Changing Tides
Riding the wave of retirement
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- Allocating bundled payments
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FEATURE

10 Changing Tides
Because the time needed to bring a new physician up to speed is substantial, the retirement wave matters for all members of a radiology group.
The Future Is Now

New power dynamics can help us find our place in an old-power world.

The opportunities and challenges of finishing training and beginning a career in the current medical landscape are multifaceted: mounting medical school debt, burnout, corporatization, and anxiety about AI and its implications for the profession, to name a few. However, emerging radiologists are also benefiting from a robust job market and exciting new technological advances.

The YPS represents this group of over 6,000 radiologists, who are in their first eight years of practice after training or under the age of 40. YPS members have risen to many unforeseen challenges in radiology, while also positioning themselves and the subspecialty for success beyond the reading room. Many YPS members are seizing opportunities to consult for AI companies and to improve workflows in their practices.

We are fortunate to have Geraldine B. McGinty, MD, MBA, FACR, at the ACR’s helm to provide us with new opportunities to engage our membership. Her leadership style, which incorporates many elements of “new power” dynamics (based on the book New Power: How Power Works in Our Hyperconnected World — and How to Make It Work for You), has opened countless doors for RFS and YPS involvement in the leadership of the College. In December 2018, the YPS, the ACR Senior and/or Retired Section (SRS), and @RadiologyChicks hosted an enthusiastic book club discussion on this topic of new power, with author Henry Timms and SRS Chair Catherine J. Everett, MD, MBA, FACR, serving as panelists. It is these types of collaborations between generations that will help all of us better understand each other and ultimately result in quality care for our patients.

The concepts of mentorship and sponsorship are also being embraced by the ACR leadership. These types of relationships are essential to the success of individual radiologists and the profession as a whole. As YPS members emerge as private practice leaders and begin to head academic divisions, this type of training grows in importance. The need to plan for smooth leadership succession is essential, and YPS members have access to radiology experts and thought leaders in the field. The more seasoned members of the College are eager to provide mentorship and advice to our mid-career members. Many of the connections that lead to these strong relationships are starting over social media, which RFS-YPS Liaison Amy K. Patel, MD, noted during her Fast 5 presentation at RSNA 2018: “We are all equals on social media.”

Social media allows YPS members to directly reach out to key players, such as patients, presidents of large private practice groups, the ACR BOC, AI companies, and those who are working specifically in a particular area of interest. The new power concept of transparent communication led YPS Social Media Liaison Taj Kattapuram, MD, to be invited as a Grand Rounds speaker after an exchange on Twitter.

I am optimistic that the ACR will always be at the forefront of advocating for our patients and profession. The ACR Commission on Patient- and Family-Centered Care is an excellent example of the type of forward-thinking we need to adapt to our changing practice environment. As we transition from volume to value-based medicine, the expectations of a radiologist will change dramatically. Dania Daye, MD, PhD, a radiology resident at Massachusetts General Hospital/Harvard Medical School, co-led the implementation of a virtual consult program directly connecting radiologists to patients (read the full Imaging 3.0® case study at acr.org/Virtually-Connected).

The ACR understands the changing needs of our patients and the fluid definition of what a career in radiology is going to mean for the generation coming into practice now. Despite the challenges the YPS section faces, I believe a career in radiology will continue to allow us to be fulfilled and intellectually stimulated, as we provide excellent patient care.
TMIST and DBT: A Game Changer for Breast Imaging

During a session held at RSNA 2018, practice leaders were encouraged to participate in the first large randomized controlled trial that would identify women for whom digital breast tomosynthesis (DBT) may outpace 2D digital mammography in reducing the occurrence of advanced-stage breast cancer. The Tomosynthesis Mammographic Imaging Screening Trial (TMIST) will be comprised of 165,000 healthy women, ages 45 to 74, at 130 sites throughout North America. “Decision-makers rarely update clinical or payment policy without randomized controlled trial data,” says Etta D. Pisano, MD, FACR, principal investigator and ACR Chief Research Officer. “I urge imaging practices to take part in TMIST and help shape future breast imaging care.”

For more information, visit acr.org/TMISTTrial.

Now Available: Special Edition Module on Adult Cancer Imaging

Learn key aspects of imaging diagnosis and pitfalls for a variety of adult malignancies in the new Adult Cancer Imaging Special Edition Module 2019 from the ACR Continuous Professional Improvement™ (CPI) program. This comprehensive module, chaired by Annick D. Van den Abbeele, MD, FACP, Angela A. Giardino, MD, and Christopher G. Sakellis, MD, and written by a panel of CPI cancer imaging experts, includes at least 50 self-assessment questions and offers up to 8 CME/SA-CME. Choose the print publication or the online examination and receive a free e-book copy. Members save $35 per module when selecting six modules through a customized CPI Select Six Series.

Learn more at acr.org/cpi.

Update Your Profile on ACR.org

The ACR.org website is designed to meet individual members’ interests. Based on the profile and practice information you enter in your My ACR profile, the content you see on acr.org (when you’re logged in) will be tailored to your specific needs. Allowing us to know more about you also helps us to assess gaps and develop appropriate programs and services for you. Finally, take some time to complete the diversity and practice information on your My ACR profile!

Get started through the My ACR tab on acr.org.

ACR Application Now Available Online

ACR is seeking eligible applicants to apply for the degree of Fellow. FACR is among the highest honors bestowed on a member. Members of good standing having at least 10 consecutive years of membership and volunteer contributions to leadership positions are among the criteria to achieve this honor. This designation symbolizes exceptional achievement in the fields of diagnostic radiology, IR, nuclear medicine, radiation oncology, and/or medical physics. Applicants are encouraged to confer with their chapter associations to meet deadlines for chapter review which is the first stage of the candidacy process.

Learn more and apply at acr.org/FACR.

Value in Breast Imaging

Registration for the largest breast imaging conference in the world, the Society of Breast Imaging’s annual symposium, is now open.

During this year’s symposium, which will take place April 4–7, 2019, in Hollywood, Fla., attendees will learn how to improve interpretive accuracy using all modalities, learn about new and important aspects of multidisciplinary care during the mock tumor board, and understand how to navigate new FDA quality requirements.

To register for the meeting, visit SBI-online.org.

New CME Activity: Exploring Changes to Payment Policy

As the focus of reimbursement moves from fee-for-service to a value-based payment model, understanding reporting requirements and thresholds will be critical to thriving under the Quality Payment Program. The new module challenges participants to better understand this shift and provides tools to enable a successful transition. Participants can earn 3 AMA PRA Category 1 Credits™ upon completion of the free activity.

To access the module through your ACR account, visit bit.ly/Payment_and_Policy.
Application Process Open for Goldberg-Reeder Travel Grant

Diagnostic radiology and radiation oncology residents and fellows who want to volunteer in low-to-middle income countries can apply for the Goldberg-Reeder Resident Travel Grant. Awarded by the ACR Foundation, the grant was established to encourage international volunteer service among members-in-training. Since 2008, 39 residents and fellows have received the grant and traveled to 25 countries to contribute to radiology and healthcare efforts. Applications are now being accepted for 2019; the deadline is June 30, 2019.

For more information, visit acr.org/Goldberg-Reeder.

Global Humanitarian Award: Nominate Yourself or a Colleague Today!

Do you volunteer your radiological care to an underserved population in a low-to-middle income country? Do you know a colleague providing radiological care as a volunteer abroad? You or your colleague may be eligible for a Global Humanitarian Award. Established by the ACR Foundation, the award recognizes outstanding individuals and organizations for their extraordinary volunteer efforts to improve radiological care in underserved and developing areas. Award applicants can be self-nominated or nominated by a peer. The winners of the 2019–2020 Global Humanitarian Awards will be announced at ACR 2020 in Washington, D.C. The deadline for submission is Aug. 31, 2019.

Information about the award and past winners can be found at acr.org/ACRF-Award.

New Value-Based Imaging CME Activity for Referring Clinicians

As part of R-SCAN®, a new podcast on adult minor head trauma is now available in the Value-Based Imaging Activities series. Radiologists and an emergency physician discuss when CT imaging is appropriate in cases of minor head trauma in adults. The series, which consists of educational activities for referring clinicians to optimize image ordering based on evidence, offers free 10-minute podcasts that discuss strategies of image ordering and highlight how ACR Appropriateness Criteria® support Choosing Wisely® recommendations.

To access Adult Minor Head Trauma and other podcasts with a free ACR login, visit acr.org/AppropriateImagingActivities.

Many American families now cite the cost of healthcare as their biggest financial concern, and as many as 1/3 of U.S. adults have gone without recommended care, did not see a doctor when sick, or failed to fill a prescription due to cost.

—Pamela T. Johnson, MD, vice chair of quality and safety in the department of radiology at The Johns Hopkins Hospital. Read more at bit.ly/RadInvaluabletoValue-BasedCare.

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## CALENDAR

### February

1–3 Society for Pediatric Radiology
Pediatric MSK Imaging Course, Denver

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

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

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

11–13 American Institute for Radiologic Pathology (AIRP®) Correlation Course, AFI Silver Theatre and Cultural Center, Silver Spring, Md.

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

28–29 Transcatheter Aortic Valve Replacement, ACR Education Center, Reston, Va.

### March

4–5 Nuclear Medicine, ACR Education Center, Reston, Va.

11–13 Neuroradiology, ACR Education Center, Reston, Va.

15–17 Cardiac MR, ACR Education Center, Reston, Va.

10–11 AIRP Correlation Course, AFI Silver Theatre and Cultural Center, Silver Spring, Md.


### April


8–11 AIRP Categorical Course: Thoracic and Cardiovascular, AFI Silver Theatre and Cultural Center, Silver Spring, Md.

17–19 MSK MR (Elbow, Wrist/Hand, and Specialized Topics), ACR Education Center, Reston, Va.


25–27 Breast Imaging Boot Camp With Tomosynthesis, ACR Education Center, Reston, Va.

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### SPOTLIGHT ON IMAGING 3.0

#### Waiting for Results

When Jennifer L. Kemp, MD, FACR, had a personal experience with the anxiety that comes with awaiting imaging results after a scan, she decided to try to do something about it. Thirteen years ago, Kemp’s husband was diagnosed with stage 3 rectal cancer, and she saw “the absolute terror that [he] went through as he awaited the results of every CT scan.” According to Kemp, “Before that, I didn’t realize how many of my patients were going through the same thing.”

Subsequently, Kemp developed a consultation program in which the radiologists on her team deliver results to patients immediately after their imaging exams. With some planning, work, and collaboration, Kemp and her team were able to improve patient, radiologist, and physician experiences through this new patient-centered initiative.

To read the full case study, visit acr.org/Imaging3-InstantResults.

#### Early Detection Is Key

Recognizing the need for a system by which patients could access lung cancer screening early enough to make a difference for their prognosis, radiologists at Elkhart General Hospital (EGH) in Indiana partnered with that state’s existing smoking cessation group to establish a lung cancer screening program. Since the program’s founding in 2012, the EGH team has diagnosed 29 lung cancers — more than 50 percent of which were stage one. “As a radiology department, we are committed to offering new services that will improve patient health,” says Albert W. Cho, MD, vice chair of radiology at EGH. “We had been interested in developing a lung cancer screening program for a while to address this public health crisis. Once we had the LDCT capability and buy-in from other departments, we saw an opportunity to help drive the implementation.”

Read the full case study at acr.org/Imaging3-BreatheEasier.

#### Assuaging Patient Anxiety

When John F. Feller, MD, medical director and founding partner of Desert Medical Imaging, served on the committee that ultimately established RadiologyInfo.org 20 years ago, a survey showed that 80 percent of people had no idea what radiologists did or how they did it. “As imaging experts, we saw it as our responsibility to address this information gap,” Feller says. “With people increasingly turning to the web for information, we decided to create a website that patients and families could access any time to learn more about radiology and get answers to questions about specific imaging exams.”

RadiologyInfo.org is now home to plain-language video and text descriptions of more than 240 radiological procedures. The resources are available in English and Spanish. In this case study, Feller and colleagues discuss how they are encouraging patients to use the website to educate themselves on their imaging procedures and on the field in general. “When patients arrive for their exams well-informed,” Feller says, “they have fewer questions and feel less anxious about their procedures, saving radiology practices like mine time and money while improving patient care.”

To access the case study, visit acr.org/Imaging3-CalmingPatientsFears.
QPP in Year 1

How did radiologists do in the first performance year?

The Quality Payment Program (QPP) performance scores are in for 2017 — the first performance year under the QPP. These results provide an early glimpse into how physicians and other healthcare providers fared under the program. In general, physicians (including radiologists) did quite well in year 1, but the bonus payments were underwhelming.

Before discussing the 2017 results, let’s review some basics. The QPP has two payment arms: the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). A hybrid of the two, called the MIPS-APM, also exists. Of the two payment arms, the more commonly reported one is MIPS. Under MIPS, all eligible providers, referred to as eligible clinicians (ECs), receive a score from 0 to 100. A threshold score is assigned above which a positive adjustment (bonus) is earned and below which a negative adjustment (penalty) is incurred. ECs who participate in an advanced APM at a required level of either payment amount or percentage of patients are exempt from MIPS. They receive an additional bonus and are referred to as qualified providers (QPs).

In 2017, more than a million physicians and qualified healthcare providers participated in the QPP. In round numbers, there were 1 million MIPS ECs, 100,000 QPs, and approximately 50 MIPS-APM participants. CMS labeled 2017 as a transitional year, which made participation — and avoidance of a penalty — relatively easy. The 2017 threshold score of 3 took minimal effort to satisfy, and the ability to score even higher on the 0–100 scale proved quite attainable. Among the 1 million MIPS ECs, the median performance score was 89. Those practices reporting via the group option did better than practices reporting as individuals (the median was 91 for group reporting versus 60 for individual). Large practices did better than small practices (90 for large versus 38 for small). About 95 percent of ECs either scored neutral or received a bonus. A remarkable 71 percent received a performance bonus and an additional positive adjustment for exceptional performance. Only 5 percent of MIPS participants (see table) suffered a penalty.¹

What do these high scores mean in dollars and cents? MIPS is a budget-neutral system, meaning losers pay winners. Since there were few losers in 2017, the required budget neutrality scaling factor was less than 1 (0.3 to be exact). As such, even with the exceptional performance funds earned, the maximum positive adjustment for a perfect score of 100 was only 1.88 percent.¹ The maximum penalty was 4 percent.

The QPP will continue to evolve. Full implementation was intended for 2019, but this date has been delayed due to the Bipartisan Budget Act of 2018.² Regardless, the performance threshold will increase from 15 for 2018 to 30 for 2019. The exceptional bonus threshold is also increasing to 75 for 2019. As a result of these updates, participation will require greater effort by ECs to avoid a penalty and to score favorably. The percentage bonus may increase, as there will be more losers to pay winners. This may provide more motivation and justify investment.

Two trends are especially relevant: large practices performed better than small practices and the group reporting option allowed for higher scores. The value of group reporting was recently validated by researchers who found a larger number of reported measures, in addition to higher scores.³ The development of advanced APMs has been slow. Most radiologists will be paid through fee-for-service for the foreseeable future, which makes MIPS especially relevant to us. Moreover, our QPP results will be available to the public via the Physician Compare tool on Medicare’s website. The Commission on Economics and the Commission on Quality and Safety remain committed to helping our members succeed in the QPP.⁴

ENDNOTES

Year 1 by the Numbers

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<tr>
<th>Positive and Exceptional Performance Adjustment</th>
<th>Positive Adjustment Only</th>
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<td>71 percent of participants</td>
<td>22 percent of participants</td>
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<th>Neutral Adjustment</th>
<th>Negative Adjustment</th>
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<td>2 percent of participants</td>
<td>5 percent of participants</td>
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<th>Overall Median Score</th>
<th>Group Reporting Median</th>
<th>Individual Reporting Median</th>
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<td>89 out of 100</td>
<td>91 out of 100</td>
<td>60 out of 100</td>
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<th>Large Practice Median</th>
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<td>90 out of 100</td>
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AI Use Cases:
What Radiologists Need to Know

While computer science experts understand how to train computers, it falls to radiologists to help AI developers understand which problems need to be solved to improve patient care.

Working to solve problems that don’t exist is a waste of everyone’s time. Preventing that fruitless pursuit is a key goal of the ACR Data Science Institute™ (DSI) Data Science Subspecialty Panels.

Use cases are the mechanism by which DSI communicates to the AI developer community the tasks AI could perform that would be useful to radiologists and could improve patient care. More specifically, a use case is a narrative description and flow chart defining the goal of an AI algorithm — including required clinical inputs — and describing how the algorithm would best integrate into radiologists’ workflows alongside other radiology tools.

Why Develop Use Cases?

While computer science experts understand how to train computers to process images, they often do not understand which parts of a radiologic study are most relevant to patient care. As radiologists, we take this knowledge for granted. For someone with no medical background, however, it is next to impossible to determine what is clinically relevant without some guidance.

Clinical relevancy may involve identification of specific imaging findings, accurate quantification of imaging biomarkers, classification of pathological conditions, or a change in appearance from an earlier study to a later study. Even when algorithms are capable of identifying a clinically relevant finding or pathological condition, it is important to ask: Is this a problem worth solving?

While an AI algorithm could train a computer to count the fingers on a hand radiograph, there would be no benefit to the radiologist reading the study. A better alternative would be a narrow AI system that could quietly evaluate every visible scaphoid bone on a hand or wrist radiograph, then alert the radiologist when it detects a fracture.

An algorithm that supports detection and classification of certain fractures also would be a welcome addition to most radiologists’ armamentarium, if it is integrated with existing systems and doesn’t hinder the workflow. To be accepted by the market and provide value-added patient care, an algorithm will need to be clinically useful and readily integrated into radiologists’ standard workflow. And that’s where the ACR DSI Data Science Subspecialty Panels come in.

How Are DSI Use Cases Novel?

ACR formed the DSI in 2017 with the goal of creating a framework for implementation of machine learning in the radiological professions. From the start, DSI set out to define clinically relevant use cases for the development of AI algorithms in medical imaging, IR, and radiation oncology. The Data Science Subspecialty Panels were formed early on to begin considering a broad range of possible use cases for AI and make recommendations on their potential impact.

The panels are comprised of radiologists with diverse backgrounds and include both academic and private practice radiologists. Panel members collaborate to identify relevant AI use cases and prioritize them for use by developers to build relevant AI algorithms. Some panels include radiologists who spend a significant portion of time in industry. These panel members understand the perspective of a radiology software/services vendor and can provide input as to which projects are feasible and which are unrealistic at this point in AI development.

How Do the Use Case Panels Work?

The dozens of volunteer experts recruited by DSI in 2017 to begin developing use cases were tasked with creating a usable framework for AI algorithm developers, then build on that framework to create clinically relevant use cases. Panel volunteers included physicians, medical physicists, data scientists, and software engineers, among others.

Once the panels were assembled, each radiologist was asked to submit two or three problems from their practices that might be amenable to an AI solution. Panelists then made “elevator pitches” for their concepts during panel meetings and other panel members provided comments.

At this early stage, ideas for potential use cases were only discarded if the panel felt they were not within the
Changing Tides

Radiologists approaching retirement may have a sustainable role in a swiftly moving healthcare landscape.
When considering what the future of radiology will look like— maybe 10 years from now—you might have visions of AI commanding imaging practices. You may see women and minorities assuming top leadership positions. Perhaps you believe behemoth healthcare groups will continue swallowing up smaller practices. Your best guesses aside, one future change is certain—a significant, aging physician workforce will give way to younger radiologists with different skill sets.

It behooves the radiology leaders of today to recognize the coming transition and prepare for fewer staff and changing roles. “There are radiologist shortages already, especially in rural areas,” says Catherine J. Everett, MD, MBA, FACR, chair of the ACR Senior and/or Retired Section and a diagnostic radiologist at Coastal Radiology in New Bern, N.C. “There are not enough people to do the work, practices don’t have enough resources, and healthcare is changing and increasingly dependent on imaging.”

A national shortage of specialty physicians—potentially upwards of 31,000 by 2030—poses a real risk to patients. With the baby boomer sector of the workforce nearing retirement age, many radiology managers will be looking for emerging leaders to sustain their practices. Because the time needed to bring a new physician up to speed is substantial—and with a third of practicing full-time radiologists now age 55 or older—the retirement wave matters for all members of a radiology group.

Trusted Resources

“You can’t teach experience; it just comes with time,” notes Efrén J. Flores, MD, officer of radiology community health improvement and equity at Massachusetts General Hospital. “When I sit down with a more senior radiologist, it’s a fascinating learning experience,” he says. “Just listening to how they approach the cases and listening to stories about the department—how it once was and how it has evolved—is helpful. You can’t afford to disregard that kind of information.”

Keeping experienced radiologists can benefit everyone, Flores believes. According to Flores, phasing out of the everyday routine of full-time clinical work can be difficult for more senior radiologists who are accustomed to performing at a high level all the time. “But taking on new roles within the organization can lead to valuable mentoring opportunities to junior faculty, in addition to the education of students and other specialists, with whom they are a trusted voice,” he says.

A primary care doctor, for example, who is accustomed to listening to and learning from a particular radiologist about X-rays or CT scans will feel the effect of that specialist’s retirement, Flores says. “Senior radiologists also have a lot of leverage at radiological society events and state chapter meetings,” he says. “Their words may carry more weight because they have experienced certain situations firsthand.”

Changing Roles

A quarter of radiology practice leaders surveyed report at least one radiologist retiring from their practice in the past year. Those same leaders say they still employ a once-retired radiologist “in some capacity.” This is telling in two ways. One, high-functioning physicians may be reluctant to step away from lifelong service altogether. Two, there are challenging gaps to fill when they leave.

Giving senior radiologists as many options as possible when nearing retirement can alleviate transition anxiety. “We’ve had some success letting people phase out over a four-year period,” says John J. Cronan, MD, FACR, chair of diagnostic imaging at Rhode Island Hospital and professor at Brown University School of Medicine. “They start out working a four-day work week, then a three-day week, two days, and so on. They only take call for the first year or so and then there’s no call at all.”

Many senior radiologists want to remain an active part of a group if they feel their contributions are still valuable, Cronan says. That may mean consulting for hospitals or assuming an advisory committee position. But there is plenty of clinical work too if they want it, he notes. “I know a radiologist who came back to work just to read plain films,” Cronan says. “The younger doctors don’t want to do that. They’ll read an MRI over an abdominal X-ray.”

Readying for Retirement

Planning for retirement includes being psychologically ready to let go of a full-time work routine while creating a meaningful and enjoyable new lifestyle. So how can radiologists successfully transition from full-time work to retirement?

• Work part-time for busy practices or academic centers. Many groups need help in areas that younger radiologists have less experience in or prefer not to spend much time on, such as reading plain film, chest X-rays, fluoroscopy, etc.

• Provide locum tenens coverage. The absence of an experienced radiologist who has seen a little bit of everything during her career can wreak havoc for managers.

• Offer seasonal or as-needed relief. Some senior radiologists are happy to fill in for younger colleagues during the holidays or when childcare or family matters need attention.

• Teach and consult. Older radiologists may enjoy sharing what they’ve learned over the years or getting involved in quality improvement activities—serving as a hospital representative or heading up an advisory committee.

• Volunteer. Multiple national radiology groups (ACR, RSNA, etc.) and subspecialty societies are in need of physician specialist volunteers who won’t shy away from a large time commitment. There’s also a need for radiologists abroad in poor and underserved countries.
DID YOU KNOW?

More than $\frac{1}{3}$ of today’s active physicians are projected to turn 65 within the next 10 years — and many may retire before age 65.¹

According to the Association of American Medical Colleges, physicians ages 35 or younger are projected to work 13 percent fewer hours than earlier cohorts.²

Radiologists are retiring earlier now than they did 10 years ago, in part because they are better off financially than they were during the radiology job drought of 2010.⁴

40% of radiologists who retired in 2017, were 65 years of age or younger.³

ENDNOTES

There is an underestimated need for general radiology skills, says Travis Singleton, executive vice president at Merritt Hawkins, a national physician search/recruiting firm. “A subspecialist radiologist coming out of training or fellowship is not close to what a radiologist was 10 years ago when you look at productivity patterns,” he says. “My message to employers is that the majority of the general radiologists you have left are the ones who are nearing retirement. They are going to slow down at some point and leave, and their replacement is going to be more subspecialized and work much less if current production holds. The numbers I have seen indicate that average RVUs per radiologist have declined from 10,200 in 2006–2007 to 8,907 in 2016 — a clear indicator of where things are going.”

“We love fellowship-trained subspecialists,” notes Everett. “But you’ll come across some who can’t do anything outside their subspecialty. So there may be a huge shortage of radiologists with light IR skills, for instance, who can function in a smaller, 100-bed hospital.”

Keeping senior radiologists around longer — in some capacity — could mitigate these types of potential problems. Phasing-out strategies requiring less volume, targeting select modalities, and mandating fewer on-call shifts can incentivize older radiologists. Still, there are other factors that make it difficult for managers to accommodate everyone.

Generational Drivers

Discussing options to keep more senior radiologists active within a group can become a contentious conversation with younger members pushing for change. Radiology leaders should be mindful of personality clashes that may disrupt workflow or compromise quality of care.³

“You need some incentives for the older radiologists to stay,” Cronan says, “but you also need new blood coming in.” Fewer personal relationships with colleagues can drive older radiologists into retirement, Cronan says, and there’s probably no way to fix that. But they may also be encumbered by the newer computer systems and administrative tasks that may not seem as formidable to younger radiologists.

When building your future staff, “your practice really needs a good mix,” Flores says. “You should embrace senior members but have an even mix of mid-career and young faculty.” The mid-career radiologists need to transition at some point to the senior level positions, he says, while senior radiologists can offer guidance to younger staff while taking on smaller roles. “We all need to go through the right steps to move up to the next spot in line,” says Flores.

As the shuffling of radiologists, from older to younger, plays out over the next decade, certainly workforce demands will change. For now, the radiology job market is robust, Singleton says. Salaries are generally not a source of concern for job seekers, he adds. They focus more, he says, on finding a position that puts their subspecialty skills to use while working fewer hours. “It’s already hard to find enough ‘boots-on-the-ground’ general radiologists to fill positions and cover the work. Five years ago, we thought these jobs would be irrelevant, and it hasn’t proven to be that way,” Singleton says.

“As radiologists, we are on the forefront of healthcare and technology,” Flores says. “But we still need to foster professional relationships and interact with those who’ve paved the way for us. Embrace them while you still can.”

By Chad Hudnall, senior writer, ACR Press

ENDNOTES
The Art of the Apology

Patient conversations following a life-changing diagnosis or medical error may prove challenging to unprepared radiologists.

As imaging continues to drive clinical diagnosis, it has become a source of medical errors. Most of these errors are attributable to radiologists’ interpretations — through missed, incorrect, or delayed diagnoses.¹

In a recent interview with the ACR Bulletin, Stephen D. Brown, MD, associate professor of radiology and ethicist at Boston Children’s Hospital/Harvard Medical School, discussed what he sees as a growing need to train radiologists and their teams on how to communicate more confidently and compassionately with patients following an adverse event. Difficult patient conversations often call for disclosure of a mistake and an apology to patients and their families.

What type of training could help physicians facilitate patient conversations following a mistake?

You need training targeting high-risk, low-frequency events. Clinicians should practice in a controlled, mentored setting before having to engage in real-time under great stress. We’re all human, and apologies are hard — but they get easier for everyone when you’re prepared to be straightforward. Radiologists can gain much from this kind of training, especially since recognizing the need for compassionate error disclosure is relatively new. The ACGME is now recommending communications skill-building for trainees, particularly around adverse events. The fact is that all of us, even those of us in the field for a long time, can benefit from this training.

Why are frank and in-person talks critical in radiology?

Patients may never meet their radiologists, but evolving best practices suggest they should. You never want patients to find out about unfavorable findings or medical mistakes through an online portal. They should find out through direct, open, and honest communication. Furthermore, patients who feel like they have been dealt with openly and honestly may feel more positive about treatment and be less likely to litigate. Poor communication around errors can also generate substantial clinician distress. Conversely, good communication with patients after errors may help physicians heal themselves.

How can timely and thoughtful conversations contribute to a better patient experience?

First, patients get the information they need when they need it, so they can make the best and most timely decisions for themselves. If there are financial repercussions for a serious error, they can seek the compensation they need when they need it — not 10 years later. Many patients know that errors occur, and they may access their portals to read their reports. What if they read, for example, that a lesion was present earlier and nothing was done about it or it went undetected? They could lose trust and faith in the entire healthcare process. Open conversations when an error occurs can provide the emotional validation patients need to move forward.

How can apology and disclosure training help when treating underserved patient populations?

Certain populations have experienced significant healthcare disparities and may have legitimate historical and cultural distrust of the medical system. To empower them and validate their experience, open and honest communication offers the optimal path. If you hide something and a patient or family finds out later another way, you are likely to undermine their faith in care going forward — and to continue systemic inequities.

In radiology, what is the biggest challenge to disclosing errors and initiating an apology?

Although patients hope for and expect disclosure, there’s still a culture in radiology that underappreciates what the purpose is, what the thresholds are, and when disclosure is appropriate. Let’s say someone on your team makes a reasonable interpretation that turns out to be incorrect and leads to a delayed cancer diagnosis. You may encounter considerable debate and conflicting guidance over whether to disclose or discuss it with the family. As a specialty, we need a common framework for understanding what’s appropriate and what to do. There are workshops that provide the when, why, and how for having a conversation.

What’s available to radiologists interested in improving their disclosure and apology skills?

I direct my hospital’s Institute for Professionalism and Ethical Practice (IPEP), which works globally, training institutions, teams, and clinicians with a hands-on approach using unscripted simulation situations. For

continued on page 21
Proving Our Value in the RBRVS

Radiologists must understand the building blocks of current FFS payment systems as medicine transitions to a value-based reimbursement landscape.

After three years attending and participating in the AMA/Specialty Society RVS Update Committee (RUC) — which makes recommendations to CMS on assigning appropriate relative values for Current Procedure Terminology (CPT®) codes — I strongly feel that more radiologists should understand the valuation process. As we prepare for changes in the healthcare system, the reality is that future value-based payment systems for radiologists will likely be predicated on the principles established by the resource-based relative value scale (RBRVS).

CPT and RUC Processes

Fee-for-service-based reimbursement comprises two central pieces: coding and valuation. Those are encapsulated in two processes: the CPT and RUC processes, respectively. More than half a century ago, the AMA created CPT codes to be used for filing reimbursement claims and tracking procedures. CPT became the national coding standard for reporting physicians’ and other healthcare professionals’ services under the Health Insurance Portability and Accountability Act of 1996.1

Established in 1992, RBRVS looks at the relative value of physicians’ work, as defined by the CPT codes, when compared to one another.2

The process of adding/revising and valuing CPT codes is outlined in the accompanying graphic. CPT codes are managed by the AMA through an advisory panel of practicing physicians, representatives from private insurance, CMS, and the co-chair of the Healthcare Professionals Advisory Committee (HCPAC). The AMA created the RUC to advise CMS on appropriate relative values for these CPT codes. The RUC is comprised of members appointed by national specialty societies, as well as the chair of the RUC, the co-chair of the HCPAC, representatives from the AMA and the American Osteopathic Association, the chair of the AMA’s Practice Expense Advisory Committee, and the CPT editorial panel.3

Valuation of Codes

The concept of relativity is central to the RUC process. Codes are valued with consideration of how the amount of physician work compares to other codes in the fee schedule. Any new codes introduced or considered to be potentially misvalued will typically require re-examination of any related codes in order to preserve the relative value in the fee schedule. For example, in 2016, CT neck with IV contrast (CPT code 70491) was identified on a CMS high expenditure screen as potentially misvalued. Codes 70490 and 70492 (CT neck without IV contrast and CT neck without and with IV contrast) were re-evaluated by the RUC at the same time. In the valuation process, CMS re-affirmed the current value for 70490 and 70491, and increased the value for 70492.

Through an annual process, CMS and the RUC identify potentially misvalued codes through screens for high expenditures, fastest growth, and new technology, to name a few. An explanation of these and other screens is beyond the scope of this article. Through the Patient Protection and Affordable Care Act, Congress and CMS have become devoted to the monitoring of whether services have become overvalued. CMS has formalized a process for the public to nominate potentially misvalued codes. This year, Anthem nominated several codes, including a radiology code based on RUC validation projects by the RAND and Urban Institute. In particular, the RAND report selected a few codes to evaluate absolute time estimates, ignoring the concept of relativity.4

The process of RUC valuation is a lengthy one and was developed with multispecialty physician input. Essentially, specialty societies expressing interest in participating in the valuation process will create a survey based on a RUC-validated instrument. The survey is sent to random specialty society members, and the data from the survey provided by you, the specialty society members, ultimately is factored into the value of the code. The important variables are the amount of physician time a procedure or service requires and the intensity and complexity of the work. Time is perceived as easy to measure and compare. Recent studies scrutinizing the RUC process have focused on the absolute time component.4

However, comparing the intensity and complexity of procedures is more of an art, being difficult to quantify and requiring the expertise of specialty societies. Mental effort and judgement are factors, which account for the level of knowledge required, the complexity of decision-making, and the amount of clinical data that must be considered given the potential pathology. Length of training and amount of skill required to perform...
a particular procedure, as well as psychological stress factors — such as risk of significant complications, morbidity, and mortality — are also considered.

Finally, the RUC examines the recommended code valuations relative to other codes across the fee schedule to ensure that the code is not under- or overvalued. CMS makes final determinations of valuations based on RUC recommendations. In the recently published Final Rule, CMS accepted 80 percent of RUC recommendations. CMS publishes the proposed rule in July of each year and solicits feedback from stakeholders. This is an important process, allowing specialty societies to work together with the AMA to advocate for appropriate valuation.

Future Value

Despite current pressures to increase productivity, we must take the time to ensure appropriateness of imaging and maintain quality in our work. Even within a fee-for-service environment, we are not rewarded for volume. Reimbursement to physicians within the Medicare Physician Fee Schedule is shared across the house of medicine — from a fixed amount of money that is distributed each year. As imaging volume increases, an adjustment factor is used to calculate the dollar value of the RVU. If overall volume increases, the RVU dips lower in value. Furthermore, as imaging volume increases disproportionately to the rest of healthcare expenditures, total payments to radiology increase at the expense of payments to other specialties. As specialty society advisors continue to advocate for proper valuation of radiology services and fight against controlling utilization through valuation, we as radiologists need to ensure we are championing appropriate imaging, improving our reports, and communicating with clinical colleagues and patients to remain visible and valuable to our stakeholders.

Melissa M. Chen, MD, is a clinical neuroradiologist in the department of diagnostic radiology at the University of Texas MD Anderson Cancer Center, the American Society of Neuroradiology Alternate Advisor to the RUC, and chair of the ACR Commission on Patient- and Family-Centered Care Economics Committee.

ENDNOTES

LEADERSHIP

From the Battlefield to the Reading Room

How can radiologists lead their teams in high-stakes environments?

“...A good general, like any true leader, does not actually do anything, but only sees that enough people with proper training and the right weapons (in working order, and calculated to be effective against a specific enemy’s way of fighting) are in the right place and time with a motivation to fight.”

Radiology training and practice provide little opportunity for formal education in leadership skills. The Bulletin caught up with U.S. Army Reserve Brig. General W. Scott Lynn, MD, a neuroradiologist with Radiology of Huntsville in Alabama, to discuss leadership, the fast-paced world of military radiology, and the key to quality patient care. Lynn, one of the highest ranking radiologists in the U.S. armed forces, was significant in the formation of the ACR Military Radiology Subcommittee.

How have your experiences as a military radiologist changed the way you practice?

I carry foundational lessons learned in the U.S. armed forces to every aspect of both my military and civilian careers. I joined the U.S. Army after attending Vanderbilt University on a four-year Reserve Officer Training Corps scholarship. During freshman year, each cadet learns the importance of being a good follower, and several fundamental
“You learn how important it is for those in charge to build and maintain trust throughout the team by communicating clearly and effectively.”

leadership principles grow out of this experience. The cadet learns the importance of serving on a team and of subjugating their own personal interests to those of the group. You learn humility, realizing that others may know more than you do, or may have skills that you have not yet acquired. You learn how important it is for those in charge to build and maintain trust throughout the team by communicating clearly and effectively.

How does leadership on the battlefield translate to leadership in the radiology practice?

A team effort is fundamental to leadership in both fields. At its core, the art of good leadership transcends the boundaries of a particular endeavor. Coalescing an organization around a clear vision, inculcating and facilitating a “unity of effort” for the team, and inspiring men and women to most effectively use their strengths and talents — all of these form the foundation of good leadership.

In medical practice, patient care provides focus for the team’s personal and organizational efforts. Our radiology team includes everyone in our department: our transporters, technologists, nurses, and administrators all partner with us to care for the patient in a professional and kind way. In the military, our mission is similar, but things can get more complicated — America’s service members and their families are the focal point of care. However, this care takes place within the broader construct of the military and national priorities established by our elected civilian leaders. Sometimes these priorities take us to the battlefield, where resources and time can be extremely limited and risk is high.

Military service and College membership are highly complementary at the individual level. How is ACR addressing the needs of military radiologists?

While the ACR represents our collective interests in providing high-quality, efficient care to our patients, staying involved has been historically challenging for military physicians. Many of the ACR pathways to involvement start with state chapters. For an active-duty military physician who might be moving every two to four years, establishing ties to a state chapter can be difficult. For those serving as active reservists in the military, the old construct of serving one weekend a month and two weeks a year has changed as well — especially for physicians who perform leadership duties in addition to clinical functions. Much of the physician’s extra time is spent contributing to the military segment of organized medicine instead of the state arena. The ACR recognized those challenges in 2017 and has been actively working to encourage military radiologists through the Commission on General, Small, Emergency and/or Rural Practice.

What advice do you have for future radiologists?

Be a team player both within your practice and your hospital. At different points in my Army career, I’ve experienced firsthand how poor leadership can damage esprit de corps and hinder organizational effectiveness. The leader serves the team, not the other way around. One of my favorite Army lessons is that leaders eat last. The leader always makes sure the team has food before the leader eats. This way, if food is scarce or time to eat runs out, the leader goes hungry instead of the soldier. Leaders sacrifice for those they lead. These principles equip both physicians and Army officers to better serve their organizations and, ultimately, to provide quality care to patients.

ENDNOTE


U.S. Army Reserve Brig. General W. Scott Lynn, MD, (right) talks to soldiers from one of his unit’s 248-bed combat support hospitals during a field training exercise at Fort Hunter Liggett.
Battling Blind Spots

Radiology leaders are first movers in Vanderbilt’s training efforts to recognize and mitigate unconscious bias.

“...I hope you like country music.” That’s what friends told Reed A. Omary, MD, MS, FACR, when he left Chicago to lead the radiology department at Vanderbilt University Medical Center (VUMC) in Nashville, Tenn. “That’s a perfect example of unconscious bias,” he says. “We may be known as ‘Music City,’ but healthcare is actually Nashville’s biggest industry.”

Unconscious bias is not limited to gender, race, or ethnicity. People can form stereotypes about any social group — whether we’re aware of such biases or not. And these unconscious impressions about others can impact both our personal and professional lives, including hiring, managing, and interacting with team members, evaluating trainees, and providing patient care.¹

As part of VUMC’s efforts to make diversity and inclusion intentional, the medical center is taking deliberate action to help its entire team better understand unconscious bias and mitigate its contribution to healthcare disparities. Beginning this year, VUMC is rolling out a series of unconscious bias workshops to over 20,000 employees — with volunteer trainers, including faculty members, nursing staff, and administrators, teaching the courses.¹

Radiology Steps Up

In 2015, VUMC’s Office of Diversity, under the leadership of André L. Churchwell, MD, senior associate dean for diversity affairs, developed a one-hour unconscious bias forum. Based on its commitment to diversity and inclusion, the medical center tapped radiology as one of the first departments to pilot the session. From the outset, Omary and other radiology leaders have been at the forefront of VUMC’s unconscious bias training initiative.

“Unconscious bias is universal. If we don’t recognize it, we may inadvertently make decisions that aren’t in the best interest of our patients,” says Omary, who is the Carol D. and Henry P. Pendergrass Professor and chair of radiology at VUMC. “Based on the impact of that first session, we quickly began creating a formalized approach to conduct unconscious bias training within radiology. Since then, we’ve taken a series of actions in parallel with the medical center’s rollout of this type of critical education.”

In 2017, the Office of Diversity turned the pilot into a one-day course on unconscious bias for deans and department chairs in the School of Medicine. During this in-depth session, Omary learned more about the impact of unconscious bias and concluded that ongoing unconscious bias training would be a key departmental focus.

Toward that end, he turned to Stephanie E. Spottswood, MD, MSPH, who heads radiology’s Office of Diversity, Equity, and Inclusion, to develop a program. “Unconscious bias training is a supportive leg of our radiology diversity initiative,” Spottswood says. “We know that if we want to diversify, we need to help our residents and faculty recognize and respond to their unconscious biases. So, we solicited help from the Vanderbilt medical center team to guide us in providing that training.”
Collaboration Takes Root

Spottswood immediately reached out to Arie L. Nettles, PhD, founding director of the Office of Inclusion and Health Equity in the Vanderbilt pediatrics department, who developed a flagship program to educate and train the workforce on cultural awareness and the elimination of health care disparities.

“At Vanderbilt, whether you do heart transplants or plant flowers, we will make sure that you’re culturally aware and culturally sensitive,” Nettles says. “By learning how to identify and confront unconscious bias, it is possible to mitigate its impact and promote respect for all groups.”

Spottswood had already been holding short courses for departmental faculty and trainees to instill an understanding of the importance of diversity and inclusion and to enhance radiology’s ability to deliver culturally proficient medical care to patients. In 2016, she added unconscious bias training to the mix.

Training Shifts Mindsets

Since then, Spottswood has instituted unconscious bias workshops to help everyone in radiology recognize that unconscious bias is universal and that it can have negative consequences, if left unchecked. Over a half-day session, the training covers several key topics:

- The nature of unconscious bias and how it influences behavior
- Situations where unconscious bias has resulted in less than favorable or detrimental outcomes
- Skills to identify the presence of unconscious bias and steps to prevent bias from influencing clinical decision-making and interpersonal interactions
- Educational strategies to reduce or mitigate unconscious bias in the practice of research

The response from team members has been overwhelmingly positive, Spottswood says. “People are surprised to learn that we all have blind spots, and they are unaware how these unconscious biases might affect our everyday actions as we care for patients.”

Compensation for Participation

To effectively help radiology team members identify their blind spots, Omary and Spottswood determined the training needed to reach the widest audience possible. Two strategies advanced that goal: offering CME credit and incorporating attendance into radiology’s clinical faculty compensation plan.

“We wanted to make a statement that this training is so important that we made it part of our clinical faculty’s variable compensation plan,” says Omary. “Compensation should not just be about clinical productivity. It should also be about quality and professionalism.”

Spottswood adds, “At Vanderbilt, a small portion of our salary is variable compensation — where if we do things like attend certain seminars, it’s reflected in our paychecks. There’s positive reinforcement for doing the right thing. Plus, we gave CME credit as an added motivator.”

The incentives paid off. The first session was standing room only. Radiology achieved 100 percent attendance among faculty and residents taking the unconscious bias class.

Of course, not every radiology practice has the ability to offer CME or compensation to incentivize attendance at unconscious bias training. For those organizations, Omary has a few words of wisdom: “Just do it. Get started and grow it incrementally. And make unconscious bias training an ongoing process rather than an event, so that it stays in peoples’ thoughts.”

“Unconscious bias is universal. If we don’t recognize it, we may inadvertently make decisions that aren’t in the best interest of our patients.”

— Reed A. Omary, MD, MS, FACR

Train-the-Trainer Expands the Impact

VUMC is taking these steps on a global scale by providing unconscious bias training for all 20,000-plus employees. As part of this effort, the medical center recently held a four-day train-the-trainer program. The session prepared 16 VUMC team members to deliver a workshop for colleagues that explores how unconscious biases develop, how they influence perceptions and decision making, and how to mitigate these effects.

Spottswood was among those who the dean’s office selected to become a trainer. “We don’t want anyone to be unaware that they have unconscious bias. The train-the-trainer program will give us that universal reach.”

Nettles, who is spearheading the VUMC-wide training effort, says it’s all about getting everyone in the medical center to begin making the unconscious conscious. “We hope we can be a model, not only for academic institutions, but for medical practices everywhere to see that there are actionable steps everyone can take to reduce unconscious bias and eliminate inequities in patient care.”

By Linda Sowers, freelance writer, ACR Press

ENDNOTE

When Richard Duszak Jr., MD, FACR, professor and vice chair for health policy and practice at Emory University School of Medicine, talks about online reputation to a room full of radiologists, the slide that gets the most attention compares the Google results for him with one of his former private practice “invisible” radiologist colleagues. A leader in both health policy and IR, Duszak has an active Twitter feed and makes frequent presentations at conferences. A Google search brings up his profiles from prominent medical centers, but also awards he has won, articles about his work, and his perspectives on the field. In contrast, the search results for the “invisible” radiologist bring up a couple of third-party online rating sites over which that radiologist has no control.

After Duszak shows that slide, he says, everyone in the room pulls out their phones to Google themselves. That’s exactly what he wants. He advises radiologists to look up their own names online — and maybe search a few of their own colleagues at the same time, for comparison. There’s a good chance that their patients are also looking up their names or their practice’s name. Just as most people will check online reviews before heading to a new restaurant, many patients also check reviews before choosing a doctor. A survey showed that nearly 59 percent of respondents thought that physician rating sites were somewhat or very important when choosing a physician. Some surveys put the numbers even higher.

That’s not all bad. Checking online ratings may be a sign of increased patient engagement, Duszak observes, which studies show bodes well for health outcomes and care experiences.

Online reviews may also contain useful information for physicians and practices, says Andrew B. Rosenkrantz, MD, MPA, professor of radiology at NYU Langone Health. Payers are increasingly using patient satisfaction scores in value-based payment systems — although none are currently using commercial reviews on HealthGrades or ZocDoc. Online reviews — which often offer the opportunity for free text feedback — may offer a valuable window into what it’s like to be a patient in that practice and what aspects of the practice may need improvement.

Radiology presents some different challenges from other specialties when it comes to physician ratings and online reputations, says Rosenkrantz. His team at NYU conducted an analysis of more than 1,000 Yelp reviews of radiology outpatient centers. Only 13.5 percent of the patient reviews mentioned the radiologists themselves. Reviews were much more likely to focus on the professionalism of the staff, facility wait times, and equipment.

According to Duszak, this might indicate a missed opportunity. “Radiologists get rated less frequently than other specialists who have more face-to-face time with patients. But, when we do get rated, we score better than the average doctor,” he says.

So how can radiologists improve their online reputation? Duszak and Rosenkrantz offer the following advice:

**Take a whole-practice approach.** The key to positive ratings is the total package of the radiology practice — the patient experience from the moment they contact the office to the time they receive their report. That includes interactions with staff, parking, and wait times. Rosenkrantz recommends thinking about the patient experience from beginning to end and adjusting policy or providing staff training to improve that experience. Online reviews are one source of information about patient experience; in-house patient satisfaction surveys and other patient feedback can offer additional insights.

**Let patients see you.** Radiologists are increasingly encouraged to interact with patients when they can, introducing themselves or meeting to explain findings. While not always possible, this can improve the patient experience and, therefore, online reviews. Without this interaction, Duszak points out that the first time a patient notices the radiologist’s name may be on a bill — not always the best introduction.

**Monitor what’s out there.** Third-party sites pull information from publicly available sources, which can be out of date or just plain wrong. Most sites will give physicians the opportunity to correct or add information. Although it can be difficult to keep up with all the sites out there, Duszak recommends radiologists at least fill out a profile on Doximity, which supplies information for the U.S. News and World Report physician directory.

**Address comments carefully.** Negative reviews happen, and these public posts remain online with a wide
AI Use Cases

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The Art of the Apology

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scope of the specific panel or were not considered to need specific input from radiologists. The vast majority of use cases that were proposed moved forward to the next round of review. Details of concepts were then put into templates provided by the DSI.

During panel conference calls over the next few months, individuals presented their draft concepts and received feedback on various aspects of each proposed use case. After the calls, DSI staff incorporated changes to the drafts and sent them on to the presenting panel member for editing.

What’s on the Horizon for Use Cases?

To achieve success, panels will rely on a broad array of stakeholders — including individual ACR members, academic departments, other radiology societies, and the developer community itself — to submit fresh ideas for use cases. This will help keep the AI engine running and create a best-in-class directory of hundreds of AI use cases.

By Jay W. Patti, MD, chair of an ACR Data Science Institute™ use case panel and chief radiology informatics officer at Mecklenburg Radiology Associates in Charlotte, N.C.

The Art of the Apology

By Emily Paulsen, freelance writer, ACR Press

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The Art of the Apology

By Jay W. Patti, MD, chair of an ACR Data Science Institute™ use case panel and chief radiology informatics officer at Mecklenburg Radiology Associates in Charlotte, N.C.

ACR Legal Disclaimer: Members should consult with a qualified lawyer in their jurisdiction before deciding to apologize or express sympathy to any patient.

ENDNOTE
How is diversity and inclusion in radiology improving?

“Just take a look at current ACR leadership makeup from the BOC to the RFS. Consider how well the #HeForShe campaign has done. And look at how social media is raising awareness about diversity in radiology — it’s bringing radiologists together for each other and for patient care.”

— Taj Kattapuram, MD, breast and interventional radiologist in Arvada, Colo.

“We must continue to hold ourselves accountable and not fall victim to our unconscious biases. The goal is to make sure we create as level a playing field as possible for all who want to take part in our wonderful specialty.”

— Vivek Kalia, MD, MPH, MS, musculoskeletal radiologist at the University of Michigan in Ann Arbor

“At our institution, our program director is closely involved with college-wide diversity efforts and specifically brings in local students from underrepresented groups to shadow in the reading room and get a glimpse of radiology.”

— Zachary S. Jeng, MD, diagnostic radiology resident at Baylor College of Medicine in Houston
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