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The Pennsylvania Radiological Society

A Chapter of the American College of Radiology

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PRESIDENT'S MESSAGE

Matthew S. Pollack, M.D., FACR

In 1915, several radiologists in Altoona, Drs. G. D. Bliss, W.A. Reilly and Harry W. Stewart discussed and recognized the merits of forming a society dedicated to X-ray diagnosis and X-Ray or radium treatment. They created the Roentgen Ray Society of Central Pennsylvania, which evolved into the Pennsylvania Radiological Society.

Over the ensuing 99 years, radiology has, of course, undergone immense change. Radiologists have become more removed from the patients whose diseases we diagnose and treat. We all recognize that our specialty has, ironically, an "image problem" among much of the public, including our patients and our elected officials. An ACR-sponsored survey in 2008 found 50% of patients did not know what a radiologist does; most could not distinguish us from radiologic technologists. More recent research from Indiana University, presented at the 2012 RSNA meeting, mirrored these findings. Those researchers concluded: "we must explore the barriers of our medical system that prevent radiologists from being visible to patients".

Recently, our professional societies have decided to address this crucial issue. The RSNA's campaign, "Radiology Cares", is dedicated to a patient-centered practice of radiology where radiologists engage our patients directly. A cornerstone of the ACR's "Imaging 3.0" is patient-centered care.

In the same vein, I shared an idea of mine during my inauguration speech at the annual Pennsylvania Radiological Society meeting in September: A PRS-sponsored website where the public could submit questions about any aspect of radiology or radiation oncology and receive an individualized response from a PRS member.

The response to my proposal was well-received and with a stellar team of volunteers, composed of Tom Chang, Tessa Cook, Todd Hertzberg and Howard Chen, we are in the process of building such a website. The project is in an early stage of development and, for now, we refer to it as "Ask a Radiologist". When the website is ready for primetime, the Q & As will be posted on the homepage and will also be archived, accessible for searches by users. When applicable, there will be links to other websites, like Radiology Info, Image Gently, ACR appropriateness criteria, Mammography Saves Lives, etc., where the user can obtain additional information on the topic. Once the site is up and running, we will vigorously market it to the public.

If this project is to succeed, we will need many PRS members to volunteer a few minutes of their time as contributors to "Ask a Radiologist". So, if you would be willing to receive and answer one or two such questions each year, please contact me.

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On October 2nd and 3rd, 2015, the Pennsylvania Radiological Society will be hosting its Centennial meeting at the Rittenhouse Hotel in Philadelphia. I am honored to be presiding over what will be a fantastic weekend. We will have CME courses on both Friday and Saturday, organized, once again, by the indefatigable Bob Pyatt. On Saturday afternoon, free transportation will be provided to attendees and their families for excursions to a number of venues, such as the Philadelphia Museum of Art, the Barnes Museum and the revamped Philadelphia Zoo. If there is interest, we will assist registrants in obtaining tickets to Saturday matinee performances at several of Philly's excellent theaters.

The Saturday night banquet should be extra-special with many past presidents attending and several terrific speakers. So mark your calendars now. I look forward to seeing you at the 100th meeting of the Pennsylvania Radiological Society.

Matthew S. Pollack, M.D., FACR
President,
Pennsylvania Radiological Society
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Attention!

There is a new Pennsylvania law taking effect January 1st, 2015, requiring CME regarding child abuse recognition and reporting. Even for radiologists. See below.

"2 credit hours from a Department of Human Services' (formerly DPW) approved course on the topic of mandated child abuse recognition and reporting for a license renewal (effective 1/1/2015) OR 3 credit hours from a Department of Human Services' approved course on the topic of mandated child abuse recognition and reporting for an initial license (effective 1/1/2015). - See more at:

http://www.pamedsoc.org/mainmenucategories/education/cme-tracker/md-cme-requirements.html

http://www.dos.state.pa.us/portal/server.pt/community/child_abuse_ce_providers/21920

http://www.pamedsoc.org/MainMenuCategories/Laws-Politics/Analysis/Laws-Analysis/Child-abuse/Child-abuse-reporting.html

Editor's Note

Saurabh Jha MD MS MBBS

It's a privilege serving as the Editor of the Bulletin for the Pennsylvania Radiological Society. The Bulletin is an important complement to the JACR because all politics is local. And the same applies to economics and advocacy.

It's my intention to make the content locally relevant but also reflective of the national issues facing radiologists.
Specifically, I have the following goals.

a) Feature ACR 3.0 successes and struggles.

   As you probably know, the ACR is leading radiologists from a volume to a value-driven model of practice. Essentially, this boils down to non-interpretive work such as consultative services, clinico-radiological conferences, attention to quality and others. For success ACR 3.0 will require both a top down and bottom up approach. Here the Bulletin can help share stories of success and challenges.

b) Explain the great work in advocacy at the state level.

There is a temptation to think of advocacy only at a national level. But there is a lot of activity and impact at the local level. Ian Amber, radiology resident, writes about advocacy and the work of the indefatigable Klines.

c) Explain economics and reimbursements.

Reimbursement in radiology is complex. Complexity means that we can be hit but not realize why or how. It's complex. Andrew Wilmot, attending at the University of Pittsburgh, explains the how. Future historians and economists may explain why.

d) Have more contribution from radiology residents.

This is one of my most important goals. If you are a resident and wish to voice your concern, a suggestion or just muse or even vent, send me a piece.

2015 will be an exciting year. Wishing you all a happy and prosperous new year.

Saurabh Jha MD MS,
Assistant Professor of Radiology,
University of Pennsylvania.

Before the End of the Day

Po-Hao (Howard) Chen MD

"Before the end of the day," a staff radiologist placed a gentle but firm hand on my shoulder a few months into my first year in residency, "we should talk about your report." I felt a dull tugging in my stomach, worried that something had gone seriously wrong - an incorrect diagnosis, a poorly phrased finding, an embarrassing lapse in voice recognition leaving out the "no" in front of "evidence of cancer." Maybe I was completely off-base, having seen a finding that did not exist and perhaps called it "highly suspicious." Maybe the ordering physician called my attending on her personal cell phone to complain.
Maybe it was the patient who called.

"I have a few stylistic recommendations for how to draft your report." Nobody made a telephone complaint, no technical snafu from the dictation system, and no cancer-free organs resected by an omitted negation. And so she and I sat and reviewed the specific wordings of each find, discussing how different word choices convey different levels of concern and judgment, even when the findings themselves remain the same.

For many radiology residents, at some point during training the inevitable question has come up, "why do we spend so much time on the body of the report if it will not change the Impression section? Isn't the diagnosis all that matters?"

Renowned Duke University behavioral economist Dan Ariely tells a story about meeting a locksmith. When the locksmith was an apprentice and called upon to open the door for an unfortunate homeowner, he would mull over the lock for hours, trying to identify the type of lock and figure out how to open it without destroying the mechanisms. For his hours of work and sweat, the apprentice locksmith was paid and tipped handsomely. Decades later, the same locksmith had become so proficient he took only seconds to open the same doors without breaking a sweat. Ironically, clients stopped giving him a tip but began to complaint about his charges, "this much money for 30 seconds of work?" Dan Ariely then went on to describe the phenomenon experimentally, showing that perception of value is a function of both the quality of the work and the invested work.

While this conclusion does not mean a radiologist should produce five-page reports for each chest radiograph, it does suggest that both showing the thought process (identifying the lock and sweating over the mechanisms) and actually making the diagnosis (picking the lock) are independent contributors to value – and therefore independently important – in diagnostic radiology.
For many clinicians and most patients, the radiologist has no face. On the other hand, the interpretation report does have a face. A typo may suggest carelessness, an uncorrected dictation error may suggest laziness, and disorganized report may suggest incoherent clinical thought process. Because the radiologist is not there to defend the clinician's judgment of her report, the report must defend itself with well-organized clinical arguments that lead to the final impression.

This is why report style, accuracy, and structure are among the most salient teachings of radiology residency training. Most residents began as scribes - the first skill I acquired was to be able to buffer increasingly lengthy sentences in my head

while typing out every word an attending radiologist muttered during a review. Then we learn from the theme of words that keep surfacing: *Round mass, lobulated mass, spiculated mass, necrotic mass, heterogeneous mass, homogenously enhancing mass, ill-defined mass.*
Then radiology residents learn to combine descriptors. *Heterogeneously enhancing lobulated mass.* We learns words that can be used to keep piling features onto a finding and keep postponing the inevitable period that must accompany the end of every sentence:

> *There is a heterogeneously enhancing mass that is lobulated and necrotic in the center, which measures 2 by 3 centimeters along the greatest cross-section, and with some evidence of invasion of nearby structures such as the posterior 4th rib...*

As our skills mature we learn to tie the clinical findings together, removing extraneous words:

> *Heterogeneously enhancing lobulated mass with necrotic center measuring 2 by 3 centimeters in the right posterior pleura, demonstrating invasion into the adjacent posterior 4th rib...*

Ultimately, each radiology trainee develops a unique style. Some learn to separate objective findings from subjective assessments. Some began their reports with an overview of the underlying findings before prescribing a line-by-line analysis.

But these are independent skill sets. Style is not so much how a radiologist decides to pack as many features of a finding in to a sentence as knowing what *not* to pack into a finding. It is also about deciding where to put the diagnosis, how long to make the differential, and how much uncertainty to associate with each diagnosis. "Finding your style" requires as much clinical knowledge as cleverly applied grammar tricks to find the best balance of the clinically important descriptors.

If clinical knowledge is the "hard skill" one acquires through radiology training, then writing style on an interpretation report is the corresponding "soft skill." It is the rapport-building and the bedside manner of diagnostic radiologists. At the end of the day, those words become our firm handshake, our confident smile, and our white coat.

Po-Hao (Howard) Chen MD
Resident in Radiology,
University of Pennsylvania

2015 PRS Annual Meeting Educational Program

Robert S. Pyatt, Jr., MD, FACR

PA Radiological Society 100th Annual Meeting
October 2-3, 2015
Draft Program

The details of the 100th Annual Meeting, at The Rittenhouse Hotel in Philadelphia are being finalized. The Program will be on Friday afternoon and Saturday morning. Here is a snapshot of the speakers and some topics:

-Richard Duszak, MD, FACR, CEO of the Harvey L. Neiman Health Policy Institute. Rich will give 2 presentations. Rich is the #1 ranked speaker from years past at the PRS meeting.

-Geraldine McGinty, MD, FACR, Chair, Commission on Economics. Geraldine is back by popular demand also. Hear the latest insight into Radiology's Economic issues and how your practice can respond, from the highly regarded Chairwoman !

-David Levin, MD, FACR, previous Gold Medal Recipient of the RSNA and ACR, speaking on Future Trends in Diagnostic Imaging – see the future of Imaging thru Dave's eyes !

-Larry Muroff, MD, FACR, speaking on Radiology Economics and Practice Issues, also back by popular demand, giving 2 presentation. Larry is highly respected as the guru of radiology practice issues and solutions. His talks are among the most focused on the real issues and what Rads must do to survive and thrive.

-Richard Gunderman, MD, back by popular demand from our 2012 meeting. Dr. Gunderman gives a unique perspective on Imaging and our role in medicine.

-Ben Strong, MD, Chief Medical Officer of Virtual Radiology (VRad). Insights and experience from the largest radiology practice, covering 50% of US hospitals after hours, and a whole lot more, including teleradiology quality affirmations, and the future of teleradiology.

-Michael Bruno, MD, speaking on the future of Radiology Quality and Patient Safety and the Hershey Medical Center Failsafe Program (dealing with follow-up methods for unsuspected unrelated significant ED findings, as reported in the Wall Street Journal)

-Eric Faerber, MD, FACR and "Hot Topics Facing Radiology Residents and Fellows in Pennsylvania, and the US". This is also back by popular demand. Hear what the Residents and Fellows say are their #1 issues.

Robert S. Pyatt, Jr., MD, FACR
Chair – Education Committee
Chambersburg Imaging Associates

Radiology Reimbursement Cut Summary

Andrew Wilmot MD

Health care spending as a percentage of GDP is higher in the United States than any other country (1). A 2008 Government Accountability Office report identified imaging services as a major source of accelerated health care spending. From 2000 to 20006, Medicare spending for imaging services doubled from $7B to $14B (2).

Radiology has been a major target of efforts to decelerate growth in health care spending. In our current fee-for-service environment, health care expenditure is the product of utilization and unit cost. Restricting access and utilization is a politically unpopular idea, and therefore reductions in unit cost (lower reimbursement) have carried the day.

Table 1 outlines the myriad ways in which radiology reimbursement has been cut since 2006 (3). These methods have included Multiple Procedure Payment Reduction (MPPR), Utilization Rate (UR) Adjustments, Practice Expense Relative Value Unit (RVU) Adjustment, Code Bundling, and Capital Interest Rate reduction. Reimbursement cuts were initially applied only to the technical component of imaging, but cuts have subsequently been applied to the professional component as well. While the methods differ, the net effect is the same, lowering reimbursement.

According to the ACR, radiology has experienced $6B in Medicare cuts since 2006. Imaging use is down 5% with spending on imaging down by 21% (4). Table 2 outlines examples of payment reductions between 2006 and 2013 (5). It is possible that these figures will encourage the government to redirect further efforts at cost containment elsewhere, however the Diagnostic Imaging Services Access Protection Act intended to prevent further Medicare cuts to imaging and reverse the MPPR to the professional component was not approved in 2013. The ACR staunchly opposes further reimbursement cuts. As an alternative method to control imaging costs in the future, the ACR advocates controlling utilization by minimizing inappropriate utilization through use of appropriateness criteria and decision support. The most recent Sustainable Growth Rate (SGR) patch which passed in April 2014 requires computerized decision report by 2017, and also mandates that CMS (Center for Medicare & Medicaid Services) must disclose the data supporting its MPPR involving the professional component.

On top of the reimbursement cuts to date, there is the ever-looming threat of the Medicare SGR passed in 1997, meant to ensure that annual increases in health care spending per Medicare beneficiary does not exceed growth in GDP. Each year since 1997 a temporary "doc fix" has been passed. With each passing year, the consequences of no temporary "doc fix" grow. At present, were the "doc fix" not to be extended, there would be an across the board 24% reduction in Medicare reimbursement that would affect all medical specialties.

While some radiology reimbursement cuts have been redistributed to other specialties and others have helped trim the federal deficit, the effect on the field of radiology and on patient care is less clear. Out of necessity, radiology groups have focused on increased productivity per radiologist and in many cases groups have likely adjusted hiring in response to the cuts. This in turn has impacted the job market for young radiologists, and the past few years have demonstrated a trend towards higher vacancies in radiology residency positions. Decreased reimbursement also has left less money to invest in technological innovation and advancement of the field. In

terms of patient care, the likelihood of diagnostic errors is potentially increased by higher workloads, which threatens the quality of patient care and leaves radiologists in a legally precarious position should an error occur.

It is an uncertain time in radiology and in medicine, as the government's long-term plan for health care spending is undergoing transition. There is an inflection point at which reimbursement cuts may become unsustainable to the specialty of radiology and perhaps that point has already been reached. In the words of our President, "moving the ship of state is a slow process…you can't just whip them around and go in a new direction." The government is unlikely to recognize that inflection point until after it has been surpassed, and even then may take years to react. While radiologists attempt to adapt to the new value driven payment environment, they must also work to defeat the misconception that imaging reimbursement remains a major driver of health care inflation. In that way the process of whipping around the ship can begin before we are already over the cliff.

1. Health Expenditure as Percentage of GDP, 2009-2013. The World Bank. http://data.worldbank.org/ indicator/SH.XPD.TOTL.ZS. Accessed November 1, 2014.

2. Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices. Government Accountability Office, June 2008. http://www.gao.gov/new.items/ d08452.pdf. Accessed November 1, 2014.

3. Letter from ACR Chair Paul H. Ellenbogen, MD, FACR, to Congressional Leaders, February 6, 2013. http://www.acr.org/~/media/ACR/Documents/PDF/News/Medical%20Imaging%20Cuts%2020062013%20FINAL.PDF. Accessed November 1, 2014.

4. Levin DC, Rao VM, Parker L. Physician orders contribute to high-tech imaging slowdown. Health Aff (Millwood) 2010; 29:189-95.

5. HPA Memo Impact of PFS on Imaging 2006-2013. http://www.acr.org/~/media/ACR/Documents/PDF/Economics/Medicare/HPA_memo_Impact_of_PFS_on_imaging_20062013.pdf. Accessed November 1, 2014.

Table 1: Summary of Radiology Reimbursement Cuts

	Cost Cutting Measure	Details
2006	MPPR	A 25% reduction applied to the technical component of any additional exams within a family of codes performed during the same patient encounter.
2007	Reimbursement Caps	Technical component reimbursement capped at the lesser of the Physician Fee Schedule or Outpatient Prospective Payment System.
2010	UR Adjustment	Utilization rate increased from 50% to 62.5%.
2010	MPPR	Technical component reduction increased from 25% to 50% for additional exams within a family of codes.
2010	Physician Practice Information Survey	Downward adjustment in Practice Expense RVU per hour applied to radiologists, phased in over 4 years.
2011	UR Adjustment	Utilization rate increased to 75%.
2011	Bundled codes	Bundling of codes for exams commonly performed together, with lowering of both the technical and professional RVUs.
2011	MPPR	50% reduction to technical component for additional exams broadened across families of codes.
2012	MPPR	25% cut to professional component applied to certain additional codes interpreted by one radiologist.
2013	MPPR	25% cut to professional component extended to exams interpreted by separate radiologists.

2013	Capital Interest Rate	A component of the reimbursement formula, adjusted from a fixed 11% to a sliding scale of 5.5-8% linked to the prime rate, thereby lowering reimbursement. Lower values applied to more expensive equipment.
2013	Room Time Assumption	The time a room is assumed occupied for CT and MRI (a component of the reimbursement formula) is reduced.
2014	UR Adjustment	Utilization Rate adjusted from 75% to 90%.
2014	Bundled codes	Bundling of breast interventions, with lowering of RVUs.

Adapted from ACR Chair Ellenbogen letter to Congressional leaders, February 2013

Table 2: Payment Reductions from 2006-2013

Description	2006 pay	2013 pay	Change in total pay 2006-2013 ($ millions)	% Change in total pay
Mri brain w/o & w dye	$1,118	$439	-$173	-61%
Dxa bone density, axial	$139	$45	-$148	-68%
Repair venous blockage	$658	$133	-$58	-80%
Chest x-ray	$36	$27	-$28	-25%
Ct angio abdominal arteries	$745	$457	-$6	-39%
Mri lwr extremity w/o & w/ dye	$1,089	$446	-$7	-59%
Mammogram, screening	$86	$72	-$10	-16%

Adapted from HPA Memo Impact of PFS on Imaging 2006-2013

Andrew Wilmot MD,
Assistant Professor of Radiology,
University of Pittsburgh

Regulatory Matters: Lobbying, the Legislative Process, and Radiology

Ian Amber, MD

Winter approaches and the myriad political ads invading our TV space, cluttering our mailboxes, and piercing the radio waves have finally abated. With the end of another midterm election season, most of us prepare to place politics on the proverbial back burner. For John and Monica Kline, the son and daughter of the late Lt. Gov. Ernie Kline and current partners in Kline Associates Ltd., the lobbying firm responsible for advocating on behalf of the Pennsylvania Radiological Society, the start of a new political cycle means a new dawn.

Pervasive media coverage of "lobbying" and "special interests" creates a perception of duplicitous backroom dealings amidst a sea of political backstabbing. For the average radiologist, entanglement in this political morass may appear frustrating at best. However, as radiologists, we must remember every issue has a champion; if we fail to forcefully advocate for our field, countless other interest groups would happily escort our specialty to the gallows.

Advocating for our specialty begins by establishing goals at the local and state level vis-à-vis our city and state radiologic societies. The executive board of the Pennsylvania Radiological Society formally meets with the Klines biannually. Beyond formal meetings, the board remains in close contact with the Klines through weekly updates and discussions. While the Klines maintain relationships with politicians of both parties, Monica is a registered Democrat; John is a registered Republican. This allows them to approach Harrisburg in a genuinely bipartisan manner, thus ensuring our advocacy remains strong regardless of how the political winds gust.
During an active legislative calendar, two broad categories of issues exist: issues relating directly to radiology (i.e. mandatory breast density reporting) and issues involving medicine as a whole. Depending on the issue at hand, the goal from organized radiology's perspective ranges from ensuring a bill passes or fails to subtle revisions in statutory language. While bills originate in committee, with the help of favorable contacts and the 24/7 news media, our leadership often develops a plan for potential upcoming legislation before the first hearing begins.

Once committee hearings open, the Klines begin by meeting with the appropriate representatives. Our goals are two-pronged: identify and retain the vote of favorable representatives and single out and sway the undecided ones. Unlike the filibuster-induced Washington gridlock, our state legislature functions by simple majority rule. Not every representative must support our issues; only enough legislators to ensure a majority. By focusing on achieving a majority, we can target our outreach efforts more precisely and effectively.

Like radiology itself, targeting supportive representatives embodies the definition of subtle art. Our legislators hail from all parts of the state and represent a diverse mix of professions and cultural backgrounds. For some representatives, an educational meeting with the Klines may suffice to secure a favorable vote. Other representatives require physician level technical information pertaining to radiology. In these instances, our leadership at the PRS is "on-call" to meet interested representatives and answer questions to better articulate our perspective of issues. This combination of dedicated lobbying and physician outreach allows radiology to respond quickly and engender support at critical junctures.

By this point, many astute readers may begin feeling overwhelmed. As individual physicians, most radiologists focus on some combination of interpreting images, performing procedures, and administrative/research roles. Political activism may seem like an additional job in and of itself. It is! Therefore, logistically, we need lobbyists to advocate on our behalf. However, successful radiological advocacy requires more than lobbyists and the PRS leadership.

In our current divisive political climate, a bill proclaiming yogurt as the official state snack of New York and Jello the official state snack of Utah met resistance from the pretzel and ice cream communities respectively. While the consequences of a farcical vote for state snack are miniscule, any issue related to health has the potential for serious political repercussions. To sway certain representatives, a groundswell of support must exist to justify taking a favorable political position. This begins with participation in "storm-the-capital" type days on behalf of radiology, but must continue long after the camera crews leave.

Stating that "regardless of our current commitments, we must make time" is a cliché usually received with at best a polite nod. However, political activism is important for all training levels and practice models to ensure a prosperous future for our field. For the politically inclined, it means participating in organized radiology and contacting our representatives to ensure our voices are heard. For the more reticent, it may mean covering a reading room to allow our colleagues the freedom to propagate the voice of radiology. Our current organizational framework is one of the most respected in the country. By educating members at all training levels of the importance of the political process, we will ensure our future stays bright for years to come.

Ian Amber, M.D.
Radiology Resident
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The author would like to acknowledge the gracious help of John and Monica Kline for participating in a phone interview to provide source material for this article.

Tweet Tweet

Tessa S. Cook, MD PhD

I saw something at RSNA 2014 that I hadn't seen before: enterprising attendees had substituted their Twitter handles for their first names on their conference badges. And here I'd thought putting my Twitter handle on the first and last slides of all my presentations and encouraging the audience to tweet me had been ingenious.

In the past few years, the number of physicians on social media has skyrocketed. Radiologists are no exception, and in fact, are some of the most prolific tweeters out there. Our radiology societies are also taking advantage of this incredible resource to stay in touch with members and share the latest news and advances in the field.

For those of you unaccustomed to social media, one advantage of Twitter is that you can be a passive observer until you feel comfortable contributing to the conversation. When you first join, you don't have to send any tweets yourself. Instead, you can follow others and enjoy their discussions. Before long, you'll find topics and discussions of interest and begin to participate yourself.

Many of you are probably thinking: why on earth would I do this? There are many reasons--educating yourselves and others, sharing ideas with colleagues, engaging more fully in national or regional conferences, marketing your practice. But most importantly: communicating with your patients. For many of our patients, finding information online is as much a part of their medical care as going to a doctor's appointment. They read what we, as the experts, are posting. They respond. They ask questions. Twitter is an incredibly underutilized tool for the face of radiology, not only to our patients but to our referring providers from other specialties.

So how should you get started? Go to http://www.twitter.com and sign up. Choose a Twitter handle. Keep it to less than 8-10 characters if you can, because everyone's only got a precious 140 characters with which to share their wit and knowledge. Start following your fellow PRS members: @asset25 (myself), @RogueRad (Harry Jha), @MaryScanlon, @PyattBob, @RasuShrestha. Follow your national societies: @RadiologyACR, @RSNA, @ARRS_Radiology and more. Follow some of the speakers from the 2014 PRS meeting: @RichDuszak, @DrGMcGinty (Geraldine McGinty).

And if you're still not convinced, find me at the next PRS meeting and I'll set you up on Twitter personally.

Tessa S. Cook MD PhD
Assistant Professor of Radiology,
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