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OCTOBER 2018 | VOL.73 | NO. 10

Bulletin

revealing the truth

battling misinformation
about screening



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Feature

10 Revealing the Truth **COVER STORY**

Misinformation abounds when it comes to screening, but radiologists can change the conversation.

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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Dana H. Smetherman, MD, MPH, MBA, FACR, Chair of the ACR Commission on Breast Imaging
Guest Columnist

While we focus on the one woman in eight who will be diagnosed with breast cancer in her lifetime, we must not forget the other seven.

Respect the Past, Embrace the Future

The ACR Commission on Breast Imaging will continue to prioritize cost-effective, efficient care for every woman.

I recently read *Under Our Skin* by NFL veteran tight end Benjamin Watson. U.S. District Judge Madeline H. Haikala (my former high school classmate) required all parties in a school desegregation case to read Watson's autobiographical reflection on race in our country. Although there is much to ponder in *Under Our Skin*, I was particularly impressed by Watson's sincere efforts to seek understanding by seeing the world through the eyes of those whose opinions differ from his own. As I outline my vision for the ACR Commission on Breast Imaging, I am not only shamelessly appropriating Watson's format, but also trying to adopt at least some of his philosophy.

I'm honored. Many have described themselves as standing on the shoulders of giants. It certainly feels that way as the chair of the Commission on Breast Imaging. My predecessors, including immediate past chair Debra L. Monticciolo, MD, FACR, literally wrote the book and helped develop the Mammography Quality Standards Act, the ACR BI-RADS® lexicon, ACR accreditation, and the body of evidence that proved the value of screening mammography to decrease breast cancer mortality. Breast imaging is a model of ACR's Imaging 3.0® initiative and has led the way in value-based care for radiology. The revaluation of mammography CPT® codes provides a powerful example of how payment policy can reflect the benefit radiologists add by directly communicating with patients. I am humbled to follow in the footsteps of these incredible leaders.

I'm frustrated. Despite our many achievements, breast imaging regularly finds itself in the crosshairs. Naysayers suggest radiologists will be replaced by AI and that big data will make our knowledge and skills obsolete. Despite the evidence that annual screening mammography beginning at age 40 saves the most lives, some outside our specialty focus on the short-term anxiety of being recalled after screening and are relentless in their efforts to de-emphasize and disprove the life-saving benefit of mammography.

I'm motivated. Shortly after I was appointed chair of the Commission on Breast Imaging, an ACR member challenged a rating in the ACR Appropriateness Criteria® for stage I breast cancer and was understandably concerned about the potential ramifications of that rating

on reimbursement. Many breast imagers need only look to their own practices to see examples of the consequences of payment policy. On a daily basis, our patients decide whether to delay and even forgo breast imaging procedures because they cannot afford the deductibles and co-payments for services that are not fully reimbursed by payers. The Commission on Breast Imaging must help our members and patients navigate the rocky economic terrain of the current U.S. healthcare system.

I'm enlightened. In August, I traveled to San Francisco with several Ochsner Health System colleagues to meet with venture capitalists, technology companies, and healthcare startups for a "Silicon Valley immersion." Although these entrepreneurs were respectful of our medical expertise and eager for our opinions, they were also candid in their assessment that our healthcare system is encumbered with barriers and not responsive to the needs of patients and providers. As a result, our obstacles have become their business opportunities to relieve friction and eliminate pain points for patients, who they view as consumers.

I'm concerned. The United States has the highest total cost and per capita expense for healthcare in the world, but this has not resulted in universally best-in-class health outcomes. Although the most lives are saved by beginning annual screening mammography at age 40, the majority of women will never be diagnosed with breast cancer. Current evidence does not give us the insights we need to determine who will (and who will not) benefit from early detection of breast cancer. Big data and AI may be the keys that allow us to tailor screening strategies to each woman and customize treatment for maximum benefit. While we focus on the one woman in eight who will be diagnosed with breast cancer in her lifetime, we must not forget the other seven.

I'm optimistic. So, what is my vision for the Commission on Breast Imaging? We should respect the past, but also embrace the future. We must build on the rigorous methodology and evidence our predecessors have given us and, using the power of technology, move forward to provide the most cost-effective, least harmful, and most efficacious breast care for every woman and those who care about her. **B**

Follow-up Testing Risks of Mammography Screening

Out of every **100** women who get a screening mammogram:



Mammography Saves Lives®
... one of them may be yours

To learn more about mammography benefits and risks visit mammographysaveslives.org

New Resources for Breast Cancer Awareness Month

The ACR and Society of Breast Imaging (SBI) have added tools and resources to the new Mammography Saves Lives™ website to help explain the benefits and risks of getting (and not getting) annual mammograms to their patients.

Resources include a new series of high-definition educational videos that members can download and use to educate patients and providers about common breast cancer myths and misconceptions — including the frequency of overdiagnosis and false positives. A downloadable infographic helps explain to patients and referring providers the actual risk of callback and biopsy related to annual screening. You will also find the latest research to explain why the ACR and SBI continue to recommend that women begin annual mammograms at age 40.

For more information, visit mammographysaveslives.org.

JACR Adds New Patient-Friendly Appropriateness Criteria Summaries



The *JACR*® earlier this year unveiled the first examples of the ACR Appropriateness Criteria® summarized in plain language to help patients better understand which imaging tests may be most appropriate for their particular condition. “These patient-friendly summaries empower patients to more fully participate in their care, and are already strengthening the doctor-patient relationship,” said *JACR* Editor-in-Chief Bruce J. Hillman, MD, FACR. “They also help ordering physicians and radiologists better communicate the reason they are requesting, or performing, a particular imaging test.” The new patient-written summaries are part of a larger effort by the ACR to provide more patient- and family-centered radiology care. There are currently 17 patient-friendly summaries and the ACR with more to come.

To access the summaries, visit bit.ly/AC_Summaries-JACR.

It's Time to Renew

Your involvement in the ACR is extremely important to advancing the profession of radiology. We appreciate your contributions and commitment to providing your patients with quality care. And we are proud to support you by advocating for you on Capitol Hill and the RVS Update Committee, helping you achieve best practices in patient safety, providing you with participation discounts for required reporting, and giving you access to award-winning publications.

Renew online now at acr.org/renew.



Nicole B. Saphier, MD, director of breast imaging at Memorial Sloan Kettering Monmouth Regional, addresses mammography myths and misinformation at a video shoot in Dallas in April.

New ACR Video Series Debunks Mammography Misinformation

The ACR has produced a series of educational videos that address common breast cancer myths and misconceptions. The videos will help women and their families make more informed screening decisions by providing the facts on overdiagnosis, screening risks versus benefits, screening and outcomes in underserved communities, and other hot-button issues. You can download the videos, post to your practice website, include in emails to patients, and share on social media. Also, consider sharing with your referring providers to clear up any confusion they may have.

Watch the videos at mammographysaveslives.org.

In my career, I have been the 'first woman' in many organizational leadership positions.... Yet should we be still celebrating such 'firsts' at this point in our field's evolution?

— Carolyn C. Meltzer, MD, FACR, in the *JACR*® article "Women Leaders: Myths and Challenges," at bit.ly/LeaderMyths.

NMD Helps Mammography Facilities Improve Performance

In the battle against breast cancer, mammography facilities have a powerful tool — the National Mammography Database™ (NMD) — to help compare and benchmark performance. As part of the National Radiology Data Registry, NMD allows participants to:

- Receive quarterly feedback reports providing comparisons to peer facilities along with benchmarks of measures such as cancer-detection rates, positive predictive values, and recall rates (these reports exceed FDA's audit data collection requirements)
- Access physician- and facility-level reports to assess practice patterns, measure progress, and target specific areas for improvement
- Leverage data already collected under the Mammography Quality Standards Act federal mandate
- Document your quality of service with an online marketing toolkit that includes a participant seal, customizable ads, and news release template
- Meet reporting requirements for the Quality Payment Program's Merit-Based Incentive Payment System

For more information on participating in the NMD, visit acr.org/nmd.

New Communications Curriculum Fills Important Training Gap for Residents



The ACR Commission on Patient- and Family-Centered Care Committee on Education has released a free and interactive resource for residency training

programs that instructs residents on how to communicate effectively with patients, families, and physicians. The formalized curriculum, developed by Carolynn M. DeBenedictis, MD, David S. Sarkany, MD, Priscilla J. Slanetz, MD, MPH, FACR, and a panel of experts, satisfies the Accreditation Council for Graduate Medical Education's requirements for resident communication training and includes module-based learning, patient/doctor simulations, skills assessments, and communication templates from sample case studies. Programs are encouraged to begin using the resource as part of their year 1 resident curriculum to set a strong foundation for patient engagement.

For more information, visit acr.org/CommCurriculum.

JACR Impact Factor Jumps Again



According to the recent 2018 Journal Citation Report, the *JACR*® has achieved a 2017 Impact Factor of 3.383, a 16 percent increase over

last year's impact factor of 2.929. The journal is now ranked third among general radiology journals.

The Impact Factor measures a journal's relevance to the scholarly publishing community. The 2017 figure is calculated by dividing the number of citations in 2017 by the total number of scholarly articles published in 2015 and 2016.

"This continuous high level of performance reflects our ongoing commitment to provide our readers the highest quality research and commentary by and for radiology professionals," said Bruce J. Hillman, MD, FACR, outgoing editor-in-chief of the *JACR* (read the Q&A with Hillman on page 14). "I have no doubt that Dr. Ruth C. Carlos, our new editor-in-chief, will continue to further this growth trajectory as radiology and healthcare continue to rapidly evolve."

Visit acr.org/Impact-Factor for more information.

In Memoriam: Luther W. Brady, MD, FACR



Luther W. Brady, MD, FACR, an ACR Gold Medalist, passed away in July at the age of 92. Brady was revered as one of the world's foremost radiation oncologists and had a transformative impact on his field and medicine as a whole. During his career, Brady served as president of virtually every major professional society related to radiation oncology, including the ABR, the American Radium Society, RSNA, and the American College of Radiation Oncology (of which he was founding president).

Brady also served as chair of the ACR

Radiation Therapy Oncology Group from 1980 through 1987.

Brady's work was instrumental in establishing modern radio-oncological treatments for eye tumors and cervical cancer, for which he established new standards of care. As one of the ACR's most distinguished and venerated alumni, Brady will be remembered as an icon in radiology and radiation oncology, and the ACR thanks him for all of his invaluable contributions to the field.

To learn more about Brady's life and work, visit bit.ly/GW-Luther-Brady.

Virtual Colonoscopy Appeals to Younger Patients

Virtual colonoscopy is an American Cancer Society–recommended screening exam for those at average risk for colon cancer. Requiring no sedation and taking only minutes to perform, the procedure — also known as CT colonography — is just as accurate as standard colonoscopy and less invasive. “This can appeal to the many Americans ages 45–50 that the new American Cancer Colorectal Cancer Screening Guidelines recommend be screened,” said Judy Yee, MD, FACR, chair of the ACR Colon Cancer Committee. Virtual colonoscopy has proven to increase colorectal cancer screening rates — and at a lower cost than standard colonoscopy.

Colorectal cancer deaths are on the decline, but disparities remain. “Virtual colonoscopy can help increase screening in underserved areas and reduce racial and ethnic disparities in colorectal cancer outcomes, but only if Americans have covered access to all ACS-recommended screening exams through private insurers and ultimately Medicare,” said Yee. Currently 37 states require insurance policies to cover virtual colonoscopy.

To learn more, visit acr.org/Virtual-Colonoscopy.



A 3D image of a large polyp identified on a CT colonography screening examination at Einstein/Montefiore Department of Medicine in New York.

New Study Finds Decline in IVC Filter Procedures

Inferior vena cava (IVC) filter placement and retrieval procedures in Medicare beneficiaries have declined over the last decade, according to a new Harvey L. Neiman Health Policy Institute® study published online in the *JACR*®. The study, which amassed data from 1994 through 2015, found a significant increase in IVC filter replacement rates up until 2008, then showed a decrease between 2008 and 2015. “Despite prior dramatic growth, the utilization of IVC filters in Medicare beneficiaries markedly declined over the last decade, likely relating to evolving views regarding efficacy and long-term safety,” said Andrew B. Rosenkrantz, MD, MPA, lead study author, professor and director of health policy in the department of radiology at NYU Langone Health, and a Neiman Institute affiliate research fellow.

Read the full study at bit.ly/IVC_Trends.



We need to recover the true purpose of a radiology report, which is to help health professionals take good care of their patients.

— Richard B. Gunderman, MD, FACR, in the *JACR*® article “The True Purpose of a Radiology Report,” at bit.ly/ReportPurpose.



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.

Preparing for RSNA 2018

A radiology resident offers some key tips for first-time attendees in advance of the largest medical conference of the year at bit.ly/RSNA_2018.

Diversity in Radiology: Are We There Yet?

The current state of diversity in radiology and the need for necessary actions to bring about meaningful change were the topics of discussion at the 2017 Intersociety Summer Conference. Read more at bit.ly/Diversity-Radiology.

The Rundown on AI

A radiology resident delves into how AI affords radiologists an opportunity to add value to the field at bit.ly/AI-in-Radiology.

CALENDAR

October

- 12–14 14th Society for Pediatric Radiology Advanced Symposium on Pediatric Cardiovascular Imaging, *Walnut Creek, Calif.*
- 12–14 Body and Pelvic MR, ACR Education Center, *Reston, Va.*
- 15–19 AIRP Categorical Course: Musculoskeletal, AFI Silver Theatre and Cultural Center, *Silver Spring, Md.*
- 19–21 Cardiac MR, ACR Education Center, *Reston, Va.*
- 26–28 ACR Annual Conference on Quality and Safety, The Westin Copley Place, *Boston*
- 29–31 Emergency Radiology, ACR Education Center, *Reston, Va.*

November

- 9–10 Prostate MR, ACR Education Center, *Reston, Va.*
- 9–11 Society for Pediatric Radiology Pediatric Oncologic Imaging Course, *Memphis, Tenn.*
- 12–13 Breast MR With Guided Biopsy, ACR Education Center, *Reston, Va.*
- 15–17 Breast Imaging Boot Camp With Tomosynthesis, ACR Education Center, *Reston, Va.*
- 25–30 2018 RSNA Annual Meeting, McCormick Place, *Chicago*

December

- 7–9 Coronary CT Angiography, ACR Education Center, *Reston, Va.*
- 10–12 Neuroradiology, ACR Education Center, *Reston, Va.*



Radiology's History of Independence

How did our profession become free within payment systems?

Independence Day commemorates our country's Declaration of Independence from Great Britain's rule. That decision to become an independent nation has stood the test of time. The United States of America is now the oldest enduring republic in the history of the world. Similarly, the specialty of radiology has itself declared independence several times during its history. Granted, the stakes were lower, but in each instance that decision has also stood the test of time. As a result, radiologists have been the beneficiaries of the ACR's vision, and radiology is a robust, rewarding, and influential profession.

Today, our independence is no longer secure. We are experiencing pressures to cede our independence to larger entities, non-radiologists, and even AI. Maybe now is the time to do so. But before we choose to relinquish our independence, it is worthwhile to revisit decision points in our past, when we chose independence for our benefit:

- The founding of Medicare
- The creation of diagnosis-related groups (DRGs) for hospital inpatient payments
- The establishment of the resource-based relative value scale (RBRVS) used to determine how much physicians should be paid

Strengthened by this freedom and security, radiology professionals can pursue innovation, bold and revolutionary ideas, and make remarkable contributions to patient care.

In the early 1960s, Medicare was crafted to include two parts: Part A to pay hospitals and Part B to pay physicians. Initial proposals had radiology paid under Medicare Part A, which could have made radiologists overly dependent on the hospitals. We declared independence. With the help of ACR's first lobbyist, J.T. Rutherford (a former Democratic U.S. congressman and state legislator), we became a part of Medicare Part B, recognized and paid in the same manner as other physicians. We wanted recognition as independent physician professionals. We demonstrated our willingness

to assume not only the associated status but also the responsibility.

Then in the 1980s, a new system of payment was created that involved paying hospitals for inpatient services. This system involved single, bundled payments to hospitals for inpatient care based on DRGs. In President Ronald Reagan's 1987 budget, radiology professional services would have been paid for under the DRGs. From that single DRG payment, radiologists would have been paid separately at whatever rate the hospital was willing to pay. We resisted and, again, declared independence, allowing us to be paid the same as the other physicians in the hospital. As a result — and to this day — our professional fees are paid separately from the hospital's payments.

A decade later, in the early 1990s, the RBRVS was created as the means to pay physicians within the Medicare Physician Fee Schedule. The ACR had already created a radiology relative value scale (RVS) for the Civilian Health and Medical Program of the Uniformed Services. Our independent spirit prompted the creation of a separate resource-based fee schedule. Rather than re-create a new RVS for radiology, we advocated for the integration of our existing fee schedule into the broader RBRVS, ensuring separate recognition of our services.

Because of these actions, which have proven to be the right choice from a financial perspective, radiologists are independent within payment systems. Strengthened by this freedom and security, radiology professionals can pursue innovation, bold and revolutionary ideas, and make remarkable contributions to patient care. We have embraced the responsibilities that come with independence and accepted the challenges throughout our history, building a powerful, influential, and lasting medical specialty.

Today we, once again, face challenges to our hard-won independence. Some of these challenges are internal, such as the pressures to sell our practices to larger entities. Other challenges are external, such as the complicated payment models that threaten to turn radiology into a commodity rather than a professional service. In this climate, what will become of our independent spirit? Can we retain our independence while redefining our identity and expanding our influence? I do not know the answers and time will tell. But let us not forget our history of standing for independence. Let us be inspired by it. **B**

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revealing the truth

Radiologists battle misinformation and speak up for their patients.

Radiologists know screening is important. There is strong evidence that screening for cancers — lung, colorectal, and breast, among others — catches these diseases early, making them easier to defeat.

Yet the numbers of patients who come in for these procedures, even when eligible, remains low. In 2016, less than 2 percent of those eligible for lung cancer screening underwent the procedure,¹ and screening rates for diseases such as breast, cervical, and colorectal cancers also remain below federal target rates.²

There are many reasons why patients don't get screened, including a lack of awareness. Additionally, patients may face financial burden, fear of what happens next if the test is positive, or anxiety about potential discomfort. But many are simply misinformed. And the wealth of misinformation about screening can dissuade patients from life-saving procedures.

The Realities of Misinformation

Misinformation and lack of knowledge abound when it comes to screening. "Lung cancer screening in particular is at a disadvantage because it's such a new technology," says Ella A. Kazerooni, MD, MS, FACR, interim chair of the department of radiology at the University of Michigan and chair of ACR's Lung Cancer Screening Registry Committee and Lung-RADS™ Committee. In addition to lagging awareness about lung cancer screening, false information about the procedure itself is common. "Patients may be concerned about the radiation dose in these screenings," Kazerooni adds. "However the radiation exposure in these tests is low, and older patients who are eligible for these screenings have little lifetime risk associated with the exposure, compared with the risk of having lung cancer. Without appropriate context for this radiation concern, some patients may opt to avoid screening."

Judy Yee, MD, FACR, chair of the ACR Colon Cancer Committee and chair of the department of radiology at Montefiore Health System and Albert Einstein College of Medicine in New York, adds, "A lot of patients avoid colonoscopy for colorectal cancer screening because they're concerned about the invasiveness and the associated requirements, such as having to have another person accompany them. Although you do need to have dietary restrictions before you undergo CT colonography (virtual colonoscopy), patients can drive themselves after, eliminating some of the logistical hurdles patients might worry about."

“A lot of patient education and outreach is done at the grassroots level. All you have to do is start sowing the seeds, no matter how small.”

– Ella A. Kazerooni, MD, MS, FACR

Physician Concerns

Referring physicians, while they might not have false information, are also looking to be educated about screenings, from whom to screen and whom not to screen, and how to manage abnormal screens, says Kazerooni. “Primary care physicians are very concerned about incidental findings. Often, the low-dose CT will find additional issues, and referring physicians don’t always know what to do with that information,” Kazerooni says.

Concerns and misinformation about radiation exist in breast imaging as well, says Dana H. Smetherman, MD, MPH, MBA, FACR, chair of the ACR Commission on Breast Imaging and chair of the department of radiology and section head of breast imaging at Ochsner Medical Center in New Orleans. “A lot of patients and referring physicians are also concerned about the anxiety that multiple procedures or additional images related to a recall from screening mammography might cause, as well as the pain associated with the procedure,” says Smetherman.

The First Steps

One way to combat misinformation about screening is to spread factual information about the term. To do that, you have to create relationships with stakeholders: referring physicians, patients, and patient advocacy groups, says Cheryl R. Herman, MD, FACR, breast imager and assistant professor of radiology at Washington University School of Medicine in St. Louis.

Smetherman notes that one way to establish a good relationship with referring physicians is to help make the communication process seamless for them. “Understand that these physicians are extremely busy too. Reach out to them and see how they want to be contacted,” she says.

Yee suggests being an open resource for referring physicians, no matter your environment. “Actively approach your referring providers and offer to provide the latest literature and educational lectures. Participate in multidisciplinary conferences. These approaches can help other physicians understand how imaging tests can be used for cancer screening,” she says.

“Have open communication with your referring physicians, such as calling or emailing them with answers to questions they might have,” adds Herman. Herman also requests to visit internal medicine meetings at her institution, where she initiates quick discussions on screenings and any updated screening information that referring physicians might need. Another way that Herman reaches referring physicians is through her reports. If she sees a diagnostic patient who should be considered for additional screening, such as breast MRI, she adds that recommendation at the bottom of the report.

Radiologists can also help provide information to referring physicians at their clinics and in their hospital administrations by passing along some of the resources the ACR has to share. For example, when she was approached about referring physician concerns with incidental findings, Kazerooni shared the recently published ACR Incidental Findings Committee’s white paper on thoracic CT (available at bit.ly/2018-Incidental-Findings). Yee also addresses concerns about colorectal screening by sharing a patient brochure (available in English and Spanish) developed by the ACR Colon Cancer Committee (available at acr.org/CRC-Resources).

USPSTF Finalizes Lung Cancer Screening Research Plan

The U.S. Preventive Services Task Force (USPSTF) released its final research plan Aug. 16, 2018, for the scheduled update to its lung cancer screening guidelines. Here are a few notable points:

- The final research plan recognizes the term *low-dose CT* to describe the screening services rather than a standard CT.
- The task force recognized that the use of screening may result in more cancer cases being detected at an earlier stage of progression.
- The USPSTF added a contextual question about smoking cessation interventions among patients receiving LDCT screening, and added unnecessary treatment, bronchopleural fistula, and respiratory failure to the list of eligible harms.

“Screening needs to have a face, and radiologists need to be it.”

– Cheryl R. Herman, MD, FACR

Looking for material to share with your referring physicians?

The ACR has several resources on breast, lung, and colorectal screening:

- ACR Colon Cancer Screening Resource Page: acr.org/CRC-Resources
- ACR Breast Cancer Screening Resource Page: acr.org/Breast-Resources
- The ACR and Society for Breast Imaging Screening Guidelines for At-Risk Women: acr.org/ACR_SBI
- ACR Lung Cancer Screening Resource Page: acr.org/LCSR
- Patient-facing resources to print out and share:
 - So You're Coming in for Lung Cancer Screening: bit.ly/Lung_Infographic
 - So You're Coming in for a Mammogram: bit.ly/Mammo_Infographic

Patient and Community Outreach

According to Kazerooni, another way to dispel misinformation and fear is to reach out to patients directly. This is especially important for patients eligible for lung cancer screening, who often feel stigmatized, says Kazerooni. “Patients who have lung cancer often feel or are approached as if they gave the disease to themselves by smoking — that it’s their fault. Even if patients are not smokers, they have been treated as if they’re lying about smoking.” Kazerooni adds, “A lung cancer patient is just like any patient who has cancer. They are afraid, anxious, worried about their families, and do not deserve the stigma they face. It’s important to educate our communities so that everyone can understand that.”

Herman suggests radiologists go out into their communities and spread the word about the importance of screening at workplaces, churches, and local health fairs. “News and radio stations are usually looking for physicians to come talk about screenings, especially during awareness months,” says Herman. “If your institution or practice has a public relations department, consider partnering with them. They’ll know who to start with and how to contact places that might be suitable. They’ll also be able to give you tips on how to speak and what to do during interviews.” The more outreach you do, the more doors will open, so say yes when you can, advises Herman.

You can also look to your institution to see what groups are already connected, suggests Smetherman. Often cancer survivors or community outreach groups are already involved and may be open to you speaking at their meetings. These groups might have other outreach connections you can pursue.

Finally, reach out to those you communicate with every day. “People in your personal life are just as important to reach out to and may be even more open to learning,” says Smetherman. Kazerooni adds, “A lot of patient education and outreach is done at the grassroots level. All you have to do is start sowing the seeds, no matter how small.”

According to Kazerooni, partnering with patient advocacy groups is another way to dispel misinformation and alleviate concerns. Patient advocacy groups often have a lot of resources to share and have already done groundwork in making connections within the larger community. Physicians and advocacy groups are natural partners. “We both have the same goal: saving lives,” says Kazerooni.

To connect with patient advocacy groups, check with your institution, suggests Smetherman. Visiting various community events may also introduce you to advocacy groups. “I’ve found that our patients often end up becoming advocates,” Herman says. “You can also speak to them to see if they may know of opportunities.”

The Bottom Line

Patients learn about screening from a variety of sources — from the media, from referring physicians, and, most importantly, from radiologists. Radiologists perform these procedures, and they’re the ones with the most knowledge, so it makes sense that they do outreach, says Smetherman. Doing so not only helps patients realize that screening saves lives, but that those doing it are important partners in the care team. Herman says, “Screening needs to have a face, and radiologists need to be it. We need to show we’re physicians who care for our patients and more than just an extra charge on the bill.” **B**

By Meghan Edwards, freelance writer, ACR Press

ENDNOTES

1. Davenport L. “Lung Cancer Screening Rates Only 2 Percent Across US.” Medscape. Available at bit.ly/Lung_ScreeningRate. Accessed Aug. 12, 2018.
2. “Screening Rates for Several Cancers Miss Their Targets.” National Cancer Institute. Available at bit.ly/Screening_Target. Accessed Aug. 12, 2018.

Medical Judgment Can Be “False” Under False Claims Act

Some federal courts recently have ruled that physicians may be accountable legally for providing unneeded patient care — and falsely claiming such care was needed.

ACR members confront medical necessity daily. Should a patient undergo a diagnostic study, interventional or breast imaging procedure or radiation therapy? Some federal courts recently have ruled that physicians may be accountable legally for providing unneeded patient care — and falsely claiming such care was needed. These cases appear to have unusual facts that make them distinguishable. Yet they signal that judges may agree with prosecutors in looking behind your medical judgments. The following article sheds light on the situation and is reprinted with our colleagues’ permission.

In two separate instances this summer, federal appellate courts held that a doctor’s medical judgment can be “false.”¹ In June, the Sixth Circuit reversed a judgment that had acquitted a cardiologist charged with criminal healthcare fraud stemming from his interpretations of angiograms.² Then in July, the Tenth Circuit ruled medical judgment can be false for purposes of the False Claims Act (FCA), 31 U.S.C. §§ 3729–3733. In *United States ex rel. Polukoff v. St. Mark’s Hospital*, the court reversed a district court’s order dismissing an FCA qui tam action (i.e., a lawsuit that a whistleblower brings), rejecting the district court’s holding that medical judgment cannot be false under the FCA.

The relator, Dr. Gerald Polukoff, a doctor who worked with defendant Dr. Sherman Sorensen, alleges Dr. Sorensen received unlawful payments from Medicare by performing unnecessary heart surgeries and falsely certifying the surgeries were medically necessary. He filed suit against Sorensen and several institutions where Sorensen practiced. The government declined to intervene. The district court ultimately granted defendants’ motions to dismiss, holding that medical opinions cannot be proved objectively false as required under the FCA. The Tenth Circuit reversed and remanded.

The court reasoned that medical judgments can be “false” for at least three reasons. First, it emphasized courts must broadly construe the FCA to reach all types of fraud. Second, the court said just because the allegedly false statement is stated as an opinion does not

necessarily mean it is incapable of being false. And third, the court cited precedent for the principle that medically unnecessary medical procedures can form the basis of FCA actions. As a result, the court held that a doctor’s certification that a procedure was medically necessary is “false” under the FCA if the procedure was not “reasonable and necessary” as defined by the Medicare Program Integrity Manual. Though the court acknowledged its holding could expose more doctors to FCA liability, it pointed to the Supreme Court’s statement in *United Health Services, Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989 (2016), that the related elements of materiality and scienter should prevent abuse of the statute.

This holding echoes an opinion from the Sixth Circuit two weeks earlier that a doctor’s determination of the degree to which a blood vessel has narrowed, as interpreted from an angiograph, “is a fact capable of proof or disproof,” and “it is up to the jury... to decide whether the government’s proof is worthy of belief.”³ In holding that “opinions are not, and have never been, completely insulated from scrutiny,”⁴ the Sixth Circuit appeared to be opening the door to scrutinizing whether a particular medical judgment was “false or fraudulent.”

The government immediately attempted to capitalize on the Sixth Circuit’s ruling. The day after *Paulus* came down, it hailed the decision as a “reject[ion]” of the proposition that conflicting expert testimony on the issue of medical necessity insulates a defendant from FCA liability for “false” medical judgments.⁵ The government has also immediately put *Polukoff* to use, citing it in another case and arguing that the Tenth Circuit’s approach reflects a “proper understanding of falsity” that should allow the government and relators to avoid dispositive pretrial rulings in medical-judgment cases under the FCA.⁶

Though *Paulus* and *Polukoff* broaden the scope of potential liability in medical-judgment cases, they do not mean every medical-judgment case will survive beyond a motion to dismiss or summary judgment. Even the Sixth Circuit recognized that “the government might have a hard time proving that [the defendant] saw one thing but

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Looking for more RADLAW?

Read past editions of the column at bit.ly/ACR_Legal.



Passing the Baton

The outgoing editor of the *JACR*[®] reflects on how the journal has carved out a unique niche in the radiology community.

Outgoing *JACR*[®] Editor-in-Chief Bruce J. Hillman, MD, FACR, chats with Ruth C. Carlos, MD, MS, FACR, incoming *JACR* editor-in-chief, at the ACR 2018 opening session.

After launching the *JACR*[®] and spending 15 years at the helm, Bruce J. Hillman, MD, FACR, will be stepping down as editor-in-chief at the end of this year. The former chair of radiology at the University of Virginia talked with the *ACR Bulletin* about the journal's early days, the evolution of the specialty, and his plans for what comes next.

Is it true that you didn't want to be the editor-in-chief initially?

What I wanted was for the ACR to not have a journal at all. About a year before the College decided there was going to be a journal, I got called into an all-day meeting to discuss that very subject. At the conclusion of the meeting, there was a vote. Turns out I was the only one who voted against it. And I did that because I didn't have the foresight to see the niche that the *JACR* now fills, which is non-clinical content that helps radiologists care for their patients, run their practices, and chart their careers.

In the end, I'm grateful I lost that vote. This has turned out to be a great job, and the publication has grown into something I feel very proud of and I hope readers look forward to each month.

What value do you see for radiologists using social media?

Virtually everything out there is a two-edged sword, but this is a real two-edged sword. The fact is, it does allow for the development of a community and relationships

far beyond what used to be available. You used to have to know people, network, and meet in much more formal situations. So that part of it is good. You become more of a piece of a larger whole.

On the other side, you can sink an enormous amount of time into social media. It's fun and you can persuade yourself that it's very useful — that you're building a network. But the truth is that an awful lot of what you read on Twitter and Facebook is really not worth your time, in my opinion. I think there's a lot of junk on social media, so when you participate it's important to know when you've reached the limit of its value to you.

You write an editorial each month. Do you have a favorite?

My single favorite editorial is from April 2018. It's about how entertainment can provide a history that really didn't occur. If you allow yourself to believe that you're watching a true story, you can become an easier mark for misinformation.

What advice would you give to young radiologists just starting out?

It's really an individual thing, but I would say there are three things to consider. First, learn to read and write well. It doesn't matter what you want to be. If you can read and write well, that's a huge step forward in building a career. The second thing is you should get the advice of not just one person, but many people — particularly people who have some vested interest in you. Third, don't be afraid to change. You can make mistakes and learn what you could do better. Discover what you enjoy and what you do well. For instance, from the moment I got my first job, I thought I was destined to be the chair of a radiology department. I thought that's what I was going to be, but that turned out to be wrong.

What advice would you give to your successor?

While Dr. Carlos has had a lot of advice from me up to this point, I would say the main thing moving forward is to trust her own instincts and continue to be as creative as she can to keep the *JACR* on the leading edge of journalism. I think we've done that successfully.

What are your plans after you step down from the journal?

Well I've already written a few books that you could call creative nonfiction. I'm working on a third now, and it's really a challenge because it's technical enough that there

“Bruce has shaped the *JACR*[®] into one of the most widely read and influential journals out there — in the process advancing our priority to deliver exceptional evidence-based care.”

— Ruth C. Carlos, MD, MS, FACR, incoming editor of the *JACR*

may not be much readership for it. It's about how the National Institute of Biomedical Imaging and Bioengineering was established over a 20-year period by a small group of radiologists. It's got some real heroes in it — wonderful characters who fought off impossible odds.

I also plan to continue playing golf and do more fly fishing, all over the world. It's going to be a great retirement.

Is there anything else you'd like to share with us?

I'm extremely grateful for the ACR. I really owe my career to the College. The things I'm proudest of and where I've made the most difference in our specialty all came through the ACR. When you get the opportunity to do something that truly has meaning to other radiologists into the future, you feel fortunate. **B**



Read Hillman's favorite editorial in the *JACR*[®] at bit.ly/TrueStory_JACR.



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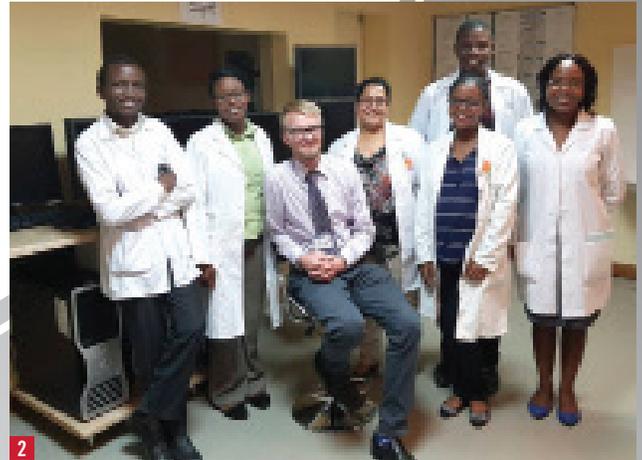
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The Road Well Traveled

Three radiologists look back on their experience with the ACR Foundation's Goldberg-Reeder Travel Grant.

The ACR Foundation's Goldberg-Reeder Travel Grant Program is designed to facilitate radiology knowledge-sharing, while assisting health facilities with radiological care in low- and middle-income countries. The latest group of recipients brought their skills, expertise, and energy to Zambia, Tanzania, and Namibia, where they worked with local colleagues and patients to advance radiological care. Fresh from their travels, the recipients shared their insights and experiences with the *Bulletin*.

Andrew Olsen, DO Zambia

Now a fellow in Portland, Ore., Olsen spent four weeks of his final year of radiology residency living in Lusaka, Zambia, and working at the University Teaching Hospital — a 1,800-bed hospital that serves as the city's premier center of medical education.

What was the most memorable part of your experience?

Our primary goal in traveling to Lusaka was to initiate a newly organized class of radiology trainees into a multi-year radiology training program, analogous to a residency program. We would start most days giving one or two hours of formal lectures, after which the Zambian trainees returned to the hospital's radiology department to work until lunch. While they spent the remainder of the morning working with the hospital's local in-house radiologists, we would interpret a large backlog of MRI and CT cases. This backlog was the unfortunate result of a shortage of Zambian radiologists, which this new training program is intended to alleviate.

What lessons did you learn during your travels?

I gained invaluable experience interpreting studies for diseases and conditions that were rarely seen among our patient base during my residency at the University of Rochester's Strong Memorial Hospital in New York. The combination of infectious agents that I think of as exotic (such as schistosomiasis, malaria, tuberculosis, and listeria), a very high prevalence of immunocompromised patients due to HIV infections, and the often-too-late initial presentation of many patients, resulted in a very different practice experience than I am used to. I had access to doctors with experience interpreting these studies, who were willing to help me make sense of them.

My time in Zambia has been the highlight of my radiology training career, and I hope it will be the beginning of many opportunities that allow me to collaborate with radiologists from a diverse set of backgrounds.

Krishna Patel, MD Tanzania

Patel was in the diagnostic radiology residency program at Dartmouth-Hitchcock Medical Center in Lebanon,



Where will your travels take you?

The ACR Foundation's Goldberg-Reeder Resident Travel Grant awards grants each year to qualified radiology and radiation oncology residents and fellows seeking to spend at least one month assisting healthcare in a developing country. Learn more at acr.org/Goldberg-Reeder.



N.H., and intended on doing a fourth-year elective in global health, when she applied for the Goldberg-Reeder Travel Grant to support that endeavor. Now a breast and body imaging fellow at Memorial Sloan Kettering Cancer Center, Patel focused primarily on helping train radiology residents at Kilimanjaro Christian Medical Centre (KCMC) in Moshi, and at Muhimbili National Hospital (MNH) in Dar es Salaam — two of the biggest radiology residency programs in Tanzania.

How did you choose your location?

Timothy B. Rooney, MD, associate program director of the radiology residency at Dartmouth-Hitchcock, had a contact at KCMC who expressed interest in having radiologists come and train some of their residents, specifically in breast imaging. Dr. Rooney, who heads the global health elective, was also in contact with Frank J. Minja, MD, assistant professor of radiology and biomedical imaging at Yale University, who had an established contact with the residency program at MNH.

The project at KCMC involved putting together a breast imaging workshop for the residents and assistant providers, including a lecture series and a hands-on ultrasound-guided biopsy workshop on gelatin molds. The goals of the project at MNH were to aid curriculum development for the residents through a lecture series and to improve the efficiency and technology in the reading room by introducing a dictation software system.

Do you have any new goals for yourself based on your experiences in Tanzania?

Global health has always been an interest of mine. Through these projects I recognize how important continuous education is to make a lasting change in developing countries. Visiting a country and giving lectures to residents once is not enough. We need continuous effort to slowly bring about change. I hope to find a hospital or residency program in a developing country that may need help with training more radiologists — one that I will be able to return to on an annual or biannual basis to help bring about progress.

Why is the Goldberg-Reeder Travel Grant such an important initiative?

Many radiology residents and medical students don't recognize the need for global health work in radiology. Through grants like this, that awareness and support can be achieved.

Naiim Ali, MD Malawi, Namibia, and Uganda

Ali was chief radiology resident at the University of Vermont Medical Center in Burlington when he received the Goldberg-Reeder Travel Grant. Currently a fellow in abdominal imaging and intervention at Brigham and Women's Hospital/Harvard Medical School in Boston, Ali traveled to Malawi, Namibia, and Uganda with his grant. He focused on provider relations in Malawi and Namibia and patient relations in Uganda. Ali is a member of the board of trustees and a clinical affairs officer at Imaging the World™ (ITW), an organization that integrates low-cost ultrasound programs into remote healthcare facilities that often lack radiologists, other skilled personnel, and imaging equipment.

Did you meet with community resistance to new practices like radiology?

The first ITW ultrasound site was established in Uganda in 2010. For many patients and community members, ITW's introduction of ultrasound to rural clinics was the first time they had seen an ultrasound machine. Myths about the potential harms of ultrasound were rampant, often spread by traditional healers. Meeting with community members to discuss the benefits and risks of ultrasound and its potential impact in improving patient care was key in obtaining community buy-in.

What were the limitations you experienced?

We faced many challenges in implementing a new ultrasound system at Mercy James Centre (MJC) in Blantyre (one of the few providers of pediatric intensive

1. Andrew Olsen, DO, discusses an ultrasound result with Dr. Ruth Phiri.
2. Pictured left to right are Dr. Sabuni Mwimanenwa, Dr. Ruth Phiri, Andrew Olsen, DO, Dr. Suparna Sikdar, Dr. Lena Lambert-West, Dr. Chikumbi Chambwe, and Dr. Sarah Nshimbi at the University Teaching Hospital in Lusaka.
3. (Left to right) Timothy B. Rooney, MD, Krishna Patel, MD, and Matthew R. Caley, MD, perform an ultrasound-guided biopsy on a patient. The patient was referred by one of the breast surgeons (pictured back left) at the hospital.
4. Pictured left to right are Naiim Ali, MD, Moses Gondwe, clinical officer at Mtimabi Health Centre in Malawi, Asimwe Allan, IT lead with Imaging the World™, staff members at Mtimabi Health Centre (names unknown), and Chimwemwe Kaponda, an administrator with the Warm Hearts Foundation in Malawi.

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imagined Case Study



Saving a Community

In this fictionalized case study, can the radiologist at a struggling hospital convince administrators to establish a lung cancer screening program?

This is an imagined conversation between a diagnostic radiologist named Sara Roth, MD, and a patient who is an older smoker at risk for lung cancer. The setting is Crystal Plains Hospital, a fictional 200-bed hospital in rural Carteret County, N.C. Crystal Plains is not unlike hundreds of community-based hospitals across the country fighting to keep their doors open.

Our imagined conversation unfolds as Dr. Sara Roth, the radiology department chair, comes face-to-face with an opportunity to help improve patient care, generate a new downstream revenue source for her struggling hospital, and demonstrate radiology's value to the care team. But can she convince hospital administrators to establish a lung cancer screening program?

We join our scene, already in progress:

The radiology department receptionist, Angela, speaks with Mason Sharper, a patient in his early 60s. Mason's wife, Gayle, stands by his side.

Gayle: ... But there's got to be a way.

Angela: I wish there was something we could do. But like I said, we don't have a lung cancer screening program here.

Gayle: We need your help. You're supposed to help.

Mason: Gayle ... let's head on out.

Gayle: We are not going anywhere until we get some answers.

Angela: Mr. Sharper's primary care doctor has to make the referral first. The best I can do is have Dr. Erlich call Dr. Orson in Greenville.

Gayle: I can't believe there's no other option. Greenville is two hours from here.

Dr. Roth: (Entering) What seems to be the trouble?

Angela: I was just telling Mr. and Mrs. Sharper that we don't have a lung cancer screening program here.

Gayle: I'm worried my husband has lung cancer. He's older and smokes a lot. We've read that CT scans can find lung cancer early, if they're set up right.

Mason: Except they don't have the setup for it here, dear.

Dr. Roth invites the couple to her office so they can speak in private. She closes the door and offers them a seat. Mason is visually uncomfortable, reluctant to talk about what he's experiencing. Dr. Roth pours Mason and his wife a cup of coffee.

Gayle: Well go on, Mason. Tell the lady.

Mason: You see, first it was my brother Elden. He's smoked two packs a day forever. Then last year, he was diagnosed with lung cancer. He's gone downhill fast.

Gayle: Mason's a heavy smoker too, so naturally we're concerned.

Dr. Roth: We're not here to judge. Some people worry everyone will think they brought lung cancer on themselves, but that's not our M-O here.

Mason: Anyhow, we came here since you are the experts. But since you don't have the setup ...

Dr. Roth tells the couple that while they do have a CT scanner on site that can do the test, they haven't set up a screening program, mainly due to funding — or the lack thereof. Gayle says that going all the way to Greenville is hard on them, since they can't rely on their 1996 Bonneville over that distance.

Beyond that, their friends and family all work and can't take time off to drive them. Then Mason says something that stops Dr. Roth in her tracks: He knows at least two dozen other heavy smokers who should all get screened.

Identifying a Community Need

Dr. Roth leaves the room in a rush, promising to return. Moments later, she tracks down the hospital president, Proctor Barnstable, and pulls him in to speak with the couple. They exchange greetings.

Dr. Roth: Mr. Sharper worries he might have lung cancer. And he knows more people who need to get screened — a lot more people.

Gayle: My husband has friends at the Elks Lodge who'd all sign up if he told them to. If you had a program, that is.

Barnstable: Lung cancer screening programs are important. I'm sorry to say we've had our share of challenges trying to set one up here. In all honesty, we can't jump over a nickel to save a dime.

Gayle: Consider helping us, Mr. Barnstable. My husband's life may depend on it.

Once the Sharpers leave, Dr. Roth makes her case to the hospital president: They could do a lot of good for the community if they started a lung cancer screening program. But Barnstable rightly worries about funding such a program, especially since most of the patients the hospital serves are either uninsured or Medicaid recipients.

Dr. Roth suggests covering screening for underinsured and uninsured patients with a grant from the hospital foundation. She also notes that in the long run, in addition to saving lives with early treatment and meeting a desperate community need, lung cancer screening could open up a whole new downstream revenue source for the hospital, allowing onsite doctors to treat patients who turn out to have lung cancer.

Beyond that, Dr. Roth contends that if they help enough patients, the program will pay for itself: They'll make use of their CT scanner during the day and run lung cancer screenings during downtimes, early in the day and late in the afternoon. Or, better yet, they can work the screenings in between other exams. These are relatively quick exams since no IV contrast is necessary. To market the program, they'd invite self-referrals and rely on word of mouth.

Since quite a few potential lung cancer patients have come in inquiring about scans lately, Barnstable agrees to allow Dr. Roth to develop a proposal for the next board meeting. Over the ensuing weeks, she researches a plan to establish a lung cancer screening program at the hospital.

Laying the Groundwork

During her extensive research, Dr. Roth finds that she must assemble a dynamic team that includes not just radiologists but also a pulmonary medicine specialist, a thoracic surgeon either within their hospital or locally to whom they can refer a small number of patients, a primary care physician to help with outreach, and tobacco treatment experts. In addition, most lung cancer screening programs have a clinical coordinator or nurse navigator who, among other things, helps patients determine whether or not screening is right for them.

After finalizing her plan, Dr. Roth presents her business case to the board. In attendance are a few department heads she'll need to win over to her effort. She stands at a lectern and walks the group through her PowerPoint presentation. Before long, everyone is engrossed in the charts and graphs that appear on the large screen behind her.

Armed with her research and supercharged by the warm reception she received at the board meeting, Dr. Roth begins visiting the heads of each of the relevant hospital departments to recruit the lung cancer screening team. At each stop, she shares her ambitious target for the program: Enlist 50 patients in the clinic during year one, then add 50 additional patients each subsequent year for the next five years.

The final leg of Dr. Roth's planning efforts involves enrolling patients. Deciding to cast a wide net, she will sign up lung cancer screening candidates from the surrounding counties, in addition to relying on referrals. To this end, Mason Sharper invites her to an Elks Lodge meeting, where she gives a modified version of her PowerPoint presentation. Half of the three dozen members in attendance ask for an appointment before she leaves. **B**

By Chris Hobson, senior communications manager, ACR Press



Have a suggestion for a future case study?

Imagined Case Studies envision scenarios that radiologists will likely encounter at some point during their careers. These fictionalized stories impart lessons and promote discussions that radiologists can apply every day in real-world practice. Share your ideas with us at acr.org/CallforCaseStudies.



Michael Booker, MD, MBA, is a radiology resident at the University of California, San Diego, and an ACR Moorefield Fellow.

How do you approach conversations about medical issues with family members?

A family member recently had a series of imaging studies performed and asked me to clarify a few findings in the report. Many were boilerplate for people their age (fat containing inguinal hernias, white matter hypertensive change, multilevel degenerative disc disease), but they generated apprehension and anxiety. I wish we, as radiologists, had a better way to communicate to patients when we think findings are normal — or at least fairly normal — the same way I was able to do with this individual.

Given that patients have increasing access to medical records, does the fundamental approach to the radiology report need to change? On one hand, if I stopped mentioning benign findings, would my thoroughness be brought into question? Am I even provided enough patient history to make these determinations accurately? Standardized reporting encourages us to comment on the appearance of every organ, but it is much harder to omit minor findings when the alternative is asserting “unremarkable.” There is no easy answer, but we can save our patients some undue anxiety by better contextualizing findings within an expected normal range. Resources such as the Lumbar Imaging with Reporting of Epidemiology Protocol for degenerative lumbar spine changes and the Diagnostic Imaging 2018 – Quality Measures (developed by an ACR multidisciplinary technical expert panel) already provide roadmaps for just this purpose. And you may even save your family members from undue stress and anxiety. **B**

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Connecticut – Danbury Radiological Associates, a subspecialized group practice in the southwest Connecticut/northern New York suburbs, seeks a fellowship-trained breast imager. The responsibilities will entail a substantial amount of breast imaging, along with some general radiology (primarily cross-sectional imaging and radiography). Danbury Radiological Associates covers a busy, multidisciplinary breast center, a second-large mammography practice, Danbury Hospital, New Milford Hospital and multiple offices.

Contact: To apply, send CVs to ToniAnn Marchione at dratoniann@comcast.net.

Michigan — A private group in Rochester, Mich., has a partnership-track position for a fellowship-trained IR starting Jan. 1, 2019. The candidate is expected to participate in general rotations and PET/CT skills are a plus. The hospital-based practice is in a suburban setting with a state-of-the-art interventional suite. The applicant should be fellowship-trained and/or CAQ-certified.

Contact: To apply, send CVs to Katherine Scharer at kscharermd@gmail.com.

Utah — Utah Radiology Associates is seeking a full-time diagnostic radiologist (DR) for musculoskeletal and/or neuroradiology. The candidate will also read mammography and rotate through all DR shifts. The overnight shift is optional and is paid a differential. Utah Radiology Associates is a progressive, 25-provider, physician-owned group.

Contact: To apply, send CVs to radjobs@utahradiology.com.

Remote — MedStar Medical Group Radiology, the radiology practice for MedStar Health, is expanding their team of full-time radiologists to cover ER and trauma imaging during evening and night hours. The work can be done remotely. A full range of benefits is available. The group will consider candidates located throughout the United States.

Contact: To apply, send CVs to James Jelinek at james.s.jelinek@medstar.net.



A handwritten signature in blue ink, appearing to read 'Amir Hedayati'.

AMIR HEDAYATI, MD
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- **COAST-TO-COAST POSITIONS**

Reasons to Choose Us

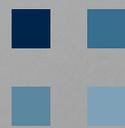
- Physician-led practices supported by fellow physicians within our local, regional and national level infrastructure
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Comment on 2019 ACR Practice Parameters and Technical Standards

- September 24 – October 12
- October 15 – November 2

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Carrie is a former ACR employee who volunteered to participate in this advertisement.