ACR LEADERSHIP | INTEGRITY | QUALITY | INNOVATION

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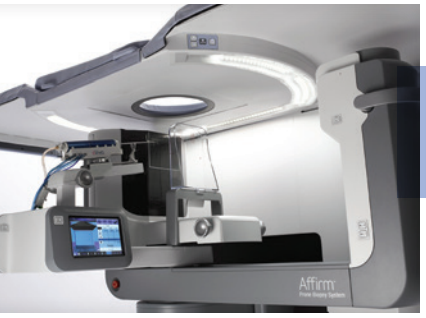
Bulletin



From Three Biopsies Daily to a Referral Center for Challenging Cases

In the competitive landscape of breast imaging, how does a facility stand apart and earn a reputation as a center of excellence and respected referral center? For Harriet Borofsky, MD, of Mills-Peninsula Women's Center, a referral center in San Mateo, Calif., a key factor is the Hologic Affirm® prone breast biopsy system.

A New Problem

In 2014, Mills-Peninsula Women's Center fully transitioned to Hologic's 3D Mammography™ systems to improve breast cancer screening. That's when they realized they had a new problem: how to biopsy the subtle calcifications and lesions they found through tomosynthesis screening while using a breast biopsy system that relied upon 2D imaging? So, when tomosynthesis-guided biopsies were introduced to the market, the technology was embraced with open arms.

"We struggled. Thank goodness we got the Affirm system, which was the only way to biopsy lesions seen under tomosynthesis only," said Dr. Borofsky. "Essentially, 2D stereotactic biopsies have become obsolete. We don't use it ever. Instead, we're using tomosynthesis for guidance of all lesions."

Initially Mills-Peninsula made the transition by acquiring an Affirm® upright biopsy system. Later, they added the Affirm® prone system, marrying the benefits of tomosynthesis-guided biopsies with the advantages of a prone table. Today, they perform biopsies on both Affirm® prone and upright systems, allowing them to care for the widest spectrum of patients possible. This new biopsy capability had a tremendous impact on the facility — and not just in the biopsy suite. It ultimately made it possible for Mills-Peninsula to become a local referral center for difficult biopsy procedures, in addition to increasing capacity and improving patient experience.

> "Because we have the prone table, we have become a referral center for difficult biopsies and difficult lesions."

A Center of Excellence for Patients

For Mills-Peninsula, establishing itself as a referral center is paramount to its success. Dr. Borofsky noted local centers refer difficult biopsies to their facility, which elevates their status as a center of excellence offering state-of-the-art technologies.

"It puts our breast center in the community spotlight. It speaks to our mission, which is to be a center of excellence for our patients and our community. Not only do we want to provide the best quality care, but we also want patients to have a good experience. We want them to feel confident we're the center to come to for care."

A recent patient referral to Mills-Peninsula illustrates this perfectly. The patient had a baseline mammogram during which the breast compressed very thin, about 18 millimeters, and showed suspicious amorphous calcifications. Initially, a surgical excisional biopsy was recommended because the facility could not perform a needle biopsy, but the surgeon later referred the patient to Mills-Peninsula.

What was impossible for another facility was now, thanks to the Affirm® prone system, a straightforward and simple procedure for Mills-Peninsula. "That's a lateral arm approach and a five-minute procedure," affirmed Dr. Borofsky.

Previously, biopsies requiring a change in approach were difficult and time consuming. Thanks to the lateral needle approach, "You can basically biopsy any lesion in the breast, even breast tissue that compresses very thin," explained Dr. Borofsky. "When the procedure is fast, efficient and goes well, and even more so when it's complicated, [the Affirm system] is incredible. It's a huge improvement to the prone table that we had before."

Increasing Volume When Time is of the Essence

Mills-Peninsula has seen a distinct increase in capacity since making the transition to the Affirm® prone breast biopsy system.

"We used to schedule a maximum of three stereos in a day," said Dr. Borofsky. "Now we can do three in the morning and two in the afternoon. We could probably do more; the procedures go so quickly."

Part of what makes this increased volume possible is the speed of performing biopsy procedures, even difficult ones, with the Affirm® prone system. "We're a very busy center, so time is a stress and patients are waiting. If I'm in and out of the biopsy room in 5 minutes, that is awesome. That's literally how long I am in the room for most one-lesion procedures."

The other factor is confidence. For Dr. Borofsky, part of her confidence in her biopsy procedures comes from enhanced image quality and a broadened field of view offered by the Affirm® prone system.[i] The high-quality imaging of the system allows clinicians to pinpoint extremely subtle lesions, including low contrast distortions and faint calcifications, quickly and confidently.[i] Additionally, the detector is more than 6.5 times larger than previous generations of prone biopsy systems, offering an expansive view of the breast to allow for easy targeting.[i,ii]

"If you're not 100% sure, you have a larger field of view to know where you are in the breast. If you have to reposition, you know where you need to go. The larger field of view is a big advantage to the new Affirm system."

Prioritizing Patient Experience

Prioritizing patient comfort and satisfaction is another way Mills-Peninsula sets itself apart as a center of excellence. When it comes to patient experience, Dr. Borofsky has two primary goals: reducing patient anxiety and allaying any concerns.

"I try to allay all of the anxieties associated with a biopsy if I am able. I want her to feel confident she is A) in the best and the most experienced of hands and B) that we have all the technologies at our finger tips to make the procedure as accurate, quick and least invasive as possible. And the [Affirm] prone table really assists in that regard."

For Dr. Borofsky, a quick and efficient biopsy procedure plays an important role in the overall patient experience.

"In terms of speed, probably the most important aspect of the technology is conspicuity of lesions. Whether it's calcifications, architectural distortion, round or irregular masses — if you can target on that first sweep of tomosynthesis images and see the lesion, you've already saved so much time."

Previously, stereotactic biopsies could take 30-45 minutes — a frustrating, yet accepted, reality of older systems and technologies. That no longer has to be the case, nor is it the case for Dr. Borofsky's patients.

"If a patient is on the table for 30 minutes just to localize the lesion, that's going to be an awful experience that she will not forget. If she is up and off the table in 10 minutes, and we localize the lesion on the first tomo sweep, that is a procedure that has a minimal impact."

In fact, a recent survey found more than 95 percent of patients agreed their Affirm® prone biopsy procedure was faster, more comfortable and less painful than expected.[iii]

"Patient feedback is always positive," affirmed Dr. Borofsky. "When you call patients with results, the response is always 'oh my gosh, Dr. Borofsky, that was so much easier than I had anticipated.' That speaks to procedures that go well."

In the end, it all comes back to the Hologic Affirm® prone breast biopsy system.

"We have utilized Hologic's technologies for such a long time. I think Hologic has really set high standards for innovation, certainly in the area of breast imaging technologies."

HOLOGIC®
The Science of Sure

Opinions expressed are solely those of the participants.

[i] Compared to the MultiCare® Platinum system. [ii] Compared to existing dedicated prone biopsy systems. [iii] Based on a survey of 165 patients post-procedure at 3 hospitals.

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

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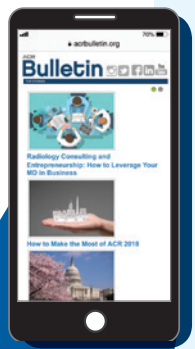
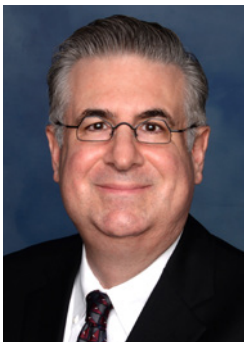
QUESTIONS? COMMENTS? Contact us at bulletin@acr.org
Archives of past issues are available at ACRBULLETIN.ORG



Check out the digital edition!
Read more at **acrbulletin.org**

CLARIFICATION: The July *Bulletin* article "Getting It Right" reported that effective Jan. 1 of this year, The Joint Commission has implemented new requirements for fluoroscopy. Since publication of the July issue, The Joint Commission has decided to delete the fluoroscopy user training requirement from the requirements that went into effect Jan. 1. Please visit www.imagewisely.org for The Joint Commission's full statement or contact dgress@acr.org for additional information.

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



Ian A. Weissman, DO, FACR

Chair, GSER Network Veterans Affairs Subcommittee

Guest Columnist

Building External Relationships

ACR is working with radiology leaders in the VA to increase engagement, participation, and member value.

As the Civil War came to a close, President Lincoln made a pledge to those who had fought: "To care for him who shall have borne the battle, and for his widow, and his orphan." That vow is carried through today by the physicians and medical staff who serve and honor America's veterans. These words resonate with me and my colleagues who have pledged to serve these patients. As physicians, we are proud to work for the Veterans Health Administration — which offers unique opportunities to develop quality and patient-outcome measures in radiology, as well as system-wide, value-based initiatives.

One of the ACR's strategic priorities is to build collaborative external relationships. Under the leadership of Robert S. Pyatt Jr., MD, FACR, chair, and Eric B. Friedberg, MD, FACR, vice chair, of the ACR's Commission on General, Small, Emergency and/or Rural Practice (GSER), a strengthening collaboration has occurred between the ACR and the U.S. Department of Veterans Affairs (VA) and the military. The success of the ACR 2019 plenary sessions on emergency and military radiology (and last year's session on radiology in the VA) illustrates the value that comes from exchanging ideas and building on important shared initiatives that are part of the strategic focus of the GSER Network VA Subcommittee.

The Subcommittee is working with radiology and radiation oncology leaders in the VA to bring forth positive change through initiatives that increase engagement, participation, and member value. This includes supporting ACR advocacy activities, such as the recent successful effort to abandon a VA proposal that would have allowed non-radiologists to interpret imaging studies. Efforts to build upon ACR-subsidized educational offerings for VA and military radiologists are also priorities.

I met Tahira F. Ahmed, MD, and Michelle L. Dorsey, MD, at the Radiology Leadership Institute® (RLI), and both have brought their leadership experience to the Subcommittee. According to Ahmed, chief of breast imaging at the VA in Washington, D.C., "It is a privilege to be part of a group that takes an active role in improving communication amongst all VA radiologists and, as a result, improving the overall patient experience." Dorsey, chief of radiology at the Phoenix VA Healthcare Systtem, is currently a White House Leadership Fellow addressing mission-critical challenges and developing cross-agency initiatives.

As a VA radiologist, my personal experience through the RLI has been tremendously positive. I am grateful for the mentoring and support I received while completing the RLI Leadership Mastery program. My involvement in the RLI led to a cultural transformation, as I am always thinking about better ways to provide exceptional healthcare. It is my great pleasure to work with my dedicated ACR colleagues, and to identify and mentor new leaders through ACR. Together, we are collectively advocating to improve the care of our patients. Dr. Friedberg says, "It has been a true pleasure partnering with Dr. Weissman. We have all greatly benefited from his strong leadership and exceptional advocacy efforts, which were uniquely recognized at this year's annual meeting where he received the ACR's Advocate of The Year award."

Other VA subcommittee members include Amilcare Gentili, MD, chief of radiology at the San Diego VA, who says, "The Subcommittee provides an avenue to establish collaboration of VA physicians on a variety of topics, such as patient safety, quality, and research." David C. Semerad, MD, has served in the Army, and brings his firsthand experience to improving the care of veterans through the Omaha VA. According to Semerad, "All veterans made many sacrifices to preserve our way of life, and the best way to thank them is to give 100 percent every day you go to work."

Drew Moghanaki, MD, MPH, chief of radiation oncology at the Atlanta VA, is currently leading two national research projects, including the VA-Partnership to Increase Access to Lung Screening — which has now reached over 25 VA medical centers across the country. The success of research projects like these rely upon interdisciplinary collaboration among colleagues and demonstrate what the ACR and VA can accomplish together. Moghanaki and I both serve on ACR's Lung Cancer Screening 2.0 Steering Committee to move forward these initiatives. According to Moghanaki, "It is an honor and pleasure each day to serve the fine veterans of this country. Together we can show how the VA can lead the way to solve some of our most difficult healthcare problems."

We are fortunate to have such extraordinary radiologists and radiation oncologists at the VA who, together with the ACR, are moving forward positive initiatives to improve the care of our veterans. B

Dr. Weissman would like to acknowledge the role of Eric B. Friedberg, MD, FACR, in the development of this column.

engage

If you would like to contribute ideas to the GSER Network VA Subcommittee, please share your thoughts on VAROCKS, an open community on ACR Engage at engage.acr.org.

Left to right: Lexia Chadwick, Baotran Vo, Brian Thomas, Raymond B. Wynn, MD, FACR (preceptor), Victoria Gonzalez, and Naomi Isaac convened in Rosemont, Ill., for this year's ACR-Nth™ Dimensions PIER program.

ACR Kicks Off Nth Dimensions Summer Internship Program

With the help of several members of the Chicago Radiological Society's Diversity Committee, the ACR welcomed five new radiology interns for the Nth Dimensions™-ACR Summer Internship Program on Saturday, June 1, at the Orthopedic Learning Center in Rosemont, Ill. Orientation for the 2019 class included a Sawbones Workshop that highlighted radiology and radiation oncology, as well as orthopedics. ACR volunteers introduced the interns to procedures such as catheterization, inferior vena cava filter placement and retrieval, and US-guided biopsies and aspirations. They also demonstrated how radiation oncologists plan and execute radiation treatment for patients. The ACR-Nth Dimensions PIER internship gives first-year medical students the opportunity to become more familiar with the field of radiology. The 2019 ACR-Nth Dimensions PIER scholars and their preceptors are as follows:

Lexia Chadwick	Raymond B. Wynn, MD, FACR, and Anil Sethi, PhD, both of Loyola University
Victoria Gonzalez	Andrea A. Birch, MD, Vanderbilt University
Naomi Isaac	Michele H. Johnson, MD, FACR, Yale University
Brian Thompson	Derek L. West, MD, Emory University
Baotran Vo	Susan J. Ackerman, MD, FACR, and Meryle J. Eklund, MD, both of the Medical University of South Carolina

Raymond B. Wynn, MD, FACR, and Jan Cox, senior director of operations, represented the ACR Commission for Women and Diversity. Chicago volunteers included Ritu Arya, MD, Kirti Kulkarni, MD, Alice Y. Yao-Lee, MD, Ashley Altman, MD, and Carina W. Yang, MD. This workshop offered a glimpse into the activities slated for the 2019 Chicagoland Radiology Expo, which is planned for Sunday, Nov. 10, and sponsored by the Chicago Radiological Society.

For more information about the ACR PIER Program, please contact Jan Cox at jcox@acr.org.

RLI Summit: Roadmap for a Changing Landscape

Ready to sharpen your non-interpretive skills? Hear from radiology's top players on high-impact business theories to transform how you manage your department at the 2019 RLI Leadership Summit, taking place Sept. 6–8 at Babson College in Wellesley, Mass. This year's gathering will show you how to operate within new payment systems, redefine your personal brand, drive better decision-making with your team, and develop greater resilience to remain relevant. You will have the opportunity to join sessions led by business school experts and today's radiology thought leaders, network with your peers and share best practices, and learn strategies to assess and solve real-world practice problems.

To register for the meeting, visit acr.org/RLI-Summit.

ACR Selects Inaugural Medical Physics Fellow

Ashley E. Rubinstein, PhD

In January, the ACR BOC approved the establishment of the Richard L. Morin, PhD, Fellowship in Medical Physics, sponsored by the Commission on Medical Physics. The fellowship provides the opportunity for one or two medical physics residents to obtain direct exposure to the functions of the ACR across departments, areas, and programs. A fellow's focus can be determined by their domains of interest, as well as the current happenings around the College. Areas of potential interest to a fellow include but are not limited to quality and safety, practice parameters and technical standards, the ACR Dose Index Registry®, accreditation, the ACR Data Science Institute™, education, economics, research, the Harvey L. Neiman Health Policy Institute®, and government relations. According to Mahadevappa Mahesh, MS, PhD, FACR, chair of the ACR Commission on Medical Physics, "The fellowship allows us to provide a medical physics resident-in-training an opportunity to learn about the inner workings of the College and at the same time attract younger medical physicists to become members of the College and contribute to all of the important work we will be doing in the coming years as we continue moving into value- and population-based healthcare."

To read a Q&A with the first fellow, Ashley E. Rubinstein, PhD, visit bit.ly/MorinFellowship_Rubinstein.

Spend an Hour With RLI's Experts

The Radiology Leadership Institute® Power Hour series is a selection of free, bi-monthly webinars that provide radiologists at all career stages with valuable insights on a host of leadership and healthcare topics. Chaired by Jennifer E. Nathan, MD, and C. Matthew Hawkins, MD, each 60-minute webinar will provide expert analysis supported by data and practical tools that participants can use to promote better team workflow and improved service quality.

The next in the series, "Challenging Physician Issues," will take place on Wednesday, Aug. 28, 2019, at 7:00 p.m. EDT. Faculty members Cheri L. Canon, MD, FACR, and Marta E. Heilbrun, MD, MS, will share their experiences with tough physician issues that arise and how they ultimately overcame them.

For more information and to register, visit acr.org/RLI_PowerHour.

Study Finds Increased CT Use in ED for Suspected Urolithiasis Patients

New research, performed in conjunction with the Harvey L. Neiman Health Policy Institute®, examines changing characteristics of utilization and potential disparities in ED patients undergoing CT of the abdomen and pelvis (CTAP) for suspected urolithiasis. Patricia Balthazar, MD, a radiology resident at Emory University, and her team used the Nationwide ED Sample, which is the largest publicly available all-payer ED database in the country to study patients from 2006 to 2015 with a primary diagnosis of suspected urolithiasis. The annual numbers of ED visits for suspected urolithiasis and associated CTAP examinations per visit were determined along with patient demographics, payer status, and hospital characteristics as potential independent predictors of utilization.

According to Balthazar, "Overall, CT utilization rates in the ED continue to increase over time despite government and medical specialty organization initiatives to restrain the growth of advanced imaging services. Although the U.S. population grew by 6.9 percent from 2006 to 2014, the annual ED visits for suspected urolithiasis increased by 17.9 percent, and the number of visits for suspected urolithiasis involving advanced imaging increased by 100.8 percent." Balthazar notes that these findings provide important information to practicing clinicians, researchers, and policymakers interested in optimizing the use of advanced medical imaging in the ED.

Read the full study online in the *JACR*® at bit.ly/CT-Use.

Here's What You Missed at ACR 2019

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.**

Reflections From a #RADmama

An attendee offers a glimpse into what it was like to attend ACR 2019 with a child in tow. Read more about her experience at **bit.ly/Radmama.**

Meeting With a Mentor

ACR 2019 featured a mentorship program that matched residents with seasoned attendings to help them navigate the meeting. Learn how one resident shared her meeting experience with the ACR BOC chair at **bit.ly/ACR2019_Mentorship.**

My First Time at ACR 2019

A resident provides the scoop on her first annual meeting experience and why she's planning to return to ACR 2020 at **bit.ly/ACR2019_AReflection.**

AMA Ed Hub: A New Learning Resource

A new educational resource is now available to ACR members. The AMA Ed Hub™ features one-stop, online education in clinical and interdisciplinary topics from a variety of trusted sources, including the ACR — the first AMA partner in this learning initiative.

Access new education today at bit.ly/AMA_EdHub.

CALENDAR

August

- **12–15** AIRP® Categorical Course: Neuroradiology, AFI Silver Theatre and Cultural Center, *Silver Spring, Md.*
- **19–21** AIRP Categorical Course: Pediatric Imaging, AFI Silver Theatre and Cultural Center, *Silver Spring, Md.*

September

- **6–8** RLI Leadership Summit, Babson Executive Conference Center, *Wellesley, Mass.*
- **6–8** Coronary CT Angiography, ACR Education Center, *Reston, Va.*
- **9–Oct. 4** AIRP Correlation Course, AFI Silver Theatre and Cultural Center, *Silver Spring, Md.*
- **12–13** Breast MR With Guided Biopsy, ACR Education Center, *Reston, Va.*
- **12–15** The Society for Pediatric Radiology (SPR) 2019 Fetal/Neonatal Imaging Course, Children's Hospital of Philadelphia, *Philadelphia*
- **16–20** AIRP Categorical Course: Abdominal Imaging, AFI Silver Theatre and Cultural Center, *Silver Spring, Md.*
- **19–21** Breast Imaging Boot Camp With Tomosynthesis, ACR Education Center, *Reston, Va.*
- **25–27** Neuroradiology, ACR Education Center, *Reston, Va.*

October

- **5–6** 2019 ACR Informatics Summit, Ronald Reagan Building/International Trade Center, *Washington, D.C.*
- **8–10** Abdominal Imaging, ACR Education Center, *Reston, Va.*
- **10–12** ACR Annual Conference on Quality and Safety, Sheraton Denver Downtown Hotel, *Denver*
- **11–13** Body and Pelvic MR, ACR Education Center, *Reston, Va.*
- **14–15** CT Colonography, ACR Education Center, *Reston, Va.*
- **14–Nov 8** AIRP Correlation Course, AFI Silver Theatre and Cultural Center, *Silver Spring, Md.*
- **18–20** Cardiac MR, ACR Education Center, *Reston, Va.*
- **21–25** AIRP Categorical Course: Musculoskeletal, AFI Silver Theatre and Cultural Center, *Silver Spring, Md.*

By Ezequiel Silva III, MD, FACR, Chair

The Economics of the Hippocratic Oath

When we discuss healthcare economic principles with patients, we build upon their trust in us.

"I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick."

This portion of the Hippocratic Oath encourages that we recognize that illness has far-reaching effects on our patients and their families. Illness threatens their ability to support themselves and their dependents. This financial uncertainty often occurs suddenly and with little time for planning or preparation. By acknowledging these secondary circumstances, we have an opportunity to strengthen the doctor-patient relationship.

Such economic uncertainties have existed since the earliest versions of the Hippocratic Oath. How do we take this patient insight to an even higher level? We must continue to evolve — as the economic realities facing patients today, just like medicine itself, are evolving. In addition to worrying about their jobs, income, and time away from work, patients must also understand and deal with insurance coverage, deductibles, copays, and pre-authorizations. They must also consider quality, outcomes, clinical pathways, and patient experience. And they, like us, must also consider new and innovative concepts, such as digital medicine, digital therapeutics, and AI. For the newly diagnosed, terms, acronyms, and concepts surrounding their disease are unfamiliar; so are many economic terms. All of this can create large information gaps. As physicians, we are well positioned to fill these gaps. We have the trust of our patients and society in general. We have the credibility borne out of years of training and experience. And most of us took the oath.

To use economics to strengthen our relationship with patients, the requisite economic base should not be viewed as a separate component of the care we provide. Such concepts and discussions are not separate from the art and science of medicine described in other parts of the Hippocratic Oath. They are complementary. When we understand, communicate, and discuss healthcare economic principles with our patients, we build upon their trust in us. Imagine that we are discussing our diagnostic and therapeutic plans with a patient when the following questions arise: "Doctor, what does this five-digit code on my explanation of benefits mean? Is that procedure covered by my insurance? And what are all these coverage requirements?" Our ability to answer, or at least attempt to answer, such questions (within the context of our broader healthcare discussion) is yet another opportunity for us to connect. It takes the doctor-patient relationship to a higher level. It makes us more valuable.

The task of engaging our residents, fellows, and new physicians in healthcare economics falls not only on our training programs but also on the ACR. We can also engage with our young physicians as they enter practice and find themselves introduced to the realities of business and healthcare economics. And we cannot forget practicing radiologists who are equally eager for updates on the innovations before us.

Understanding the potential economic consequences of illnesses is a continuum of care worth embracing and an important opportunity for our entire profession.

To uphold certain ethical — and economic — standards is a personal challenge. Perhaps in the future, we will find ourselves on the other side of the discussion, as patients, and look to our physicians for information and answers. Understanding the potential economic consequences of illness is a continuum of care worth embracing and an important opportunity for our entire profession. Integrating relevant and meaningful conversations into our patient interactions satisfies that very personal pledge most of us took the day we became doctors. B

Making Decisions Together

Shared decision-making is a term applied to the communication process between a physician and patient. A lack of awareness of the price of imaging keeps patients from making informed choices on care. Visit the Price Transparency Blog Series at bit.ly/Cost_Lacking to read more on the topic of cost discussions in healthcare.

ACR 2019

SPECIAL REPORT

THE PURSUIT OF ORGANIZATIONAL EXCELLENCE

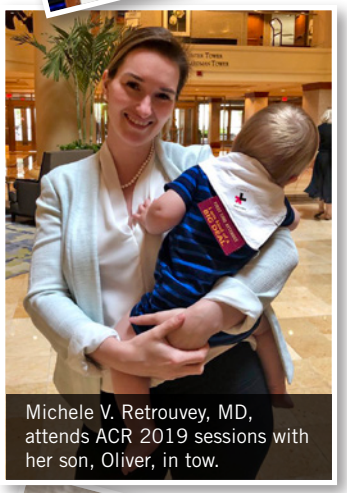
Left to right: Robert Peng, MD, Samantha G. Harrington, MD, Dania Daye, MD, PhD, Holly R. Brideau, MD, Ronald Mercer, MD, and Scott W. Gerwe, DO, participate in the American Association for Women Radiologists' Evening for Equality.

K. Elizabeth Hawk, MS, MD, PhD, catches up with Andrea Borondy Kitts, MS, MPH, a patient advocate and *JACR*® associate editor.

James M. Milburn, MD, FACR, and Adam D. Olsan, MD, FACR, take a break from Capitol Hill Day.

Moreton lecturer Ben Harder delivers his address to ACR 2019 attendees.

"In my years on the BOC, I have been very impressed by the degree to which the college reflects on its myriad activities and attempts to refine and improve them for the benefit of its members," said now past ACR President James A. Brink, MD, FACR, during his Presidential Address. Brink spoke about the College's robust strategic planning process that enabled the organization to affirm its core values of leadership, integrity, quality, and innovation and articulate its core purpose — to serve patients and society by empowering members to advance the practice, science, and professions of radiological care.



Michele V. Retrouvey, MD, attends ACR 2019 sessions with her son, Oliver, in tow.

Amy K. Patel, MD, discusses the value of mentorship with Yasha Parikh, MD, a radiology resident.

According to Brink, the drivers of organizational excellence are key elements such as effective program assessment, leadership skills such as emotional intelligence, and high-functioning teams who focus on a just work culture. Brink also pointed to the need for leaders who manage effectively, both up and down. "Everyone's voice and diverse perspective is important," said Brink. "Treat others like one would like to be treated. That is one of the main ways we can continue to excel as an organization."

William T. Thorwarth Jr., MD, FACR, Daniel Picus, MD, FACR, and Ezequiel Silva III, MD, FACR, are pictured during the Thorwarth Award presentation.

Left to right: Katarzyna J. Macura, MD, PhD, FACR, Pamela T. Johnson, MD, FACR, Stacey J. Keen, MD, FACR, and Mahadevappa Mahesh, MS, PhD, FACR, participate in the Convocation ceremony.

BEING WELL TOGETHER

The ACR 2019 keynote address called on practice leaders to harness the power of leadership to decrease burnout on their teams.

It is a well-known fact that physician burnout is a worsening problem. But how do we help ourselves? How do we help others? These were the questions posed to ACR 2019 attendees during the keynote address by Lotte N. Dyrbye, MD, MHPE, an internist at the Mayo Clinic in Rochester, Minn. During her address, Dyrbye, whose research focuses on the well-being of medical students, residents, and physicians, urged attendees to address physician burnout head on by reducing the stigma around the problem and demonstrating how radiologists can support their fellow professionals.

Dyrbye noted that recent research shows that each year 2,400 physicians leave their profession due to burnout.[1] "Some physicians are cutting back on hours but others are just leaving the medical profession altogether," said Dyrbye.

According to Dyrbye, burnout also threatens professionalism in the workplace, which can lead to dishonest behavior, decreased altruistic professional values, decreased empathy, and problems identifying and managing conflicts of interest.[2] Dyrbye pointed to research that shows female and younger physicians are more likely to experience burnout. In addition, female physicians are four times more likely to die by suicide than the general female population.[3] According to Dyrbye, these sobering statistics point to the need for action among organizations and leaders.

"We should be aiming for more than just the absence of burnout," said Dyrbye. "We need organizations to have strategies for building social support."

Dyrbye called on leaders and employees to ask questions such as what administrative burdens are getting in the way of their employees' productivity? What detrimental aspects of your work environment can you change? Asking these questions, noted Dyrbye, is vital for patients to receive compassionate care from committed, competent, and professional physicians.

In her address, Dyrbye also advised attendees to modify aspects of their behaviors that may be placing them at risk for distress. These changes could mean cutting back on work hours and nights on call, making time for more recreational activities, and developing healthy relationships with colleagues, as well as people outside of work.

"Talk with your spouse, family, and friends," urged Dyrbye. "Protect your time with them and away from work. Remember to say to yourself, 'Yes, I am a doctor, and...' Spend time on your 'and' to truly achieve optimal well-being." B

By Nicole B. Racadag, MSJ, managing editor, *ACR Bulletin*

ENDNOTES

1. Sinsky CA, Dyrbye LN, West CP, Satele D, Tutty M, Shanafelt TD. *Mayo Clin Proc.* 2017;92(11):1625-1635.
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Being Well Together

The ACR Radiologist Well-Being Program includes a well-being self-assessment, a toolkit of resources for recovery, and an educational curriculum for strategies to promote well-being. Access the program at acr.org/Well-Being.

AUSPICIOUS CONNECTIONS

Matching seasoned radiologists with eager minds yields two-way edification.

◀ ACR BOC Chair Geraldine B. McGinty, MD, MBA, FACR, poses for a selfie with her mentee Candace S. Potter, MD.

▼ Jamaal Benjamin, MD, PhD, meets with José M. Morey, MD, to discuss entrepreneurship and innovation at ACR 2019.

"Show me a successful individual and I'll show you someone who had real positive influences in his or her life." A quote attributed to actor Denzel Washington manifested in a wildly popular mentoring match-up during ACR 2019 — leaving mentors and mentees alike grateful for a chance to propel radiology into a changing future.

While ACR's annual meeting is always an opportunity for radiologists at any career level to network and learn from their peers, the College this year showed its commitment to guiding (and learning from) the next stewards of the specialty. "ACR 2019 provided a unique opportunity to connect with our radiology community, and I didn't want any attendee to miss out," says BOC Chair Geraldine B. McGinty, MD, MBA, FACR. McGinty was matched with Candace S. Potter, MD, chief resident at University of Massachusetts Medical School.

"Via Dr. McGinty and other networking opportunities, my perspective of my future career changed," Potter says. "I was reminded of how lost I was in the beginning, transitioning from medical school to residency. This pairing re-inspired me to stay in contact with the education side of radiology, helping medical students navigate their way into one of the best specialties in medicine."

During the registration process for the meeting, registrants were asked if they wanted to meet a mentor or connect with a mentee. More than a quarter of those who registered indicated, "Yes."

"I think mentoring helps you meet new people, grow your network, open doors, and provide opportunities to get involved," says Chelsea Schmitt, a medical student at the University of South Florida Morsani College of Medicine. Her mentor was Andrew K. Moriarity, MD, vice chair of the ACR YPS. "Mentors can give guidance on how they've approached situations in the past," she says, "and they have a perspective you don't yet have as a student."

For mentees, an introduction to the world of organized radiology is worth saying yes to. It's an opportunity to learn something new — even if it isn't exactly what they expect. Mentors at times will have to give tough feedback to those they sponsor. There will be other times when the mentee becomes the teacher — giving experienced radiologists insight that may guide them if they mentor someone new down the road.[1]

PURPOSEFUL POTENTIAL

"My approach to mentoring starts with a focus on building a diverse and vibrant professional network," McGinty says. "I leverage that network to support my mentees in building their own Kitchen Cabinet."

Individual interests that play into the best that radiology has to offer is the point. "I chose to sign up because I was excited to meet a radiologist who was interested in sharing their advice or perspective with a medical student who is interested in the field," Schmitt says.

Prospective mentors should look for authenticity in prospective mentees, McGinty says. That doesn't necessarily mean that you have to care about everything that they find interesting. Be ready to help, guide, and answer questions — but be careful not to pretend that what interests them interests you.

Good mentoring benefits all generations of radiologists. Rewarding faculty members for voluntary mentoring encourages the practice. Distinguishing a mentor from an educator is an important nuance. Mentors are often expected to provide emotional support, counseling, and empathy. Those offerings become especially useful when guiding new generations through unprecedented challenges to secure their place in the field.[2]

Mentors should be honest, good at listening, and accessible. Prospective mentees should make time for the experience they are gaining and appreciate the time mentors commit to give.[3] Beyond mentoring opportunities available through networking events, radiology departments should consider establishing structured processes for identifying and preparing mentors.

Regardless of your title, your busy schedule, or your other commitments, connecting with other radiology professionals is worthy of your time, Potter believes. "Once you've made your way through the struggles of medical school and residency, it's easy to trek forward and not look back," Potter says. "But there must be a great sense of achievement in being able to look back and help guide someone else through their journey."

"I take every opportunity to direct sponsorship opportunities to my mentees — with the only expectation being that they pay it forward," McGinty says. "So far my return on investment has been outstanding." B

By Chad Hudnall, senior writer, ACR Press

ENDNOTES

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Moreton lecturer Ben Harder discusses the importance of data-driven healthcare decisions.

MAKING DATA-DRIVEN DECISIONS

In a changing medical landscape, patients are increasingly taking charge of their care.

This year's Moreton lecturer wants to equip patients with the information they need to make the best decisions about their healthcare. And not just any information, says Ben Harder, managing editor and chief of health analysis at *U.S. News & World Report*, but good information — as in, information that comes from data.

"We had a small team that was working on hospital rankings with a data contractor, and I was watching what users were using on our website and realized that there was this enormous demand for more information about the hospitals," Harder says, recalling changes that began about a decade ago. "So we shifted some of our resources to do more around the data and expand the scope of the rankings."

The *Bulletin* spoke with Harder about what he wants the medical industry — and radiologists in particular — to know about the sometimes controversial rankings, and how practices can use them to help improve care.

Does the *U.S. News* Best Hospitals rankings provide a functional Yelp?

I don't want to stop anyone from going to Yelp, but I don't want that to be the sole source of information they're relying on. Anecdotally, we hear that patients use many different resources, so it's not as if they choose Yelp or *U.S. News;* they'll look at *U.S. News* and then a bunch of other websites as well. And probably over time patients have gotten better — because we've all gotten better — at triangulating out personal truth from the information we encounter online.

Why should patients take charge of their care?

The shift toward consumerism in healthcare creates new responsibilities for each stakeholder in the ecosystem. If patients are responsible for picking their providers and paying for more of it than they're used to, they need to understand the quality, cost, value, and choices, and be able to make an informed decision. You can't expect patients to make smart decisions if they don't have information. But it also obviously changes the responsibilities for the providers. So the clinicians then have the opportunity to provide data-based guidance to patients and also provide context and medical expertise.

What do you think about the push for price transparency in healthcare?

We get asked, "Why don't you incorporate price and cost into the different ratings?" Again, it depends on the question you're asking, which problem you're trying to solve, and for whom. Ultimately, people whether patients or payers or both need to make decisions with both quality and cost in mind, and that's the whole value equation. To do that, they need to have a good understanding of quality and cost. We've taken on the role of measuring quality because we can do that well.

What's trickier for us to measure is cost. First, we simply don't have good data on cost, because there's not a lot of transparency around it. And even if we did, there's a challenge when you talk about cost in healthcare: the cost to whom? To provide meaningful cost information to parallel our quality information would be difficult, because the total cost that each hospital charges for a product or service doesn't necessarily tell the whole story of the cost for the patient. For example, while Hospital A may charge more in general for a hip replacement than Hospital B, the out-of-pocket cost for a patient at Hospital A may actually be lower based on a patient's insurance and the insurance company's relationship with the hospital. Quality is generally an attribute of a hospital, whereas cost is very individualized and dependent on the insurance relationship.

What do you want radiologists to take away from your lecture?

Measurement and public reporting — telling the public how different providers have performed — can be good. It can be done well or it can be done badly. So we should focus on how we can do measurement well, and how we can make sure that we crowd out whatever bad measurements may exist so that patients are using real information to make decisions and doctors are being evaluated fairly. B

Left to right: Guillermo E. Pepe, Guillermo Pepe, MD, and Richard N. Hirsh, MD, FACR, celebrate receiving the GHA award at ACR 2019.

Richard N. Hirsh, MD, FACR, is pictured with the volunteer mission team in Bluefields, Nicaragua, in 2007.

GLOBAL IMAGE

ACR 2019 Global Humanitarian Award winners bring radiology to those most in need.

Women are the bedrock of our societies. That belief drives the work of this year's ACR Foundation's 2019 Global Humanitarian Award winners, who are making a global difference in the lives of women, their families, and communities by creating accessible breast health services.

The Global Humanitarian Award (GHA) recognizes individuals, organizations, and programs committed to increasing access to quality radiology services in developing and underserved countries. The World Health Organization estimates that half of the world's population lacks access to basic radiological services, and the ACR Foundation hopes this recognition will encourage more volunteer outreach to improve patient care globally.[1]

The award for individual work went to Richard N. Hirsh, MD, FACR, a radiologist who, for more than 30 years, has led breast cancer and mammography training projects in multiple countries in Eastern Europe and Central America, as well as India, Israel, and Vietnam. Following the early years of his work, Hirsh decided to set up his own nonprofit, Radiology Mammography International.

RESIDUAL RADIOLOGY

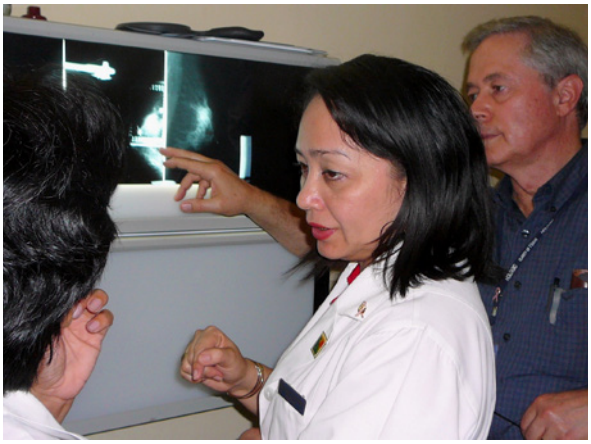
Creating sustainable programs for breast health, cancer detection, and treatment has always been the goal, Hirsh says. "A lot of doctors go into an area and perform procedures for hundreds of patients and then leave — they're done," he says. "My goal is bringing in new equipment, meeting the technicians and RTs, and choosing locations where the program will most likely succeed."

Mammography equipment has been donated over the years by large medical equipment and imaging companies. "We try to leave one or two machines at different sites in the country we're visiting," Hirsh says. "Many of these areas, especially in the Balkans, were at one time war-torn." Whatever radiologists they may have are likely overworked, understaffed, and have little or no equipment when Hirsh and the team arrive.

Hirsh tries to return about six months after the initial visit to the country. On the next trip, the team of radiologists and RTs provide breast imaging and address staff and patient questions. Field service engineers are there too, making any necessary repairs to the equipment. Health educators are also an important component of the team, Hirsh says, as well as anyone who speaks the native language. Letting the local community know about the availability of services and emphasizing that you want the program to work long-term are key to these types of efforts.

Hirsh says his volunteer groups set out to train local healthcare staff and volunteers on how to use new mammography and US equipment. "Everything we do here in the United States we try to share — our knowledge and our skills."

Hirsh says that people have asked him over the years why he doesn't focus on things like clean water, immunizations, or other basic, life-saving medical services. "It's simple," he says, "I focus on breast cancer because I'm a radiologist. If I were some other kind of doctor, maybe I'd focus on other things." Plus, he adds, especially in underdeveloped countries, it's critical that women get the healthcare attention they need. "They are the core of the family — the foundation, in any society," says Hirsh. "They are a stabilizing force." The majority of cancer cases — 57 percent — now occur in low- and middle-income countries. And 65 percent of cancer deaths worldwide occur in these countries.[2]



Far left: Guillermo Pepe, MD, inspired his son Guillermo E. Pepe to create the first telemammography network in Latin America.

Left: Hirsh trains local healthcare staff in Nicaragua on how to use new mammography and US equipment.

Below: Hirsh is pictured with staff at the Amman Al Shamel Health Center in Jordan in 2008.

TRAILBLAZING TELERADIOLOGY

Mamotest, a telemammography network (the first in Latin America) in Argentina, won the GHA organization award. The Pan American Health Organization has ranked Argentina as second most at risk for breast cancer deaths in all of Latin America — with approximately 20 women from that country dying each day from the disease.

"My father is a radiologist, a breast imager. He used to visit me when I lived in Europe, where I worked mostly as an entrepreneur involved in start-ups," says Mamotest founder Guillermo E. Pepe. "He would express to me his frustration about the situation in Argentina. He said that all the women he diagnosed had come to him too late."

"Our network of clinics allows us to support women who have few economic resources by giving them access to a quality breast exam," says Pepe. Yearly breast exams are hampered by lack of technology (old analog equipment), a shortage of breast imagers in rural areas, and few national wellness campaigns to stress the importance of breast screening.

Mamotest now runs a dozen diagnostic clinics in six provinces throughout Argentina. These clinics are set up with state-of-the-art mammography units (digital and 3D) and equipped for breast US and stereotactic biopsy. This is giving women access to screening services once out of reach — before it's too late. The imaging performed at the clinics is sent to a central location, where radiologists and other medical specialists evaluate the scans and submit a report — usually within 24 hours.

Pepe spends a lot of time trying to raise capital and expand Mamotest's services to more women. "We also promote new laws in Argentina that will support women's healthcare," he says. According to Pepe, Mamotest has been credited with the passage of new legislation that allows women one workday off per year to see their OB-GYN and to get a mammogram.

"The good news is that many organizations — state government and the Catholic Church — are supportive of what we want to do," Pepe says. "The challenge is that Argentina is lacking in economic resources. We're really trying to partner with anyone, hospitals or non-governmental organizations, to spread the word about our wellness campaign throughout the country."

Mamotest is already serving 50,000 Argentinian women each year. "Soon we hope to offer teleradiology services in other Latin American countries beyond Argentina," Pepe says. Pepe has meetings scheduled with officials in Paraguay, for instance, to explore offering services there.

"We need to democratize access to this kind of high-quality diagnostic care for women," Pepe believes. "We can prevent suffering and save the lives of the women who are the fundamental rock of our societies."

LIFE-CHANGING CHOICES

"You don't find time; you make time," Hirsh says. All of the projects he has been involved with included teams of professionals who had full-time jobs. They used personal vacation time to make the trip, with no additional pay. "It's a sacrifice," he says, "and it takes some convincing to convey the value — not just the value to patients, but the value it brings to physicians as human beings."

By Chad Hudnall, senior writer, ACR Press

ENDNOTES

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Submit Your Nominations

GHA recipients have until Aug. 31 to self-nominate or be nominated by a peer. Visit acr.org/Global-Humanitarian for more information.

DOLLARS AND SENSE

The Economics Forum focused on payment policies under MACRA, CPT® code valuation, the work of the RUC, and Medicaid payments.

The 2019 Economics Forum, moderated by Ezequiel Silva III, MD, FACR, chair of the ACR Commission on Economics, kicked off with "the payment schedule that loves to be ignored," said the ACR's advisor to the RUC, Kurt A. Schoppe, MD. But the role of the Hospital Outpatient Prospective Payment System in reimbursement policy is becoming more important. Schoppe advised radiologists to take an active role in hospital cost reporting, to educate themselves using ACR resources, and to act now by raising concerns with hospital finance departments.

Eric M. Rubin, MD, a member of the ACR Coding and Nomenclature Committee, talked about the College's work on Current Procedural Terminology (CPT®) code valuation. He stressed the need to protect existing code valuations and to work to ensure new codes accurately describe the work being done. Rubin also posed the question: Why are there no CPT codes for AI?

Lauren P. Golding, MD, vice chair of the ACR MACRA Committee, described some of the current challenges the ACR is facing in light of the 2019 fee schedule, including CMS' rejection of many RUC recommendations for radiology codes. Golding also noted that Anthem's nomination of seven high-volume codes as potentially misvalued could be seen as a conflict of interest in an attempt to influence Medicare physician reimbursement rates. "This could be a big win for their bottom line but a big loss for physicians and for patients," she said.

Part two of the forum featured a debate-style format consisting of five rounds during which two experts presented opposing positions on their assigned topic. After each debate, the "winner" of the round was chosen based on audience applause — indicating which of the two arguments was the more compelling. The goal of the new format was to take the temperature of the room (and thus ACR's membership) on contentious topics in radiology.

A lively debate centered on whether Alternative Payment Models (APMs) are achieving the desired outcome or not. Americans are spending more on healthcare than ever before, with expenditures topping out at almost 20 percent of gross domestic product. Two-thirds of people who file for bankruptcy cite healthcare expenditures as the reason for their financial downfall, and many find themselves struggling between paying for healthcare and paying for groceries.[1] This grim reality has led to efforts at health reform — APMs — that encourage a shift from fee-for-service to value-based payment, which prioritizes efficient and high-quality care over volume growth. This is a transformation that is happening whether radiology likes it or not, it was argued, and though it may not yet be perfect — "Rome wasn't built in a day and healthcare transformation isn't going to happen overnight either" — it's in radiologists' interests to engage and participate in the reform rather than let it happen and remain uninvolved, which could lead to commoditization of the field.

The argument against APMs called for CMS, third-party payers, patients, and physicians to wake up to the reality that APMs are a sinking ship. APMs have cost CMS 70 million dollars since inception in the state of New York alone — for a program that was designed to save, not lose, money, it was argued.[2,3] Seventy percent of participants have indicated they will be exiting the program, which is not indicative of something that's working.[4] Three main reasons for this failure were presented: reimbursement deficiencies, an inherently unfair system, and benchmark deficiencies. This round garnered a tie.

The final debate posed the question, "Price transparency: now or ever?" The argument for more transparency pointed out the "moving train" nature of the issue; it's already happening because patients are demanding it and legislators are noticing. So radiologists can either become involved and advocate for the field or let others do it for them, at their own peril: "If you're not at the table, you're on the menu."

The opposing argument against increased transparency noted that according to CMS, we already have it — "they've hung the 'Mission accomplished!' banner on the issue."[5] Not only has transparency failed to provide any real understanding by the public of the costs associated with healthcare, but it's muddied the waters even more due to the confusing and very individualized costs associated with healthcare. Our focus should be on finding actual meaningful quality measures that reflect patient outcomes and experiences, it was argued, rather than on simply providing opaque lists of costs that are meaningless to the consumer and actually promote a "race to the bottom on price." Audience response deemed this last round another tie. B

By Chad Hudnall, senior writer, and Cary Coryell, publications specialist, ACR Press

ENDNOTES

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2. Spanko A. ACOs cost government money, but skilled nursing opportunity remains large. *Skilled Nursing News*. May 19, 2019.
3. Spanko A. Instead of saving $1.7 billion, ACOs cost Medicare $384 million. *Skilled Nursing News*. April 1, 2018.
4. Inserro A. NAACOS releases survey showing concerns with MSSP model. *AJMC*. May 2, 2018.
5. Gooch K. 5 thoughts from hospital leaders on the CMS price transparency rule. *Becker's Hospital Review*. January 9, 2019.

◀ Lauren P. Golding, MD, debates Gregory N. Nicola, MD, FACR, on the topic of MACRA at the Economics Forum.

ADVOCATING FOR THE PROFESSION

Ashley Evens, MD, Kimberly M. Beavers, MD, Andrew Cibulas, MD, Rajendra P. Kedar, MD, FACR, and Michael Damiano, MD, participate in Hill Day.

Over 500 radiologists, fellows, and residents participated in the annual lobbying effort during ACR 2019.

Capitol Hill Day is an annual reminder that legislative advocacy is alive and well in radiology, ensuring protection of our patients and profession in the future. This year's Hill Day had one of the highest levels of engagement and participation in history. Over 500 radiologists visited over 275 congressional offices to discuss four key legislation issues affecting radiology and patient care.

SURPRISE BILLING

Mitigating unexpected medical bills is a critical issue in today's healthcare economy and presents challenges for many patients. The so-called surprise medical bills refer to unforeseen charges received after care is provided, typically in a multidisciplinary setting where multiple physicians are involved. Although the patient may be in an in-network facility or initially see an in-network physician, consultants and other billable services may not be covered, unbeknownst to the patient. The goal of discussing this matter was to encourage legislators to protect patients by providing more detailed information on in- and out-of-network services and hold insurance companies accountable.

THE PROTECTING ACCESS TO LIFESAVING SCREENS ACT (PALS) Act was initially introduced by Rep. Debbie Wasserman Schultz (D-Fla.) to protect patient insurance coverage for screening mammograms between the ages of 40 to 49. In both 2009 and 2016, the U.S. Preventative Services Task Force (USPSTF) gave screening mammograms for women ages 40 to 49 a grade of "C." As a result, insurance companies would no longer be required to cover these services.

The PALS Act placed a moratorium on the USPSTF breast cancer screening guideline change. However, this moratorium is set to expire on Dec. 31, 2020. The ACR, the Society of Breast Imaging, and the American Society of Breast Surgeons advocate for annual screening mammography in average risk women beginning at age 40. As cost could serve as a significant barrier to the diagnosis of early breast cancer, we encouraged legislators to extend the PALS Act to ensure coverage of lifesaving screening mammograms.

THE MEDICARE ACCESS TO RADIOLOGY CARE ACT (MARCA) addresses the importance of radiologist assistants (RAs) in today's modern radiology practice. RAs are master's degree-equivalent healthcare professionals who, under the supervision of a radiologist, perform minor procedures. With their assistance, radiologists are able to care for significantly more patients in a timely fashion. The MARCA bill aims to allow radiologists to submit claims to Medicare for RA services to financially support this valuable radiology service.

THE RESIDENT EDUCATION DEFERRED INTEREST ACT (REDI) addresses the increasingly prevalent issue of student loan debt. The average medical student debt in 2017 was $195,000. During medical school and residency training, students accrue interest on their loans, even when qualifying for deferment or forbearance. In practical terms, this means a radiology resident who has $300,000 in student loan debt after the completion of medical school will pay approximately $75,000 in accrued interest during their residency.

This financial hardship could discourage students from pursuing a career in medicine, which poses a significant threat to the future workforce when combined with the projected shortage of 121,300 physicians by 2030.[1] The REDI Act halts the accrual of student loan interest during training. This would not affect the repayment of the principal of the loan and would provide significant relief for young physicians. With this eased financial burden, there is more incentive for bright minds to enter medicine in the future without the fear of insurmountable debt.

The crucial takeaway from ACR Hill Day 2019 is that in an uncertain healthcare climate, radiologists are intensifying their involvement to advocate on behalf of their patients and profession. The ACR acknowledges this commitment and is working to further expand and support advocacy efforts through the RAN and the Commission on Government Relations. Collectively, these efforts will help move the College's legislative agenda forward and undoubtedly translate to the continued success of our field. B

By Kimberly M. Beavers, MD, a breast imaging fellow at Memorial Sloan Kettering Cancer Center

ENDNOTE

1. Davis D, Dill M. Projected shortage of physicians through 2030. Association of American Medical Colleges April 11, 2018.

Visit bit.ly/HillDay_2019 to see tweets from ACR members on Capitol Hill Day 2019.

LEADING THE WAY

ACR members gather to bestow the College's highest honors.

Each year, the College recognizes individuals who stand above the rest — their work supports quality patient care and advances the specialty. In 2019, 96 recipients donned their caps, gowns, and colors representing their medical schools and marched down the aisles in recognition of receiving their ACR Fellowship award. In addition to the fellows, the celebration honored the 2019 Honorary Fellows and ACR Gold Medalists.


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1. (Left to right) Howard B. Fleishon, MD, MMM, FACR, Geraldine B. McGinty, MD, MBA, FACR, and Marta Hernanz-Schulman, MD, FACR, prepare for Convocation.
2. (Right to left) John M. Holland, MD, FACR, Abid Irshad, MD, FACR, and Jon A. Jacobson, MD, FACR, are inducted as new fellows.
3. Seung Hyup Kim, MD, is presented with ACR Honorary Fellowship.
4. Bibb Allen Jr., MD, FACR, celebrates receiving the ACR Gold Medal with Ezequiel Silva III, MD, FACR.
5. Manuel L. Brown, MD, FACR, is awarded the ACR Gold Medal.
6. Anne W.M. Lee, MD, prepares to receive ACR Honorary Fellowship, accompanied by Seth A. Rosenthal, MD, FACR.
7. James A. Brink, MD, FACR, presents James L. Morrison with the Distinguished Achievement Award.

INTRODUCING THE NEW ACR EXECUTIVE COMMITTEE

Standing: Jacqueline A. Bello, MD, FACR; Katarzyna J. Macura, MD, PhD, FACR, Vice President; James V. Rawson, MD, FACR, Secretary-Treasurer; Mary C. Mahoney, MD, FACR; Amy L. Kotsenas, MD, FACR, Vice Speaker; Richard Duszak Jr., MD, FACR, Speaker; Dana H. Smetherman, MD, MPH, FACR

Seated: Howard B. Fleishon, MD, MMM, FACR, Vice Chair; Geraldine B. McGinty, MD, MBA, FACR, Chair; Debra L. Monticciolo, MD, FACR, President

ACR 2019 Election Results

The following individuals were elected at ACR 2019 to represent the College.

President
Debra L. Monticciolo, MD, FACR

Vice President
Katarzyna J. Macura, MD, PhD, FACR

Board of Chancellors
Robert S. Pyatt Jr., MD, FACR
William Small Jr., MD, FACR
Johnson B. Lightfoote, MD, FACR
Timothy L. Swan, MD, FACR

Council Steering Committee
Timothy A. Crummy, MD, FACR
Lauren P. Golding, MD
K. Elizabeth Hawk, MD, MS, PhD
David C. Youmans, MD, FACR

College Nominating Committee
Scott F. Cameron, MD
Candice A. Johnstone, MD
Taj Kattapuram, MD

To learn more about the new officers named at ACR 2019, visit acr.org/New-Leadership.

ABR UPDATE

The Council Meeting at ACR 2019 opened with an ABR report, delivered by President Brent J. Wagner, MD. Wagner highlighted programmatic improvements that continue the vision of the ABR, starting with the addition of self-assessment CME. "In 2014, we expanded the self-assessment CME requirements to include all enduring materials, like journal-based activities," Wagner said. "Self-assessment material is required by the Accreditation Council for Graduate Medical Education for enduring material, so we wanted to make it easier to meet that requirement."

According to Wagner, in 2016, the ABR broadened practice quality improvement requirements to include quality and safety activities that are already part of practice. "So any of you who do Mammography Quality Standards Act, RADPEER®, or some other improvement process — if you're an active participant in these, these all satisfy your requirement," Wagner said. "The idea here was to not have you duplicate, for the purpose of the board, activities that you're already doing."

In 2017, the recertification exam, previously required every ten years, was suspended to ease the burden for practicing radiologists, Wagner said. "To have to go away from your practice to study and to take the exam was a cost that the radiologist would bear," Wagner said. Since the exam's suspension, the ABR has been focusing on the new process introduced earlier this year, which Wagner reported has anecdotally been well-received so far. "We're going to be making improvements as we evolve over time," he said. "So far, we view this as a huge improvement."

Wagner closed by emphasizing the ABR's commitment to serving the long-term interests of the profession and serving them well. According to Wagner, "We need to do that by developing processes and programs that are rigorous enough that they're credible to the public so that they mean something, but at the same time not onerous on practicing radiologists."

TIME'S UP

This year's Diversity Forum made the case for building a more welcoming specialty.

ACR 2019's Diversity Forum, entitled, "#MeToo Comes to Medicine: Transforming the Culture," featured a talk by Reshma Jagsi, MD, DPhil, deputy chair of the department of radiation oncology and director of the Center for Bioethics and Social Sciences in Medicine at the University of Michigan. The standing-room-only forum centered around the issues of gender inequities, including unconscious biases, gendered expectations of society, and overt discrimination and harassment.

Jagsi started the talk by establishing a baseline with the audience: diversity is good. "We know from considerable social scientific research that diversity promotes collective intelligence," Jagsi said. "When we bring people together who have vastly different backgrounds and experiences, they actually interact in ways that make them more likely to solve problems." It's no secret that the medical field is lagging when it comes to diversity — and particularly in radiology, Jagsi said. She began investigating the issue more seriously when she noticed how many more men published than women in the medical field. "There's something dysfunctional," she said. "Something is happening that's preventing women from ever reaching the point where they submit for publications."

Jagsi's research led her to discover example after example of this gender inequity. "Women aren't entering radiology at the same rate as other specialties," she said. And when they are, they're getting paid less for doing the same work. Jagsi cited a study that showed a $12,000 discrepancy between male and female doctors even after controlling for productivity, specialty, and many other factors. Women are also disadvantaged in negotiations.[1] "Women don't ask. They don't negotiate as aggressively as men — and if they do, they're dinged for doing so."

Then there are our deeply ingrained notions of gender roles, Jagsi said. She referenced a study in which groups of people were sent a single CV with all of the same information, except that one version had a man's name at the top and the other a woman's.[2] Both the men and the women said the man's CV was stronger despite no material differences in the content. "We have to continually be aware of our unconscious biases," Jagsi said.

"We also have to acknowledge that we're not playing on a level playing field," Jagsi said. This is especially the case when it comes to caregiving responsibilities. "Women are far more likely to be responsible for child and elder parent care," she said. In a study where participants were asked how they handle times when their usual childcare plans fall through (like a snow day or a sick child, for example), 43 percent of the women said they mostly deal with it themselves, versus 12 percent of men.[3]

During the second half of her talk, Jagsi discussed sexual harassment and the ways in which it disadvantages and disempowers women. She cited a study in which, when asked the question, "In your professional career, have you encountered unwanted sexual comments, attention, or advances by a superior or a colleague?" 30 percent of the women indicated that they had.[4] "This is a floor, not a ceiling for the rate of this experience," Jagsi said. "And this is not without consequence. Sixty percent of those who experienced harassment had perceived negative effect on confidence in themselves as professionals, and nearly half reported that the experience negatively affected their career advancement."

After publishing her studies, Jagsi heard from women who spoke of their harassment and their reluctance to tell anyone out of fear of being stigmatized or perceived as victims.

"Organizational psychologists have shown us that harassment is more common in historically male-dominated fields like medicine, where big power differentials and hierarchies exist," Jagsi said. "It's also problematic when institutions are perceived to tolerate the behavior. So there are a lot of challenges in our current system."

"The first half of this talk was about gender equity, and the second half is about sexual harassment. And how do those two fit together? They fit together as a vicious cycle," Jagsi said. Gender inequity creates an environment in which sexual harassment can occur, and sexual harassment then contributes to gender inequity, according to Jagsi. "So we have to break this vicious cycle."

"WE KNOW FROM CONSIDERABLE SOCIAL SCIENTIFIC RESEARCH THAT DIVERSITY PROMOTES COLLECTIVE INTELLIGENCE."

–Reshma Jagsi, MD, DPhil

Jagsi recommended we learn from the social scientific studies that have been done on this issue for the past three decades. "What we have to do is we have to gather data specifically within each of our institutions and each of our specialties, both to inform interventions and to demonstrate that lack of institutional and organizational tolerance for these behaviors," she said. "The act of gathering data demonstrates that commitment. We have to clarify our policies, because the lowest rates of harassment occur in organizations that proactively develop, disseminate, and enforce sexual harassment policy, and we absolutely have to address interactions with patients and families."

It's vital that we focus on equity, Jagsi said, because we have to change the very structures that are supporting harassment. "While we see many positive strides that are being made and we are on the right track, there is more work to be done. Ultimately gender equity has to be promoted

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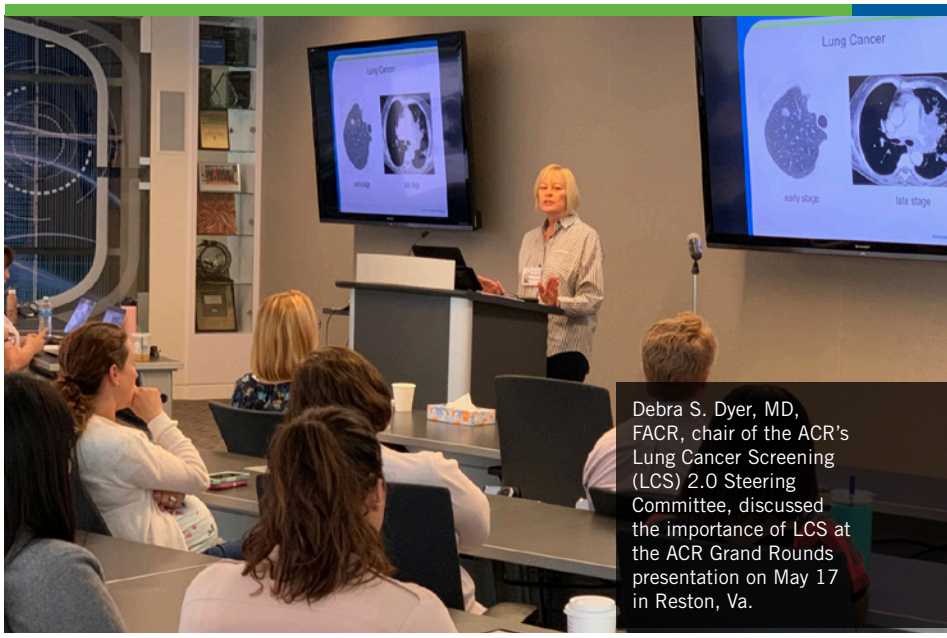
Clearing the Barriers

How can radiologists take charge to improve awareness, decrease stigma, and challenge the uptake rate when it comes to lung cancer screening?



Debra S. Dyer, MD, FACR, chair of the ACR's Lung Cancer Screening (LCS) 2.0 Steering Committee, discussed the importance of LCS at the ACR Grand Rounds presentation on May 17 in Reston, Va.

Lung cancer is by far the leading cause of cancer death among both men and women. In fact, each year more individuals die of lung cancer than of colon, breast, and prostate cancers combined. This amounts to approximately 390 deaths per day.[1]

The U.S. Preventive Services Task Force began recommending lung cancer screening (LCS) for current and former heavy smokers of at least 30-pack years, ages 55–80, in December 2013. By January 1, 2015, LCS was covered by commercial health insurance plans. By February 5, 2015, Medicare coverage was in place. However, uptake rates have remained astonishingly low, says Debra S. Dyer, MD, FACR, chair of the department of radiology at National Jewish Health in Denver and chair of the ACR's Lung Cancer Screening 2.0 Steering Committee. Despite evidence of its effectiveness in the National Lung Cancer Screening Trial and the recently-released results of the European NELSON and MILD trials, LCS faces a slew of challenges related to stigma, who can get screened, and reimbursement. This new committee was created to help make LCS as successful as mammography and colon cancer screening — and grew out of mutual frustration among radiologists that LCS was not being utilized to help improve care.

Understanding the Statistics

The National Lung Cancer Screening Trial showed a 20 percent reduction in lung cancer mortality with targeted low-dose CT (LDCT) for LCS. However, according to a 2018 study based on data from the ACR's National LCS Registry, only 1.9 percent of eligible individuals underwent LDCT in 2016.[2] Encouragingly, a recent analysis of 2017 behavioral risk factor surveillance data across 10 states indicated 14.4 percent of those eligible had a CT scan to check for lung cancer in the previous 12 months, with significant state-to-state variation.[3] But we are still missing a lot of people at risk, notes Dyer.

Dyer and others believe several issues, related to stigma and the CMS requirements, may be keeping LCS from being as successful as its screening counterparts.

Today's society has less empathy for patients who haven't quit smoking, says Andrea Borondy Kitts, MS, MPH, *JACR*® associate editor and a lung cancer and patient advocate, consultant, and patient outreach and research specialist at Lahey Hospital and Medical Center. According to Borondy Kitts, it's easy to forget that tobacco companies targeted heavy smokers when they were just teenagers, spending billions of dollars on advertising campaigns. "There's a lot of stigma about people who smoke, and a misconception that they caused their own disease so they don't deserve to get screening," says Borondy Kitts. "It's really a difficult situation."

Stigma is not the only barrier to increasing LCS uptake. "There are a number of barriers to LCS that don't exist for mammography and colon cancer screening," says Dyer. The requirement of a shared decision-making visit for patients undergoing LCS is one of the more onerous LCS-specific CMS rules. It means patients must meet with their primary care provider to discuss the benefits and risks of LCS, as well as receive counseling on smoking risks and cessation services. This shared decision-making is not required for any other screening service, such as mammography.

"Physicians are so overwhelmed with the number of patients they see," says Borondy Kitts. "They may not be talking to patients about LCS for many complex reasons. Maybe they only have five minutes and have to decide between many important topics they could discuss." Dyer believes that the shared decision-making was a fine idea in theory, but wonders, "Wouldn't it be great if primary care doctors could do this with every patient for every issue? Instead, this has turned out to be a great barrier."

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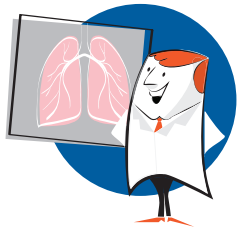


A six-week web series, which began in June, addresses the basics of implementing your own LCS program. Upcoming segments are: What You Need to Know About Logistics of Lung Cancer Screening with Kim L. Sandler, MD, on Aug. 6, and LungRads 1.1 Update with Ella A. Kazerooni, MD, MS, FACR, on Aug. 13. To register, visit bit.ly/LungScreenSeries.

Richard Duszak Jr., MD, FACR, Speaker, and
Amy L. Kotsenas, MD, FACR, Vice Speaker

Demystifying Policymaking

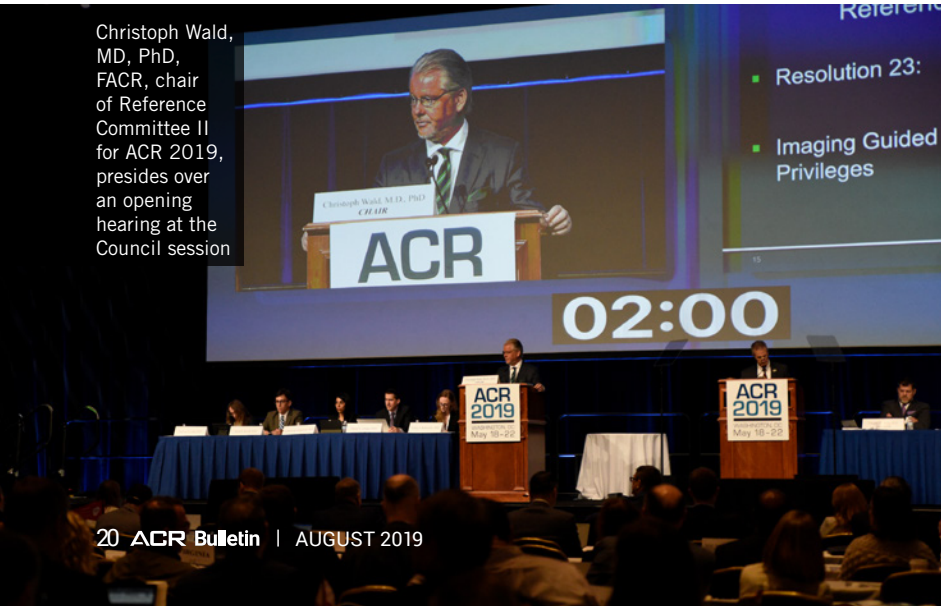
The transparent manner in which the ACR makes policy distinguishes it from other radiology professional societies.

A representative body of 373 individuals elected or selected by ACR chapters and other organizations, the ACR Council is empowered by our bylaws to "establish official actions and policies for the College." Convening each spring in Washington, D.C., our council debates a variety of resolutions — for example, several may pertain to practice parameters and technical standards, and others relate to meatier and sometimes controversial issues such as board certification and firearms safety.

Inclusive and representative policymaking is hard work. ACR Councilors — who are all volunteers — are expected to be informed and engaged at each year's annual meeting. Councilors carefully review 40 to 50 resolutions in advance of each meeting, and then caucus with colleagues across the country to ensure that proposed policies are most relevant to their constituents, profession, and patients. Effective councilors devote dozens — and sometimes hundreds — of hours each year to these important duties.

The council's policymaking processes (at least at first) can seem as daunting as they are laborious. In the remote past, those councilors adept in parliamentary sportsmanship had the upper hand in formal debate. Neophytes to the process often found themselves too intimidated to speak — which effectively silenced many valuable and important opinions and perspectives.

In recent years, deliberate efforts have focused on making council meetings more inclusive and welcoming — and also more efficient. Multiple opportunities for online input from all ACR members (i.e., not just councilors) now exist during the development and refinement of practice parameters and technical standards, which now go through multiple rounds of digital field review comment and pre-meeting reconciliation. Those ongoing and iterative processes help ensure that substantive issues are identified — and hopefully representatively addressed — before council meetings, so that the council can focus its debate exclusively on outstanding thorny issues still requiring reconciliation. Additionally, policy resolutions are distributed electronically months in advance of each annual meeting, so councilors can be true representatives and confer with their colleagues back home before arriving in Washington, D.C. And at each annual meeting, all members in attendance (not just councilors) are encouraged to participate in reference committee open hearings — well-attended venues intentionally unencumbered from the Byzantine formalities of parliamentary rules, designed to tease out the "will of the Council" and catalyze meaningful and productive formal debate.



Christoph Wald, MD, PhD, FACR, chair of Reference Committee II for ACR 2019, presides over an opening hearing at the Council session

While our council is still legally required to follow formal parliamentary procedure when adopting policies, these antecedent informal processes streamline that formal debate considerably. Our goal has been — and continues to be — ensuring that every member has a chance to speak in a manner that is most meaningful and inviting.

All in all, we've made a lot of progress over the years as we strive to make our council debates more inclusive. But we can still do better. Portions of the council's historic standing rules and procedures are not as clear as they could (or should) be. As the council's presiding officers, we would prefer not to make on-the-fly rulings to correct unnecessary ambiguity during formal proceedings. Declaring a well-meaning member to be "out of order" on the council floor unnecessarily stifles further engagement. That's why we are now forming a work group on council rules and procedures. Our goal over the next two years will be to work with our new parliamentarian and our entire CSC to revise these important documents that guide how we conduct business each year. As your newly elected speaker and vice speaker, we are committed to doing this inclusively and transparently. As such, we anticipate sharing draft documents with all councilors through ACR Engage for review and comment.

Our hope is that this approach will not only demystify our current policymaking processes, but also make them better. If you have comments or suggestions, please reach out to us, as your elected leaders, or to ACR staff Trina Behbahani at tbehbahani@acr.org and Catherine Herse at cherse@acr.org.

Time's Up

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through recognition and changes at the institutional level," Jagsi said. "Having groups like your group here to promote conscious consideration of diversity and provide safe space for discussion of these issues is really important." Jagsi suggests organizations like ACR share lessons learned and experiences as much as possible.

"We must employ women, promote more women, and integrate women into every level of the organization so we have what scholars have described as a 'well-integrated, structurally egalitarian workplace in which women and men equally share in power,'" Jagsi said.[5] "Time really is up and it's not just in radiology, it's across the board in medicine." B

By Cary Coryell, publications specialist, *ACR Bulletin*

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ACR CEO William T. Thorwarth, Jr., MD, FACR, ACR Vice President Katarzyna J. Macura, MD, PhD, FACR, and 2017 PIER scholars Manal Saif and Sherley Demetrius show their support for #HeforShe.

Clearing the Barriers

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When CMS approved LCS it decided to do things a little differently, says Dyer, who notes it was perhaps an experiment, though no one knows for certain. CMS also mandated several other requirements for patients undergoing LCS. For instance, each patient must be entered into a national registry. The College has the only CMS-approved registry for LCS. But this means someone needs to be responsible for entering the data. "To pull all of this together and offer LCS at your practice takes a team," says Dyer.

Improving the Uptake

That's why the College founded the new LCS Steering Committee. "Radiologists need to have more of a leadership role in screening," says Dyer. "We read these scans. We need to step up at our institutions, hospitals, and practices and champion LCS. But we can't do it alone. We have to have partners: pulmonologists, primary care providers, oncologists, and thoracic surgeons." The committee is working with stakeholders and patient advocacy groups to spread awareness and promote screening, she notes.

To start, the committee has established several working groups, each charged with its own overarching task to tackle: general outreach to primary care physicians and patients, implementation of LCS, economic issues, and incidental findings. The latter is another major issue for LCS. "We don't just find nodules," Dyer says, "we find other abnormalities that require attention, and we need to provide clear recommendations on next steps." She adds that the committee is creating a one-page reference document for primary care providers and nurse navigators on managing incidental findings, as well as one for LCS program coordinators on economics and billing issues.

The goal is to educate more individuals about the benefits of LCS and how to navigate any challenges and complications, Dyer says. "We want to empower the radiologist, and provide tools to increase the uptake of LCS." B

By Alyssa Martino, freelance writer, ACR Press

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What is your most memorable experience from the ACR annual meeting?

"My favorite part of ACR 2019 was creating the impromptu question and answer session for medical students. This was particularly special to me because I proved to myself that one person can make a difference. Additionally, I realized how easy it can be to engage medical students — which can encourage them to consider a career in radiology long-term. These types of events serve as both a recruitment tool and a platform to build mentor-mentee relationships."

— Yasha Parikh, MD, radiology resident at Mount Auburn Hospital in Cambridge, Mass.

"This was my first ACR meeting and it was great getting to meet the leaders in our field in a less rushed and more personal setting. The highlight of the conference was visiting Capitol Hill and having the opportunity to advocate on behalf of our profession and patients."

— Hari M. Trivedi, MD, assistant professor of radiology and biomedical informatics at Emory University in Atlanta

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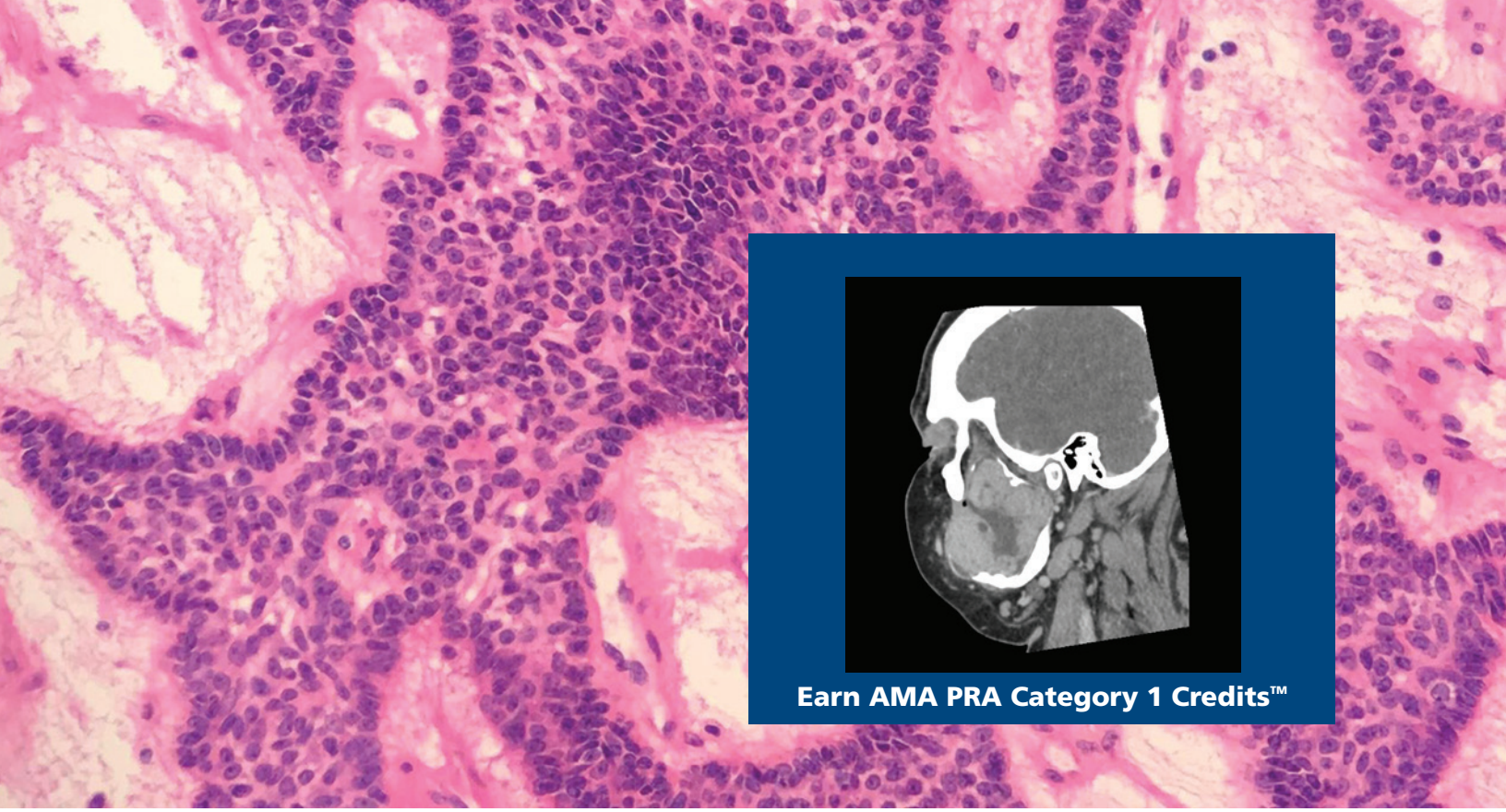

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