with ACGME requirements that mandate residents demonstrate proficiency in the essential radiology milestones of interpersonal and communication skills.

"The curriculum provides confidence and comfort for residents," says DeBenedectis, "and allows them to practice having critical discussions with patients." Because conversations between patients and radiologists often involve unpleasant news — such as a cancer diagnosis or telling a parent that their child is sick — they can be highly emotional. As such, the required level of expertise and empathy can be daunting for radiologists untrained in effective communication skills, DeBenedectis says.

According to Sarkany, one distinguishing feature of the curriculum is the interactive component in which residents role-play in fictitious scenarios. "This is an area of medicine that you can't really teach by giving a lecture," says Sarkany. "But if you put the resident into a scenario where they don't know what they're walking into — that's when they really get to practice the intangible aspects of being better communicators."

Sarkany notes that some of these intangible aspects include sitting down with the patient at eye level instead of standing, asking open-ended questions, repeating yourself, asking patients if they understand, reading body language, and avoiding medical jargon.

Finally, the curriculum is customizable, allowing program directors the flexibility to add as much, or as little, content to their existing curricula as they choose. For instance, the scenarios in the interactive component can be portrayed either by professional actors or residents trained to play those roles. The information can also be presented in video form.

"Not all programs are the same," says DeBenedectis. "We've created the curriculum so you can tailor it to your facility and your resources and still get a similar benefit."

The ideal implementation of this curriculum would be early in a residency program, so residents can repeat and hone these skills over time. However, there is no wrong time to teach these skills. According to DeBenedectis, "The only wrong thing to do would be not to train residents in these vital patient-centered skills." B

By Makeba D. Scott, freelance writer, ACR Press

ENDNOTES

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AMY L. KOTSENAS, MD, FACR

At RSNA 2017, Saad Ranginwala, MD, shared how the radiology department at Cincinnati Children's Hospital uses social media to drive engagement with patients, families, and the professional community.

Controlling the Narrative

How can social media advance radiologists' careers?

Early in his career, Tirath Y. Patel, MD, (@TirathPatelMD) a radiologist at Houston Radiological Associates, came across Saurabh Jha, MBBS, (@RogueRad) an assistant professor of radiology at the University of Pennsylvania, on Twitter. The two began conversing and although they had never met in person, formed a fast friendship. "Thanks to this relationship, I was able to be involved in scholarly projects with Dr. Jha," says Patel.

Social media comes in all different forms, and it's increasingly becoming a valuable career tool for radiologists. According to Patel, because of relationships forged online, such as the one with Jha, he's been able to participate in projects and committees that he otherwise would not have been made privy to. "Having a larger network is usually good, not only for career goals, but also for basic enrichment of the mind when exposed to different viewpoints," says Patel. "That network can also increase a radiologist's scholarly presence to disseminate and discuss academic work, which could also lead to even more opportunities."

Creating a Brand

According to Saad Ranginwala, MD, (@SaadR) social media is available to a wide audience and can therefore be used by radiology organizations to disseminate a brand or public image for their institution. "Hospitals can highlight notable staff, important events, accomplishments, and other things they want to showcase to the world," says Ranginwala, a pediatric radiologist at Lurie Children's Hospital of Chicago.

Ranginwala adds that having a social media presence allows radiologists to control their own narratives rather than someone else doing it for them. "Radiologists can lend their personal expertise to situations and establish themselves as leaders in the most prominent public forum currently available," he says.

Teaching the World

Social media can also be vital for radiology education. "Social media is such a huge part of our daily lives," says Ranginwala. "Posting educational content on social media allows for small snippets of learning to occur within our daily workflow, without us taking extra time to seek out educational materials. I see a number of cases each day without making any great extra effort."

Ranginwala notes that on an international level, social media allows radiologists to reach users all over the world who may never otherwise have the opportunity to see cases other radiologists are exposed to. For instance, ACR (@RadiologyACR) posts a new Case in Point™ every day to Twitter and Instagram, which radiologists can use to test and improve their clinical knowledge. The ACR also posts a weekly multiple-choice question based on Continuous Professional Improvement™ modules, and after giving followers a few days to weigh in, posts the correct most likely diagnosis. The radiology department at Cincinnati Children's Hospital (cincykidsrad) uses Instagram to share a single case under a daily theme.

Getting Started

The easiest way to get started on social media is to just jump in, says Ranginwala. "Start by choosing your platform and make an account," he says. Different platforms can have different uses. Ranginwala notes that Instagram and Figure 1, an online social networking service for healthcare professionals to post and comment on medical images, are great mediums for organizational promotion and education. But pay attention to what you're posting, advises Patel. He says that one of the biggest concerns physicians have with starting social media is patient privacy and medical advice. "My recommendation has always been to think of social media as a public setting such as a sidewalk," says Patel. "Would you discuss a patient's case with or give medical advice to a stranger on a sidewalk? Probably not."

Ranginwala notes that once you get started on social media, the possibilities are endless. The more active users are, the better known they can become. Patel likens it to a snowball effect. "Being involved on social media led to projects, which in turn led to even more projects and scholarly activities," says Patel. "However, if it weren't for that initial snowflake, there would be no growing snowball."

By Meghan Edwards, freelance writer, ACR Press

How can social media influence your academic career? Listen to the *JACR*® Radiology Firing Line podcast, "Social influence in the Academic Space," at bit.ly/SoMed_Academia.

Battling Information Overload

How can radiologists achieve work-life balance amid the never-ending flow of updates?

Information has never been more accessible. Between conferences, medical journals, and social media, radiologists can find the newest research and start a dialogue with others in the field almost instantly. However, the pressure to stay perpetually up to date can have insidious consequences for radiologists attempting to balance the never-ending stream of technological advancements, their daily work, and their personal well-being. The term *information overload*, coined in 1971 by the writer Alvin Toffler, refers to a state of mental exhaustion, impaired decision-making, and dulled cognition that is a result of a constant influx of information. In a field as complex as radiology, the abundance of information and the expectations to stay abreast of clinical, policy, and practice management updates can sometimes prove counter-productive to quality patient care and radiologist well-being.[1]

With every technological advance, the everyday realities of a radiologist's work change. "There is a constant need to stay informed because our field is on the forefront of technological advances, and we have to stay abreast of those changing technologies," says Courtney M. Tomblinson, MD, neuroradiology fellow at Vanderbilt University Medical Center in Nashville, Tenn. "It can be challenging when every day there is a new machine or technique or imaging sequence."

Before the advent of PACS, reports were typed from scratch, signed, and taken to the referring physician by hand. As advancements have shortened report turnaround times, this technology also brings an expectation of timeliness from referring physicians that does not always take into account the human behind the machine. As radiologists point out, immediate responsiveness is not always possible or preferred. "If you feel you have to get everything done right away, you are going to live in a state of unease and discomfort," says Richard B. Gunderman, MD, PhD, FACR, chancellor's professor of radiology at the Indiana University School of Medicine.

On top of the stress these expectations impose on the radiologist, they also may lead to subpar reports. "Quicker turnaround doesn't always equate to a quality report," says Kerri Vincenti MD, chief radiology resident at Pennsylvania Hospital in Philadelphia. "If a referring physician has a specific question about a time-sensitive report, it is not unreasonable to ask a radiologist to take a look, but they have to understand that there are limitations."

In addition to the advancing technologies within the radiology field itself, the changing digital landscape at large has meant that discussions are shifting to social media platforms. Social media has completely changed the way information is disseminated. Now that texts, emails, and social media notifications follow many radiologists home, it is even more critical to make informed choices about the return on investment associated with each information input.

"I do think that one of the contributors to burnout is the sense that 'I am paddling as fast as I can and getting farther and farther behind, that I am just drowning in a sea of information,'" says Gunderman. "While we may have added a lot more resources vying for our attention we still only have a limited number of hours in the day, so it's placing a premium on our ability to discern what is really worth knowing."

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"There is a constant need to stay informed because our field is on the forefront of technological advances and we have to stay abreast of those changing technologies."

– Courtney M. Tomblinson, MD

PHOTO: PETER PALAGI

Courtney M. Tomblison, MD, reviews 3D printed coronal images of a patient's face and sinuses during her diagnostic radiology residency at the Mayo Clinic in Arizona.

The Year in Quality and Safety

The ACR Q&S team reviews the biggest highlights for 2018.

From accrediting digital beast tomosynthesis (DBT) to exploring AI at the ACR Annual Conference on Quality and Safety (Q&S), it's been a big year for the College's Q&S team.

Accrediting DBT

2018 saw a notable addition to the ACR's accreditation program. On April 9, the FDA transitioned the accreditation of DBT systems to the ACR. These units were previously approved through the FDA certificate extension program. According to Krista Bush, senior director of accreditation for the ACR, "The ACR started accrediting DBT units on April 9, and since then we have had 1,476 units that have applied for mammography accreditation with their DBT units (at the time of this article's printing). It is important that these units are accredited because DBT is an improvement over full-field digital mammography."

For more information and FAQs on how your practice or facility can pursue DBT accreditation, visit acraccreditation.org.

Achieving Success With R-SCAN

Since R-SCAN® launched in 2015, much progress has been made in optimizing imaging care. After providing access to clinical decision support (CDS) and other tools to decrease unnecessary testing, R-SCAN participants evaluated their cumulative impact to find excellent results. Here are a few highlights:

- 42 practices show that ordering of appropriate imaging studies improved by over 10 percent
- More than 12,000 cases have been reviewed retrospectively via R-SCAN
- Most projects involved imaging for suspected pulmonary embolism, low back pain, and inconsequential adnexal cysts
- The program introduced the CDS R-SCAN Registry, now in pilot phase, which will become one of seven registries under the ACR National Radiology Data Registry.

"As R-SCAN enters its fourth year, collaborating radiologists and referring clinicians continue to demonstrate R-SCAN is a valuable tool for transitioning to value-based, patient-centered imaging care," says Judy Burleson, MHSA, ACR senior director of quality management programs.

> "Radiology thrives with technology advances. AI tools and algorithms integrated into imaging technology delivers valuable guidance at the point of care, allowing insight into improvement opportunities."
>
> **— Judy Burleson, MHSA**

Focusing on AI

The ACR Annual Conference on Quality and Safety convened in October in Boston, with a new focus: AI. Attendees had the opportunity to learn more about the future of AI and its impact on radiology from the ACR Data Science Institute™.

"Quality improvement is a data-driven field," explains Burleson. "Radiology thrives with technology advances. AI tools and algorithms integrated into imaging technology deliver valuable guidance at the point of care, allowing insight into improvement opportunities. We're on the cusp of the AI explosion in imaging, and the DSI's use cases are at the forefront."

Jacqueline A. Bello, MD, FACR, chair of the ACR Commission on Quality and Safety, agrees. "We continue to be a leader in the quality space and will continue to keep ACR members updated on how to provide patients with the best and safest care possible," says Bello, "ACR's Annual Conference on Quality and Safety was our next step in that very direction."

A first-of-its-kind series of standardized AI use cases from the ACR Data Science Institute™ will accelerate medical imaging AI adoption by ensuring that algorithms:

- Address relevant clinical questions
- Can be implemented across multiple electronic workflow systems
- Enable ongoing quality assessment, and
- Comply with legal, regulatory and ethical requirements

For more information, visit acrdsi.org.

DATA SCIENCE INSTITUTE™
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Keeping Up With PAMA

Another change from CMS has allowed the ACR's focus on CDS to continue its impact in the healthcare field. Beginning on Jan. 1, 2020, PAMA will go into effect, requiring providers to consult Appropriate Use Criteria before ordering diagnostic imaging (including CT, MR, nuclear medicine exams, and PET scans for Medicare patients). The mandate includes a phased rollout from CMS. Starting in July 2018, early adopters entered a voluntary reporting period. And in January 2020, a one-year testing period with no penalties will commence.

Fortunately, the College already provides tools for CDS, such as the ACR Appropriateness Criteria® (AC). The AC fulfill the new CMS mandate for consulting CDS prior to diagnostic imaging in Medicare patients. Although several CDS systems exist, the ACR and the National Decision Support Company have developed CareSelect Imaging™, which uses the AC and other guidelines to advise providers ordering imaging for patients. B

By Alyssa Martino, freelance writer, ACR Press

PHOTO: MEGAN GIMPAPA

Anjali Jha, a high school student in Washington, D.C., joined her mentor Ross W. Filice, MD, an associate professor and chief of imaging informatics at MedStar Georgetown University Hospital, to discuss the future of radiology at the 2018 ACR Quality and Safety Conference in Boston.

To stay updated with all of the ACR's Quality and Safety initiatives, from practice parameters and technical standards to accreditation and registries, read past issues of "Inside Quality and Safety eNews," at acr.org/QSeNews.

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Class Act

Radiologists get a lesson in conveying empathy to patients.

Imagine your 6-month-old patient's parents are anxiously waiting in the next room. Ultrasound images confirm a tumor in their son's liver. Now, you must convey the bad news. But these aren't actual parents.

This is a simulation, and the nervous people next door are professional actors who specialize in improvisation and are trained to respond to various medical scenarios. These innovative workshops — offered by the Program to Enhance Relational and Communications Skills or PERCS — are held at Boston Children's Hospital (BCH) to teach radiologists and other practitioners how to communicate effectively with patients and their loved ones.

Participatory Learning

Few doubt the importance of teaching interpersonal and communication skills to healthcare professionals. In fact, these critical skills are core ACGME competencies mandated for radiology residents. However, traditional instruction through lectures and readings "place learners in a passive mode, merely absorbing information," write two former PERCS participants in *Academic Radiology*.[1]

Several BCH leaders realized the need for more hands-on instruction regarding communication with patients. Simulation has become commonplace in medicine, but only for practicing technical skills. "Usually, simulation focuses on procedural learning with mannequins," says Elaine C. Meyer, PhD, RN, BCH's Institute for Professionalism and Ethical Practice (IPEP) director and associate professor of psychology at Harvard Medical School in Boston. "We thought, 'Wouldn't this be a great way to learn how to interact with patients?'" The PERCS workshops began in 2002. PERCS has subsequently developed workshops to improve communication and interpersonal skills in various medical disciplines. As Meyer notes, however, radiology was not an initial focus because radiologists have not historically practiced "front line" patient communication. Now, times are changing, and Imaging 3.0® and PERCS are helping ACR members adapt.

Prepping PERCS-Radiology

PERCS' lack of radiology workshops didn't last long. Stephen D. Brown, MD, pediatric and obstetric radiologist at BCH, PERCS-Radiology director, first developed a program with IPEP about difficult conversations in prenatal care. "[The program] focuses on communication after ultrasound diagnoses of fetal abnormalities," he explains. Brown immediately realized that similar programming would benefit radiologists, especially because "initiatives to provide patient reports directly through web-based portals are becoming widespread."

In 2011, Brown secured a two-year grant from the RSNA Research and Education Foundation to establish PERCS-Radiology. The funds have been used for several purposes, such as bringing nonlocal radiologists to Boston to attend the daylong workshops. Brown has run a dozen radiology-specific workshops.

Mary H. Scanlon, MD, FACR, diagnostic radiology residency program director at the Hospital of the University of Pennsylvania (HUP) in Philadelphia, and a PERCS-Radiology participant, agrees about the program's benefits. Accordingly, she is establishing a similar program at her own hospital. Scanlon is creating a video of best practices for difficult conversations. Each year, she plans to run one in-person simulation on communication topics used at BCH, while adding scenarios her own trainees have faced. "Other people can use the scenarios

Boston Children's Hospital wrote up or create their own local scenarios like I'm doing," Scanlon explains. "Radiologists in general should be out talking to patients every day."

Daily Rundown

PERCS-Radiology participants arrive early in the morning and, over the course of the day, learn to talk with patients about three important topics:

Communicating bad news: Before the actors step in, participants each give an example of a difficult conversation they've had and then watch a 90-second video in which an obstetrician conveys to a woman that she has had a miscarriage. Individuals then briefly discuss the dynamics of conveying bad news.

Next, one volunteer goes into a separate room to tell the parent — an actor — of a child with an unexpected liver tumor found through ultrasound. "Everyone else watches on closed circuit TV," says Brown. Each scenario has been vetted by Brown and IPEP faculty. "All of the conversations that we have emanate from my own experiences in radiology and the challenges that I and my colleagues have had," Brown emphasizes.

Medical errors: The workshop then moves on to the second module, which includes a didactic lecture, practical pointers, a model coaching session, and, finally, a conversation with actors in which there has been a delayed diagnosis of a child's cancer. Brown adds that for this scenario, "We always have the radiologist go in with an oncologist." According to Brown, parents are asking to speak with radiologists more frequently, and it's something for which the specialty ought to be prepared.

Radiation risk: The third workshop module provides radiologists with tools to interpret radiation risk in layperson's terms. "We discuss essential concepts of medical radiation risks and talk about the debates surrounding radiation going on in the medical literature," says Brown. "Then we enact a scenario around a child who needs a CT scan to exclude appendicitis, but has a very anxious parent."

Despite diverse topics, the day's main objectives remain to enhance the competence, confidence, and comfort of the learners. "We talk about verbal and nonverbal ways of communicating — such as tone of voice, body posture, and eye contact — and the fact that one size does not fit all," says Brown.

Expanding the Reach

So far, participants have given positive feedback about PERCS' effect on their daily practice. "Participants report that they feel better and are more prepared to have difficult conversations," says Meyer. "They have some concrete communication skills and are better able to establish trustworthy relationships with patients and families."

"In the spirit of the RSNA grant, we're doing what we can to disseminate this model," Brown emphasizes. "We are trying to partner with professional organizations and put on workshops in educational forums nationally. We're hoping people from around the country will see its value." B

> "All of the conversations that we have emanate from my own experiences in radiology and the challenges that I and my colleagues have had."
>
> **— Stephen D. Brown, MD**

By Alyssa Martino, freelance writer, ACR Press

ENDNOTE:

1. Gunderman, RB and Brown, BP. "Teaching Interpersonal and Communication Skills." *Ac Rad.* 2012;(19)12:1589–1590. Available at bit.ly/Teaching_CommSkills. Accessed Oct. 31, 2018.

Putting a face to radiology is an important aspect of Imaging 3.0®. Read more patient engagement case studies at acr.org/Patient-Engagement.

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To share your own experience with Imaging 3.0 complete the form at bit.ly/case_submit.

Five Things I Want My Radiologist to Know

A patient shares her insights into small things radiologists can do to make a big difference.

The Radiologist's Toolkit for Patient- and Family-Centered Care offers practice-specific online resources to help radiologists enhance patient-engagement skills and offer more patient-centered care. Access the toolkit at PFCCTookit.acr.org.

My first cancer diagnosis came in August of 2008. Since then, I've been to five different hospitals in five different states. I'm living with ovarian cancer for the fourth time. In order to monitor my condition, I've had regular CT scans of my chest, abdomen, and pelvis for the last ten years. I'm also currently part of a clinical trial which has necessitated scans as frequently as every two months for the past two and a half years. Additionally, I have some brain irregularities that are monitored with regular MRIs. So I have had a lot of regular scanning at many different hospitals across the country — from big university hospitals to small community radiology sites.

Most of my experiences with the healthcare system have been positive, but there are definitely areas for improvement. It's possible that chronic patients notice these things more than the average patient because of the frequency with which we're involved in the imaging process. On the other hand, these added stressors affect all patients, whether they have imaging just a few times or multiple times a year. Here are the things I want my radiologist to know about my experience as a patient.

1 I Want to Know Who You Are.

Throughout all of the imaging I've had, I've never met any of my radiologists. The radiologist is an important part of my care team and the decisions we make, so it's strange not to have an opportunity to communicate with them. The bottom section of my radiology reports direct me to a website or my referring doctor for further help in understanding what's happening. The report lists the radiologist, but there's no contact information.

Through my involvement with the ACR Commission on Patient- and Family-Centered Care, I hear from many radiologists who do in fact want to connect with patients. It makes me wonder if you, as a radiologist, realize that it's really hard for patients to figure out how we would ever contact you. Your contact information isn't available on a website and there's no way in the patient portal to write to you. Without those connection points, how could patients reach out and have a connection with you? Simply giving them the option — or even the encouragement — to contact you would go a long way in improving the patient experience.

2 Imaging Can Be Scary.

Many patients really struggle with imaging. Radiology can be one of the most stressful pieces of our care due to "scan-xiety" (i.e., the anxiety associated with getting a scan, waiting for the scan to process, and getting feedback on what's actually happening in your body). And we remember our imaging experiences because of this anxiety and the associated chance that a scan will lead to bad news about our condition.

The radiologist is an important part of my care team and the decisions we make, so it's strange not to have an opportunity to connect with them.

3 Being a Patient Is Inconvenient and Sometimes Distressing.

For me, one of the most challenging aspects of the imaging experience is having to repeatedly fill out the same forms. Every two months I have to try to remember all of these extensive details and squeeze them into these tiny little boxes on these tiny little lines – I can't even fit all the organs I'm missing onto the forms because of all the surgeries I've had over the years. So each time I go in for imaging, I'm forced to recall and record a decade of crisis, sadness, and depression. This seems like one area in which a simple change — like implementing a procedure that allows a returning patient to simply verify the continued accuracy of a form — could alleviate a great deal of stress.

4 I Am Not an Imaging Expert, but I Want to Understand My Report.

I consider myself to be educated on my diagnosis. I read scientific journals and try hard to understand my own case at a pretty high level. It's stressful to get reports that

my referring doctor and I can't make sense of, so I can only imagine how difficult it must be for those patients who are dealing with a new and unfamiliar diagnosis. Making the report language more understandable for patients (and their referring physicians) could greatly alleviate some of the anxiety patients feel.

5 Patient Comfort Means a Lot.

The environment where patients have imaging done can make such a difference in terms of adding or reducing stress. For example, some of my imaging exams require fasting. It's an unavoidable part of the exam, but it's made more difficult when I come in for a scan and the waiting room is next to a café or my room is adjacent to the kitchen where I can smell staff heating up their food in the microwave.

There are, of course, some smaller things that have improved my imaging experience — things that don't take much effort and can make a world of difference. Anything you can do to give patients opportunities to make choices and have more control over their own experience reduces stress — like getting to choose what flavor of contrast to drink, being offered a warm blanket, and being asked how I'd like my head to be positioned. These minor things make a big impact psychologically to make patients feel like their comfort matters.

The work you're doing as my radiologist is so important to the tough life-and-death treatment decisions that I have to make. I believe that through a deeper mutual understanding, we could enhance each other's experiences. B

Amanda Itliong is a former university administrator who uses her experience with cancer and chronic illness to help improve the healthcare system through storytelling, advocacy, and training.

Battling Information Overload

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Whether it is a monitor or a cell phone screen, radiologists are interacting with technology day in and day out. Although these are critical elements of the job, there are few substitutes for face-to-face interaction with peers when it comes to fostering a positive work experience. "In the information age, we think our most important sources of knowledge are our smart phones or access to the Internet," says Gunderman. "In fact, what we need more than ever are good mentors, good professional role models, and good educators." B

By Ivana Rihter, freelance writer, ACR Press

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About Time

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While any one person can raise the question, a group approach to end-of-life care decisions is critical. Bring in clergy if the patient or family makes a request, and include palliative care specialists to talk to whoever might be resistant to a change, Harding says. "We engage patients and families with a series of conversations about the ultimate goal of appropriately deescalating treatment, deescalating interventions, creating comfort, and allowing that patient to die with dignity."

Radiologists may be reluctant to get too deeply involved in end-of-life-care discussions, Junker says. If you do have a desire to get involved in this area, he says, you should seek out your clinical colleagues. "Tell them you would be happy to help as a consultant and you're willing to serve on an ethics or a complex care committee," he suggests.

Participating in these types of committees will not only help radiologists relate more deeply to patients, but also strengthen relationships with other specialists and across departments. A better understanding of situations in which more imaging is unnecessary may also enhance a patient's quality of life.

"If we as radiologists can be a useful part of the end-of-life-care process, then we're doing what we should be doing — serving our patients," says McGinty. "We're also potentially making sure that families are making a choice that's right for them, and that patients don't get unnecessary care, but all the care they need." B

By Chad Hudnall, senior writer, ACR Press

ENDNOTES

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Washington – A private practice in Seattle is looking to fill a nuclear medicine/PET/CT physician position. The position is a full-time partnership track and the candidate needs to be able to read all general nuclear medicine studies, nuclear medicine cardiology, PET/CTs, and diagnostic CTs. The candidate also needs to able to provide treatment for thyroid cancer, and be ABR and American Board of Nuclear Medicine-certified/eligible.

Contact: Interested candidates should send CVs to eleanordjang@gmail.com.

PHOTO CREDIT CANCER TREATMENT CENTERS OF AMERICA

Pictured left to right are Kimberley McDaniel, RN, Miriam Trejo, a breast cancer survivor, and Marnee M. Spierer, MD, at Cancer Treatment Centers of America.

Marnee M. Spierer, MD, is chief of radiation oncology and chief of staff at Cancer Treatment Centers of America, Phoenix.

Why is it important for radiologists to practice patient-centered care?

The radiologists I work with on a daily basis love the doctor-to-patient interaction and have such a huge role in a patient's plan of care. We often need a radiologist's input on our radiation treatment plans, and that is one of my greatest safeguards in taking care of my patients. That radiologist is not just reading a scan but helping me know where to aim my beam. Radiologists are crucial participants at our tumor conferences. Their input is invaluable

At my institution, we have patients who make appointments just to have consults with our radiologists. They go into the reading rooms and sit and review the scans. It's amazing for the patient — because someone who is going through cancer should always feel that he or she is at the center of everything.

"We often need a radiologist's input on our radiation treatment plans, and that is one of my greatest safeguards in taking care of my patients."

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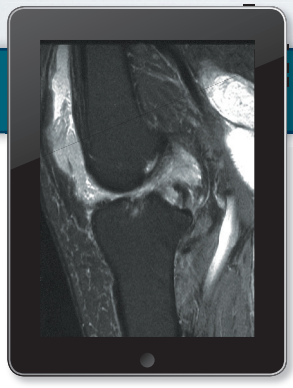
IMAGING WAS THE FIRST STEP
TO GETTING MY MOBILITY BACK

Kevin & Jasper



ACR is the gold standard in medical imaging

Medical imaging was key to the diagnosis: Kevin had rheumatoid arthritis. Movement became more difficult. The search for the best treatment led to more imaging exams and a treatment plan. Multiple joint replacements followed, including both knees. His radiology team was there every step of the way and gave him the information he needed. Now Kevin's back on his feet and enjoying things he loves … like playing with Jasper.

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Kevin is an ACR employee who volunteered to participate in this advertisement.

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