

Bulletin



Nurturing the Patient Relationship

SPECIAL ISSUE ON
PATIENT- AND FAMILY-CENTERED CARE

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Check out the digital edition!
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FROM THE CHAIR OF THE BOARD OF CHANCELLORS

Geraldine B. McGinty, MD, MBA, FACR, Chair



A Sense of Belonging

Our ability to bring about change is, in large part, based on the common foundation we share as radiologists.

I would like to use this March column to set the record straight on a few things: it's St. Paddy's (not Patty's) Day, we don't eat corned beef and cabbage in Ireland to celebrate, and until recently we spent the day attending church and the public houses closed early. Green beer? Absolutely not! Although I am a little curmudgeonly on the execution of the St. Patrick's Day holiday, I am inspired to see my Irish heritage celebrated so enthusiastically and by so many people. By some counts, the Irish diaspora numbers 80 million — not a bad statistic for a country with a resident population of less than 5 million.

The fact that "everyone is Irish on St Patrick's Day" had me thinking about the definition of belonging. As many of us become increasingly subspecialized, how do we retain our sense of a strong radiology diaspora and keep our definition of belonging to the imaging community as inclusive as possible? I believe that if we do not maintain and strengthen our commitment to what we have in common as radiologists, we will lose some of the unique value we deliver to our patients as imaging experts.

The power of our advocacy efforts is, in large part, based on our speaking with a unified voice for the benefit of our patients.

Don't get me wrong — I love being part of the breast imaging community and sharing our passion for our work as breast imagers. I see the same collaboration at organizations like the American Society of Neuroradiology and the Society for Imaging Informatics in Medicine and at our ACR meetings. I will be attending the Society of Interventional Radiology (SIR) meeting this month and am looking forward to tapping into the energy that the SIR community brings to the clinical practice of IR. The IR community has certainly been a vanguard for our Imaging 3.0[®] efforts.¹

English Prime Minister Theresa M. May controversially said, "If you believe you're a citizen of the world, you're a citizen of nowhere."² In the context of our radiology community, one might transpose that to imply that in today's healthcare system the general radiologist is less important. Yet today's graduating residents still spend a significant percentage of their time (29 to 46 percent,

depending on their area of subspecialty training) practicing outside of their fellowship training focus.³ Importantly, access to imaging services in rural areas often depends on this community. Even for those of us who practice in an academic environment, our ability to guide our referring physician colleagues and patients to the appropriate examination depends on our unique general knowledge of the entire imaging armamentarium.

The ACR Commission on General, Small, Emergency and/or Rural Practice is focused on supporting these members of our community and is ably led by Robert S. Pyatt, MD, FRCR, who practices general radiology in rural Pennsylvania. Working with colleagues such as Eric B. Friedberg, MD, FRCR, and Catherine J. Everett, MD, MBA, FRCR, the commission is focusing on issues around workforce supply and well-being, as well as creating affinity groups for our members in the VA, military, and critical access hospitals. Especially where resources are limited, our obligation as radiologists to act as responsible stewards is enhanced by our expertise in triaging patients to the most effective imaging modality.

To Prime Minister May, I would say that it is indeed possible to belong to more than one community. And to our radiology diaspora, I would say that whatever our practice type and training, we share a common purpose: to serve patients and society by empowering members to advance the practice, science, and professions of radiological care.

The power of our advocacy efforts is, in large part, based on our speaking with a unified voice for the benefit of our patients. As we think about how to engage as many radiologists as possible in advocacy efforts to amplify that voice, let us enjoy connecting with and learning from those who share our particular practice challenges or interests — but let us never lose sight of the common foundation we share as radiologists. **B**

ENDNOTES

1. Charalel RA, McGinty G, Brant-Zawadzki M, et al. Interventional radiology delivers high-value health care and is an Imaging 3.0 vanguard. *J Am Coll Radiol.* 2015;12(5):501–506. Available at bit.ly/IR_Value.
2. May T. Theresa May's conference speech in full. *The Telegraph.* October 5, 2016. Available at bit.ly/Theresa_MaySpeech. Accessed Jan. 5, 2019.
3. Bluth EI, Bansal S, Bender CE. The 2017 ACR Commission on Human Resources Workforce Survey. *J Am Coll Radiol.* 2017;14(12):1613–1619. Available at bit.ly/2017_ACRHRSurvey.

Emergency Chest Imaging Use on the Rise

A new study by Harvey L. Neiman Health Policy Institute® assesses national and state-specific changes in ED chest imaging utilization from 1994 to 2015. Over the past two decades, the use of noncardiac chest imaging increased markedly in the ED. ED use of chest radiography and CT increased by 173 percent and 5,941.8 percent. Per 1,000 ED visits, utilization increased by 81 percent and 3,915.4 percent, respectively. According to Andrew B. Rosenkrantz, MD, MPA, lead study author and a Neiman Institute affiliate senior research fellow, “Across states, utilization is highly variable, but with radiography and CT both increasing, the use of CT seems additive to, rather than replacing, radiography.”

Read the full study online in the *JACR*® at bit.ly/RiseEDChestImaging.



ACR Alternate Delegate to the AMA House of Delegates Ami A. Shah, MD, testified on the federal mandate to report breast density.

AMA Participation Pays Off

ACR successfully made the case for the AMA's continued support of Resolution 803, which advocates for access to — and insurance coverage for — supplemental screening for women with dense breasts. “The ACR holds that mammography and appropriate supplemental screening exams should be covered by insurers,” said ACR Alternate Delegate to the AMA House of Delegates Ami A. Shah, MD. “Otherwise, there may be an unfortunate disparity between women who can afford to pay for additional screening and those who cannot.” Shah, who testified in support of the resolution at the AMA's November 2018 interim meeting, added that the experience taught her “a great deal about the importance of radiology participation in the AMA. Engaging the entire house of medicine can help many of our patients.”

To read more, visit bit.ly/AMA_Shah.

“

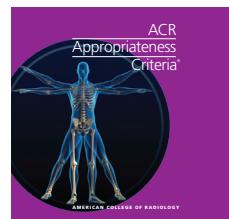
Communicating with patients quickly has a huge impact on anxiety. Patients with normal results will be anxious until they learn the results are normal. Such an easy fruit for us to pick!

— Nadja Kadom, MD,
director of pediatric neuroradiology at Emory
University School of Medicine

”

New ACR Appropriateness Criteria Released

The ACR recently released an update to the ACR Appropriateness Criteria® (AC), which includes 186 diagnostic imaging and IR topics with 914 clinical variants covering more than 1,600 clinical scenarios. This update includes seven new and 19 revised topics. Among the new topics in this most recent release are abdominal aortic aneurysm follow-up (without repair), acute mental status change, delirium, new-onset psychosis, nonatherosclerotic peripheral arterial disease, and thyroid disease.



“These evidence-based, expert-developed guidelines have long been recognized across the medical field as a national standard,” said Frank J. Rybicki, MD, PhD, FACR, chair of the ACR Committee on AC. “As we rapidly approach the beginning of the mandatory consultation of Appropriate Use Criteria under PAMA, these resources are becoming even more important to the practice of medicine.”

To view the new and revised topics, visit acr.org/ac.

Step away from the PACS station, step out of the dark room, and reach out to your local Girl Scouts troop or other youth organizations that empower young women — it's another opportunity to showcase our specialty, prove that #RadsHaveAFace and ensure radiology's relevance in the coming years.

— Susan M. Ascher, MD, professor, vice chair of research, and co-chief of abdominal imaging at MedStar Georgetown University Hospital in Washington, D.C.

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.

Transforming Ambitions into Real-World Achievement

The inaugural ACR YPS virtual book club meeting discussed the book *How Women Rise*, which outlines 12 habits that may hold women back in their careers — focusing on how these apply to early careers in radiology. Read the recap of the meeting at bit.ly/How_Women_Rise.

The Ins and Outs of Academic Radiology

An RFS member recaps his learnings from the Introduction to Academic Radiology program — a four-day, in-person course that aims to facilitate attendees' transition into academic radiology careers by providing insight into how to produce valuable research, enter productive mentor-mentee relationships, navigate an academic career, and understand radiologists' involvement in health policy. Learn more at bit.ly/ITAR.

RLI Wants to Help Kickstart Your Career



AMERICAN COLLEGE OF RADIOLOGY

The radiology landscape has changed dramatically over the past decade — and the pace of change will not subside any time soon. The breadth and scope of what radiologists need to know has expanded significantly. This means that employers are now seeking candidates with more comprehensive skill sets. Designed for residents and fellows, the Radiology Leadership Institute® (RLI) Kickstart Your Career event provides residents with valuable career-development skills and advice related to interviewing, selecting a good mentor, and how to succeed in that first year.

The workshop, taking place March 23, 2019, at the DoubleTree by Hilton Hotel in Silver Spring, Md., will feature an interactive, small-group mock interview session with faculty members, a panel of early career radiologists representing various subspecialties — all while providing an opportunity for attendees to network with both expert faculty and peers. According to Trilochan Hiremath, MD, a past RLI Kickstart Your Career attendee, “Very few opportunities exist during residency training that offer this kind of hands-on workshop with direct coaching to better position radiologists to face the challenges of transitioning into the real-world practice of radiology.”

To register, visit acr.org/Kickstart-Your-Career.

Imaging Excellence Starts Here

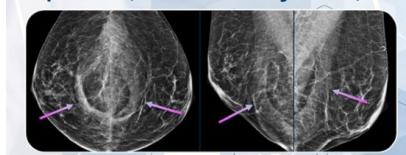
ACR membership protects the investment you have made in your education, career, and practice. We work to ensure your future relevance and success in the profession by guiding you through economic change, helping you achieve quality care, and connecting you to your radiology peers and the larger healthcare community.

One way we're working to safeguard your practice is by giving you free and discounted tools to help you navigate increasing consumerism and shifts from volume- to value-based care. These benefits include the *JACR*®, patient- and family-centered care toolkits, and resources like this special issue of the *ACR Bulletin*.

Renew your 2019 membership now at acr.org/renew.

2019 SBI/ACR BREAST IMAGING SYMPOSIUM

MAGNIFY YOUR VALUE
April 4–7, 2019 in Hollywood, FL



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.

ACR Releases New Guide for Medical Physicists

The ACR Commission on Medical Physics recently released a revised and updated version of a document entitled "Guide to Professional Practice of Clinical Medical Physics 2018." The guide aims to provide perspectives and insight regarding the aspects of professional clinical medical physics practice. It is intended for medical physicists, medical physicists-in-training, administrators, human resources personnel, and physicians.

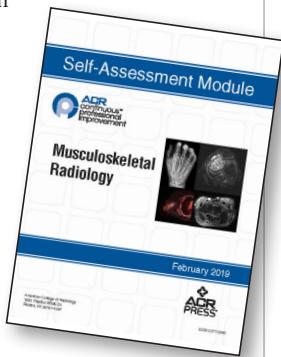
"This report is an essential guide that helps radiology professionals understand how to position and integrate medical physicists into their healthcare enterprise," says Mahadevappa Mahesh, MS, PhD, FACR, chair of the Commission on Medical Physics. "It's also a unique resource for medical physicists that provides guidance on how relationships should be structured among regulatory agencies, employers, patients, the public, and more."

To access the guide, visit acr.org/MedPhysics-Guide.

CPI Releases New MSK Radiology Module

The ACR Continuous Professional Improvement™ (CPI) program has released CPI Musculoskeletal Radiology Module 2019. Members save \$32 per module when selecting six modules through a customized CPI Select Six Series. Each CPI module includes 50 self-assessment questions written by subspecialist experts and offers up to 8 CME/SA-CME. Choose between the print publication or the online examination and receive a free e-book download.

Learn more at acr.org/cpi.



Get Ready for QPP Year 3

An ACR webinar covering important changes to the Quality Payment Program (QPP) for radiologists is now available for viewing. The hour-long program, produced by the ACR Commission on Economics and MACRA Committee, introduces new concepts in the 2019 final regulations that will help radiologists, small group practices, and multi-specialty groups more easily navigate the program. Hosted by policy experts Lauren P. Golding, MD, Richard E. Heller, III, MD, MBA, and Gregory N. Nicola, MD, FACR, the free webinar advises how radiologists and radiology staff can best fulfill QPP Year 3 requirements to earn positive payment adjustments in 2019.

Watch the webinar at acr.org/QPPYear3.

CALENDAR

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.
- 18– April 12 AIRP® Correlation Course, AFI Silver Theatre and Cultural Center, Silver Spring, Md.
- 28–29 Prostate MR, ACR Education Center, Reston, Va.

April

- 5–7 Body and Pelvic MR, ACR Education Center, Reston, Va.
- 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.
- 22–23 Breast MR With Guided Biopsy, ACR Education Center, Reston, Va.
- 25–27 Breast Imaging Boot Camp With Tomosynthesis, ACR Education Center, Reston, Va.

May

- 2–3 CT Colonography, ACR Education Center, Reston, Va.
- 9–11 Abdominal Imaging, ACR Education Center, Reston, Va.
- 16–18 Emergency Radiology, ACR Education Center, Reston, Va.
- 18–22 2019 ACR Annual Meeting, Washington Marriott Wardman Park Hotel, Washington, D.C.

The image-centric disciplines of radiology and pathology are ripe for disruption. Analyzing images is a perfect fit for AI, potentially redefining the two disciplines. AI will change radiology and pathology, likely forcing them to consider merging.

— Dimitri S. Merine, MD, radiologist at Sinai Hospital of Baltimore, at bit.ly/JACRBlog_Rad-Path



By Ezequiel Silva III, MD, FACP, Chair



Cost Discussions: What Do Patients and Families Want?

High-quality, high-value healthcare should prioritize communication, coordination, and access.

Policymakers are committed to evaluating physicians on cost performance. Cost is an integral component of the Quality Payment Program and it will affect all clinicians and their organizations. However, has anyone asked patients, families, and caregivers what they need as it relates to cost? Someone has, and the results are interesting.

A number of ACR representatives participated on one of several CMS subcommittees tasked with the construction of clinical episodes of care to evaluate clinical cost performance. For example, I co-chaired two subcommittees: one on lower extremity revascularization and another on hemodialysis access creation. To inform actions, the supporting CMS contractor gathered a Patient and Family Committee (PFC)* to hear its perspectives on clinician cost performance.

The PFC acknowledged that cost control is important to identify unnecessary or wasteful Medicare spending. However, the PFC was not willing to compromise on quality under cost-related discussions. The PFC indicated “that cost-performance information would only be meaningful to them if presented alongside information about quality of care.” In other words, the PFC was willing to accept cost metrics only if they were tied to quality. Further, “they would consider choosing a low-cost clinician if they also provided average or high-quality care.” The PFC further stressed that the goals of high-quality and high-value healthcare should prioritize communication, coordination, and access.

According to the PFC, any efforts to reduce cost must increase and protect communication. The PFC members want time with their providers, allowing them to receive information and ask questions to make informed decisions. Greater coordination of care is a related want. The PFC especially desires “coordination across clinicians and facilities (especially after a hospital stay).” During both the communication and coordination discussions, the PFC noted that medications are particularly important, “including an explanation of how to take each one and their purpose.”

What does this mean to us? Imaging results are an important component of communication, coordination, and decision-making. This affords us the opportunity to improve our communication of imaging results. For

instance, we can deliver those results in a manner that is understandable and actionable for the patient.

One could easily extrapolate their wants on medications to understand their wants on imaging. If they want an explanation of their medications, might they want the same for imaging? What can PFC members expect from their imaging encounters? Who will communicate the results and decide on therapies and next steps? For instance, what follow-up imaging or therapies are necessary after a hospital admission, ER visit, or clinic visit? And why? Interoperability also has a role in these discussions. It makes sense that patients would expect their imaging to be accessible across different sites — and not through a CD that they carry themselves, but through a seamless interface.

The PFC did not discuss price transparency, which is presumably not only a related expectation of patients and families but also the focus of policymakers at multiple levels. Hence, this should be on our radar.

This brings us back to quality. One way to reduce cost is to reduce the volume of imaging. However, any attempts to do so must ensure that access to appropriate, high-quality imaging is maintained. The imaging clinical decision support mandate, also known as the Medicare Appropriate Use Criteria program, is a means to achieving the goal of decreasing inappropriate imaging while encouraging appropriate imaging. It is also a means to providing a platform for communication involving the radiologist, ordering physician, patient, and family. Place-of-service discussions are also important to cost control. Systematically moving from one site of service to a lower-cost site may be acceptable. However, this must occur only when the quality of the site to which care is steered is validated.

“Quality is our image” is the ACR’s tagline, and it applies at multiple levels described by the PFC. Quality patient-centered care includes ensuring the proper studies are performed at the right time. Our ability to effectively communicate those results to all stakeholders involved in care coordination is an important opportunity. Patients expect it. **B**



The ACR's Patient- and Family-Centered Care Toolkit offers materials to enhance your understanding of — and participation in — new practice and payment models and help you provide more patient- and family-centered care. Access the toolkit at PFCToolkit.acr.org.

*The Patient and Family Committee is not to be confused with the ACR's Commission on Patient- and Family-Centered Care.

Nurturing the Patient Relationship

By placing patients at the center, radiologists can alleviate burnout and provide better care.

How can our patients become our partners? And why is it important that we think of them that way — that we expand the role that not only patients, but also their families, play in their own care?

These are the important questions continuously circled in this *ACR Bulletin* special issue on patient- and family-centered care (PFCC). You've probably heard this term over the last several years. In fact, its core concepts were developed jointly by patients and providers more than 20 years ago. Certainly, you've seen PFCC written about in the *JACR*® and talked about at the top annual conferences. But if you haven't yet taken a moment to step back and think about what PFCC means to you — and to your patients and their loved ones — here's a primer before you dive deeper into the specific stories featured in this issue.

What Exactly Is PFCC?

According to an article published in the *JACR*, many related and intertwined terms are associated with PFCC.¹ Some call it simply "patient-centered care." Others prefer "co-design" or "co-production with patients and providers." Some even modify to "person- and family-centered care." Regardless, the most agreed upon definition of PFCC is "a model of providing care in which the patient and family are partners with the provider and care team."² In short, PFCC means approaching the planning, delivery, and evaluation of healthcare in a way that forms a partnership between providers, patients, and families.

Indeed, PFCC can take myriad creative and effective forms in the healthcare setting. As James V. Rawson, MD, FACP, chair of the ACR Commission on Patient- and Family-Centered Care, writes alongside his coauthors in the *JACR*, "PFCC is a joint journey through an ever changing landscape of new technologies, new treatments, and increasing patient involvement in their own health and healthcare."³ For an oncologist, PFCC might mean listening closely to a family's priorities for their child with leukemia before suggesting treatment plans and then working closely with the child and family to help choose the right route. For a department head, PFCC might mean hiring more diverse staff in their department to decrease implicit bias toward patients and broaden the base of experience within the practice. For imagers specifically, PFCC could also mean altering radiology reports to be more

patient-centric, evaluating which information and components are most important and how to ultimately communicate what they mean to a patient's health ([learn more on page 14](#)).

According to the Institute for Patient- and Family-Centered Care, PFCC also takes into consideration the fact that a patient and his or her family are the ones to determine who the "family" is. For some, it may include extended family or those not related by blood. This essential mind shift is all part of putting patients and their loved ones at the center of care and decision-making.

"As radiologists, we must fight the temptation to depersonalize images."

—Cheri L. Canon, MD, FACP

Why Is PFCC Important to Radiology?

In the era of Imaging 3.0® and the shift to value-based care, radiologists need to be on the forefront of PFCC. As Cheri L. Canon, MD, FACP, writes, "As radiologists, we must fight the temptation to depersonalize images."² She adds that radiologists have a unique risk of becoming disconnected from patients, because they are so often isolated in the reading room. But by placing patients at the center of care — as PFCC necessitates — imagers can mitigate burnout and provide better care.

What does this look like exactly? And how can radiologists be better advocates for PFCC in their own departments or practices? The pages of this issue illuminate the innovative and forward-thinking ways radiologists are approaching PFCC to be better partners to patients and their families — no matter the form that essential partnership might take. B

By Alyssa Martino, freelance writer, ACR Press

ENDNOTES

1. Rawson J, Moretz J. Patient- and Family-Centered Care: A Primer. *J Am Coll Radiol*. 2016;13(12):1544–1549. Available at bit.ly/PFCCPrimer.
2. Slanetz, J et al. Fostering Patient- and Family-Centered Care in Radiology Practice. *J Am Coll Radiol*. 2018;15(5):784–786. Available at bit.ly/FosteringPFCC.



One Size Does Not Fit All

How can radiology departments improve the overall imaging experience for patients with obesity?

More than one-third of Americans are obese and the number continues to climb. In June of 2013, the AMA classified obesity as a disease, but the condition has challenged healthcare providers for decades, with radiology departments attempting to shoulder the weight of the obesity crisis and the logistical and technical hurdles it creates.^{1,2} Imaging larger patients poses unique challenges when it comes to obtaining the images, the quality of the images themselves, and the accessibility, comfort, and safety of the patients.

Identifying Challenges

Raul N. Uppot, MD, assistant professor of radiology at Harvard Medical School, has long been interested in this issue. As a fellow at Massachusetts General Hospital, he was curious about a phrase he saw used frequently in radiology reports: "limited by body habitus." "When writing a report on a patient, a radiologist will use this phrase if they feel the images are not of diagnostic quality or they might miss something because of it," says Uppot. He decided to do a search on the phrase in all of the reports at his facility, in all of the various modalities, starting from when the data became available in 1998. As he suspected, there was a clear rise in the use of the phrase in radiology reports each year. He also found this correlated with graphs of rising obesity in his state of Massachusetts.³ Uppot found it troubling that so many obese patients were receiving these essentially inconclusive reports because of the insufficiencies of current imaging equipment (machines that were not powerful enough to produce diagnostic quality images in larger patients).

Aside from issues with image quality, Uppot observed that a few patients couldn't even fit in machines at his facility. This, he felt, was unacceptable. "The worst thing for a patient is they take off work, they take the time and drive all the way to your facility, they wait for the appointment, just to be told they can't have their imaging done. If you can't even image them, how can you treat them?" Or worse, he says, they have a bad experience trying to fit into a machine that's too small.

Assessing Needs

Christine Abbott, a business operations specialist at Augusta University Health in Georgia and a patient advocate on the ACR Commission on Patient- and Family-Centered Care Informatics Committee, had that experience when going in for a biennial MRI. Abbott, who suffers from multiple sclerosis, felt the MRI machine getting tighter every time. On one instance, Abbott recalls, she told the RT, "I will not fit in that." The RT politely reassured her that she would, removed all the padding in the machine, and said, "Tell me if you get hot." Abbott was in the machine for



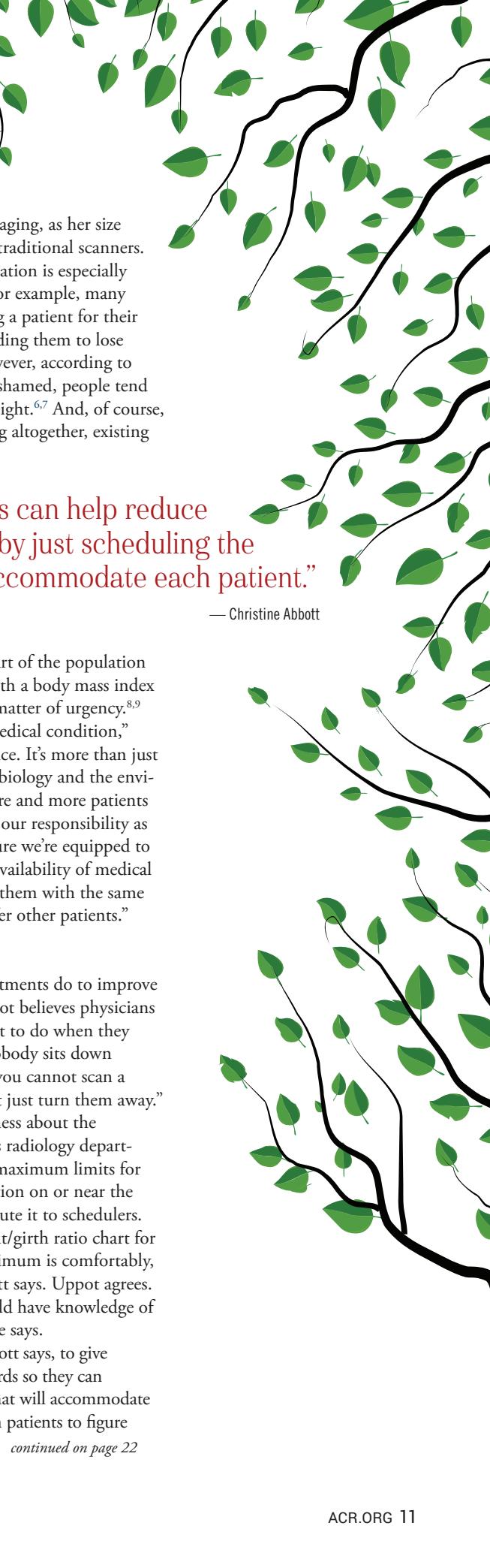
an hour and when it was time to get out, she found herself stuck. “I had to do a little shimmy to get out, and despite getting stuck the technician made me go back in for the second part of my imaging,” says Abbott. “It was scary and a little embarrassing and I thought to myself, ‘Never again.’”

Abbott’s experience is not unique and is one that Uppot has been trying to raise greater awareness of. In 2007, Uppot published a paper that provided an objective measure of the challenges radiologists face in imaging obese patients, including the inability to accommodate large patients on currently designed imaging equipment and difficulties in acquiring desired image quality.⁴ He began giving talks around the country to bring attention to the lack of awareness that medical personnel have about the maximum height, weight, and girth for machines at their facilities. “If you asked all the radiologists at RSNA, for example, what their machine limits were, the vast majority would not know,” says Uppot. According to him, this results in patients like Abbott being booked for machines that may not accommodate them — a problem that could be avoided by having these maximums posted on each machine in the facility and communicated to the staff scheduling the appointments. He also advocated for bigger machines — for manufacturers to build and release them, and for facilities to acquire them.

Uppot has observed an evolution over the last decade of more companies recognizing and capitalizing on the market for bigger machines, as well as radiologists and RTs changing protocols to be more accommodating for obese patients. Unfortunately, Uppot says, most healthcare systems — in their attitudes, equipment, and facility design — are ill-equipped to meet the needs of this epidemic.⁵

Scott Kahan, MD, MPH, director of the National Center for Weight and Wellness in Washington, D.C., and a faculty member at Johns Hopkins Bloomberg School of Public Health, agrees that problems remain with the imaging and treatment of obese patients. “Of course, there’s technical challenges of getting good imaging results in patients that have a lot of extra body tissue, but there’s also real psychosocial issues,” says Kahan. “Whether intentional or not, heavier people often experience weight-shaming during healthcare interactions. This leads to avoiding healthcare, including imaging, for fear of further stigmatization.”

According to Kahan, weight stigmatization is surprisingly common. “It is often inadvertent — many providers don’t order a test or prescribe a treatment because it is assumed that heavier patients won’t be compliant with recommendations,” says Kahan. “It can also be unintentional — years ago, one of my



patients was sent to a zoo for imaging, as her size could not be accommodated in traditional scanners. But intentional weight stigmatization is especially common and misunderstood. For example, many physicians believe that criticizing a patient for their weight gain or harshly commanding them to lose weight will be motivating.” However, according to Kahan, studies show that when shamed, people tend to gain more rather than lose weight.^{6,7} And, of course, if patients delay or forgo imaging altogether, existing health issues can worsen.

“Radiology practices can help reduce worry and anxiety by just scheduling the right machine to accommodate each patient.”

— Christine Abbott

Given the largest growing part of the population in the United States is people with a body mass index greater than 40 kg/m², this is a matter of urgency.^{8,9} “Bottom line: obesity is a real medical condition,” Kahan says. “Obesity isn’t a choice. It’s more than just a behavioral issue; it’s driven by biology and the environment. We’re going to see more and more patients who have severe obesity, and it’s our responsibility as medical professionals to make sure we’re equipped to treat them — both in terms of availability of medical technology and by approaching them with the same care and compassion that we offer other patients.”

Finding Solutions

So what can radiology departments do to improve imaging for obese patients? Uppot believes physicians need more education about what to do when they encounter an obese patient. “Nobody sits down and says, ‘What happens when you cannot scan a patient?’” says Uppot. “You can’t just turn them away.”

Abbott believes more awareness about the machines is critical. She suggests radiology departments develop matrices for the maximum limits for machines and post this information on or near the machines themselves and distribute it to schedulers. “There should be a height/weight/girth ratio chart for every machine — what the maximum is comfortably, safely, and with padding,” Abbott says. Uppot agrees. “Every person on the team should have knowledge of maximums for the machines,” he says.

It would also be helpful, Abbott says, to give schedulers access to medical records so they can schedule patients for machines that will accommodate their size. “Don’t put the onus on patients to figure

continued on page 22

Changing the Conversation

How can practices consider LGBTQ patients' unique needs and become more inclusive?

Consider this fictionalized situation: Jack, a transgender man, is sitting in the waiting room of a breast imaging center. The staff at the front desk call out, "Jessica" (the name given to Jack at birth). When Jack responds and walks up to the staff person, the gender of the name called and the expressed gender of the person who walked up are obviously very different. Jack, the other patients in the waiting room, and the staff person now are all potentially uncomfortable. And for Jack, the center is no longer a safe space.

The situation above and others like it might seem like the result of a harmless mistake, but failing to consider the needs of lesbian, gay, bisexual, transgender, and queer (LGBTQ) patients can be critical to their healthcare experiences. LGBTQ patients are all different and have unique needs that should be considered. This article will be using the term "transgender" as an umbrella term — which does not describe one specific group but a wide range of people with varied concepts of gender identity, such as bigender (having more than one gender), nonbinary (experiencing gender outside the traditional gender binary of male or female), as well as individuals who are at different stages of transitioning from one gender to another.

Access to Care

Recent polls indicate that 4.5 percent of the U.S. adult population identifies as LGBTQ, with 8.1 percent of millennials identifying as LGBTQ in 2017.¹ The transgender population comprises approximately 0.6 percent of this group, and this number is expected to grow as society

becomes more accepting of gender identities that do not align with one's biological sex.² However, LGBTQ patients are often marginalized and face significant health disparities. For example, according to the 2015 U.S. Transgender Survey Report, released by the National Center for Transgender Equality, 33 percent of the 27,715 respondents reported at least one negative experience related to being transgender when receiving healthcare, such as being verbally harassed or refused treatment because of their gender identity.

Further, nearly a quarter of the respondents reported not seeking healthcare when they needed it due to being mistreated as a transgender person.³ Lesbian, gay, and bisexual men and women face similar issues. A nationally representative survey conducted by the Center for American Progress in 2017 found that 8 percent of lesbian, gay, and bisexual respondents reported a healthcare provider had refused to see them because of their sexual orientation or gender identity in the past year.⁴ "It's a horrifying idea that people are not seeking healthcare and treatment such as mammography because they're not going to be treated well or because they will be made to feel uncomfortable," says Yasmin Carter, PhD, assistant professor of translational anatomy in the department of radiology at the University of Massachusetts Medical School in Worcester.

Invisible Patients

According to Carter, "Not only are there access to care issues, but there's a trickle-down effect where physicians then don't include transgender and other LGBTQ patient data in larger analyses and studies. Breast cancer research often doesn't include the discussion of gender, meaning these individuals are invisible in the research."

"The only thing we know for sure is we don't have enough information," says Valerie J. Fein-Zachary, MD, breast imager at Beth Israel Deaconess Medical Center and assistant professor of radiology at Harvard Medical School. "For example, we don't know the incidence of breast cancer in lesbians — we may assume it's the same as heterosexual women, but we have observed that many lesbians have more risk factors, due to nulliparity or greater rates of obesity, alcohol use or smoking, but we don't know. We also don't know if hormone use by transgender women or testosterone use by transgender men are risk factors. Not knowing these things means I can't give good counsel as a physician, and that's a concern."

Carter agrees. "This is a massive problem because this inadequate research results in, at best, variable guidelines for transgender and queer patients, and almost nothing in the way of population statistics," she says.

Open Environment

So how can radiologists help solve this problem? According to both Fein-Zachary and Carter, radiologists can make their practices more inclusive and welcoming to ensure that all patients feel comfortable and safe seeking care. One of the easiest ways to do this is to include rainbow flags or stickers around the practice or on staff badges, say Fein-Zachary and Carter. “Their presence says, ‘This is a safe space, and I am a safe person,’” says Carter. Adds Fein-Zachary, “Small details like this are easily missed if you’re not looking for them, but for these individuals, it makes a world of difference.”

Another way to make a practice more inclusive is to consider the unnecessary gendering of the departments. Some practices such as breast imaging facilities tend to be highly feminized, featuring pink hues everywhere, from the décor to gown color. “Mammography is still a gendered concept; we mostly think of it as a women’s issue. Consider: do you have gender neutral bathrooms? What color are the gowns? What sizes are your gowns? When you provide materials for patients, be sure you’re providing something that can cover and be comfortable for a range of individuals,” advises Carter.

Some practices, such as Fein-Zachary’s, have separate waiting rooms for men and women. “We treat our transgender women the same as we treat our cisgender women [women who identify with the gender assigned at birth],” says Fein-Zachary. “They go to the women’s waiting room and the women’s changing room. Transgender men are asked to wait in the same areas and changing rooms as cisgender men.”

Preferred Terminology

Considering the language you and your staff use is also critical. Often, the legal name of a transgender patient entered into the medical record is not the preferred name, and the gender of the legal name does not match the expressed gender of the patient. If a staff member uses the legal name instead of the preferred name, not only is the patient extremely uncomfortable, but that staff member has essentially made the patient come out all over again.

To combat this situation, make sure staff use the preferred pronouns and names of the patients. To accomplish this, make sure the intake forms and medical records include spaces for this information. Physicians also have to be sure that this information is being shared among staff, so that all staff along the chain will use preferred language. “Make sure that information is being entered in the medical record,” says Fein-Zachary, whose practice has the preferred name in parentheses next to the legal name.

Another language consideration are terms used for the body. “Some individuals prefer you use ‘chest’ instead of ‘breast,’” explains Carter. Adds Fein-Zachary, “There is a white overlay to the term ‘lesbian,’ so some women of color patients prefer we use the term ‘gay’ to identify them. You have to be conscious people have different preferences — you can’t automatically assume someone’s identity.”

And if you’re unsure of what term to use? Ask. However, be sure to restrict your question to the individual’s case and

remember that your patient’s role is not to educate you about all things LGBT. “Before you ask, make sure your question is medically relevant. Curiosity is completely normal and human, but it is not helpful or appropriate for the patient,” says Carter.

Finally, make sure your entire staff is trained in these inclusivity practices, says Carter. “We have to do it along the whole chain, from the provider to the technologist to the valet. Even the billing office should be considered. If the patient is misgendered, when working with insurance, that patient could wind up paying for everything instead of having coverage,” she says.

Where to Start

According to Fein-Zachary, if radiologists are looking to get started making their practices more inclusive or offering training for their staff, they should check out institutions that are considered facilities of excellence in LGBTQ care (see sidebar).

The most important thing is to remember that changing a practice takes time, says Fein-Zachary. “No facility changes overnight, and we are constantly learning. It’s an ongoing process,” she says. Carter agrees. “Inclusivity is not about creating unnecessary or burdensome priorities for your practice,” she says. “It’s about understanding that each of our patients has unique needs. By understanding this, we can build the patient-provider relationship in exciting and unique ways.” **B**

By Meghan Edwards, freelance writer, ACR Press

ENDNOTES

1. Newport, F. In U.S., Estimate of LGBT Population Rises to 4.5%. Gallup. May 22, 2018. Accessed Jan. 30, 2019. Available at bit.ly/2018_GallupPoll.
2. Goldberg JE, Moy L, Rosenkrantz AB. “Assessing Transgender Patient Care and Gender Inclusivity of Breast Imaging Facilities Across the United States. *J Am Coll Radiol.* 2018;15(8):1164–1172. Available at bit.ly/AssessingTransCare.
3. 2015 U.S. Transgender Survey Report. National Center for Transgender Equality. 2016. Available at ustranssurvey.org.
4. Mirza SA, Rooney C. “Discrimination Prevents LGBTQ People from Accessing Health Care.” Center for American Progress. January 18, 2018. Accessed Jan. 22, 2019. Available at bit.ly/LGB_Discrimination.

Get Started

Look to the following resources to make your practice more inclusive.

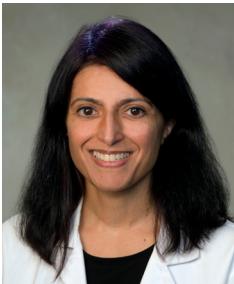
- The National LGBT Health Education Center training modules lgbthealtheducation.org
- The AAMC Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development bit.ly/AAMC_DiversityResources
- Fenway Health fenwayhealth.org
- The Human Rights Campaign Healthcare Equality Index Resource Guide for Healthcare Facilities bit.ly/hei_resourceguide
- University of California, San Francisco Lesbian, Gay, Bisexual, and Transgender Resource Center bit.ly/UCSF_ResourceCenter
- Whitman-Walker Clinic Training and Education Resource Page bit.ly/WhitmanWalker

Report to the Patient

Provider understanding and patient empowerment hinge on how radiologists present findings.

A radiologist's report should be succinct, accurate, actionable, and easy for ordering providers and patients to understand. This is the message Hanna Zafar, MD, associate professor of radiology at the hospital of the University of Pennsylvania's Perelman School of Medicine, sends to radiologists looking to move the needle on effective patient care.

With patient satisfaction tied to how clearly ordering physicians are able to relay information to patients — and what sense patients can make of their imaging results — radiologists should be moving away from meaningless jargon and antiquated formats. In a recent interview with the *Bulletin*, Zafar discussed creating reports that can lead to meaningful patient discussions and better healthcare outcomes.



We want patients to become more involved in their own healthcare. We want them to understand their results and how to act on them.

What do you consider an ideal radiology report?

It's a report that combines imaging findings, including pertinent negatives, with relevant patient history to answer clinical questions succinctly and clearly. It should be devoid of voice recognition and grammatical errors. Structured reporting can greatly assist in achieving these goals. The report should also include potential next steps, when warranted.

Why are you advocating for more patient-friendly reports?

My interest in improving communication with patients is a natural extension of my interest in improving communication with ordering providers. The radiology report is our product. Radiologists are, in many respects, inconsistent in how we create that product. We frequently include descriptive prose and terms that may be sensible to other radiologists, but do not make sense to providers and patients. It's almost as if we write reports for one another. Our impressions are often lengthy, listing findings and technical descriptions (e.g., increased T1 signal) without a clear or preferred diagnosis — or guidance on possible next steps. We can do better.

How can radiologists improve the readability of reports?

Be clear, brief, and put your nickel down in the impression. While patient preferences vary, most patients want to access radiology reports and receive radiology results from their ordering provider. Given this, reports need to be short and written in plain language, so it becomes useful as a shared decision-making tool for both patients and providers.

What components of a report are helpful to the patient?

Brevity. Patient understanding of radiology reports is inversely correlated with report length. Structured reports with subheadings for organ systems in the findings section make it easier for providers and patients to locate pertinent negative or positive findings. Including images in a report can improve patient understanding. A patient may not understand the terms "rales" or "ronchi" on an office physical exam note. However, they are more likely to understand they have pneumonia when they see a white area in their lung base surrounded by normal black lung tissue.

In addition, including the name and contact information of the interpreting radiologist within a report can make it easier for patients and ordering providers to reach you directly with questions. And no, there is no significant increase in phone calls reported by radiologists who do this. Finally, patients want their results quickly. We need to dictate results in a timely fashion, offer patients an opportunity to review their results with a radiologist if they desire, and decrease the time it takes to post results through online portals.

Should radiologists use the word "normal" in a report?

Radiologists fear the word "normal," I believe, because of medicolegal concerns. If an organ is not normal and you say it is, you have falsely reassured the patient and opened yourself up to a lawsuit. We come up with other terms in lieu of normal, such as "unremarkable." However, an interpretive error that contributes to patient harm is a potential liability, regardless of the language used. If we didn't see an abnormality, it doesn't matter if you said normal, unremarkable, or wrote 30 sentences of prose iterating what you didn't see. I like to use the word "normal" because it is brief and reassuring. A lot of the macros in my practice include the word "unremarkable." There are only so many times in a day I can remove it. What I find amusing is that you literally remarked on something — so it's not unremarkable!

What's at stake if radiology reports stay the same?

I mentioned earlier that the report is our product. That's

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My Genetically Altered Life

A radiologist recounts her journey as a patient undergoing treatment for lymphoma – and its impact on her as a physician.

Wolverine, Spiderman, Wonder Woman, and Deadpool — superheroes most of us love. Why? They have super powers and escape death because of some type of genetic alteration. Humans have always been fascinated with escaping mortality.

I should be dead, probably two years ago. But I am alive. Although I do not have a super power, I am a genetically altered human.

My story began eight years ago, when I was 48. I was practicing radiology with a large group, mothering three kids with a supportive husband, running races, and eating healthy. Twenty-four hours after I felt a 14-mm supraclavicular lymph node, I made the diagnosis when I looked at the CT monitor — lymphoma.

Six years later, after 14 rounds of chemotherapy with 16 different poisons, four lymph-node biopsies, three indwelling ports, four lumbar punctures, three bone marrow biopsies, septic shock, a broken arm, complete hair loss twice, and head-and-neck radiation, I stepped off a PET/CT scanner and immediately saw the multiple hypermetabolic lymph nodes. I broke down and sobbed. My diffuse large B-cell lymphoma had relapsed nine months after an autologous stem cell transplant. A few days later, I was told that I had no allogenic bone marrow match, and my life expectancy was six months or less without treatment.

Being a physician-patient has some advantages. Reading the research literature in lymphoma, I knew that CAR T-cell therapy had shown promise in phase 1 trials. CAR T-cell is a process in which T-cells are removed from a patient using apheresis and the cells modified in a specialty lab. A viral vector is used to insert a CAR protein into the T-cells. When the T-cells are reinfused, they attack all B-cells carrying the CD19 antigen, normal and abnormal. The process results in an acquired, manageable immunodeficiency and, hopefully, complete remission. Desperately searching for an open space in a Phase 2 trial, I found one open spot in the United States. It was like winning the lottery. There was hope.

My T-cells were removed in May 2016. Although I was supposed to be reinfused in July 2016, there were laboratory and FDA delays. At first, I was given a bridging chemotherapy, but the therapy was discontinued prior to treatment. During this delay, there was rapid clinical progression of my disease

with my palpable lymph nodes doubling in size every few days, which was both frightening and surreal.

Finally, on Sept. 14, 2016, I received my tiny bag of 6 million CAR T-cells via a quick IV flush. A host of medical personnel were in the room for the infusion completing my genetic alteration. Now we would wait, but not for long. Twenty-four hours after infusion, I had a low-grade fever, and my lymph nodes began to melt like ice cubes. Five days later, almost all the lymph nodes were gone as the side effect of cytokine release syndrome (CRS) began. I had Grade 2 CRS with a fever of 104 degrees and marked hypotension. Four weeks after the infusion, I returned to work — with all of my hair. Three months later a complete remission was confirmed. I had been given a second chance at life.

The JULIET trial was a success with 40 percent of patients obtaining a complete remission. The CAR T-cell product, KYMRIAH, was approved by the FDA in 2017, so others may now receive this treatment. Phase 1 trials of new CAR T-cell products have begun in several solid tumors, including stage 4 breast cancer.

Becoming a physician was a lifelong dream, and I remain dedicated to the field of radiology. Grateful to be working, I have a special connection to cancer patients. With my second chance, I am relishing life including becoming open water dive-certified three months after CAR-T. I have been diving in Tahiti, climbed up Skellig Michael in Ireland, hiked in Chilean Patagonia, and have run the Cooper River Bridge Run twice. Furthermore, I remain committed to giving back by fundraising for cancer charities, including the Lymphoma and Leukemia Society. Like many of you, I have interpreted hundreds of thousands of images. However, ironically, my greatest contribution to medicine may not be as a radiologist but as a patient. B

Robyn L. Stacy-Humphries, MD, is a radiologist with Charlotte Radiology in North Carolina.



Calming Patients' Fears

A California radiology practice leverages RadiologyInfo.org to ease patients' anxiety about imaging.

For the patient in the exam room, the impending imaging study is anything but routine. Maybe she's there because of a lump she hadn't felt before. Maybe he's wondering if he'll ever be able to climb the stairs to his bedroom again without pain. Whatever brings patients into Desert Medical Imaging in southern California's Coachella Valley, John Feller, MD, knows they already have plenty to worry about without being scared of the unfamiliar machines that will capture images of their bodies.

This fear is often born from simply not knowing what's going to happen during the exam. So Feller, medical director and founding partner of Desert Medical Imaging, and his team have committed to inviting incoming patients to visit RadiologyInfo.org, a website that describes more than 240 imaging procedures, before they walk through the door.

Desert Medical Imaging has done this in several ways: 1) The practice has become a RadiologyInfo.org affiliate, meaning the group links directly to RadiologyInfo.org from its website and RadiologyInfo.org links back to the practice's site; 2) the group's schedulers share RadiologyInfo.org with patients and encourages them to visit the site before they arrive for their appointments; and 3) the group shares RadiologyInfo.org both with referring physicians and with medical students who rotate through the practice and asks them to share it with their patients.

"RadiologyInfo.org is a wellspring of information that patients can visit any time of the day or night to prepare for their exams," Feller says of the site. "When patients arrive for their exams well-informed, they have fewer questions and feel less anxious about their procedures, saving radiology practices like mine time and money while improving patient care."

Demystifying Radiology

During the last two decades, teams of radiologists with the ACR and RSNA have partnered to develop RadiologyInfo.org. Together, they have populated the site with high-definition videos and plain-language explanations to help patients and families understand and prepare for their imaging exams.

Feller was on the committee that established the site 20 years ago. "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."

The site includes in-depth written descriptions of imaging studies that are searchable by disease type and patient population. It also includes "Ask Your Radiologist" videos.

"The site features information that's accurate and jargon-free," Feller says. "It ensures that patients and families actually understand what they're seeing, hearing, and experiencing during the exam."

Empowering Patients

When patients have this information, they can engage more fully in their care, and that can have a real impact on outcomes, explains Arun Krishnaraj, MD, MPH, associate professor of radiology and medical imaging at the University of Virginia Health System and co-chair of the RSNA-ACR Public Information Website Committee.

"We know anecdotally that patients who review RadiologyInfo.org often have a much better overall healthcare experience, and a much better grasp of radiology's role in their care," Krishnaraj says. "Every radiology practice should be thinking about how to provide this information to help patients prepare for and understand their radiology exams."

Desert Medical Imaging first linked to RadiologyInfo.org from its website in 1998, not long after the practice opened, Feller says. The practice's website includes descriptions of every exam it provides, and each of these explanations ends with a link to RadiologyInfo.org.

Have Your Patients Visited RadiologyInfo.org?

RadiologyInfo.org, jointly developed and sponsored by RSNA and ACR, has answers to patients' common imaging questions, including detailed explanations of what they will experience in various X-ray, CT, MRI, ultrasound, radiation therapy and procedures. Information on the site is available in both English and Spanish.

The screenshot shows the RadiologyInfo.org homepage. At the top, the logo "RadiologyInfo.org" is followed by "For patients". A search bar is on the right. Below the header, a navigation menu includes "Test/Treatment", "Children", "Screening/Wellness", "Disease/Condition", "Safety", "En Español", and "More Info". A "Spotlight" section lists recent posts: "Pediatric PICC Line Placement", "Contrast-enhanced Voiding Urosonography", "Thyroid Cancer Treatment", and "Pediatric Sedation". Other sections include "Radiology and You", "RadInfo 4 Kids", and "Pediatric Content". A large image shows a doctor interacting with a patient and family in an MRI room. The text "The radiology information resource for patients" is overlaid on the image. At the bottom, a "Welcome!" section provides general information about the site, and a "Please note" section clarifies that the site is not a medical facility. The ACR logo is at the very bottom.

org, urging patients to go there for more information.

With this in mind, the practice's schedulers encourage patients to visit the site at the time that they schedule their exams. They even email patients links to the specific pages on RadiologyInfo.org that correspond with their upcoming studies, making the most pertinent information easy to find.

This approach reduces the amount of time staff have to spend explaining studies to patients. It also saves the group money because it doesn't have to create its own educational materials, Feller says. "We're not a large healthcare enterprise," he explains.

"With RadiologyInfo.org, everything patients need to know about and prepare for their exams is right there — all we have to do is tell them about it."

Engaging Referrers

In addition to linking to RadiologyInfo.org and encouraging patients to visit the site prior to their exams, Desert Medical Imaging's marketing team asks referring physicians to tell their patients about the site.

During visits and even cold calls to these offices, members of the Desert Medical Imaging marketing team talk to referring doctors about the informational benefit the site can provide to patients and the time benefit it provides to referring physicians.



"Every radiology practice should be thinking about how to provide this information to help patients prepare for and understand their radiology exams."

— Arun Krishnaraj, MD, MPH

"Referring clinicians, especially nowadays, are asked to do more and more with the patient in less and less time," Feller says. "If they end up spending most of their 15-minute clinic visit trying to explain the imaging test that they're ordering for the patient, then it doesn't leave them much time to talk to the patient about anything else."

"We get a lot of traction from the bottom up — from trainees, residents, and medical students who have grown up in the digital age," Feller says. "They know that when people need information, they turn to the internet first, and they recognize the importance of directing patients to information that has been vetted by the field's top professionals." **B**

By Michael Wereschagin, freelance writer, ACR Press



Reaching Out to Children

RadiologyInfo.org has launched a new section of its website specifically for children to help them prepare for diagnostic imaging exams. RadInfo 4 Kids contains videos, stories, games, and activities that were created by children for their peers to help make them more comfortable when undergoing radiologic exams. All of the projects featured on the page are short and designed to be viewed or read quickly, which is extremely helpful during stressful emergency situations.

"An important benefit of RadInfo 4 Kids is that by calming a child, radiologic exams can be done quickly and efficiently, which can have a marked impact on improving a child's health," says Arun Krishnaraj, MD, MPH, co-chair of the RSNA-ACR Public Information Website Committee.

20.7 million patients and families visited [radiologyinfo.org](#) in 2018.

Over 245 procedure, exam and disease descriptions covering diagnostic and IR, nuclear medicine, radiation therapy, and radiation safety

Leading the Field

ACR recognizes leaders in the imaging community at this year's annual meeting.

Each year, the College awards individuals whose work and dedication advances and strengthens the specialty. Spanning continents and subspecialties, this year's recipients include individuals from across the community of imaging. Commendations will be awarded at the 2019 ACR Annual Meeting in May.

Gold Medal



Bibb Allen Jr., MD, FACP
Birmingham, Ala.

Bibb Allen Jr., MD, FACP, completed an internship and two years in general surgery and research at the University of Alabama Hospital, before completing his residency in diagnostic radiology at Baptist Medical Center in Birmingham.

The Gold Medal is awarded by the BOC to an individual for distinguished and extraordinary service to the ACR or to radiology. View the list of past recipients at acr.org/GoldMedal.

Allen's involvement with the ACR started in the early 1990s as an officer for the Alabama state chapter and working as a member of the Alabama Medicare Carrier Advisory Committee (CAC) regarding local Medicare/coverage issues. From there, Allen suggested to the ACR Commission on Economics that the College develop a network of the state CAC representatives, which became the ACR CAC Network. Allen later became a state councilor and member of the CSC. He later went on to become the ACR advisor and then ACR member of the AMA/Specialty Society Relative Value Scale Update Committee. Within the Commission of Economics, he served as chair of the CAC Network and Reimbursement Committee and then served as chair of the Commission on Economics.

After serving on the ACR BOC as chair of the Commission on Economics, Allen was elected chair of the BOC and later ACR president. As ACR president, Allen also chaired the Commission on Membership and Communications. While Allen was BOC chair and vice chair, he facilitated the development of the Imaging 3.0® initiative and worked closely with other radiology societies to ingrain the quality and value message into the radiology culture. After his term as ACR chair, Allen stayed involved in important issues facing radiology including AI and currently serves as chief medical officer of the ACR Data Science Institute™. Allen also serves as chair of the Harvey L. Neiman Health Policy Institute® advisory board.

Looking back at this career, Allen is most proud of the physicians he's worked with in his community

hospital's radiology residency program, as well as the young people recruited as volunteers for the Commission on Economics. "Two volunteers have become commission chairs and one is the current ACR BOC chair," says Allen. "Seeing their accomplishments eclipse mine warms my heart. It has been a true privilege working with them and providing modest mentorship."

Allen points to service to the ACR and organized medicine as the highlight of his professional life. "I encourage every radiologist to find the time to participate in the ACR or other specialty society," Allen says. "It will benefit you, your practice, and all radiologists."



Manuel L. Brown, MD, FACP
Detroit

While he was growing up, Manuel L. Brown, MD, FACP, had an uncle who was a radiologist. At the time, Brown found the idea boring and planned a career as a chemist or lawyer. However, on a six-month European tour between his junior and senior years in college, he visited the International Museum of Surgical Science — a trip that entranced him. He decided to go to medical school, undeterred by his advisor at the University of Michigan at Ann Arbor telling him he wasn't going to be accepted.

After completing medical school, Brown thought he was going to be a cardiologist. During his internal medicine internship, he realized cardiology was not for him — instead falling in love with radiology and nuclear medicine. He thrived at the Mayo Clinic in Rochester, Minn., staying there for 14 years. He then moved to Pittsburgh to raise two young sons and where he started a state-of-the-art PET center, practiced nuclear radiology and served as vice chair of the department of radiology at the University of Pittsburgh Medical Center. Brown currently serves as chair of the department of radiology and the Zolton J. Kovacs Endowed Chair at the Henry Ford Hospital and Health Network in Detroit.

Brown is a former ACR president and a former chair of the Commission on Nuclear Medicine and Molecular Imaging. He has participated in many organized medical societies and encourages young radiologists to do so by leading by example. According to Brown, “Whether it’s the ACR, the ABR, or the American Roentgen Ray Society, I encourage, I facilitate, and I try to get radiologists involved in radiology organizations as part of giving back to our specialty.”



David C. Kushner, MD, FACP
Virginia Beach, Va.

David C. Kushner, MD, FACP, says his life's mission has been focused on improving healthcare for children. He attributes his progress in diagnostic pediatric radiology to the hard work of

ACR members, staff, and mentors who have guided and helped him.

Born in Fargo, N.D., his journey took him to an undergraduate degree at the University of Minnesota and medical school at the University of Pennsylvania. Kushner trained in a pediatric internship and residency, followed by a research fellowship at the National Institutes of Health, after which he returned to Boston for a radiology residency at Massachusetts General Hospital (MGH). Kushner then returned to Boston for a pediatric radiology fellowship and chief residency at Boston Children's Hospital, followed by an appointment as chief of radiology at Children's Hospital of The King's Daughters, in Norfolk, Va.

Kushner currently serves as medical director for quality and safety at Children's Hospital of The King's Daughters. He also serves as professor of pediatric radiology at Eastern Virginia Medical School in Norfolk, Va. He formerly served as chief of pediatric radiology at MGH, followed by an appointment as chair of radiology at Children's National Medical Center in Washington, D.C. He has held academic appointments at Harvard Medical School and the George Washington University.

Kushner is former president of the ACR and former chair of the Commission on Membership and Communications. More than 100 of his research articles have been published in refereed and non-refereed journals. In

addition, he has written numerous book chapters and abstracts. He also contributes his time as a manuscript reviewer for several pediatric and radiology journals.

Kushner calls it a unique privilege to care for sick children and their families. According to Kushner, “When I have been able to work with my team to improve the lives of children, the reward is immeasurable.”

Honorary Fellowship



Seung Hyup Kim, MD
Seoul, South Korea

Seung Hyup Kim, MD, had no intention of being a doctor. He was interested in animals, especially fish, and in photography — hobbies that he says may have led to a career as a radiologist. When he was starting his career as a radiologist at Seoul National University Hospital, fortune struck when those senior to him took the specialties of the larger parts of the body. Only urogenital radiology was vacant, and Kim happily took it. “After 30 years as a urogenital radiologist, I can say it was one of the best things I chose in my life, and I am proud to be a part of my specialty,” Kim says.

Kim was a visiting radiologist at the University of Pennsylvania in 1989, and his mentor was Howard M. Pollack, MD, a pioneer of uroradiology. Pollack had vast collections of teaching files to prepare for his book *Clinical Urography*. Kim learned how the materials had been collected, categorized, and retrieved by using the ACR Index, an online computer system that allowed radiologists to access a list of radiologic diagnoses from any web browser. Kim did the same and published *Radiology Illustrated: Uroradiology*. Kim since has published numerous books, chapters, and papers, as well as made frequent presentations and lectures.

As immediate past president of the Korean Society of Radiology (KSR), Kim, now professor of radiology and urology at the Seoul National University College of Medicine, believes that through this award, ACR is acknowledging not only his career in Korean and international radiology, but also the efforts of the Korean Society of Radiology. According to Kim, “I am deeply grateful to ACR and KSR for this honor.”

The Honorary Fellowship award recognizes the contributions to radiology by individuals who are ineligible for ACR Fellowship. View the list of past recipients at acr.org/HonoraryFellow.



Anne W.M. Lee, MD
Hong Kong

Anne W.M. Lee, MD, became fascinated with radiology during medical school. Upon graduation, aspiring diagnostic radiologists in Hong Kong were required to complete one year of clinical work before pursuing the specialty. Lee sought advice from John H.C. Ho, MD, known to the radiology community in Hong Kong as “Emperor Ho.” Ho advised Lee to use the year to study clinical oncology. During that year, Lee found her dream career of fighting cancer and began a career treating nasopharyngeal cancer (NPC).

Lee calls NPC a unique cancer, rare in western countries but prevalent in Southeast Asia. NPC often presents in advanced stages. Lee had a leading role in revolutionizing the staging system and in rallying over 20 international experts to develop guidelines for radiotherapy planning.

Lee is most proud that the age-standardized incidence rate for NPC has decreased by 70 percent and the corresponding mortality rate has decreased by 71.4 percent from 1983 to 2016 (statistics from the Hong Kong Cancer Registry). The five-year cancer-specific survival for NPC has increased from 50 percent in the late 1970s to 85 percent in the 2010s.

Lee established the department of clinical oncology at Pamela Youde Nethersole Eastern Hospital in Hong Kong in 1994. According to Lee, when celebrating the hospital’s tenth anniversary in 2004, among the patients invited on stage was a mother with her nine-year-old daughter. The mother had been treated for Stage 2 NPC when she was four months pregnant. To minimize scatter radiation dose to the womb, Lee and her staff made a heavy lead shield to cover the abdomen for the course of 35 fractions. It took four staff to position the shield. “At that anniversary event, we wheeled out the shield and showed the little princess how we had protected her before she was born,” Lee says.

The Distinguished Achievement award recognizes highly notable service that reflects in a uniquely favorable manner on the ACR and the profession. View the list of past recipients at acr.org/DistinguishedAward.

Distinguished Achievement Award



James L. Morrison
Leesburg, Va.

James L. Morrison served as ACR’s assistant executive director of member services, retiring in 2013 after nearly 18 years with the College.

Morrison received a Bachelor of Science degree from the United States Military Academy at West Point, N.Y., in 1966, a master’s in radiological physics from Columbia University’s Vagelos College of Physicians and Surgeons, and a master’s degree in systems management from the University of Southern California.

Morrison came to the ACR in 1995 after completing over 29 years of commissioned service in both the U.S. Army and U.S. Public Health Service (USPHS). While in the Army, he worked primarily as a radiological physicist in a clinical radiation oncology setting. His 21 years as a commissioned officer in the USPHS were spent working for the FDA in the Bureau of Radiological Health and Center for Devices and Radiological Health.

Working in the clinical environment, Morrison is proud of the contributions he made to patient care. While at the FDA, he helped develop national and international radiation safety guidelines including the implementation of the Mammography Quality Standards Act of 1992. He also helped develop programs to address a variety of medical device adverse incidents. At the ACR, he recalls the dedication of ACR staff in providing superior member services. Morrison’s advice to leaders is to trust their colleagues and seek new solutions to challenges. “There are many ways to get to the top of the hill,” says Morrison. “I’m not going to tell you how to get there. Just get there.” **B**



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Nominees for 2019 Positions

At the annual meeting, the ACR Council will vote on the following slate of candidates recommended by the College Nominating Committee (CNC).

OFFICERS

- Debra L. Monticciolo, MD, FACR, of Temple, Texas, for president
- Katarzyna J. Macura, MD, PhD, FACR, of Baltimore, for vice president

COUNCIL SPEAKER

- Richard Duszak Jr., MD, FACR, of Atlanta

COUNCIL VICE SPEAKER

- Joseph G. Cernigliaro, MD, FACR, of Jacksonville, Fla.
- Amy L. Kotzenas, MD, FACR, of Rochester, Minn.

BOARD OF CHANCELLORS

The CNC recommends the following members be considered for election to the BOC:

- Robert S. Pyatt Jr., MD, FACR, of Chambersburg, Pa., has been recommended to run for a second three-year term to chair the Commission on General, Small, Emergency and/or Rural Practice.
- William Small Jr., MD, FACR, of Maywood, Ill., has been recommended to run for a first three-year term to chair the Commission on Radiation Oncology.
- Jenny T. Bencardino, MD, of Jericho, N.Y., and Johnson B. Lightfoote, MD, FACR, of Pomona, Calif., have been recommended to run for a first three-year term to chair the Commission for Women and Diversity.
- Theodore Dubinsky, MD, of Seattle, Thomas Ptak, MD, MPH, PhD, of Severn, Md., and Timothy L. Swan, MD, FACR, of Marshfield, Wisc., have been recommended to run for a first three-year term for an open position on the BOC.

COUNCIL STEERING COMMITTEE

Of the following nine candidates, four are to be elected in a contested election by the Council to serve a two-year term on the CSC:

- Timothy A. Crummy, MD, FACR, of Middleton, Wisc.
- Eric B. Friedberg, MD, FACR, of Johns Creek, Ga.
- Lauren P. Golding, MD, of Summerfield, N.C.
- Richard B. Gunderman, MD, FACR, of Zionsville, Ind.
- Seth M. Hardy, MD, MBA, FACR, of Lititz, Pa.
- K. Elizabeth Hawk, MD, MS, PhD, of Studio City, Calif.
- Andrew B. Rosenkrantz, MD, MPA, of New York City
- Kevin L. Smith, MD, FACR, of Sauk Rapids, Minn.
- David C. Youmans, MD, FACR, of Princeton, N.J.

ACR2019

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The election manual, featuring detailed information on the candidates, will be available to all councilors prior to ACR 2019 at acr.org/Annual-Meeting.

COLLEGE NOMINATING COMMITTEE

Of the following five candidates, three are to be elected in a contested election by the Council to serve a two-year term on the CNC:

- Scott F. Cameron, MD, of Newton, Mass.
- Candice A. Johnstone, MD, of Shorewood, Wisc.
- Taj Kattapuram, MD, of Arvada, Colo.
- Rajendra P. Kedar, MD, FACR, of Tampa, Fla.
- Derrick Siebert, MD, of Wausau, Wisc.

PRIVATE PRACTICE REPRESENTATIVE

- Rand J. Stack, MD, MBA, of Franklin Lakes, N.J., was selected for one two-year term as a private-practice representative to the Intersociety Summer Conference, effective in July 2019.

ASTRO REPRESENTATIVE

- William Small Jr., MD, FACR, of Maywood, Ill., was selected to serve as the ASTRO representative on the BOC for a three-year term.

One Size Does Not Fit All

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out if a machine will fit them or to tell the technician that they won't fit," Abbott says. "Some patients don't even know to ask, and they could get stuck. Radiology practices can help reduce worry and anxiety by just scheduling the right machine to accommodate each patient." Abbott also advises practices to have gowns available in larger sizes such as XLs or above so patients feel as comfortable as possible.

According to Uppot, in the age of EHRs and clinical decision support tools, the incorporation of weight limits into the ordering/scheduling process could avoid issues of patients being scheduled for procedures on equipment that they may not fit in. While many accommodations are straightforward, others may require some creativity. "Measuring girth is a challenge at some facilities," says Uppot. "One facility I know of bought a hula hoop to determine if patients were going to be able to fit. If you cannot get a good ultrasound, use your CT. CT is the most accommodating for larger patients."

"We're going to see more and more patients who have severe obesity, and it's our responsibility as medical professionals to make sure we're equipped to treat them."

— Scott Kahan, MD, MPH

Lastly, Uppot emphasizes, if you simply cannot image a patient at your facility, be prepared with information on where your patient can get the imaging done nearby: "If you are telling a patient you can't accommodate them for imaging, your next statement should be, 'But here's where you can get your scan down the road.'"

Abbott hopes that, thanks to the efforts of healthcare providers like Uppot and

Kahan, practices will have more compassion and understanding for obese patients. "There's a certain level of condemnation and a little bit of punishment for being overweight," she says. "It feels like, 'You've made this choice to be overweight, so this is the penalty for being your size: we're not going to accommodate you.'"

Kahan believes it's unacceptable for any patient to feel marginalized. "It's important to inform patients of the risks and challenges of imaging when they're bigger, but this should be done in a respectful and compassionate way," Kahan says. "I would hope that the medical field, and radiology in particular, will devote the same attention and innovation to developing solutions for imaging bigger people as they would when faced with challenges to providing quality care for any other patient group — so that we can ultimately serve patients of all shapes and sizes." **B**

By Cary Coryell, publications specialist,
ACR Press

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Report to the Patient

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true, but it's not our end game. The true measure of a successful radiology report is whether it communicates useful information to the provider and patient — and leads to an educated discussion that includes the radiologist. Even if patients don't understand every word, they should understand the salient points and start to generate questions about how the results relate to the symptoms that lead to the test and possible next steps. We want patients to become more involved in their own healthcare. We want them to understand their results and how to act on them. We can move the needle on this by changing how we write our reports. **B**



JOB LISTINGS

CLASSIFIED ADS These job listings are paid advertisements. Publication of a job listing does not constitute a recommendation by the ACR. The ACR and the ACR Career Center assume no responsibility for accuracy of information or liability for any personnel decisions and selections made by the employer. These job listings previously appeared on the ACR Career Center website. Only jobs posted on the website are eligible to appear in the *ACR Bulletin*. Advertising instructions, rates, and complete policies are available at jobs.acr.org or e-mail careercenter@acr.org.

Massachusetts — Tufts Medical Center's department of radiology is seeking a full-time and a part-time breast imager, preferably fellowship-trained. The department has an excellent equipment base. Tufts Medical Center is a not-for-profit, 415-bed academic medical center located in downtown Boston and is an EEO/AA employer.

Contact: Send confidential CVs to Barry Baker at bbaker1@tuftsmedicalcenter.org.

Washington — Vancouver Radiologists, P.C., has an opportunity available for a musculoskeletal (MSK) radiologist. The candidate must be fellowship-trained in MSK and have strong general radiology skills. Mammography proficiency is desired. The position will function between two physician-owned imaging centers and a local hospital. The position is partnership track and will involve some rotational call and weekend days.

Vancouver Radiologists, P.C., also has an opportunity for a radiologist fellowship-trained in body imaging and with strong general radiology skills. Mammography proficiency is desired. The position rotates between two imaging centers and a local hospital. The work schedule includes four weekdays and rotational weekends and night call.

Contact: Email cover letters and CVs to Cindy Mc-Casker at HR@vanrad.com.

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How do you foster patient- and family-centered care in your practice?

Over the past several months, I have started to personally speak with every diagnostic mammography patient, even if the results are benign or negative. Informing women that the results of their diagnostic mammograms are negative or benign has resulted in many of them crying with tears of joy, providing me with hugs and numerous thank yous, and then leaving in a state of euphoria and peace.

— *Samir B. Patel, MD, FACP, founder and director of the value management program at Radiology, Inc., in Mishawaka, Ind.*



By practicing patient- and family-centered care, radiologists can improve patient satisfaction, health outcomes, and the overall imaging experience, while also reducing healthcare cost and disparities.

— *Lucy B. Spalluto, MD, director of Vanderbilt University Medical Center's Women in Radiology initiative and associate director for diversity, equity, and inclusion in the department of radiology*



Our radiologists try to provide patient-friendly reports on imaging exams. Our patients can view their reports on our patient portal, so it is important that our reports be clear and understandable. Our radiologists are also available to review exam findings with patients and accompanying family members. A consultation with a radiologist is available upon request and at any time during the workday.

— *Debra S. Dyer, MD, FACP, chair of the department of radiology at National Jewish Health in Denver*

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