Bulletin... Spring 2012

The Pennsylvania Radiological Society

A Chapter of the American College of Radiology

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PRESIDENT'S MESSAGE

Mary H. Scanlon, MD, FACR
University of Pennsylvania
Philadelphia, PA

As president of the PRS, I was invited to attend the PMS Specialty Leadership Cabinet meeting held on February 7th, joining Elaine R. Lewis, MD, FACR and Cathleen A. Woomert, MD, FACR at the meeting. A presentation on the collaborative project between Capital Blue Cross and the Pennsylvania Medical Society on specialty quality measures piqued my interest - the goal of the project is to create consistent statewide specialty quality metrics in conjunction with state specialty societies. This initiative would provide a mechanism for state societies to document the value proposition of their specialty by identifying key measures for their respective areas.

Phase one measures are currently being finalized for six specialties - Gastroenterology, General Surgery, OB/GYN, Orthopedics, Otolaryngology, and Urology. Phase two measures will focus on procedural complications. Capital Blue Cross hopes to get all the Blues in Pennsylvania to adopt the measures by developing a testing plan using aggregate data and a neutral data aggregator. The quality report cards generated using these measures will be critical for employer groups deciding on healthcare plans.

After this initial stage of development, the program will be expanded to other specialties and the PRS will surely be invited to participate. With Robert S. Pyatt, Jr., MD, FACR leading the way, we will be well prepared to identify measures that document our value, commitment to quality and patient safety, and contribute to excellence in patient care. I believe there is no more important issue in the eyes of our stakeholders than the perceived dangers of radiation exposure from medical imaging, and will be strongly advocating for all radiology groups to join the ACR Dose Index Registry now.

EDITOR'S COLUMN

Anne P. Dunne, MD
Geisinger Medical Center
Danville PA

Since the future of our specialty lies with our trainees, I want to report on the results of this year's NRMP Match and on some presentations and discussions from the 60th annual meeting of the Association of University Radiologists (AUR), March 19-22, in San Antonio, TX.

2012 Match: This year's match results for diagnostic radiology continued what was believed to be the start of a trend that began last year. There are 187 radiology residency training programs in the United States. Last year, 24 programs did not completely fill in the Match for a total of 33 unfilled positions. This year, 42 programs did not completely fill in the Match for a total of 86 unfilled positions. Eleven positions were in Pennsylvania. Of all the specific residency training programs in the country, this was the 2nd worst result; pathology being the worst. While there is no definitive study to answer why this has occurred, the conjecture is that the uncertainties related to healthcare reform and to cautious

hiring by radiology groups have quickly trickled down to medical students as they did in the 1990's.

SOAP: Most if not all of these unfilled positions were ultimately filled by the new SOAP (Supplemental Offer and Acceptance Program) system instituted this year post Match. This was a controlled on-line Match program which avoided the chaos of the post-Match scramble that occurred in previous years. Starting with Match 2013, there is a new rule of "all in or all out", meaning that if an institution participates in the Match, all the training positions must be in the Match, whether the applicants are allopathic seniors, osteopaths or international medical school graduates.

AUR Meeting: The theme of this year's AUR meeting was on "Ethics and Professionalism in Radiology Education, Research and Practice". There were a number of sessions focused on recognizing and managing disruptive and unprofessional behaviors in the workplace. There was analysis on how these negative behaviors impact health care, patient safety, operations and the learning environment of medical students and residents. There was also examination of the hostile work environment and legal implications as well as examining physician behaviors that can enhance a radiology practice and promote patient satisfaction and loyalty.

The AUR's Keynote Lecture was given by Dean V. Buonomano, PhD, Professor of Neurobiology and Psychology at UCLA. The title was "Features and Bugs of the Brain's Architecture-Effects on Memory, Decisions and Pattern Recognition". This was a fascinating lecture that has implications for everyone's daily functioning as well as for developing strategies for teaching and learning. Dr. Buonomano's work has been featured in the popular press and one can access his website or book to learn more:

www.brainbugs.org
Book: "Brain Bugs: How the Brain's Flaws Shape Our Lives"; Norton, 2011.

Milestones: As initiatives in residency have been extended to board certification and hospital credentialing for practicing radiologists, e.g. the 6 core competencies, it is important to be aware of the Milestone project. To review, the core competencies are part of the ACGME's Outcome Project for residency training.

They are:
1. patient care
2. medical knowledge
3. professionalism
4. interpersonal and communication skills
5. practice-based learning and improvement
6. systems-based practice

The Milestones are an outgrowth of the Competencies. It is the development of specific benchmarks of skills and knowledge that residents in every specialty must achieve at certain stages in their residencies. This is residency specific. It will document the resident's steadily increasing mastery of the 6 competencies. This is to start in July 2013. Residency programs and radiology specialty societies are working on the specific milestones.

ABR Certification: Radiologists who were board certified prior to 2002 have life time certificates. Starting, I believe with those attaining board certification in 2002, board certification was time limited for 10 years. Starting with candidates attaining board certification in 2012, there will be continuous board certification. This means that the first "look back" will be in 3 years post certification, not 10 years. Goals will have to be reached at various time intervals. For example, there is yearly proof of state licensure. One must obtain 25 CME credits per year or 75 credits every 3 years. A PQI project must be done every 3 years. One must obtain 2 SAM's (self assessment module) credits every year or 6 every 3 years. The re-certification exam will still be taken after 10 years.

There will no longer be an unlimited time of board eligibility. As of January 2012, one must become board certified within 6 years from completion of training. If not accomplished, one needs one year of training at an ACGME accredited program before re-taking the exams.

As part of the endeavor for medicine to be responsible to the public, the ABR will start public reporting of radiologists in August 2012. There are 3 categories:
1. meets requirements of MOC (maintenance of certification)
2. does not meet the requirements of MOC
3. instructions are given of how to access information on those radiologists with life time certificates. This will explain that these radiologists are board certified but under a different system then the current MOC.

Radiology in 2020: This was an Innovations in Academic Radiology Program entitled "Impact in Academic Radiology of Health Care Reform: What Will We Look Like in 2020?" This 2.5 hour session was composed of 13 short presentations by multiple leaders and experts in radiology.

The predictions:
1. There will be fewer residents and less practical education. Faculty will be busier and will have to do more work. Resident education will have more emphasis on reading texts and learning from simulations. This is similar to the European model of education and the way things were in the 1960's. A greater proportion of practical training/experience may occur in fellowship and the first years in practice.
2. Will it be OK to have general radiologists? No. Needed will be 24/7 availability of the highest quality subspecialty radiologists.
3. Radiologists will have less autonomy and increased clinical productivity and efficiency.
4. I.T. will have a crucial role.
5. There will be structured reporting with standardized nomenclature and more standardization of protocols. Images will be annotated and marked.
6. Radiologists will have to move from description to problem solving.
7. 30-40% of imaging may be unnecessary. Great attention is being paid to PCORI: Patient Centered Outcomes Research Initiative.
8. NIH grants will decrease.
9. The bulk of research will be funded research that deals with outcomes and involves multi-institutional and multi-disciplinary projects.

10. Salaries will go down.
11. Off-campus CME days will be limited.
12. There will be decrease in travel funds.
13 There will be decrease in department budget for food, entertainment, e.g. department Christmas party
14. There will be decrease in the number of academic days given.
15. The largest threat to academics is the very large hospital systems which are not academic.

In the quarterly publication of the ARRS "In Practice", Spring 2012, vol. 6, issue 2, there is an article "Radiology 2020: A Bold Look into the Future of Radiology". Predictions include:
-personalized medicine and patient-centric care
-emerging technologies
-controlling costs
-reducing radiation dose

Recognition

Congratulations to the Diagnostic Radiology Residency Program at the University of Pittsburgh; Philip Orons, DO; Program Director!
For academic year 2011-2012, they were given an award by the AIRP (American Institute for Radiologic Pathology; formerly AFIP-a program of the ACR) for the best cases submitted by residents to the Radiologic Pathology Correlation Course. This was the second year in a row that they achieved this distinction.

And again- Congratulations to the Diagnostic Radiology Residency Program at the University of Pittsburgh; Philip Orons, DO; Program Director!
They were awarded 3rd place in the annual Philips Vydareny Imaging Interpretation Competition at the meeting of the Association of University Radiologists in San Antonio, TX; March 19-22.

1st Place Mallinckrodt Institute of Radiology, St. Louis, MO
2nd Place University of Washington, Seattle, WA
3rd Place University of Pittsburgh, Pittsburgh, PA

Announcements

89th ACR Annual Meeting and Chapter Leadership Conference
April 21-25, 2012
Washington Hilton, Washington, D.C.

As last year, the RADPAC Thank You Dinner is available only for ACRA members who have contributed or pledged $1,000.00 or more in calendar year 2012 by no later than Friday, April 6. This year's entertainment will be "The Politcos".

97th Annual Meeting of the Pennsylvania Radiological Society
September 7-8, 2012
The Rittenhouse Hotel, Philadelphia, PA

PROFILE OF DWIGHT E. HERON, MD, FACRO

Anne P. Dunne, MD
Geisinger Medical Center
Danville, PA

In an effort to inform members of the society about leaders of the PRS, we occasionally profile an individual. Dr. Heron is on the Board of Directors of the PRS. He is currently Director of Radiation Oncology and Vice Chair for Clinical Affairs at the University of Pittsburgh Cancer Institute and UPMC Cancer Centers and Chair of the Department of Radiation Oncology at UPMC Shadyside Hospital, Hillman Cancer Center and University of Pittsburgh Cancer Institute. He is Professor of Radiation Oncology and Otolaryngology and Head and Neck Surgery.

He received his Bachelor of Science degree in pre-medicine from Fairfield University, Fairfield, CT and his medical degree from the University of Rochester School of Medicine and Dentistry, Rochester, NY. He did a medical internship at Winthrop-University Hospital, SUNY-Stony Brook School of Medicine, Mineola, NY. He did his residency in radiation oncology at Thomas Jefferson University Hospital in Philadelphia, PA where he was chief resident.

Dr. Heron is author or co-author of 117 peer reviewed publications, 164 published abstracts, 104 oral and poster presentations and 3 book chapters. He has given 121 invited lectures. He is a reviewer for multiple journals. He is active in numerous national and international professional societies and committees, both as a member and in leadership positions. Among many other responsible positions, he is the National Chair of the Cancer Disparities Research Partnership Program.

From 2000-2007, Dr. Heron was Associate Residency Program Director of the Radiation Oncology residency at the University of Pittsburgh Cancer Institute. He was awarded the Teacher of the Year Award in 2001-2002 by the Association of Residents in Radiation Oncology. In 2003, he received the Presidential Award of the Society of Gynecologic Oncology. In 2005, he received the Exemplary Service Award for Medicine by the Omega Psi Phi Fraternity. Dr. Heron was highlighted as one of 140 American Doctors Changing the Face of Medicine in the May 2008 issue of *Black Enterprise*.

Dr. Heron has taught and mentored college students, medical students and residents. He is actively involved in research by participating in multiple clinical trials and being a grant recipient on multiple projects. Most interesting are projects to assess, identify and formulate solutions to cancer disparities in Western Pennsylvania and to assist racially and socioeconomically disadvantaged patients navigate health

systems to obtain timely and appropriate radiation therapy cancer care.

When asked why be became involved with the PRS and other organizations, Dr. Heron states that he has a long history of participation in such activities. It seems to be an innate interest that he finds rewarding and hopes is helpful to others. He was vice president of his medical school class at the University of Rochester and was chair of the Constitution Committee for the student body there. He has also been involved in community activities providing prostate screening to African American men and Amish men. It is overwhelming to review Dr. Heron's C.V. The message for all of us and especially for our trainees is that, where there is personal interest and the importance of the work, one can find the time to contribute. In what little extra time Dr. Heron has, he enjoys exotic cars.

WHY ALL RADIOLOGISTS SHOULD ROUTINELY CONTRIBUTE TO RADIOLOGY PAC's & MAINTAIN ACR & PRS MEMBERSHIP

David P. Mayer, MD, MS, FACR
Mercy Health Systems
Darby, PA

William "Willie" Sutton (June 30, 1901 - November 2, 1980) was a prolific U.S. bank robber. He is famously — but apocryphally — supposed to have answered reporter, Mitch Ohnstad, who asked why he robbed banks, by saying, "because that's where the money is." The supposed quote formed the basis of Sutton's law.

What is a Political Action Committee (PAC) per Federal Election Commission?

The term "political action committee" (PAC) refers to two distinct types of political committees registered with the FEC: separate segregated funds (SSFs) and non-connected committees. SSFs are political committees established and administered by corporations, labor unions, membership organizations or trade associations. These committees can only solicit contributions from individuals associated with connected or sponsoring organizations.

"We must all hang together, or assuredly we shall all hang separately"- BENJAMIN FRANKLIN.

When you are deciding where to spend or invest your hard earned income, please consider the following facts:

1. RADPAC, the ACR associated Political Action Committee (PAC), exists to provide bipartisan support for political candidates who will consider the positions held by Radiologists. Latest data has some fascinating information. In the House of Representatives, a body made up of 435 members, 162 or 37% are lawyers. In the Senate, with 100 members, 54 or 54% are lawyers. Physicians make up 3% of the House and 2% of the Senate.
2. RADPAC also reports in their latest data that our Trial Lawyer colleagues had a total of more than 5 million dollars for political action purposes versus the AMA, which had a little more than $2.5 million. Those figures are closer than many of us would have expected. However, the Trial lawyers spent in excess of $4 million of their funds this past reporting year and the AMA spent a little more than $400,000. By the way, the AMA does not support the Radiologists' position against self-referral. While the interest of the majority of AMA members does coincide with Radiology on many issues, there is a serious divergence when it comes to self-referral.
3. Among all medical specialties, the Radiologists were 3rd behind the Anesthesiologists and Orthopedic Surgeons in contributing to their representative PACs. The Anesthesiologists and Orthopedic Surgeons 2009 receipts were EACH a little more than 1.6 million versus the Radiologists whose receipts were a little over $1 million. Our ER colleagues collected just $6,000 less than Radiology. Our Orthopedic Surgical Colleagues "surprisingly" increased their contributions by almost a half a million dollars from 2007 to 2009 and Radiology by a little more than $200,000.
4. Among Radiologists, the ACR RADPAC contributions by state vary quite significantly. Pennsylvania Radiologists' contributions were meager, as only 16% contributed in 2011 for a total of ~$63,000. Sadly, among large population states, the only one with a higher percentage is Texas at a paltry 20%. Indiana and North Carolina Radiologists contributed at the rate of 24 and 27% respectively. Our New Jersey and New York colleagues must have been very hard pressed because they managed only 7 and 6% contribution rates, respectively. In Delaware, the Radiologists must have been so busy that only 3% had the time to contribute to the PAC that helps get candidates elected who will listen to our perspectives on self referral and reimbursement.
5. Medscape's 2011 Radiology Compensation Report showed that 82% would go into Radiology again and only 7% would try something else. (11% were confused about that choice.) About 45% of Radiologists had no change in salary and a noticeably higher percentage of the remainder of Radiologists salaries **went down** versus increased. The median income for male Radiologists was $360,000 and for female Radiologists $320,000.

How does the apocryphal "Sutton's Law" apply to Radiologists? Obviously, our Trial Lawyer, Orthopedic and Anesthesia colleagues understand the connection. Very simply, House of Representative members are re-elected every 2 years and are constantly in need of political donations to get elected or to stay in office. One third of our Senators stand for election ever 2 years, so there is also a very keen interest in the Senate for continuous contributions as well.

It may be surprising to some Radiologists, but a contribution to a re-election campaign does create the opportunity for "face time" where an organization's positions can be heard above the background "noise." It is also a reasonable supposition that a larger contribution is given more credence than a smaller one.

If there ever was a time for **every** practicing Radiologist to seize the opportunity to contribute to the ACR RADPAC, this would be the time, with the upcoming crucial 2012 elections arriving after just a few more months following the endless campaigning, spinning of half truths and outright negativity.

   a. 6 cm off center may cause the "auto-ma" to increase up to 100%*
2. Set up your CT X-ray dose protocols to differentiate between different size patients:
   a. e.g. up to 150lbs; 150-200lbs and > 200 lbs
   b. Adjust Noise Index to Body size*:
      i. Typical NI = 10-20
      ii. High NI (low x-ray dose) = 30-40
3. Create a culture of Radiation Dose savings with your technologists:
   a. Have them document every time they lower the standard doses on the request form
   b. Empower them (with guidance) to lower X-ray doses and given them constructive feedback on their decisions
   c. Be certain to personally speak with evening and night CT technologists who frequently are not optimally informed of protocol changes and can't be optimally supervised by a radiologist.
4. Purchase proprietary software tools (e.g. ASIR from GE) to lower required dose by decreasing noise
5. Join ACR NRDR (X-Ray Dose Registry)
6. Substitute MRI or Ultrasound when possible.

- William P. Shuman, MD: lecture @ SBCTMR
- Annual Meeting; November 2011
  "Five Quick Tricks to Cut CT Patient Radiation Dose by 40%"

IT'S DOWN TO THE WIRE

Saurabh Jha, MBBS
University of Pennsylvania
Philadelphia, PA

The Supreme Court of the United States will deliberate on the constitutionality of a key element of the Affordable Care Act (ACA) between March 26th and 28th.

The key element is the individual mandate – the requirement that all citizens, who do not qualify for federal aid, purchase health insurance.

The individual mandate is the natural corollary of another provision of the ACA – the requirement for insurers not to deny or drop insurance on the basis of pre-existing medical conditions, nor to set higher premiums on the basis of co-morbidities. If insurers are generally to survive and if they cannot participate in adverse selection, it follows that their survival is only assured if everyone participates in the health insurance market, not just the potentially ill. Otherwise, it will rapidly result in a death spiral with a permanent exodus of industries willing to provide health insurance.

There are motivations simply beyond the preservation of the health insurance market in setting the individual mandate. Under the EMTALA laws, emergency departments are mandated to treat the patient regardless of the insurance status or the ability to pay. As emergency departments have now become the de facto primary care service for many citizens, even those who are registered with primary care physicians, the EMTALA laws have considerable potential to encourage free rider behavior – i.e. it act as a disincentive for the healthy and young to enter the health insurance market.

Considering that a trip to the emergency department is rarely completed without some imaging, even it is for the sake of a formality, the costs that these free riders pass is not trivial. Someone pays the tab and it is certainly not just the 1 %. The costs are absorbed by the insured and reflected in their premiums. One can consider this a form of redistribution – except one without consent, recognition or gratitude.

The individual mandate is purported to reduce free rider behavior. In theory, the costs imposed by abolishing this negative externality ought to be reflected in declining insurance premiums. In reality, the imposition of the mandate will result in the creation of an enforcement agency (because after all, a law without enforcement is only good advice, as Abe wryly noted), whose agents will need to be paid salary and benefits, including health benefits. So it might be prudent to cage the optimism for that refund for now.

The additional allure of the individual mandate is that it gives an aura of equity and fairness. As "fair" will soon be the most popular 4 letter word in the English language, this logic is hard to resist. As long as one does not pin fairness on its exact definition, which in my opinion would be quite unfair, there is guaranteed satisfaction that the system is indeed fair, regardless of the outcome.

So with so many virtues of the individual mandate, what's not to like?

Well there is that rather inconvenient truth about a constitution which limits how much folks in Potomac can tell folks in rural Pennsylvania to do. This also has an escape route – the interstate commerce clause. Any activity that can potentially disrupt interstate commerce can be regulated by the Federal government.

But the matter is not so clear cut. The decision not to purchase insurance is a measure of inactivity. Sure the interstate commerce clause can be applied to volitional acts (such as planting vegetables for personal consumption in the back yard) but can it be used to control inactivity?

Can government limit time spent on the couch to stimulate the interstate Pilates and yoga activity? Sounds ridiculous but slippery slope arguments often are, until one is completely down the slope when the truth no longer seems scarier than fiction.

Yet healthcare is a trillion dollar industry and one enters it from the moment the conception is deemed non-reversible. Participation in the healthcare market is a social contract. There is nothing voluntary about it.

Both sides of the argument are compelling. Whatever one's view of the ACA or the individual mandate, the fact that a democratically elected government that has passed a law through constitutional means is not above the judiciary is a testament to the strength of the institutions. And for that reason alone, Americans should be proud.

AAPM Position Statement on Radiation Risks from Medical Imaging Procedures

Joseph G. Och, MS
PRS Representative to PRPAC
Medical Health Physics
Geisinger Medical Center
Danville, PA

"Risks of medical imaging at effective doses below 50 mSv for single procedures or 100 mSv for multiple procedures over short time periods are too low to be detectable and may be nonexistent. Predictions of hypothetical cancer incidence and deaths in patient populations exposed to such low doses are highly speculative and should be discouraged."

The above is part of a position statement recently issued by the AAPM (American Association of Physicists in Medicine). Taking this stand was made necessary by the stream of media attention citing the dangers of diagnostic imaging. The AAPM expressed concern that this might "*cause some patients and parents to refuse medical imaging procedures, placing them at substantial risk by not receiving the clinical benefits of the prescribed procedures.*"

The statement is especially potent when typical doses from diagnostic exams are placed in perspective:

Exam	**mSv**
Chest	0.04
Mammography	0.6
Lumbar Spine	1
Bone Scan NM	4
Cardiac NM	8
CT Abdomen	9
Coronary Angiogram (diagnostic	12

The AAPM does emphasize that "*medical imaging procedures should be appropriate and conducted at the lowest radiation dose consistent with acquisition of the desired information."*

The statement is a powerful, and refreshing, alternative to comparing Diagnostic doses to numbers of chest x-rays, or minutes of background radiation, or days at the beach.

The full text can be viewed at www.aapm.org

CALL FOR SCIENTIFIC EXHIBITS

Rickhesvar Mahraj, M.D., FRCP, FRCR
Chairman, Scientific Exhibits Committee

Subject: CALL FOR SCIENTIFIC EXHIBITS (Application Enclosed)

The Ninety-Seventh Meeting of the Pennsylvania Radiological Society will be held September 7 - 8, 2012 at the Rittenhouse Hotel in Philadelphia, Pennsylvania.

Scientific exhibits are a most important part of the Annual Meeting's educational program. All members of the Pennsylvania Radiological Society are invited to submit applications. Exhibits presented elsewhere are eligible for consideration, along with new exhibits and, by the same token, participation in the Pennsylvania Radiological Society Annual Meeting does not preclude acceptance of your exhibit at other national and subspecialty meetings. Presenting at this meeting is an ideal way to satisfy the residency requirement for research presentations. Please encourage your residents to participate.

Please complete the application form enclosed with this mailing. If additional forms are needed, please feel free to duplicate them and distribute them to your colleagues. Additional forms may also be obtained from the office of the Executive Director, Robert Powell.

Completed applications should be sent to me as soon as possible, but no later than August 20, 2012.

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PENNSYLVANIA RADIOLOGICAL SOCIETY

APPLICATION TO PRESENT A SCIENTIFIC EXHIBIT
(Deadline for application: August 20, 2012)
97th ANNUAL MEETING
RITTENHOUSE HOTEL ~ PHILADELPHIA, PENNSYLVLANIA
September 7 – 8th, 2012

Exhibits Committee: Rickhesvar Mahraj, M.D., FRCP, FRCR, **Chairperson**

TITLE OF EXHIBIT: (attach abstract of 300 words or less with application)

AUTHORS (underline principal author):

_____

INSTITUTION (if any):

_____

MAILING ADDRESS OF PRINCIPAL AUTHOR:

_____

TEL. #:_____
FAX #:_____
EMAIL :_____

EXHIBIT CATEGORY: _____

Scientific_____Review_____PA Radiological Society Only

Where has this exhibit been shown previously?

_____

All exhibits should be mounted on flat vertical panels of 3' x 4' or 4' x 6'. Illuminated exhibits will not be accepted. Table-top space and easels will be provided. If self-contained exhibit, please supply diagram and indicate:

a. Size of exhibit:_____

b. Are sound and/or moving devices included?
_____YES _____NO

c. Will explanatory printed material be distributed? _____YES _____NO

d. Additional information:_____
_____

Exhibits must be installed between 12:00 noon and 5:00 p.m. on Friday.
Exhibits must be removed between 2:00 p.m. and 4:00 p.m. on Saturday.
Exhibitors are responsible for transportation, installing and dismantling exhibits.
Members of the Exhibit Committee will be available to assist exhibitors.
Further information will be supplied with the notice of acceptance.

Signature of Applicant:

_____

Date: _____

Return Application To:
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