ACRIN® Researchers Move to Expand Horizons

Also Inside:

- Visit Radiology’s Classroom of the Future
- Access Top-Rate Education in Cyberspace
- The Face of Radiology: A 20/20 Image
Save the Dates for the ACR’s

2008 CME Conferences

Reserve spots in your calendar now for these ACR workshops and seminars covering clinical and nonclinical topics, presented throughout the year at locations across the country.

**Second Annual PET/CT Update Course**
Program Chair: James Fletcher, M.D.
Jan. 27-30, 2008
La Quinta Resort & Club, La Quinta, Calif.

**Marketing, Branding, and Promoting Your Practice: How to Stand Out From the Competition and Succeed**
Program Chair: Frank Lexa, M.D., M.B.A.
Feb. 19-22, 2008
Vail Cascade Resort & Spa, Vail, Colo.

**Cardiac CT: Supervised Case Review With Texas Radiological Society**
Program Chair: Smita Patel, MBBS
March 30, 2008
Hyatt Regency Hotel, Dallas

**33rd National Conference on Breast Cancer**
Program Chair: Debra Monticciolo, M.D., FACR
May 8-10, 2008
JW Marriott, Grande Lakes Resort, Orlando, Fla.

**Imaging With the Experts: Case Review in Neuroradiology, Mammography, Ultrasound, PET, and MSK**
Program Chair: Rona Woldenberg, M.D., FACR
May 17, 2008
Washington Hilton, Washington, D.C.

**ACR Education Center**
All state-of-the-art courses are offered at the ACR Education Center in Reston, Va. Visit www.acr.org/educenter for more information regarding these exciting next-generation courses.

**Coronary CT Angiography**
March, June

**CT Colonography: Supervised Case Review**
March, April, June

For more information on the ACR’s 2008 course lineup, visit us online today at www.acr.org/4dimensions or call (800) 227-5463, ext. 4040.
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Shifting Perception Through “Teachable Moments”

When we tell others that we are radiologists, often they look confused, wondering what being a “radiologist” means. In the world of medicine, this uncertainty suggests that we are being overlooked and not valued for the important role we play in the health care system. Despite our vital role in today’s diagnostic process, most Americans do not identify the radiologist as “my doctor” or as “one of my doctors.” Consequently, the misperception about who we are and what we do invites competition and conceals the truth about the critical services we provide.

One of the reasons our key audiences are unaware of our training and function is because we rarely have face-to-face contact with our patients. The next time you have an opportunity, I hope you will say to one of your patients (in your own words), “I am your radiologist — your physician expert in diagnosis, patient care, and treatment utilizing medical imaging.” If you create personal connections with your patients, the perceptions about our profession will change.

I urge you to seek out these “teachable moments,” which occur when you seize an opportunity to have a one-on-one conversation with a patient. To transform the current public misperception about our profession, the distance between patient and radiologist must be bridged. Patients acquire their value judgments largely through personal interactions with individual medical professionals. By developing intimate relationships with your patients, you can be part of the solution that enlightens the public viewpoint, one patient at a time.

Patients are thirsty for quality information about health care, medical imaging, and what they can do to empower themselves and their families. They are also concerned about the cost of health care. For these reasons, we must convey the value of what we do in a meaningful way. Use your “teachable moments” to educate your patients about the vital role you play in their care. After all, you are the most qualified medical specialist to read their imaging studies or provide image-guided care. You provide invaluable insight into their care and appropriate diagnostic and therapeutic expertise in their treatment management. We shouldn’t let our patients obtain information about their radiologic care from others. They should receive it from us. The time is now. The message is important. The future is in our hands.

The ACR’s new branding campaign — “The Face of Radiology” — is precisely aimed at shifting the public perception about radiology. Our multifaceted approach is targeted to our members and their patients, as well as to lawmakers on Capitol Hill. It will include grassroots efforts, advertising, public relations, and social media, and it will be strategically driven, benchmarked, and assessed at key milestones.

Through these efforts, the ACR will help you prepare for those “teachable moments” by providing you with the tools and resources necessary to educate your patients and associates about radiology (see related article on page 17). However, the College’s efforts can only go so far. It is up to us to utilize the tools and disseminate these materials to our patients, payers, partner organizations, and other health care providers.

As Nelson Mandela once stated, “Education is the most powerful weapon which you can use to change the world.” By identifying and maximizing our “teachable moments,” we can change the world one patient at a time. I am confident that we will succeed in raising the public awareness about our profession through a personalized approach to education. And when we do, it will benefit our patients, our profession … and beyond.
Q-RRO™ Launches New Process Survey

Quality Research in Radiation Oncology (Q-RRO™) is launching a new national process survey to collect data that will allow radiation oncologists to benchmark quality indicators and measure processes of care in the rapidly changing practice of radiation oncology. Having evolved from the acclaimed Patterns of Care Study that has served radiation oncology for more than 30 years, Q-RRO will focus on evidence-based measures of quality of care and the application of emerging technologies. The ultimate goal is to improve the delivery of radiation oncology services so that patients can expect better outcomes.

PROCESS SURVEY DESIGN

For the national process survey, a sample of 80 radiation oncology facilities will be invited to participate. Each facility was selected according to a two-stage, stratified sample design. All radiation oncology facilities in the United States are stratified based on academic status and facility size. Within each stratum, a random sample of facilities is selected, and within each participating facility, a random sample of eligible cases is selected for each disease site. Five separate disease-site studies are conducted simultaneously — patients treated for cancer of the cervix, breast, lung, prostate, and stomach.

Survey data will be collected through retrospective review of patient records by Q-RRO clinical data abstractors. Data elements relate to eligibility, demographics, diagnosis, staging, history, treatment, and outcome.

SPECIFIC AIMS

The study has five specific goals:

1. To define and collect data on a core set of process measures for cancers in which radiation oncology plays a major role, based on best-available evidence that these measures affect outcomes important to patients and providers and, thus, measure quality of care

2. To define and collect data on process-of-care measures for important emerging, advanced technologies based on the best-available evidence, including expert consensus

3. To document the adoption of results of clinical trials and widely promulgated practice guidelines and appropriateness criteria into use in the national practice, providing an overview of quality of care for treatment of each disease

4. To describe patient and practice-based parameters, such as age, race, ethnicity, geographic region, practice setting, and insurance status, in relation to processes of care, disease presentation, disease evaluation, treatment, compliance, and structure of treating facilities

5. To disseminate information and educate the target audiences, radiation oncologists and other oncologic physicians, health professionals, patients, and the public regarding the findings

PATIENT PRIVACY AND HUMAN SUBJECTS

Compliance with the Health Insurance Portability and Accountability Act (HIPAA) has been paramount in planning the survey. Only one data element classified as Protected Health Information (PHI) is requested — patient ZIP code — which will be used to link survey findings with external data. The ZIP code, as the only maintained piece of PHI, does not allow for subject identification.

Additionally, the Q-RRO clinical data abstractors, who review the subjects’ medical records to extract data, are medical professionals with training in human research. They will sign a Patient Information Access and Confidentiality Agreement with the facility and will complete appropriate training on patient privacy and the protection of human research subjects. The Q-RRO survey should qualify for a waiver of consent under the Common Rule and a waiver of authorization under HIPAA.

ULTIMATE GOALS

Nearly two-thirds of all cancer patients will receive radiation therapy at some time during their illness. In many instances, the efficacy of the radiation therapy administered will be critical to overall treatment success for the individual patient. Q-RRO seeks the ultimate goal of improving not only how radiation oncology services are delivered but also the treatment outcome that future patients can expect. We need the help of radiation oncologists and their department members and staff — especially if your facility is asked to participate in this survey.
NEW MEASURES APPROVED

The ACR has been working with the American Medical Association Physician Consortium for Performance Improvement (Consortium) to develop additional performance measures for potential inclusion in the 2008 Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI) program. In the current 2007 PQRI program, two measures specifically apply to diagnostic radiologists.

The eight draft measures developed relate to mammography, reducing CT dose, recording fluoroscopy exposure time, and stenosis measurement in carotid imaging reports. The draft measures were open to public comment, prior to vote by the full Consortium and the Ambulatory Care Quality Alliance (AQA) for approval. Measures must be approved by the AQA for possible inclusion in the 2008 PQRI program. The AQA approved these measures on October 26.

These measures will allow much greater participation in the bonus program by a larger segment of the ACR membership. Members can find updates on approval status of the measures at the ACR Web site (www.acr.org) — from the home page, visit “P4P” under “Hot Topics.”

ACR’s Outreach to Members

ACR’s staff members have made numerous presentations to members about pay-for-performance programs and initiatives, including talks at the Practice Leaders meetings in Washington, D.C. (September); Santa Monica, Calif. (October); and at the Pennsylvania Radiological Society (October). Detailed information on the PQRI program has also been presented via Radiology Business Management Association (RBMA) Webinar and audio conferences, and at the RBMA Full Educational Conference. These informative events drew a great deal of interest and participation.

If you have questions about PQRI and its impact on radiologists, please contact the ACR at P4Pquestions@acr.org.

ACCREDITATION UPDATES

Because of recent revisions to the ACR Practice Guideline for the Performance of a Breast Ultrasound Examination, the ACR Committee on Breast Ultrasound Accreditation has updated the program requirements for ACR Breast Ultrasound Accreditation.

The new guideline was approved at the ACR Annual Meeting and Leadership Conference in May and went into effect Oct. 1, 2007. The primary changes to the program requirements address interpreting physician qualifications, equipment specifications, and image labeling.

All facilities applying for ACR breast ultrasound accreditation or renewing their existing breast ultrasound accreditation must meet the new program requirements.

Visit the ACR Web site at www.acr.org for more information.

ICR ’08 MARRAKESH: JUNE 5-8, 2008

“Towards Efficient Radiology for All”: This is the powerful theme of the 25th International Congress of Radiology (ICR), sponsored by the International Society of Radiology. The goal of this Congress is to adopt appropriate strategies that will make radiology accessible to underprivileged and disadvantaged communities. This informative conference promises to deliver stimulating sessions, panel discussions, and refresher courses; cover a wide variety of practice and policy issues; and feature world-renowned speakers.


Pre-Tour Egypt & Casablanca: May 25-June 4, 2008: ACR members can take advantage of group travel arrangements, prior to the Congress at ICR ’08, organized specifically for them. Cruise the Nile, explore Cairo, Casablanca, and more — on your merry way to Marrakesh!

For tour details, visit the American Travel Association Web site: www.travelata.org/tours_detail.cfm?tourid=80.

PEDIATRIC IMAGING CONFERENCE

Join radiologists, pediatricians, pediatric health-care workers, and other individuals who care for infants, children, and adolescents at the 2008 ALARA (As Low as Reasonably Achievable) conference focusing on imaging safety and quality for children in the emergency setting. The conference will be held Feb. 23-24, 2008, at the Hyatt Regency Orlando International Airport in Orlando, Fla.

To review a complete program, visit The Society of Pediatric Radiology at www.pedrad.org.

CALL FOR NOMINATIONS Reminder: The deadline for submitting information for elected and selected positions effective in May 2008 is December 30, 2007. For more information, visit www.acr.org. “About Us.” Please send candidate letters, CVs, photos, and information forms to Mary Jane Donahue at mjdonahue@acr.org.
Visit ACR Classroom of the Future in March

In March 2008, the College will expand its education programs significantly with the opening of its new Education Center, which will feature interactive courses and progressive teaching techniques that are personalized for each individual student. The new center, equipped with state-of-the-art imaging technology, will be located across the street from the ACR headquarters in Reston, Va. Developed specifically for radiologists who want to remain at the forefront of the profession, the new ACR Education Center is radiology’s Classroom of the Future.

Students will benefit from a mentored self-study approach, sophisticated simulation technologies, and world-class faculty. The curricula kickoff includes coronary CT angiography and CT colonography, with the opportunity to solve problems and receive frequent feedback from a team of expert faculty.

ACR — EXPERIENCE THE DISTINCTION

The ACR Education Center offers such advantages as customized tools and equipment, the top specialists in today’s emerging imaging technologies, and a hands-on teaching approach offering the following unique benefits:

- A low ratio of participants to instructors allows continuous interaction and mentoring. Experiential training will move you through 50 supervised case reviews.
- Workstations that replicate your clinical practice environment advance the quality of learning the moment class begins. (You will select your preferred workstation when you register.)
- A Certificate of Proficiency — useful for MOC, hospital and insurance credentialing, and accreditation — will be awarded at the completion of each course.

MEASURE YOUR PERFORMANCE

The ACR Case Engine is our proprietary learning methodology, designed to measure your performance as you complete each series of cases. Built on an unparalleled repository of cases, the ACR Case Engine will navigate you through the curriculum and ensure that you master the learning criteria before moving on to the next topic.

CLINICAL APPLICATIONS

Coronary CT Angiography

Course Director: Shawn D. Teague, M.D.

This three-day course is designed to enhance your clinical practice skills by providing intense training on how to interpret coronary CT angiography exams under the supervision of expert faculty. Participants use tailored, individually selected workstations and scanner simulation technology and will earn 18 AMA/PRA Category 1 Credits.”.

Course offered March 7-9, March 31-April 2, and June 20-22.

CT Colonography: Supervised Case Review

Course Director: Matthew A. Barish, M.D.

This two-day course will teach you the appropriate techniques and interpretation skills vital to CT performance. It also includes a forum to discuss research initiatives, regulatory issues, and the reimbursement environment. Participants will earn 15 AMA/PRA Category 1 Credits”.

Course offered March 17-18, April 17-18, and June 9-10.

REGISTER ONLINE AND SAVE

Registration is now open for the debut courses at the new ACR Education Center. You’ll save the most when you register online at www.acr.org/educenter. “Early birds” get the best rate by registering before the deadline. If you have not received your registration brochure with an application in the mail, you may download a copy from our Web site at www.acr.org/educenter or call (800) 373-2204 for a print copy. Telephone registrations are not accepted.

NEXT-GENERATION MILESTONE

The new ACR Education Center will provide the full spectrum of learning tools, cutting-edge technology, and curricula focused on the most advanced imaging topics and technologies — at all levels — whether you’re in training or already in practice.

To view course updates and the latest news and information, visit www.acr.org and click on the “ACR Education Center” icon.
New ACRIN® Leaders Describe Expanded Research Agenda

Through the management of clinical trials of imaging technologies, the American College of Radiology Imaging Network (ACRIN®) has achieved world-renowned success in its effort to lengthen and improve the lives of cancer patients. Now, as ACRIN embarks upon the 2008–2012 grant period, a new phase of growth has emerged, bringing with it new leaders, expanded research goals, and a broadened focus.

This article describes ACRIN’s future goals, including an effort to broaden its services into other clinical areas, including cardiovascular, metabolic, and neurological diseases. Cancer research opportunities continue to receive funding from the National Cancer Institute (NCI), but two new exciting developments are the ACRIN Foundation and the ACR Image Metrix™, which will provide additional funding along with an opportunity to earn income that can be funneled back into expanded research endeavors.

ACRIN WELCOMES NEW LEADERS

Thanks to ACRIN’s successful grant renewal efforts, the Network is poised to grow in new ways during the upcoming 2008–2012 grant period. As of Jan. 1, 2008, three ACR members will officially assume ACRIN leadership roles. Mitchell D. Schnall, M.D., Ph.D., from the University of Pennsylvania, will become Network chair; Barry A. Siegel, M.D., FACR, from Washington University in St. Louis, and Denise R. Aberle, M.D., from UCLA, will become deputy co-chairs.

Schnall says, “ACRIN’s site visit went as well as we could have imagined. We received an outstanding score and some helpful comments from the review committee. The whole grant renewal process has really prepared us for the next five years.”

ACRIN’s new research has several different strands, Schnall says, including “the development of qualitative and quantitative imaging biomarkers, which will be a major focus of ACRIN going forward. Imaging plays an incredibly valuable role in measuring functional and anatomical aspects of cancer. This will help us identify clearly the characteristics of someone’s cancer as well as characteristics of the response to therapy.” Developing these biomarkers will support the goal of personalized cancer care envisioned by NCI and the international cancer community.

A BRIDGE TO THE FUTURE

In the past, ACRIN has conducted important large screening trials for populations that have a relatively low incidence of cancer, but, Schnall states, “As we go forward, we’re going to see imaging used in conjunction with blood tests and gene analysis as we work to develop sophisticated, multimodality screening approaches. These trials won’t involve imaging in isolation; instead, we’ll use imaging in connection with other risk-assessment modalities as we refine the populations we screen and treat.”

Schnall notes that he is seeing more and more interest in early phase trials that bridge the gap between early Phase I human
The American College of Radiology

studies and multicenter clinical trials. This interest has led to the creation of the ACRIN Experimental Imaging Committee, which will help develop early phase trials that fill this need.

EXPANDING ACRIN’S RESEARCH SERVICES

ACRIN is also working to help the clinical cancer research community develop and execute the imaging components of other protocols, both through expanding the core laboratories and working in collaboration with other groups. “We’re embracing our role as a service organization with specialized expertise that we can share with others,” Schnall says.

“ACRIN will play a key role in the newly created ACR Image Metrix, the contract research organization established earlier this year as a for-profit subsidiary of the ACR,” he continues. This commercial venture, headquartered in the College’s Philadelphia research office, will offer ACRIN’s services to industry, and it will provide an opportunity to earn income that can be recycled back into ACRIN.

Finally, Schnall sees ACRIN broadening its focus by bringing imaging research into cardiovascular, metabolic, and neurological diseases. He adds, “We think we’ve built a program that’s been relatively successful with cancer. We’ve set up committees and developed an agenda — for cancer. Now, in addition to continuing our NCI-funded cancer work, we would like to use funding from the ACRIN Foundation and our new Image Metrix™ venture to expand ACRIN outside of cancer research and develop clinical agendas in other areas.”

Hillman Tackles New Ventures

Bruce Hillman, M.D., FACR, who has served as ACRIN’s chair since its inception in 1998, will officially step down at the end of 2007. Incoming Chair Mitchell Schnall says simply, “Bruce built ACRIN. He built the infrastructure, the operations, the brand. Thanks to him, people know who we are, and we have cachet in the imaging and cancer research communities. He worked tirelessly to get the resources for this infrastructure, and he should get immense credit for building the program out of nothing.”

Siegel, incoming deputy co-chair for functional imaging, feels equally appreciative of Hillman’s efforts. “Bruce has done a spectacular job of getting ACRIN organized and motivated,” he remarks. “ACRIN has been responsible for shifting the culture of radiology research, and ACRIN’s programs have had a ripple effect throughout the National Cancer Institute and the cancer research community.”

Hillman will continue to be actively involved in ACRIN research activities as the chief scientific officer of ACR Image Metrix™, which officially opened for business earlier this year. In a complementary role, he will also serve as chair of ACRIN’s Industry Relations Committee beginning in 2008.

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ACRIN’S STRONG, NEW LEADERSHIP

Two physicians who have played key roles in ACRIN will assist Schnall in overseeing ACRIN’s ambitious agenda. The deputy co-chair position, held by Schnall since ACRIN’s inception, has now been split into two more specialized positions.

Siegel, who will become deputy co-chair for functional imaging, has been working with ACRIN for nearly a decade. He oversaw the creation of ACRIN’s PET Core Laboratory, played a key role in the development of the National Oncologic PET Registry, and helped develop and implement PET standards for several different trials. “That work has helped me understand ACRIN as an organization,” he says. “I’m very much into the nuts and bolts of helping sites solve their day-to-day problems.”

Aberle, the new deputy co-chair for anatomical imaging, serves as principal investigator for the high-profile National Lung Screening Trial. Her interest in informatics has led her to advise ACRIN on several new initiatives to organize image and nonimage data from all ACRIN clinical trials into a searchable resource. “Having been a part of ACRIN for many years, I have a good sense of the organization’s strengths and weaknesses,” she says. “I appreciate the opportunity to serve in this new role.”

Schnall praises both of his deputy co-chairs. “Both of them bring an incredible passion for imaging science, for radiology, and for ACRIN,” he says. “They have complementary expertise; Barry’s experience is in nuclear medicine, radiopharmaceuticals, and regulatory and technical issues. He knows all of the key players in the community that we need to be able to tap into — government, private, academia.”
The American College of Radiology Imaging Network (ACRIN®) presented the findings from five medical imaging clinical trials during a plenary session at the 2007 ACRIN Fall Meeting held at the Ritz-Carlton in Arlington, Va., Sept. 27-30. Key results include:

- The primary results of the National CT Colonography Trial, led by C. Daniel Johnson, M.D., from the Mayo Clinic, demonstrated that CTC is highly accurate for detecting intermediate and large polyps and that CTC’s accuracy is similar to colonoscopy’s. The clinical trial evaluating CTC as a primary colorectal cancer-screening option is the largest to date.

- Wendie Berg, M.D., Ph.D., FACR, from American Radiology Services at Johns Hopkins and the lead investigator of the Screening Breast Ultrasound in High-Risk Women Trial, reported that ultrasound combined with mammography found a statistically significant increase in cancers compared to mammography alone. These results pertain to the trial’s first-year screening results. However, investigators also found that the risk of false-positive results associated with screening ultrasound remains a barrier to its increased use.

- An innovative study led by Jeffrey Weinreb, M.D., FACR, from the Yale University School of Medicine, on the use of MRI combined with MR spectroscopy (MRS) for the staging of prostate cancer found that, overall, no improvement in accuracy was noted for combined MRI/MRS over MRI alone.

- A study on the success of radiofrequency ablation (RFA) in treating painful bone metastasis demonstrated that RFA can be performed safely and offers a novel treatment option for select patients whose cancer has metastasized to the bone. Damian Dupuy, M.D., from Rhode Island Hospital is the trial’s principal investigator.

- The results of the cost-effectiveness of digital mammography analysis were presented by the study’s lead author, Anna Tosteson, Sc.D., from Dartmouth-Hitchcock Medical Center. She reported that breast-cancer screening using age-targeted digital mammography appears cost-effective. In contrast, universal digital mammography screening is not, at the present time, cost-effective based on current reimbursement rates. The analysis data are from the Digital Versus Film-Screen Mammography Trial, first reported in 2004.

More information about the results of these trials will become available at the time of their publication.

Schnall contends that the key to ACRIN’s success is within its professional community, from the radiologists in academic and private practice who accrue patients to studies, to administrators in departments that support ACRIN’s studies, to research coordinators across the country. These individuals — along with the staff at headquarters and the scientists who propose and envision studies — all create key collaborative links. He concludes, “It’s the buy-in and efforts of all of these people that make ACRIN successful.”

Investigators Announce Trial Findings
The ACR Appropriateness Criteria® (AC) is a tool that puts quality first. Based on the latest evidence, the AC was developed to help referring physicians select the most appropriate imaging exam or radiology treatment for a specific patient and condition. In 2007, the ACR updated 25 key topics under the leadership of expert panels of radiology professionals. The College currently performs annual reviews to provide updates for more than 165 topics. Identifying additional topics is an ongoing process, which enables the ACR to present the best guidance and information to radiologists and referring providers.


currently produces an annual update for the ACR Appropriateness Criteria. The update is based on the latest scientific evidence and is aimed at helping radiologists and referring physicians select the most appropriate imaging exam or radiology treatment for a specific patient and condition. The College currently performs annual reviews to provide updates for more than 165 topics. Identifying additional topics is an ongoing process, which enables the ACR to present the best guidance and information to radiologists and referring providers.

We wish to thank the following ACR members for their hard work and leadership on developing the AC during 2007:

- Rochelle Andreotti, M.D., Women's Imaging Panel Chair
- Curtis Bakal, M.D., Interventional Radiology Panel Chair
- Lawrence Bassett, M.D., Women's Imaging Breast Panel Chair
- Michael A. Bettmann, M.D., Chair, AC Committee
- Robert L. Bree, M.D., MHSA, Gastrointestinal Panel Chair
- Richard Daffner, M.D., Musculoskeletal Panel Chair
- Patricia Davis, M.D., Neurology Panel Chair
- Isaac Francis, M.D., Urology Panel Chair
- Laurie Gaspar, M.D., M.B.A., RO-Brain Panel Chair
- Richard Gunderman, M.D., Ph.D., Pediatrics Panel Chair
- Nora Janjan, M.D., RO-Bone Panel Chair
- Peter Johnstone, M.D., Vice Chair AC Committee, RO Topics
- Arfa Khan, M.D., Thoracic Panel Chair
- Andre Konski, M.D., RO-Rectal Panel Chair
- Benjamin Movsas, M.D., RO-Lung Panel Chair
- Andrea Ng, M.D., RO-Hodgkin’s Lymphoma Panel Chair
- Rachel Rabinovitch, M.D., RO-Breast Panel Chair
- Mack Roach III, M.D., RO-Prostate Panel Chair
- E. Kent Yucel, M.D., Cardiovascular Panel Chair

The ACR’s systematic process of developing criteria provides credible guidelines for radiology decision making based on scientific analysis and broad-based consensus techniques. The end result is high-quality radiology.

INSTANT, POINT-OF-CARE ACCESS

Released in October, the latest version of the ACR Appropriateness Criteria Anytime, Anywhere™ application for PDAs is compatible with Palm and Pocket PC platforms. This latest release provides topics and ratings for the various modalities directly on a PDA and now features the estimated “relative radiation level” (RRL) for imaging exams.

All RRL assignments are based on reviews of current literature and the experience of medical physicists and radiologists. Potential adverse health effects associated with radiation exposure are important elements to consider when selecting the appropriate imaging procedure. RRL estimates can factor into this decision. In some exams, dose estimates from published studies or practice experience vary significantly; in these cases, the reviewing committee conservatively assigned the higher-level RRL.

NEW DATABASE VERSION

Additionally, an exciting new database version, designed to be incorporated into decision-support processes and software, is in the final stages of development. This new version offers a feature that is not currently provided in other AC products: ICD-9 and CPT® coding information. This coding will help users identify the conditions and procedures discussed in the AC narratives, but it is not intended as a substitute for official CPT and ICD-9 coding guides. The database version will be available by the second quarter of 2008.

The new version, along with more information and news about the ACR Appropriateness Criteria, is available at www.acr.org/ac. If you have specific questions, please contact Christine Waldrip at (800) 227-5463, ext. 4793, or e-mail acr_ac@acr.org.
Two new products aimed at providing enhanced service to all ACR members will be introduced in 2007–2008. The ACR needs your participation to help us achieve the best results and greatest benefits for you and your practice.

**NOW SHOWING: “MY PROFILE”**

Last May, the ACR launched “My Profile,” a Web-based interface that allows you to establish your individual profile, which, in turn, assists the ACR in better serving your specific needs. The “My Profile” kickoff in November 2006 included a survey mailed to roughly 22,000 members who received invoices. Survey responses were entered into a drawing for three Apple video iPods, and the contest ran until March 30, 2007. More than 5,400 surveys were received through this initial effort, and the submitted data were entered into the new “My Profile” service on the ACR Web site. The “My Profile” site on the ACR’s home page launched in May 2007.

“My Profile” includes the following information. Your:

- Subspecialty description
- Estimate of hours spent in clinical and nonclinical tasks
- Unique identification information
- Address and contact preferences
- Demographic data, which include a breakdown of clinical time spent using specific modalities, as well as further information on the focus of modality use for specific subspecialty/organ system and body part

**KEEP US CURRENT**

Please keep your profile up-to-date. To access your profile, visit [www.acr.org](http://www.acr.org). “My Profile” is located on the dark blue bar running horizontally across the top of the ACR’s home page. Click “My Profile” and proceed to the log-in page. Your user name is the first and last initials of your name, in all lowercase letters, followed by your 8-digit membership number. Your password is your last name in all lowercase letters. If your name is fewer than six characters, please add the number 9 to the end of your name (e.g., for the last name of “Fox,” your password would be fox999). Once initially set, your password may be changed to any six-character combination of letters and/or numbers.

**COMING SOON: PRED**

Built on the same premise as “My Profile,” the ACR will launch the practice of radiology environment database (PRED) in the winter of 2008. PRED, a relational database, will link individual radiologists to their site of service and to the practice in which they are employed. Specific information identifying practice leadership, contact information, radiologists, business managers, and aggregate demographic information will be collected. Also, similar data about each site of service that the practice covers will be gathered.

The ACR’s staff members have been working diligently to obtain basic information about radiologists, radiology sites, and radiology practices for more than a year. This effort included fusing multiple databases to link information and an exhaustive, ongoing search for practices, sites of services, and the location of radiologists. In the coming months, once the site is launched, practices will be asked
to both provide and corroborate data and keep information current. As more information on PRED becomes available, the ACR will provide practices with updates.

INFORMATION TO BENEFIT YOUR PRACTICE

Both “My Profile” and PRED will allow the ACR to provide you with more tailored benefits and services. By identifying the specific clinical activity of radiologists and radiology practices, the College will be able to direct programs and services customized to specific individual and practice needs. In addition, this information will allow the College to analyze trends in the profession, facilitate communities of shared interest, and initiate the sharing of knowledge among practice leaders. Importantly, from an advocacy standpoint, the ACR believes that information from “My Profile” and PRED will assist the College in better measuring the possible effect of existing Medicare, public and private policies on the profession. Further, the ACR will utilize this and other information to better educate Congress and other public policy makers on the potential impact of future policy proposals on the profession.

VISIT THE ACR BOOTH AT RSNA

Seize Your Chance to Win BIG!

Visit the newly designed ACR booth at the 2007 Radiological Society of North America (RSNA) conference in Chicago, Nov. 25-30. ACR staff members will be on hand at booth #4701 in the South Hall to answer your questions and help you explore the latest educational tools and product demos.

When you visit the booth, you can also enter a drawing to win a video iPod by simply updating your member profile with your current demographics on the spot. Your information will later be entered into the practice of radiology environment database (PRED), a powerful new tool designed to enhance your ACR membership. PRED is our proprietary relational database that will help us represent your interests while providing unparalleled, targeted membership benefits.

While at the booth, you can explore the newest lineup of online lectures from the ACR Campus™ and other educational programs. For example, you can review the most recent addition to the popular PSE series, Chest Disease VI, Volume 52, which includes 22 cases and in-depth discussions on medical conditions and modalities. Plus, be sure to preview the just-released demos of new ACR products and services, including the Mammography Case Review focusing on self-evaluation. This new CD features zoom-and-pan images and allows you to test your knowledge and get immediate scoring. And, once the National Data Registry (NRDR™) is populated with data, you will be able to see how your facility compares with others both regionally and nationally through a live portal of NRDR.

Career seekers and employers: Visit the ACR’s Professional Bureau, South Hall, Room S102B.

Courtesy: Matthew Sutor
Scientific and Nonclinical Research

START HERE: www.acr.org; Click on “Research”

Clinical Research. Through the outstanding research efforts of the American College of Radiology Imaging Network (ACRIN®) and the Radiation Therapy Oncology Group (RTOG®), the ACR plays a vital role in determining how patients will be cared for in the months and years to come. Read about the innovative research and noteworthy scientific studies conducted by these groups and how their findings could affect the future of radiology.

Socioeconomic Research. The ACR’s socioeconomic research team offers critical insight into the radiology profession’s nonclinical trends. Here, you’ll gather expert analyses of key issues affecting your practice and future developments that could impact your workplace.

ACR Image Metrix™ offers a full menu of imaging core lab services from a world-class team of physicians and scientists. Published papers and surveys on various research topics.

Send an e-mail to the ACR (research@acr.org) to request free assistance for your research activities, including study design, statistics, and manuscript preparation.

Information about RTOG, ACRIN, and Quality Research in Radiation Oncology (Q-RRO®).

ACR Fellowship in Health Services Research information.

Research news, meeting information, and relevant articles.

Extensive list of presentations by members of the ACR Health Services Research Department.

Published papers in socioeconomic research on subjects such as cost and utilization, clinical studies, and the employment market for radiologists.

Online Connections

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On Sept. 28, 2007, the American College of Radiology Imaging Network (ACRIN®) released the long-awaited results of its multicenter National CT Colonography Trial (ACRIN 6664). This trial was conducted in 15 centers across the United States, included more than 2,500 patients, and was designed to determine the ability of CT colonography (CTC) to detect colonic polyps in an asymptomatic screening population.

The results of the trial, soon to be published, yielded impressive sensitivity and specificity for polyps larger than 6 millimeters and have encouraged speculation that reimbursement for screening CTC may be close at hand. Unfortunately, that is not the case. In this month’s report, I will summarize the current status of reimbursement for CTC and indicate potential pathways that might expand reimbursement to include CTC when used for screening.

In order for reimbursement to occur for any medical service, a CPT® code for that service must exist. CPT codes describe medical procedures and services; they do not typically describe the indications for those procedures and services. Medical necessity determines the appropriate indications for which procedures and services will be paid, and these indications are defined by ICD-9 codes.

There are two commonly used categories of CPT codes. Category I codes are the codes we all know best, and describe medical services that have met rigorous requirements of the CPT Editorial Panel. They have also undergone extensive survey analysis of resource-based cost by the American Medical Association Relative Value Update Committee (RUC) and have been assigned a relative value unit (RVU) required by Medicare and used by many private payers to determine payment.

Category III codes are temporary codes used for new technologies or services. They are also created by the CPT Editorial Panel but are not assigned an RVU by the RUC and are not included in the Medicare Physician Fee Schedule (MPFS). Coverage and payment levels for Category III codes are at the discretion of the local Medicare contractor or private payer.
There were no specific CPT codes for CTC until 2004. At that time, the CPT Editorial Panel established two category III codes. In a departure from prior policy, one code was created for screening CTC and the other for diagnostic CTC. Medicare coverage for the diagnostic CTC code has been established at the local level, through local coverage determination (LCD) in all 50 states and the District of Columbia. There is no Medicare coverage for the screening code.

Medicare coverage for diagnostic CTC comprises three general categories. Medicare contractors in all 50 states and Washington, D.C., will cover CTC for the indication of incomplete colonoscopy. Three states will cover this indication only for an obstructing lesion. All others will provide coverage for incomplete colonoscopy due to spasm, diverticulitis, redundant colon, aberrant anatomy, extrinsic compression, or scarring from prior surgery. Medicare contractors in nine states will cover for preoperative cancer staging and determination of colonic wall invasion. Twenty-four states offer Medicare coverage for CTC when colonoscopy for symptomatic patients is contraindicated.

The private payers impose greater restrictions on coverage. Sixteen Blue Cross Blue Shield (BCBS) plans consider CTC experimental for any indication and will not provide coverage. Eighteen BCBS plans provide CTC coverage for incomplete colonoscopy. Aetna and Humana cover CTC for incomplete colonoscopy, and CIGNA extends coverage when colonoscopy is contraindicated.

At the October 2007 CPT Editorial Panel meeting, a workgroup convened to address potential migration of the existing Category III codes to Category I status. This workgroup was comprised of an equal number of radiologists and gastroenterologists and included payer representatives. Its goal was to develop an acceptable code structure in time to meet the February 2008 deadline for inclusion in the 2009 MPFS.

Depending on how the CPT Editorial Panel regards the ACRIN CTC trial results, several scenarios are possible. The Category III screening code could be retained with creation of a national coverage determination (NCD) by the Centers for Medicare and Medicaid Services (CMS), requiring participation in a national data registry. Standard Category I codes (with and without contrast) could be created with NCD for screening and LCD for non-screening. Legislation could be passed to add CTC to tests currently approved within colorectal screening guidelines, allowing CMS to determine coverage jurisdiction at either the national or local level. In any case, coverage for CTC screening is not close at hand but should be accelerated through the bureaucratic process by the ACRIN 6664 trial results.

Please contact Anita Pennington (apennington@acr.org) or Kathryn Keysor (kkeysor@acr.org) if you would like to know the details of CTC coverage provided in your state.

2008 Candidates Address Health Care

Most likely, many ACR members are interested in the health-care reform proposals of the major presidential candidates. That’s why the Advocate has summarized the proposals of the top six potential Democratic and Republican nominees.

As of October, the information released by these candidates varies widely. One commonality is the desire to reduce medical errors, improve efficiency, and detect health threats by investing in a standardized method of electronic medical recordkeeping. Beyond that, their level of personal commitment and views on government involvement seem to differ. Each summary concludes with the candidate’s Web site so that members can continue to track the candidates’ views on this important American debate.

The Democrats

Senators Hillary Clinton (N.Y.), John Edwards (N.C.), and Barack Obama (Ill.) share many similarities in their health-care reform proposals. All three candidates support mandatory employer contributions (i.e., “play or pay”), which require employers to either cover their employees’ health insurance policies completely or help them defray the costs. They also want to boost preventative care and expand coverage for all children by improving Medicaid and the State Children’s Health Insurance Program (SCHIP). As far as pharmaceutical reform, the three candidates would approve drug reimportation and limit direct-to-consumer advertising.

Hillary Clinton has developed an extensive health-care reform agenda for her presidential platform, focusing on universal coverage and insurance company reform.

Clinton is a staunch supporter of “guaranteed issue” — which means that all Americans should be able to obtain health care coverage, regardless of ability to pay or pre-existing conditions. In addition, Clinton wants to prohibit the practice of “community rating,” whereby insurance companies rate premiums based on the current or predicted health status of the community.
Clinton also proposes the creation of a “Best Practices” institute, which would research and disseminate information about the comparative effectiveness of drugs, devices, and treatments.

Malpractice reforms are also a large part of the Clinton health care proposal. Such reforms include measures to reduce the number of lawsuits, encourage patient safety, and provide liability protections for physicians who disclose medical errors and offer to negotiate fair compensations. Lastly, Clinton wants to reduce overpayments to Medicare Advantage plans.

For more information, visit www.hillaryclinton.com/feature/healthcareplan.

SENATOR JOHN EDWARDS (N.C.)

John Edwards’ health-care reform plan mandates that every American must obtain health insurance. To make it affordable, Edwards would require employers to either cover their employees or help finance their health insurance. In addition, he would create new tax credits, expand Medicaid and SCHIP, and reform insurance laws.

His proposed reform also targets insurance companies by requiring insurers to impose fair premiums regardless of age, job, pre-existing conditions, and medical history. To promote transparency, Edwards would mandate that insurance companies provide health care consumer reports to the public.

As president, one of Edwards’ reform objectives is to create more efficiency by requiring insurers to spend the majority of their premiums on patient care through a system of national accounting standards. In addition, he promises to create regional “health care markets,” or nonprofit purchasing pools that provide a choice of competing insurance plans. These markets would give Americans the needed bargaining power to purchase affordable, high-quality health plans and help cut costs for businesses offering insurance. The markets would be available to everyone whose jobs do not offer comparable insurance plans and to employers that choose to join rather than offer their own plans. To subsidize premiums for this type of coverage, Edwards would offer income-related, health insurance tax credits to qualified individuals.

Edwards’ plan includes the promise of creating patient-centered “medical homes.” These homes could provide a coordinated, team-effort approach, allowing primary-care physicians to effectively navigate quality of care for their patients, especially those having multiple specialists. For patients with chronic diseases, Edwards would formulate a public plan to monitor their health, and for all Americans, he would remove patents for breakthrough drugs.

To help evaluate effectiveness of care, Edwards’ reform strategy would require hospitals to provide “consumer reports” (or report cards). Furthermore, he reasons that medical errors would be reduced as his plan would require evidence-based medicine and pay for performance.

For more information, visit http://johnedwards.com/issues/health-care.

SENATOR BARACK OBAMA (ILL.)

Barack Obama’s health-care reform proposal is similar to Edwards’ in that he would also require hospitals to produce report cards. Obama also asserts that he would try to prevent insurers from overcharging physicians for malpractice insurance. His new public program, the National Health Insurance Exchange, would help uninsured people and small businesses obtain health insurance, while providing income-related subsidies for enrollees.

One characteristic that sets Obama apart from the other Democratic candidates is that his proposed health coverage is not universal, nor is there an individual mandate that would require all Americans to obtain health insurance. Furthermore, his plan states that the federal government would assume some of the employer costs associated with catastrophic illnesses, while cutting government subsidies to Medicare Advantage.

Obama would increase the use of generic drugs and create an independent institute to guide reviews and research on the comparative effectiveness of drugs, devices, and treatments. He also proposes allowing more flexibility for states to innovate on health care reform and to create new models for reducing medical errors.

For more information, visit www.barackobama.com/issues/healthcare.

The Republicans

Presidential candidates Mitt Romney (Mass.), Rudy Guiliani (N.Y.), and John McCain (Ariz.) believe in the power of the market to solve America’s health care needs. They also contend that the government should avoid mandating health insurance to individuals and employers. In addition, they support reforming the medical liability system and increasing the availability of health savings accounts (HSA).
Giuliani believes we need to increase visibility of price, provider qualifications, and risk-adjusted procedure outcomes. Finally, Giuliani wants to reform the medical liability legal system by putting an end to frivolous lawsuits without limiting compensation for real economic loss.

For more information, visit www.johnmccain.com.

GOVERNOR MITT ROMNEY (MASS.)

As governor of Massachusetts, Mitt Romney proposed and signed into law a bureaucratic plan called “The Connector,” which requires that every citizen obtain health insurance or pay a penalty (unless they can prove they can’t afford insurance). In addition, businesses with more than 10 employees must pay an annual fee if they are unable to provide coverage for their employees.

As a presidential candidate, however, Romney does not support an individual mandate. Instead, he says we should encourage market dynamics and allow states to work out their own approaches. Romney also believes that the state health insurance market should be deregulated and reformed, while federal spending on “free care” should be redirected to help low-income, uninsured Americans purchase private insurance. Meanwhile, his plan is to expand and grow HSAs, promote Medicaid innovation, and provide opportunities for people to choose health insurance in the private sector.

If Romney is elected president, he will advocate for medical liability reform, including federal caps on punitive and other noneconomic damage awards in medical malpractice cases. He also supports the full deductibility of qualified medical expenses, which means that Americans could deduct the cost of health insurance and out-of-pocket medical expenses from their taxes.

For more information, visit www.mittromney.com.

SENATOR JOHN MCCAIN (ARIZ.)

John McCain’s health-care reform agenda follows the Republican philosophy of individual responsibility and market reform. He also believes in reforming medical malpractice laws, expanding programs like SCHIP, and improving health care for veterans. Unlike his political opponents, McCain is mainly focused on reducing costs rather than helping the uninsured due to what he sees as a crisis of unsustainable health care spending.

McCain’s cost-cutting agenda for health care includes promoting generic drugs and biologics, supporting walk-in health clinics at stores such as Wal-mart, and giving nurse practitioners more responsibility for health care since they tend to be less expensive for consumers. In addition, his plan is to set national standards for measuring treatments and outcomes and permit doctors to practice medicine across state lines.

Additionally, McCain has stated that he would extend Bush’s tax cuts and offer tax credits that Americans could use toward the purchase of health insurance policies. While McCain wishes to expand the use of HSAs, he does not support insurance coverage mandates for individuals and employers.

For more information, visit www.mittromney.com.

RUDY GIULIANI (N.Y.)

Rudy Giuliani’s health-care reform proposal is based on a free-market principle. He says that if Americans had the freedom to choose their own health care, it would increase competition and lower costs while improving the quality of care. If the cost of health insurance goes down, more people would have the means to purchase coverage, he believes. Giuliani says we can improve health care by empowering patients and doctors, not government bureaucrats. He promises to bring greater accountability and efficiency to the evaluation process for new drugs by ensuring that government regulation does not delay new cures or needlessly cost lives.

Giuliani would reward states for innovative solutions by offering block grants, which would also help to reduce health costs, enroll eligible uninsured, and solve adverse selection issues. According to Giuliani, more than 1,900 state mandates limit coverage options and increase costs from 20 to 45 percent. Giuliani would see to it that state regulations do not deny access to affordable coverage. If they do, people should be allowed to purchase insurance through interstate markets.

Giuliani proposes to offer subsidies and “health insurance credits” to make insurance more affordable to low-income Americans. These subsidies and credits could be combined with other sources, like Medicaid and employer contributions, to further enhance affordability. His plan also offers tax breaks of up to $15,000 for families who buy their own insurance. In addition, his method supports vouchers and tax refunds as well as the expansion of HSAs.

In order to expand competition, improve quality, and reduce cost,
Giving the Public a 20/20 Image of Radiology

The ACR announces the launch this fall of its “Face of Radiology” branding campaign, a major coast-to-coast media initiative designed to open eyes, shape opinion, and raise the stature of radiology among current and potential patients, policy-makers, payers, and other health care providers.

The need is acute. Today’s challenging health care arena finds radiology on the defensive and at risk of becoming a marginalized discipline. A perceptual disconnect of radiology — of who radiologists are and what we do — has worked to lower the quality in patient diagnosis and care, invite competition into our domain, disadvantage us in the policy arena, and undercut adequate reimbursement levels. This cannot continue.

ACR’s “Face of Radiology” branding campaign will give us a powerful tool to help position our profession for a stronger, brighter tomorrow. The branding of radiology, like the branding of so many disciplines and services today, will open doors, burnish our reputation, and communicate our core values wherever we go. Radiologists long accustomed to working quietly — even anonymously — will see our ongoing branding campaign speak loudly and clearly for them, telling audiences: Your radiologist is a physician expert in diagnosis, patient care, and treatment through medical imaging.

Unlike the “Stella” campaign, our “Face of Radiology” campaign will have a spirited and unmistakable message that corrects this perceptual disconnect. We will use measurable benchmarks, target influencers at the national and grassroots levels, and work with time-tested public relations methods.

CREATING VISIBILITY

Our reach will be far and wide. We will reach Capitol Hill by way of focus-group surveys, radio spots, the electronic edition of The Washington Post, and by advertising for three months in such influential publications as The Weekly Standard, National Journal’s CongressDaily/A.M., Roll Call, The Hill, and NationalJournal.com.

We will reach patient advocacy groups and other key influencers through the ACR Web site, Daily News Scan, ACR Bulletin, and special mailings. And, because popular culture perpetuates this perceptual disconnect, the “Face of Radiology” branding campaign will target the all-important social media, among them YouTube and Facebook.

We will also reach radiology program directors and residents. Residents — the torchbearers of our venerable profession — will team with the Resident and Fellow Section (RFS) to develop outreach opportunities, content for the RFS Web site, and materials for distribution to the Armed Forces Institute of Pathology (AFIP).

ACR’s “Face of Radiology” branding campaign will give us a powerful tool to help position our profession for a stronger, brighter tomorrow.

BRANDING MATERIALS FOR YOUR USE

And yes, we will reach out to you, our valued 30,000 ACR members, knowing you are best positioned to educate and enlist the support of your own patients. As an ACR member, you will receive a five-minute educational DVD video that will provide your patients with insight into the radiologist’s role. We will also reach patients by way of talk shows, speakers bureaus, and ongoing PR initiatives. To help make this happen, the new ACR Center for Best Practices will serve as a vast repository for talking points, fact sheets, Web content, mailers, brochures, newsletters, and sample ads.

As you can see, this is an all-out, coordinated offensive. For now, rest assured that the ACR is ready and able to sustain a major push. At a time when many in our ranks are feeling pessimistic, “The Face of Radiology” branding campaign gives us a powerful new tool to position radiology for a brighter future. With so much at stake, now’s the time to roll up our sleeves and get to work.
Access Top-Rate Education in Cyberspace

The ACR Campus™ provides members with opportunities to earn continuing medical education (CME) and self-assessment module (SAM) credits online. Using a variety of convenient Web-based learning formats, customers can preview and purchase Web-based lectures and case-based virtual reality learning programs, all from the convenience of a desktop. The Virtual Lecture Hall series and the Grand Rounds Lecture series are two learning tools found at the ACR Campus: http://campus.acr.org.

Here, radiologists and residents alike can explore the most up-to-date curriculum from the case files of radiology’s best-known experts and enjoy the benefits of a modality-based online learning experience.

VIRTUAL LECTURE HALL SERIES

The Virtual Lecture Hall series is a perfect example of the ACR’s commitment to providing members with convenient, innovative educational opportunities. To meet your busy schedule, this modality-based learning experience offers lectures by renowned experts in radiology and is available online worldwide, 24 hours a day. Additionally, you can customize your curriculum by choosing an individual lecture or the entire lecture series. Either way, this lecture series is an easy way to meet educational requirements and enhance your professional development objectives.

IMPROVING RADIOLOGY IN DEVELOPING NATIONS

Developed under the direction of Program Chair Maurice M. Reeder, M.D., FACR, Virtual Lecture Hall presentations are geared to a global audience and emphasize state-of-the-art thinking and technology. As such, the talks are offered free of charge to radiologists in some developing nations.

These nations include some countries in Africa, Central and South America, Eastern Europe, Russia, and Asia.

No login is required. Most radiologists practicing in developing countries have computers, some with high-speed wireless Internet access. If not, many can access such technologies through nearby medical centers or universities. The ACR is providing the Virtual Lecture Hall series as part of its commitment to facilitating improvements in radiological care throughout the world and to improve the practice of radiology in developing nations.

BENEFITS AND CREDITS

Radiologists in the following countries are expected to pay a nominal fee for the Virtual Lecture Hall series: United States, Canada, Western and Central Europe, the Arabian Peninsula, Israel, Japan, South Korea, Taiwan, China, Singapore, Australia, and New Zealand. ACR-member fees range from $75 to $225; this is an outstanding value for the top-quality instruction received directly from speakers of national and international reputation. Plus, you can earn up to 10 AMA/PRA Category 1 Credits™ just by participating in this time-saving educational activity.

HOT TOPICS IN THE SERIES

The Virtual Lecture Hall is an anatomically based, online series of lectures covering some of the hottest topics in the profession. The newest series provides the latest in musculoskeletal imaging and features experts in the field, Lee F. Rogers M.D., FACR, and Donald L. Resnick M.D., FACR.
Another lecture series titled MRI of Hemorrhage by William G. Bradley, M.D., Ph.D., FACR, details the five different stages of parenchymal hemorrhage in the brain and how they can be distinguished on T1- and T2-weighted images. This series will help you understand the basis for T1 and T2 shortening by various paramagnetic forms of hemorrhage. These lectures are guaranteed to challenge the skills of practicing radiologists and residents alike.

Division Chair Barry B. Goldberg, M.D., FACR, leads the lecture series on ultrasound, along with nine distinguished faculty members from the Division of Diagnostic Ultrasound at Thomas Jefferson University Hospital in Philadelphia. This series addresses a variety of topics in ultrasound imaging, including gynecologic, obstetric, and breast ultrasound, as well as abdominal, musculoskeletal, and vascular sonography.

Other radiology experts participating in the Virtual Lecture Hall include Richard Gore, M.D., FACR; Pablo R. Ros, M.D., MPH, FACR; and Edward A. Sickles, M.D., FACR. These pre-eminent radiology professionals arrive direct to your computer anytime, anywhere — so order your virtual lectures today.

GRAND ROUNDS LECTURE SERIES

In addition to the Virtual Lecture Hall series, Reeder also manages the Grand Rounds Lecture series, which offers talks that are pertinent to specialized staff with access to state-of-the-art technology. This comprehensive, online lecture series provides information about the latest techniques for many different radiology subspecialties. Each modality-based lecture targets a specific disease state or challenging condition commonly found in today’s practices.

As with the Virtual Lecture Hall series, the Grand Rounds program is presented in a convenient, online format and features a blue-ribbon faculty of leading teachers in radiology today, sharing their expertise and experience. Most of these lectures are approved for 1.0 AMA/PRA Category 1 Credit™ and the cost is $25 for members and $15 for residents. This series is especially helpful to radiologists in practice or in training, and now you can hand-pick each lecture to suit your individual needs. For more information, visit http://campus.acr.org or call (800) 227-5463, ext. 4040.

About Maurice “Mo” Reeder, M.D., FACR

Maurice “Mo” Reeder entered his senior year of medical school at the University of Maryland, following many summers of making Coca-Cola deliveries to pay the bills. Married, with two young boys, he joined the U.S. Army Senior Medical Student Program. He studied under Col. William Thompson, M.D., who, Reeder says, “… was arguably the premier bone and chest radiologist of that era.” Thompson was the first registrar for the Registry of Radiologic Pathology at the famous Armed Forces Institute of Pathology (AFIP). That was in 1957, and now, 50 years later, Reeder has developed an impressive curriculum vitae.

From 1972–1977, he was the chief of radiology at Walter Reed and consultant to the Surgeon General of the Army, retiring from the Army with the rank of Colonel. He then joined a large private-practice group in Honolulu, and was also chairman of the Department of Radiology at the University of Hawaii School of Medicine until 1997.

In addition to authoring 67 medical articles, Reeder has written nine textbooks and several CD-ROMs, including Gamuts in Radiology (co-author is Benjamin Felson, M.D., FACR), and The Imaging of Tropical Diseases (co-author is Philip E. S. Palmer, M.D., FRCP).

A 40-year ACR member and fellow, Reeder is active in six radiology and tropical disease societies and is a volunteer program director for the ACR’s Virtual Lecture Hall and Grand Rounds series.

In closing, Reeder shares these thoughts — “… I have been gratified that the ACR’s leaders agreed that we should expand the educational aspects of the ACR Web-based programs to make available the latest in technological advancements not only to ACR members, but to radiologists throughout the world.”
On March 29, Granville C. Coggs, M.D., FACR, stood proudly in the Rotunda of the U.S. Capitol to receive the Congressional Gold Medal, as President George W. Bush awarded recognition to the Tuskegee Airmen, the first black U.S. Army Air Corps (USAAC) fliers in World War II. Other dignitaries paying tribute to the airmen that day included Speaker of the House Nancy Pelosi (D-Calif.), Senate Majority Leader Harry Reid (D-Nev.), retired General Colin Powell, and Rep. Charlie B. Rangel (D-N.Y.), who, with Sen. Carl Levin (D-Mich.), cosponsored the legislation that honored these heroes.

Perhaps optimism and a bright personality are the keys to longevity, because at age 82, Coggs, a practicing radiologist, exudes both. When asked, “Of all your accomplishments, which do you personally feel are the most significant?” Coggs replies, “My wife and I were married in 1946. We are a team.” And, second: “… establishing the San Antonio Breast Evaluation Center.” The center, which operated from 1983 to 1986, was created during an era when physicians did not necessarily refer women for breast imaging.

Coggs enlisted in the USAAC, joining the Tuskegee Airmen who trained at Tuskegee Institute and Tuskegee Army Air Field in Alabama — “the only place where blacks could train,” remembers Coggs. “Segregation in the military was pervasive.”

The primary mission of these 996 Tuskegee Airmen was to escort bombers. They took part in thousands of missions in Europe, North Africa, and Sicily. And, not one bomber was lost to enemy fighter planes during their escort.

Serving through the end of the war, Coggs earned the military badges of aerial gunner, aerial bombardier, and multi-engine pilot.

**THE WILD BLUE YONDER**

Maud Currie, Coggs’ wife, “provided strong motivation” for his entry into medicine. In 1946, when she decided to move from Tuskegee to the University of Nebraska to pursue a master’s degree in nutrition education, Coggs wanted to marry her. She asked him how he would support her, and he replied that he’d become a doctor.

Coggs received his Bachelor of Science degree from the University of Nebraska and medical degree from Harvard Medical School (1953). He is featured in Harvard’s presentation, *Against All Odds — The Legacy of Students of African Descent at Harvard Medical School Before Affirmative Action 1850-1968*, by Nora N. Nercessian.

**DECADES OF “FIRSTS”**

Coggs completed his residency in radiology at the University of California, San Francisco (UCSF) in 1958, joined UCSF’s clinical faculty, and one year later, became the first black physician to be a member of the staff of the Kaiser Foundation Hospital in San Francisco.

He was greatly inspired when Betty Ford and Happy Rockefeller went public with their breast disease diagnoses, and established the ultrasound division at the UCSF department of radiology in 1972.
Next he launched into 22 years of teaching and research in radiology at the University of Texas Health Science Center in San Antonio, which included presentations at the annual meetings of the Radiological Society of North America.

AFTER RETIREMENT

In 1989, Coggs retired from the University of Texas at San Antonio with a disability based on narcolepsy. After about a year, he “left the disabled ranks,” he says, to serve the next four years as a locum tenens radiologist, traveling through Texas and California. In 2003, Coggs became a full-time radiologist for the Gonzaba Medical Group in San Antonio.

HIGH NOTES

Besides flying, medicine, and research, Coggs has many other passions and talents, including singing. Between 1982 and 1999, he was a member of the first tenor section of the San Antonio Symphony Mastersingers for six concert seasons.

In 1972, he was awarded the degree of Fellow of the American College of Radiology (FACR). He received the Legacy Award from the National Dunbar High School Alumni Association in 1999. And, he was inducted into the ninth class of the Arkansas Black Hall of Fame in 2001.

RUNNING FOR “GOLD”

Working as a radiologist at Otto Kaiser in Kenedy, Texas, in 1994, Coggs’ driving commute was 67 miles each way. “But, since I have narcolepsy, I needed to stop once or twice on the way to work to take a nap,” remembers Coggs. His wife, who was a varsity track sprinter and varsity basketball player in college, suggested he improve his physical fitness by running one mile daily. With this regimen, he was able to eliminate the naps in about a year.

When Coggs was 71, his mile run was clocked at less than eight minutes. Coggs won the gold medal for the 1500-meter run in the 1997, 1998, and 1999 San Antonio Senior Olympics. In 2000, his personal best for the 400 meter was 1:20. The next year, he overcame prostate cancer, successfully completed radiation and hormonal therapies, and won another gold medal at the Texas Senior Games in 2001.

ROLE MODEL FOR ALL AGES

Coggs continues to bicycle, participate in track events, and swim 20 minutes each morning. At the time of this interview, his sight was set on the gold at the 2007 Texas State Senior Games to be held Oct. 27.

He has two daughters, Anita and Carolyn, and two granddaughters, Aisha and Angela; has worked full time as a radiologist at Brooke Army Medical Center in Fort Sam Houston, Texas, since 2004; and continues to sing both in and out of the shower.
Interventional Radiology

ENTERAL ACCESS SERVICES

A new family of codes was developed to report the collection of percutaneous gastrostomy, jejunostomy, gastrostomy-jejunostomy, or cecostomy (or other colonic) tube procedures. These new codes are differentiated by initial placement (49440-49442), conversion (49446), replacement (49450-49452), and the mechanical removal of obstructive material (49460). All of these procedures include fluoroscopic guidance, contrast injection(s), and image documentation and reporting, which are not reported separately. A new code (49465) that describes a contrast injection for evaluation of an existing gastrostomy, duodenostomy, jejunalostomy, gastro-jejunalostomy, or cecostomy (or other colonic tube) was also created. This code also includes imaging.

Because imaging is included in the above procedure codes, CPT code 74350 (percutaneous placement of gastrostomy tube, radiological supervision, and interpretation) will be deleted.

URETERAL CATHETERIZATION

Two new ureteral catheterization codes were established to describe ureteral stent procedures completed via the transurethral approach, as there are currently no codes that describe a ureteral stent exchange without the use of endoscopy from a transurethral approach. Code 50385 describes the removal and replacement of an internally dwelling ureteral stent, and 50386 describes removal only. Both procedures are performed without the use of cystoscopy. The radiological supervision and interpretation (imaging) services provided in conjunction with these ureteral stent studies are included in the procedure codes and are not reported separately.

ENDOGRAFT SENSOR PLACEMENT

Category III codes 0153T and 0154T were converted to Category I status in 2008 and new CPT codes assigned to describe the transcatheter placement (34806) and noninvasive physiologic study (93982).

RENUMBERING AND RELOCATION OF A SELECT GROUP OF CODES USED BY RADIOLOGISTS

The relocation of a number of CPT codes to a more appropriate section of the CPT 2008 code book is a continuation of the American Medical Association organizational restructuring (CPT 5 Data Model Project) to facilitate computer processing and interoperability with various computer systems. The old codes were deleted and replaced with new codes that are located in a more appropriate section of the CPT code book. The following is a crosswalk to the new codes:

<table>
<thead>
<tr>
<th>Old Code</th>
<th>New Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>32000 (Drainage of chest)</td>
<td>replaced by 32421</td>
</tr>
<tr>
<td>32002 (Treatment of collapsed lung)</td>
<td>replaced by 32422</td>
</tr>
<tr>
<td>32005 (Treat lung lining chemically)</td>
<td>replaced by 32560</td>
</tr>
<tr>
<td>32019 (Insert pleural catheter)</td>
<td>replaced by 32550</td>
</tr>
<tr>
<td>32020 (Insertion of chest tube)</td>
<td>replaced by 32551</td>
</tr>
<tr>
<td>36540 (Collect blood venous device)</td>
<td>replaced by 36591</td>
</tr>
<tr>
<td>36550 (Declot vascular device)</td>
<td>replaced by 36593</td>
</tr>
<tr>
<td>51000 (Drainage of bladder)</td>
<td>replaced by 51100</td>
</tr>
<tr>
<td>51005 (Drainage of bladder)</td>
<td>replaced by 51101</td>
</tr>
<tr>
<td>51010 (Drainage of bladder)</td>
<td>replaced by 51102</td>
</tr>
<tr>
<td>60001 (Aspirate/inject thyroid cyst)</td>
<td>replaced by 60300</td>
</tr>
</tbody>
</table>

In addition to relocating the collection of blood specimen code, a new code (36592) was created to describe a venous collection of blood specimen that is not otherwise specified.

Editor’s note: It is important that your practice update its billing systems with the new 2008 codes when these codes become valid on Jan. 1, 2008. There is no grace period offered to implement new code sets. The Health Insurance Portability and Accountability Act (HIPAA) transaction and code set rules require the use of the medical code set that is valid at the time the service is provided.
RENAL TUMOR ABLATION
Category III code 0135T was deleted and replaced by CPT code 50593 to describe a unilateral percutaneous cryotherapy renal tumor(s) ablation. As noted in the CPT code book, the guidance is reported separately based on the type of guidance used.

Diagnostic Radiology

CARDIAC MRI
The cardiac MRI codes (75552-75556) established in 1993 have become obsolete and will be deleted since they are limited to a few indications. Eight new codes were developed to describe today’s technology, which expands the application of cardiac MRI from predominantly an anatomic test to one that performs accurate physiologic evaluations. Codes 75557-75560 describe cardiac MRI studies without contrast, and codes 75561-75564 describe cardiac MRI studies without contrast followed by with contrast and further sequences. These code sets are further differentiated by flow/velocity quantification and stress imaging.

CTA CODE DESCRIPTOR CHANGE
All computed tomographic angiography (CTA) code descriptors (70496, 70498, 71275, 72191, 73206, 73706, 74175, 75635, 0145T-0151T) will be revised to clarify that a without-contrast diagnostic study is not a required part of a CTA study. The nonenhanced scan is set up from a noncontrast scout image but does not require noncontrast axial CT images. Therefore, an editorial change to the descriptors will be made to clarify the intent of these exams as follows:

Computed tomographic angiography, [body part] part without contrast material, followed by contrast material(s) and further sections with contrast material(s) including noncontrast images, if performed, and image post-processing

RADIATION ONCOLOGY
Four new codes were created for use in radiation oncology. Three new codes describe the placement of needles, catheters, or other devices for subsequent interstitial radioelement access. Code 20555 describes placement in muscle and/or soft tissue; code 41019 describes placement in the head and/or neck region; and code 55920 describes placement in the pelvic organs and/or genitalia applications. One new Category III code, 0182T, was added to describe high dose-rate electronic brachytherapy, per fraction.

In addition, look for a descriptor change to CPT codes 77371, 77372, and 77432. The current descriptors are imprecise as they include the term “cerebral.” Because many lesions of the brain requiring this delivery and management are in the cerebellum, brain stem, or meninges, which are not precisely covered by the word “cerebrum,” the term “cerebral” will be changed to “cranial.”

NUCLEAR MEDICINE
The brain imaging codes 78600-78606 will be revised to specify the number of views required (i.e., 78600-78601 describe reported for fewer than four views, and 78605-78606 describes reported for a minimum of four views). Code 78607 will be used to report a tomographic SPECT study regardless of the number of views performed.

The cerebral vascular flow study code 78615 will be deleted and the coder directed to use 78610 (brain imaging, vascular flow study). When a brain imaging study is performed today, a vascular flow study is always performed; therefore, there is no need to have a separate stand-alone procedure code to describe a cerebral flow study.

The positron emission tomography (PET) descriptors for codes 78811-78816 will be revised editorially. The term “tumor” will be removed from the descriptor for the PET and PET/CT codes, as these codes may be used to report studies for other indications, such as infection. This change is consistent with other code descriptors in the CPT code book that do not describe indications.

OTHER
The introductory notes prior to the diagnostic ultrasound section and mechanical thrombectomy code section will be updated to provide clarification on the use of these codes. In addition, look for changes to the modifier 51 exempt listing (Appendix E) and the descriptors for evaluation and management codes, as well as numerous cross-reference updates. For a complete listing of CPT 2008 changes, see the CPT 2008 code book and CPT Changes 2008: An Insider’s View.
Medical-Legal Issues in Radiology

Bill Shields, ACR general counsel, and Tom Hoffman, ACR associate general counsel

FOREWORD

Legal issues have become a significant part of the practicing radiologist’s world. Most physicians receive little or no information about these issues in their training, and radiologists are no exception. This handbook is an attempt by the American College of Radiology to partially remedy this situation, by providing basic information about the subject to the radiologist-in-training preparing to enter private or academic practice.

—Harry Zibners, M.D., J.D., FACR
—John J. Smith, M.D., J.D.

Harry Zibners, M.D., J.D., FACR, is currently in private radiology practice with Fairfield Imaging Associates Inc. in Lancaster, Ohio, and is Of Counsel to the law firm of Stein, Chapin & Associates L.L.C. in Columbus, Ohio. He is a member of the state bars of California and Ohio.

John J. Smith, M.D., J.D., is an attorney and physician with the Washington, D.C., law firm of Hogan & Hartson L.L.P. He has broad medical practice experience as a fellowship-trained, musculoskeletal radiologist, providing both clinical care and taking part in clinical trials, and was formerly an associate professor at the Massachusetts General Hospital and Harvard Medical School.

Informed Consent

OVERVIEW

In modern medical practice, mentally competent adult patients have the right to determine whether or not they will receive a given medical treatment or service. This right is reflected in the doctrine of informed consent, which maintains that a patient has the right to know the risks and benefits of a medical service or treatment, as well as any alternatives, and to use that information as the basis for an informed decision on whether to accept that service or treatment.

Under the law, a successful informed consent action against a medical practitioner requires several elements, including a duty to the patient; legally inadequate informed consent; and patient injury resulting from that inadequate consent (the “causation” requirement). Since a radiologist or other practitioner providing a medical service to a patient has a duty to the patient under the informed consent doctrine, this first element is rarely an issue. Rather, it is the remaining two elements on which cases generally turn. The elements of informed consent are similar to those for malpractice, and as a practical matter, allegations of failure to obtain adequate consent are usually part of a larger malpractice action, which is discussed later in the text.

STANDARD FOR INFORMED CONSENT

State law determines what constitutes legally adequate consent, as informed consent actions are generally adjudicated under state law. Not surprisingly, there are significant differences in this legal standard from state to state, though the various jurisdictions can be separated into two broad groups. Traditionally, states employed the “reasonable practitioner” standard, a test that asks what a reasonable practitioner in similar circumstances would have told his or her patient as part of the consent process. In practice, the standard was established by physicians testifying as experts as to what information should have been related — a process that effectively kept delineation of the standard within the medical profession.

Reflecting the trend toward patients’ rights, many states have moved to what is known as the “reasonable patient” standard. Contrary to the “reasonable practitioner” standard, this
newer test looks to a reasonable patient and what he or she would have wanted to know about a medical service prior to consenting to that service. While physicians may testify as to the actual risks, benefits, or alternatives to the service, it is the jury (or, if no jury is used, a judge) that determines what a reasonable patient would want to know. This is considered to be a more demanding standard, as it transfers the determination of what constitutes adequate consent away from practitioners and to the court.1 What actually satisfies informed consent requirements under either standard depends heavily on the facts of a specific case, as the changing nature of medicine and the patient at issue mean that there is usually not a previous court case to serve as a “precedent” to control a subsequent court’s ruling. This fact-specific nature of informed-consent actions often leaves radiologists and other practitioners with little solid guidance as to what patients should be told prior to studies or procedures, particularly regarding rare but serious complications.

Regardless of which standard is applied, it is crucial that any information supplied to the patient be in a form that the patient can understand, as failure to do so will result in a legally inadequate consent. For example, explaining a complex interventional procedure in medical terms to a patient with a high-school education is arguably not providing that individual with meaningful information. Similarly, if the patient’s primary language is not English, failure to supply information in that patient’s primary language may result in defective consent.2

### ESTABLISHING CAUSATION

Another key requirement for a successful informed consent action against a radiologist is the demonstration of causa-

Regardless of which standard is applied, it is crucial that any information supplied to the patient be in a form that the patient can understand, as failure to do so will result in a legally inadequate consent.

### OBTAINING LEGALLY ADEQUATE CONSENT

The consent process with a mentally competent patient is rather straightforward. It involves explaining a medical service, its benefits and risks, as well as any alternatives, in a manner that the patient can understand and asking that patient whether he or she would like to proceed. Consent may be obtained in writing or verbally, though a written document with the patient’s signature is very useful as evidence of the consent. It is crucial to realize that the patient may revoke his or her consent at any time for any reason, verbally or in writing.

The informed consent process is more than a legal obligation, as it is often the patient’s initial introduction to the radiology team and its services, and accordingly serves as an ideal opportunity to build a strong doctor-patient

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2 Title VII of the U.S. Civil Rights Act requires healthcare facilities, including most physicians, to provide a means of communication for patients with limited English proficiency, and the Joint Commission on Accreditation of Healthcare Organizations and the American Hospital Association have made this accommodation a condition of accreditation. In the research setting, the Department of Health and Human Services (DHHS) regulations (45 CFR 46.116 and 45 CFR 46.117) and FDA regulations (21 CFR 50.25 and 21 CFR 50.27) require that informed consent information be presented in language understandable to the subject, and in most situations, that informed consent be documented in writing. A brief practical primer on dealing with this situation is Higginbotham, Elizabeth, “Legally Speaking: How to Overcome a Language Barrier,” RNWeb Archive Oct. 1, 2003, at www.rnweb.com/be_core/content/journals/r/data/2003/1001/Translator.html.
relationship. Care should be taken to address the patient’s questions in an honest, truthful, and unrushed manner, in an atmosphere as free from coercion as possible. Accordingly, it is desirable to obtain consent for hospital inpatients in their room, or if outpatients are involved, in a room other than the procedure room, if possible. Similarly, consent obtained under coercive circumstances, such as obtaining consent for additional intervention during a procedure, may be invalid. There is strong evidence that physicians who succeeded in building relationships with their patients during the consent process are far less likely to be the subject of malpractice litigation than those who performed rushed, impersonal consents.\(^n\)\(^.\)\(^4\)

A related issue is a matter of who on the medical team can obtain a patient’s informed consent. There is general agreement that the attending physician who is providing the service may obtain the patient’s consent. Though some commentators argue that the attending physician must personally perform this function, most authorities maintain that the attending physician may delegate the consent process to someone else on the medical team, such as a resident or fellow, or perhaps an advanced practice nurse or physician’s assistant. If the consent process is delegated, the individual performing the consent becomes the “agent” of the attending physician, representing that attending physician to the patient. While the attending physician may delegate the consent process, he or she remains liable for the legal adequacy of the consent provided, as well as the reasonable actions of the agent.\(^n\)

There is strong evidence that physicians who succeeded in building relationships with their patients during the consent process are far less likely to be the subject of malpractice litigation than those who performed rushed, impersonal consents.

For their own part, radiology residents who are asked to obtain informed consent should do so conscientiously, honestly representing their role in the team and service provided, and directing any questions they cannot personally answer to individuals who can. In practice, this means that a resident or fellow who performs a consent process as instructed by the attending radiologist or as would be considered reasonable under the circumstances would not be liable for an inadequate consent. However, if that same resident or fellow explicitly disregarded the instructions of the attending radiologist, or in some other way exceeded the authority delegated by that radiologist, that trainee could be liable for the inadequate consent, not only to the patient but also to the attending radiologist.

NOTICE: The ACR Legal Office exists to represent the College and to provide legal advice to the College leadership and the executive director, as well as to handle the day-to-day legal activities of the College. The attorneys are not licensed in all 50 states, the District of Columbia, Puerto Rico, Guam, and Canada, and therefore, cannot give direct legal advice to members or represent chapters, practices, or individual members. The office can provide general information of interest to members as well as general guidance on a variety of legal topics. All information is provided with the express understanding that no attorney-client relationship exists and that members, practices, and chapters should always consult their personal or corporate counsel on matters of concern.

The ACR Legal Department welcomes questions from members on general legal topics. We cannot provide specific legal advice but will answer questions that apply broadly to radiologists and their practices. Please submit questions in writing to:

ACR Legal Office
1891 Preston White Drive, Reston, VA 20191
legal@acr.org

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1 The degree to which physician communication skills with patients impact malpractice exposure may depend to some degree on the doctor’s specialty. Evidence that this factor is more important for primary care physicians than surgeons can be found in Levinson, W., Roter, D.L., Mullooly, J.P., Dull, V.T., and Frankel, R.M., “Physician-patient Communication. The Relationship With Malpractice Claims Among Primary Care Physicians and Surgeons,” JAMA, Vol. 277, No. 7, Feb. 19, 1997.

2 In general, a physician is not required to reveal personal information as part of obtaining informed consent. Of course, this does not extend to misrepresentation of one’s qualifications or concealing the existence of a direct financial conflict of interest. See Moore v. Regents of the University of California, 793 P.2d 479 (Cal. 1990), involving a physician’s financial interest in development of a cell line from a patient’s spleen.

3 The authority of an agent to act on behalf of a principal can be either “express” or “apparent.” Express authority exists where the principal has given explicit authority to the agent to act in his or her behalf. Apparent authority arises out of a third party’s reasonable belief that the agent has authority to act for the principal. Such a belief could be reasonable if a principal creates the appearance of an agency relationship; a third party relies on that representation; and the third party changes position in reliance on that representation. It is possible, therefore, for a principal to be held liable for the actions of his or her agent even in the absence of express instruction or permission. Hospitals have been held liable for the actions of non-employee hospital-based physicians under this legal theory. For a recent case involving a radiologist, see Roessler v. Novak, No. 2002-1670 (Fla. Dist. Ct. Appr., Nov. 7, 2003).
The following job listings are paid advertisements. The ACR Professional Bureau cannot ensure complete accuracy of all information, and publication of a job listing does not constitute a recommendation by the ACR. The ACR and the ACR Professional Bureau assume no responsibility or liability for any personnel decisions and selections made by the employer.

These job listings have previously appeared on the ACR Professional Bureau Web site. Only jobs posted on the Web site are eligible to appear in the ACR Bulletin, on a space-available basis.

Rates:
ACR members: $50 per ad, maximum 50 words. Nonmembers: $125 per ad, maximum 50 words.

Complete advertising policies, rate information, and other instructions are available on www.acr.org under the “Jobs-Career Dev” tab. Job listings are in order of state.

ALASKA - Juneau - General Diagnostic Radiologist - BC-CE physician sought to join established two-radiologist group. State-of-the-art equipment in beautiful Juneau, Alaska. Hospital-based practice with all modalities and limited interventional caseload. Nighthawk coverage after hours. Competitive compensation and benefit package. Contact: Jill Hughes Richey via e-mail at jughughsrichey@gsi.net.

ARKANSAS - Pine Bluff - Radiology Practice Opportunity - Join a team of five radiologists. Highly competitive salary with partnership track. Call 1:6 with nighthawk coverage. Outstanding benefits package. State-of-the-art GE and Toshiba MRIs (1.5T), two 64-slice Toshiba CT scanners, digital mammography, PACS. Contact: Sharon Theriot by phone at (800) 576-2377, ext. 7290 or send C.V. via e-mail to theriot@rjc.org.

CALIFORNIA - Glendale - Interventional Radiology and MSK Radiologist - Glendale Adventist Medical Center (GAMC) and Glendale Memorial Hospital (GHMH) each has 350-450 beds. GAMC has brand-new acute patient tower, with two MRI, PET/CT, PACS, and three state-of-the-art cath labs. Contact: Linh Chen by phone at (818) 434-8489 or via e-mail at linhlechen@yahoo.com. CALIFORNIA - Pomona - Fellowship-Trained Radiologists - Pomona Valley Imaging Medical Group, an expanding 10-member radiology group, is seeking one or two fellowship-trained radiologists for partnership-track positions with excellent guaranteed compensation and benefits. Hospital-based; new PET/CT, two multichannel CTs, two MR imagers, digital mammography, PACS, and an advent outpatient center joint venture. Contact: Johnson Lightfoote by e-mail at Lightfoote@msn.com.

CALIFORNIA - Sacramento - General Diagnostic Radiologist - Northern California, subspecialized private practice seeks a general radiologist for multiyear contract. Weekday work at hospitals/outpatient imaging centers, some weekends and backup call. Contact: John delaVega, M.D. Send C.V. to Radiological Associates of Sacramento Medical Group Inc., 1500 Expo Parkway, Sacramento, CA 95815; by fax to (916) 920-4434; or via e-mail to recruit@radiological.com. CALIFORNIA - Sacramento - General Diagnostic Radiologist - Partner Track - Northern California private practice seeks skilled general radiologist. Work with plain radiography, fluoroscopy, mammography, sonography, CT in inpatient/outpatient settings. Contact: John delaVega, M.D. Send C.V. to Radiological Associates of Sacramento Medical Group Inc., 1500 Expo Parkway, Sacramento, CA 95815; by fax to (916) 920-4434; or via e-mail to recruit@radiological.com.

COLORADO - Denver - Mammography, MRI, or Neuroradiology - Fellowship-trained radiologist. Great opportunity now available. We provide imaging services for three hospitals and a network of group-owned outpatient imaging centers. Excellent compensation package and partnership track available. Contact: Send C.V. by e-mail to dhspposs@yahoo.com or by fax to (303) 416-1058.

DELAWARE - Wilmington - Women’s Imaging Board-Certified Radiologist - Private outpatient practice seeking FT/PT board-eligible/eligible. Daily: 90-100 mammography and 35 ultrasound. Internet-based PACS, comprehensive benefit/vacation, generous salary, retirement plan, no call, academic experience preferred. Contact: Joseph Peacock, M.D., by phone at (302) 427-9855, by fax at (302) 427-8549, or via e-mail at peacock@diexray.com; visit www.diexray.com.

DISTRICT OF COLUMBIA - Alexandria, Va. - Musculoskeletal - Private-practice group in Northern Virginia covering two hospitals and seven outpatient offices is seeking BE/BC radiologist with fellowship training in MSK. Opportunity to practice in a high-quality environment with the latest imaging technology. Competitive compensation package and partnership-track position. Contact: Meghan Clinton by phone at (703) 824-3216 or via e-mail at mcclinton@alexandriaradiology.com.

FLORIDA - Hollywood - Body Imaging Radiologist - Large radiology group undergoing significant growth currently servicing six hospitals. Seeking BC fellowship-trained body imaging radiologist. Full partnership, competitive salary and benefits. Our needs are due to rapid growth, not turnover. Contact: Jill Avendano by phone at (954) 437-4800, ext. 2148, by fax at (954) 437-6628, or via e-mail at jill.avendano@rahmail.net.

FLORIDA - Hollywood - Mammography Radiologist - Large subspecialized radiology group undergoing significant growth is currently seeking a breast imager. Can offer per diem position with four-day week/no call and mammo rotation schedule only or mammo only full-partnership track. Contact: Jill Avendano by phone at (954) 437-4800, ext. 2148, by fax at (954) 437-6628, or via e-mail at jill.avendano@rahmail.net.


FLORIDA - Jacksonville - ED/Trauma Radiologist - The University of Florida is recruiting ED/truma radiologist. Must be M.D., BC/BE, and fellowship trained. Applications will be reviewed beginning Oct. 1, 2007, and continue until position is filled. The UF/SJ is an EEO institution. Contact: Savas Ozdemir, M.D., Search Chair, 655 W. 8th St., C-90, Jacksonville, FL 32209. Reference #00022963, #00022965.

FLORIDA - Pensacola - Diagnostic Imager - Eight-member group on Florida Gulf Coast. Strong hospital and outpatient practice is seeking board-certified radiologists for a young, dynamic, fellowship-trained group. Busy, expanding practice including five magnets. MDCT/CTA and PET/CT and IDX-PACS. Practice includes the Andrews Institute. Night call taken by a teleradiology service. Contact: Karen Schell by phone at (850) 432-6851.

FLORIDA - Pensacola - Interventional Radiologist - Eight-member radiology group on Florida Gulf Coast is seeking an interventional radiologist to join a well-developed, expanding hospital practice. We have an established outpatient interventional radiology practice and vein clinic and provide AAA endovascular repair, chemoembolization, RFA, and UFE. Excellent benefit package with short partnership. Contact: Karen Schell by phone at (850) 432-6851.

ILLINOIS - Berwyn - Interventional Radiologist - Expanding hospital-based private-practice group seeking fellowship-trained IR to share a vascular lab with another interventional radiologist. Must also be able interpret US/neuro and body CT/nuclear medicine/plain films/GI/GU/urology. Salary negotiable. Applications will be reviewed immediately. Contact: Search Chair, Radiology Department, 655 W. 8th St., Jacksonville, FL 32209. Reference #00023101.

ILLINOIS - Evergreen Park - Body Imager - Suburban Chicago practice seeks fellowship-trained board-certified musculoskeletal imager/diagnostic radiologist. Busy eight-partner practice with all modalities, including multislice CT, US, PET, MRI, NM, angle/interventional, digital mammas, and XR. PACS system. Competitive starting salary and ample vacation. Contact: Fax resume to (708) 229-5352 or via e-mail at marnett2001@yahoo.com.

ILLINOIS - Urbana - Interventional Radiology - Interventional radiologist needed due to expansion of dept. To begin, will be approx. 50 percent interventional, expanding to 75 percent interventional and 25 percent general diag. radiology. Excellent comp and benefits. 320-physician partnership, 14-physician rad team. State-of-the-art equipment. Contact: Sue Idelman by phone at (217) 337-4108 or via e-mail at sue.idelman@carle.com.
ILLINOIS - Urbana - Mammography/Women's Breast Imaging - Dir. of mammography/breast imaging. Outstanding comp and benefits, 10 weeks time off/yr., 320 phys. Partnership at two years; no call, joint app't w/u of I. Organizationally owned malpractice. Over 50 med and surg spec/subspec. Carle Hospital only. Contact: Sue Idleman by phone at (217) 337-4108 or via e-mail at sue.idleman@carle.com.


MICHIGAN - Cheboygan - General Diagnostic Radiologist - Well-established radiologist seeking one replacement and one additional diagnostic radiologist for community hospital-based private practice. 42X exams. All modalities. No angi or major interventional procedures. Nighthawk. Partnership track. Contact: Michael Sunday by phone at (231) 347-8047 or via e-mail at sunday@racc2000.com.


NEBRASKA - Omaha - Interventional Radiologist - University of Nebraska Medical Center is recruiting for interventional radiologists. The University of Nebraska Medical Center is an ED/AAE. Contact: Anthony Adelson M.D. Send C.V. and names of three references to Section Chief of Interventional Radiology, UNMC, 881045 Nebraska Medical Center, Omaha, NE 68191-1045; via e-mail to aadelson@ummc.edu; or fax to (401) 559-1027.

NEW JERSEY - Hamilton - Body Imaging Radiologist - Radiology Affiliates seeking two BC radiologists w/fellowship training in body imaging for position partnership. Interpret all modalities except angi/interventional. Three private offices in New Jersey and services three hospitals (Pennsylvania and New Jersey). Contact: Submit C.V. to G. Sanchez, M.D., c/o M. Fletcher, 3625 Quakerbridge Road, Hamilton, NJ 08619; or e-mail hr@rai.com.

NEW YORK - Orange County & Long Island - MSK, Interventional, and Body Imaging Radiologists - FT/PT MSK, interventional and body imaging radiologists needed for Orange County locations; FT/PT mammographers, interventional, and body imaging radiologists needed for Long Island locations. Contact: Send fax to (914) 666-2987 or e-mail to js@arksradiology.com.

NEW YORK - Syracuse - Chief of Imaging - The Syracuse VA Medical Center is searching for a full-time chief of imaging. The candidates must be board certified in radiology and able to support general radiology, ultrasound, CT, MRI, nuclear medicine. Contact: Linda Zavalaukas. Send fax cover letter and C.V., referencing job number 07-10-COI by COB Dec. 1, 2007, to (315) 425-2447.

NORTH CAROLINA - Elkin - Diagnostic Radiologist (Some Interventional) - We serve Hugh Chatham Memorial Hospital in Elkin, N.C., and four small community hospitals (between Sparta and Winston-Salem, N.C.). This is a partnership track with competitive salary, equal time off, and generous benefits package. Start date is immediate/flexible. Full-time regular position. Contact: Paul Beeman, M.D., by phone at (336) 816-8750 or via e-mail at pbeeman@rhcadiz nc.com.

OHIO - Cleveland - General Radiologist - Eight-member private practice, stable, congenial group seeks board-certified general radiologist. Fellowship training considered a plus. Four-day work-week with approx. nine weeks’ vacation. We cover two hospitals and several clinics. Professional sports, entertainment, and boating all nearby. Contact: Dawn Donich, M.D., by phone at (440) 479-4151 or via e-mail at dawnadonich@hotmail.com.


PENNSYLVANIA - Abington - Body Imager/MSK Radiologist - The Radiology Group at Abington Memorial Hospital is seeking two body or MSK radiologists to join our group of 25 subspecialized radiologists. The hospital is a very highly regarded 520-bed facility in a desirable suburb of Philadelphia. Contact: John Breckenridge by e-mail at jbreckenridge@amh.org.

SOUTH DAKOTA - Rapid City - Radiologist - Twelve-person group; fellowship training preferred/ not essential. Partnership track. Generous compensation/vacation. 400-bed hospital/excellent equipment/PACS/nightrhawk. Imaging center under construction. Town is 65,000/150,000 in area. Edge of beautiful Black Hills. Black Hills offer skiing, hiking, mountain biking, camping, climbing, fishing, boating, and hunting. Close to skiing in Colorado/Montana. Contact: William Zavrlic via e-mail at wzavtalk@araxray.com.

TEXAS - Austin - Body Imager - Opening with partnership track. Austin Radiological Association is looking for an applicant who will be expected to do such procedures as lung biopsy, liver biopsy, paracentesis, and thoracentesis. The position focuses on cross-sectional imaging with very little MSK. Full PACS 70+ members. Contact: Send C.V. via e-mail to richardscm@ausrad.com.

TEXAS - Austin - Breast Imager - Opening for fellowship-trained breast imager in Austin, Texas. Partnership track. High-volume breast program is fully digital with ultrasound-guided, stereotac tic, and MR-guided biopsies. This position also includes cross-sectional body imaging as well as breast imaging. Mixed hospital/clinic practice with full PACS. Contact: Send C.V. via e-mail to richardscm@ausrad.com.

TEXAS - Austin - Neuro-Interventional - Neuro-interventional opening with partnership track. Austin Radiological Association is looking for a fellowship-trained neuro-interventional radiologist. Mixed hospital/clinic practice with full PACS. Includes coil embolization and stroke therapy as well as diagnostic neuroradiology. The group has 70+ members. Contact: Send C.V. via e-mail to richardscm@ausrad.com.

TEXAS - Austin - Pediatric Radiologist - 70+ member private-practice group seeks seventh pediatric radiologist, partnership track. Mixed hospital/clinic practice with full PACS. Approximate practice mix is 75 percent pediatric, 25 percent adult radiology. Must be comfortable with basic procedures in children and adults. No mammography. Contact: Send C.V. via e-mail to richardscm@ausrad.com.

VIRGINIA - Alexandria - Mammography/Women's Imaging - Private-practice group in Northern Virginia covering two hospitals and seven outpatient offices is seeking BE/BC radiologist with fellowship training in mammography/women's imaging. Opportunity to practice in a high-quality environment with the latest imaging technology. Competitive compensation package and partnership-track position. Contact: Megan Clinton, Human Resources Manager, by phone at (703) 824-3216.

VIRGINIA - Fairfax - Women's Imager, Neuroradiologist & Body or MSK - We are looking for a women's imager to head up our women's center, a neuroradiologist, and a body imager or MSK radiologist. Contact: Send C.V. to restorrad@gmail.com.

VIRGINIA - Roanoke - Breast Imager - Carilion Breast Care Center is adding another breast imager to its comprehensive program. Opportunity to conduct original clinical research in a mutually supportive environment with core specialties, but not required. AA/EOE. Contact: Rhonda Cregger by e-mail at rhonda@carilion.com or cregger@comcast.net; or send mail to Senior Physician Recruiter, Carilion Clinic, P.O. Box 40002, Roanoke, VA 24022-0002.

VIRGINIA - Roanoke - Radiologists - Carilion Clinic is accepting C.V.s for ABMS/AOA/A-BC radiologists in all subspecialty areas for its 835-bed teaching/tertiary referral hospital with Level I trauma center, serving 1 million people throughout Southwest Virginia. AA/EOE. Contact: Rhonda Cregger by e-mail at rhonda@carilion.com or cregger@comcast.net; or send mail to Senior Physician Recruiter, Carilion Clinic, P.O. Box 40002, Roanoke, VA 24022-0002.

WYOMING - Riverton - General Diagnostic Radiology - Seeking general diagnostic radiologist to join hospital-based group. Partnership available. Benefits. 64-slice CT. Completely digital; 70-bed hospital located in the Wind River Valley. Snowmobiling, hiking, mountain climbing, horseback riding, and beautiful country. Contact: Rebecca Smith by phone at (307) 857-5241 or via e-mail at rebecca.smith@pint.net.
ACR Calendar of Events

Second Annual PET/CT Update Course
Jan. 27-30, 2008
La Quinta Resort & Club, La Quinta, Calif.
In this four-day course, you’ll develop an understanding of the rationale for selecting and using various PET and CT imaging protocols, gain insight into PET/CT variants and artifacts, and study methods for developing and optimizing a PET/CT clinical practice. Also, you’ll view an array of challenging PET/CT cases illustrating various aspects of disease manifestation and their relevance to patient management.

Marketing, Branding, and Promoting Your Practice:
How to Stand Out From the Competition and Succeed
Feb. 19-22, 2008
Vail Cascade Resort & Spa, Vail, Colo.
This conference spans four days, with classes taking up only a portion of each day. Attendees will learn about proven strategies for successfully marketing and growing a practice in these challenging times. This practical course will take you through all the steps — from developing your marketing plan to strategic implementation.

Cardiac CT: Supervised Case Review With Texas Radiological Society
March 30, 2008
Hyatt Regency Hotel, Dallas
Document 50 supervised case reviews, earn CME credits, learn from a world-class faculty, and satisfy the new ACR Guidelines and accreditation requirements. New accreditation programs in cardiac CT and cardiac MR require participation in supervised cases and CME credits in cardiac imaging.

National Conference on Breast Cancer
May 8-10, 2008
JW Marriott, Grande Lakes Resort, Orlando, Fla.
Participants will learn valuable updates on the current body of knowledge in breast imaging, with specific attention to evaluation and management of breast disease. Presentations will include hot-topic panel discussions; question-and-answer sessions; and small, single-topic workshops that provide direct interaction with leading experts.

For more information on the ACR’s courses, visit www.acr.org and click on Meetings and Events. Or, call (800) ACR-LINE for additional information.


Chest Disease VI is the 52nd book in the ACR’s popular Professional Self-Evaluation (PSE) series. As the reference of choice for residents and practicing radiologists, this outstanding volume features:

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