Bulletin *Fall 2016*

The Pennsylvania Radiological Society

A Chapter of the American College of Radiology

www.paradsoc.org

Executive Director:

John P. Kline
214 State St
Harrisburg, PA 17101
Phone: 717-695-4751
Email: jkline@paradsoc.org

Editor:

Joshua G. Tice, MD
West Reading Radiology Associates
301 S. 7th Ave, Suite #135
West Reading, PA 19611
Email: joshua.tice@readinghealth.org

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http://www.paradsoc.org/

MESSAGE FROM THE PRESIDENT:

With the 101st meeting, we have now completed the first year of the second century of this society. I would like to thank Dr. Beverly Coleman for her work as president this past year. This year was a building year. Under Beverly's leadership, we now have a fully revised and relevant set of bylaws. Our now not quite so "new" executive director, John Kline, has done a fabulous job first getting his feet wet and then completely reorganizing our office.

Our 101st meeting was an exceptional day of learning and inspiration, and I would like to congratulate Dr. Beverly Hershey on planning an excellent meeting. It was wonderful to hear from the ACR leadership Drs. James Thrall and Geraldine McGinty. I think the addition of several clinical lectures added interest and excitement to the day. Of course, the final banquet in honor of Mary Scanlon was a perfect way to end the day.

Our Society has come an incredibly long way this year and both our society and our profession have come such an incredibly long way since I began as a young alternate councilor. The issues that we face in the state of Pennsylvania today are so different and yet in many ways similar to 25 years ago. We are lucky to have the PA Rad Society and the ACR fighting to keep our profession relevant.

In writing my thoughts, I have had the opportunity to think about the mission of our society and my personal mission as president of this organization. The mission of the PA Radiological Society, as a chapter of the American College of Radiology, is to advance the science of radiology, improve radiology services to patients and the medical community, study the economics of radiology, encourage continuing education for radiologists, and establish and maintain high medical and ethical standards in the practice of radiology. I certainly think we accomplish these goals, but we can always do better.

My personal mission and goal for my presidency is to do my very best to uphold the mission of the Pennsylvania Radiological Society with a very specific focus on engagement of young radiologists and on communication. I will focus especially on communication within our society, but also communication with our patients, with our medical community, and with our colleagues in both radiology and other specialties.

Communication is so different these days. I see how our residents and young physicians communicate and learn through social media, websites and blogs. Their communication is quick (almost instantaneous) and relevant. They have the opportunity to respond instantaneously. I think that we will all benefit from incorporating some of these more updated forms of communication, to supplement what we have used in the past. With the help of our Technology Committee, I also plan to update our website to be easier to navigate.

We have a wonderful group of residents and younger radiologists involved in the society, and with the help of our newly formed Communication and Member Engagement Committee we are looking for new ways to include and involve more Pennsylvania radiologists. I look forward to working with all of you to expand our society, to improve our communication, and support radiology in Pennsylvania.

Julie A. Gubernick, MD, FACR
Philadelphia

EDITOR'S NOTE

It is a great honor to be nominated and elected as editor for the Pennsylvania Radiological Society (PRS). Since beginning practice, I have truly appreciated the topics highlighted in the Bulletin. The PRS and the Bulletin are a unique resource for all Pennsylvania radiologists. I hope to continue to provide content which will both enlighten and inform our members. I would like to thank my many predecessors for all their hard work and commitment, ensuring our membership is informed and up to date on trends in radiology, legislative issues, and resident education. I hope to continue their high standard.

As discussed by the Society's President, Dr. Julie Gubernick, part of the goal for PRS this year is to improve communication and membership engagement. We continue to face challenges of wide-ranging change within our specialty, often requiring rapid dissemination of information and timely action. The Bulletin will continue to be a vital part of the Society's strategy to communicate with members; unfortunately, we only publish two to four issues of the Bulletin per year and it is often not the proper vehicle for time-sensitive matters. As such, the PRS board directed the establishment of the Communication and Member Engagement Committee. Dr. Sonia Gupta and I will be co-chairing the committee. We hope to finalize the members of the committee in the next few weeks and begin identifying alternative means to improve communication. Many of the additional avenues being discussed involve maximizing the Society's presence on social media, such as Facebook and the ACR's Engage platform. In fact, Sonia recently created a Facebook group for the Society, which we encourage you to join (https://www.facebook.com/groups/211790602586294). The committee is open to other concepts and we encourage you to please contact Sonia or me with your ideas.

This Fall 2016 issue of the Bulletin will highlight much of the content presented at our Fall meeting, held at the Hyatt at the Bellevue in Philadelphia on September 17. Several of the presenters from the meeting have been gracious enough to contribute articles based on portions of their talks, including Dr. Geraldine McGinty, Dr. James Thrall, and Dr. Michael Bruno. Additionally, multiple residents presented a panel titled "Hot Topics Facing Radiology Residents and Fellows", which was informative and thought provoking. Also within this issue, John Kline provides a legislative update, Dr. Robert Pyatt discusses issues from the Small and Rural Practice Caucus, and Dr. Chen gives us a glance into his experience at the 2016 RLI Leadership Summit.

I hope you enjoy this Fall issue of the PRS Bulletin. Please feel free to contact me with any concerns. Likewise, I welcome content or suggestions for topics for upcoming issues.

Joshua G. Tice, MD
West Reading

101ST ANNUAL MEETING: HIGHLIGHTS

Imaging 3.0: Are we there yet?

I am always delighted to receive an invitation to speak at the Pennsylvania Radiologic Society. It is a vibrant community of radiologists from diverse practice backgrounds and the meeting line up is topical and interesting. I learn a lot. Kudos to Bob Pyatt and now Beverly Hershey for their hard work in assembling a great panel every year, I am honored to be part of it.

For the Society's centennial meeting in 2015 I spoke about the ACR's Imaging 3.0 initiative that has acted as a blueprint for our profession to successfully navigate the transition from a healthcare delivery system that rewards volume to one which is focused on delivering value. A year later I asked myself, and the audience whether the initiative had run its course. Are we there yet?

As we look back on the drivers of change and uncertainty that motivated us to seek a new path forward in 2013 it's clear that tools like PACS that made us exceptionally efficient also had a downside. We became invisible to the rest of the delivery system and as such, easily commoditized. Other specialties viewed radiologists negatively and many patients did not even know we are doctors. The result of this was cascading payment cuts that sought to reduce imaging volumes and costs, but did not in any way incentivize quality improvement. The rallying cry of Imaging 3.0 was that radiologists must become the stewards of appropriate imaging and connect more effectively with patients and referring physicians to demonstrate their value so that payment policy could align to incentivize high value imaging.

Three years later we are in a very different place. We have undergone a profound culture change with patients invited to the table at the ACR so that we can reshape our processes to be more patient centered. A patient gave the keynote speech at the ACR meeting. Legislation to mandate the use of clinical decision support for advanced imaging is a clear statement of the value delivered by radiologists and will ensure our visibility to our referring provider colleagues. Our focus on registry development to facilitate performance improvement is a demonstrable commitment to quality and radiologists are leaders in this regard. Lastly, the MACRA legislation that will, over the coming years, transition Medicare payments towards a value based methodology will provide real incentives and real penalties tied to the quality of imaging care (http://www.acr.org/Quality-Safety/Resources/MACRA-Resources). Radiologists are embedded in the decision-making processes for implementation of the legislation at multiple points.

But in my opinion the work of Imaging 3.0 is far from complete. I still hear too many practices arguing over how many RVUs each radiologist clocked up and not thinking about how to pivot towards their patients or get involved in health system governance. The implementation of the clinical decision support mandate has been pushed back due to opposition from the very physician groups who can most benefit from it. MACRA is a mindbogglingly complex program which will evolve over time and presents as many risks as opportunities.

I encourage you all to feel very optimistic as we continue on our journey however. We can feel proud of the way in which our community has embraced change and used our strengths, especially in technology, to improve care for our patients. We are in a time of great transition in healthcare policy but the principles we have laid down through the Imaging 3.0 initiative will ensure that we can indeed meet the goal set out in the ACR's Strategic Plan:

ACR members are
universally acknowledged
as leaders in the delivery
and advancement of
quality healthcare

Geraldine McGinty, MD, MBA, FACR
Vice Chair, Board of Chancellors, ACR
Asst. Chief Contracting Officer, Weill Cornell Medical College

Burnout

A number of recent surveys have painted a rather dire picture of physician burnout. A Mayo Clinic survey found that 54% of physicians suffered at least one symptom of burnout as determined by the Maslach Burnout Inventory that focuses on three categories of indicators: 1) Emotional exhaustion, 2) Depersonalization, 3) Low sense of personal accomplishment. (1) Significantly, this represented a 20% increase over 3 years with 39% of physicians experiencing some indicator of depression and 59% reporting adverse "work-life" balance. The trend toward increasing symptoms of burnout has not been seen in probability based samples of working adults in the U.S. According to a Medscape Physician Lifestyle report, radiology ranked 7th in burnout among 26 listed medical specialties.

As a corollary observation, it has been apparent for some time that suicide rates are higher among physicians than the general population. There are approximately 300-400 physician suicides per year. (2) For perspective, this represents the number of people in 2 to 3 medical school graduating classes lost to our profession each year. Male and female physicians commit suicide at 1.4 times and 2.3 times the national average respectively.

There are many speculations about the root causes of physician burnout—the intrinsic stress of practicing medicine, long hours, concerns about being sued and, now, high medical school related debt. A recent study in the Annals of Internal Medicine revealed that in 4 primary care related specialties, physicians spend 2 hours on administrative and computer tasks for every hour of direct face-to-face patient care time. (3) This is not what people went to medical school for and is undoubtedly a factor in promoting burnout. Richard Gunderman captured this poignantly in an article appearing in the *Archives of the Atlantic* entitled *The Roots of Physician Burnout* where he wrote "To promote burnout among physicians, it is only necessarily to subvert their professional and personal priorities, so that they spend all their time on little things and suffer continually from a growing sense that they are neglecting the ones that really matter." (4) Many physicians feel the balance between time spent on compliance and administrative issues versus taking care of patients is off the tracks. "Compliance fatigue" and a sense of loss of control are clearly factors in promoting burnout.

So, what can be done to address physician burnout? First, we all must acknowledge the problem and not sweep it under the rug for ourselves or colleagues. Organizations—hospitals, medical groups, professional societies—must take this issue on in a serious way to learn how to identify people at risk for burnout or worse and to put initiatives in place to combat burnout and potential suicide. Reducing isolation and promoting a culture of team building and team work can make people feel part of a supportive community and make them realize they are not alone and can call on others for help. Medical staffs and state medical societies often have assistance programs with access to counseling services but physicians are reluctant to use these services and may need to be encouraged to do so.

Group practices and academic departments should work diligently to maintain adequate staffing. Being chronically behind in the ability to get the day's work done is a prescription for burnout. However, people work at different rates so this is more challenging than it first might appear. This speaks to the importance of leaders' abilities to understand how to recognize symptoms of burnout or depression and assess their colleagues state of emotional well-being while staying alert for emerging problems. Some private practices and academic departments deliberately maintain relatively lower staffing for economic reasons such as maintaining higher incomes, which is

understandable but also increases the risks of burnout. Under this circumstance, even more diligence in assessing the state of mind and feelings of well-being of colleagues is required.

A great deal of satisfaction comes with getting work done in an efficient, hassle free and high quality way. Providing better technology to physicians that helps them get work done can restore balance to the patient care versus circumstantial minutiae equation. At MGH, we have built a dozen software programs to reduce impediments to getting work done. For example, we have a program that allows the radiologist to page the referring physician with one key stroke. The program "knows" who the radiologist is based on workstation login, the referring physician's name and pager number, the patient's name and registration number and the telephone number of the phone located at the workstation. There is no need to look anything up like the referring physician's pager number and no need to type anything into the system. One key stroke. Done. Other examples from the suite are "smart" structured reports that reduce the amount of dictation required, a program to automatically search the medical record for key data, a way to automatically import outside information into the system and decision support tools for managing incidental findings. Taken together the suite of programs gives back substantial amounts of time to the radiologist to interpret studies and provide consultations and eliminates many of the annoying repetitive tasks that undermine morale.

In evaluating people for staff appointment or reappointment, organizations and groups should try to get the "big rocks in first," that is, evaluate people on the things that really make a difference in creating value for patients and the health system—delivery of efficient high quality care with high patient satisfaction. Explicit recognition of physicians' contributions in these regards is an important corollary. If you imagine a container, it is easy to see that if you fill it first with sand—i.e. small circumstantial issues—there is no room for the "big rocks." If the focus of performance reviews is dominated by the kinds of small issues and tasks Dr Gunderman was referencing, physicians will become cynical and disillusioned promoting burn out. In my organization, we are required to complete over 15 on line modules to comply with various regulations and institutional policies. On their own merits each of these is important—can't argue with them. Taken together, they are burdensome and one wonders how passing a quiz on fire safety became a *sine qua non* for being reappointed to the hospital staff versus a consistent track record of excellence in delivering patient care.

Finally, organizations and groups should do everything they can to restore and support a better sense of control for people over their lives and careers. There are many ways to approach this. Two approaches that I find most compelling are to make sure people have opportunities to grow personally and professionally through educational programs and have the opportunity to take part in the governance of their practices. Programs like those offered by the ACR Radiology Leadership Academy speak to both personal and professional growth and should be supported. Knowing that growth in their future abilities is supported by their colleagues and leaders, helps physicians achieve a better sense of security and positive work-life balance and is a force against feelings of isolation and low self-esteem. Governance structures in medical groups and academic organizations are not necessarily democratic with votes taken for every decision but it is critical that they be participatory, that is, all stakeholders have a chance to express their opinions and have the confidence to know they will be taken seriously.

The human condition is infinitely variable and complex. No set of strategies will address every situation that may arise but being preemptive in achieving a positive, supportive practice culture and addressing root causes of burnout will go a long way in mitigating what has been a growing problem

among physicians. Burnout is like a thief in the night that steals a person's joy of life—joy of being a physician. We need to confront the issue head on. References

1. Shanafelt TD et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clinic Proceedin*gs 2015; 90:1600-1613.

2. Anzia JM. Doctors need help with stress, burnout. *Boston Globe* on line. July 29, 2016.

3. Sinsky C et al. Allocation of Physician time in ambulatory practice: a time and motion study in 4 specialties. *Annals of Internal Medicine* on line. September 6, 2016.

4. Gunderman R. The root of physician burnout. *The Atlantic magazine*. August 27, 2012.

James H. Thrall, MD, FACR
Chairman Emeritus, Department of Radiology
Massachusetts General Hospital

Error and Uncertainty

I recently gave a presentation at the 101st Annual Meeting of the PRS on the topic of error and uncertainty in our radiological practice. The lecture aimed to create a deeper understanding of radiologists' errors, the relationship of these errors to the high degree of uncertainty under which we operate, and potential strategies for error-reduction and harm prevention. In addition, I offered some thoughts on how we might better cope personally with the reality of our own errors and fallibility, by leaning primarily on published work on self-*compassion* (which is very distinct from ideas surrounding the concept of *self-esteem*).

For those who have an interest to delve into these topics more deeply, I am most happy to provide a reading list to guide further exploration:

The #1 item on this list is a fantastic book which discusses the use of quantitative reasoning to avoid errors, namely Jordan Ellenberg's *How Not to be Wrong*. I actually think it is the best and most interesting book written by a mathematician that I have ever read. Ellenberg is a Professor of Mathematics at the University of Wisconsin who has additional training in Science Writing from Johns Hopkins University.

Here is the full reference: Ellenberg, Jordan. *How Not To Be Wrong: The Power of Mathematical Thinking*. New York NY: The Penguin Press, © 2014. ISBN: 978-0-698-16384-3.

In the same vein, I can strongly recommend *The Flaw of Averages*, by Sam Savage. That full reference is: Savage, Sam L. *The Flaw of Averages: Why We Underestimate Risk in the Face of Uncertainty*. Hoboken, NJ: Wiley & Sons, © 2009. ISBN: 978-0-471-38197-6.

Both Ellenberg and Savage address the roles of quantitative thinking, statistical reasoning, and "numeracy" in general, in terms of helping us to make sound decisions that are supported by evidence and based in reality. I think that these two books are the best of the bunch.

Another book I mentioned was *Thinking Fast and Slow* by Daniel Kahneman. This is one of the best books ever on the interplay between cognitive science and behavioral economics and decision-making of all kinds. It summarizes his Nobel Prize-winning work and also specifically mentions radiologists and radiology.

Other books I mentioned in my presentation—all well worth reading—are: *Being Wrong*, by Kathryn Schulz, in which she discusses the personal experience of making errors and finding out about them later; *Why We Make Mistakes* by Joseph Hallinen, which delves into perceptual and cognitive errors that underlie our actions; *Mistakes Were Made, But Not by Me* by Carol Tavris and Elliot Aronson, which explores the dark side of how we prefer to deny and minimize our errors rather than learn from them; and *Irrationality in Healthcare* by Dough Hough, which summarizes the current state of knowledge in behavioral economics as applied to healthcare, and attempts to explain exactly *why* and *how* doctors are *predictably irrational* in their choices and behaviors. Finally, the most recently published, *Snowball in a Blizzard* by Dr. Stephen Hatch, deals with the core problem of uncertainty and also explores the nature of what constitutes actionable "knowledge" in medicine, using radiology as a specific example. Any and all of these are great additions to a radiologist's bookshelf.

Kathryn Schulz also has an excellent TED talk available online where she discusses the content of her book.

Unfortunately, there is no book yet published to my knowledge on the concept of self-compassion; however, several peer-reviewed journal articles and reviews have appeared, most notably those authored by Professor Kristin Neff of the University of Texas at Austin. See, for example, Neff, K. (2003). "Self-compassion: an alternative conceptualization of a healthy attitude toward oneself." *Self and Identity*, 2, 85–102. and Neff, D.D., Rude, S.S., and Kirkpatrick, K.L. "An examination of self-compassion in relation to positive psychological functioning and personality traits." *Journal of Research in Personality* 41 (2007) 908–916. Dr. Neff has made material available online on this subject on her academic website: http://self-compassion.org .

Finally, our own group recently published a review on the topic of radiologist errors as part of the October, 2015, *RadioGraphics* monograph on Non-Interpretive Skills. The full citation for that article is: Bruno, MA, Walker, E.A., and Abujudeh, H.H. "Understanding and Confronting our Mistakes: The Epidemiology of Error in Radiology and Strategies for Error Reduction" *RadioGraphics* 2015; 35:1668-1676.

I sincerely hope that my presentation has sparked some interest in this topic and I invite emails with questions and comments.

Michael A. Bruno, MD, FACR
Professor of Radiology & Medicine
Vice Chair for Quality and Patient Safety
Chief, Division of Emergency Radiology
The Milton S. Hershey Medical Center
Phone: (717) 531-8703
Fax: (717) 531-5596
e-mail: mbruno@psu.edu

ANNUAL MEETING: ELECTRONIC EXHIBITS

A record 36 exhibits were presented at this year's Annual Meeting. The exhibits are available for review to PRS members on the PRS website (http://www.paradsoc.org). Awards were given for the top two scientific and review exhibits. The award winners were:

1st Place Review Exhibit:	"Ulnar Sided Wrist Pain: A Review of Imaging and Clinical Features." Fenerty S, Ling S, Momah I, Jonnalagadda P, Awan O, and Ali S.
2nd Place Review Exhibit:	"Non-Obstetric Causes of Pelvic Pain in Women." Pandika V, Dravid D, Lee V, Dravid V.
1st Place Scientific Exhibit:	"Comparing Call Back Characteristics Between Digital Breast Tomosynthesis and 2D Mammography Screening." Chan TL, Zhu J, Chelten A, Schetter SE.
2nd Place Scientific Exhibit:	"Current Trends and Methods of Increasing Healthcare Professional Survey Response Rates." Mehta S, Huang J, Zigmund B.

RESIDENTS SPEAK:
"HOT TOPICS FACING RADIOLOGY RESIDENTS AND FELLOWS"

Healthcare Leadership and Quality Track (HLQ)

As a radiology resident at the Hospital of the University of Pennsylvania, I had the opportunity to take part in a dedicated track for quality improvement and healthcare leadership.

There are four major components of the track.

Core Curriculum: A 3-week seminar divided into 2-week and 1-week blocks over two years. The core curriculum focuses on leadership, quality improvement tools such as Pareto charts and statistical process control, and hospital finances. For instance, this year we discussed an article by Dr. Robert Wachter of UCSF titled "Is Ambulatory Patient Safety Just Like Hospital Safety, Only without the 'Stat'?" (Spoiler: The answer is "no").

Quality Improvement Microsystem: This component plugs the resident into the departmental QI ecosystem. The resident becomes the residency liaison to the departmental QI committee and runs the residency-wide QI subcommittee quarterly meetings. When working across disciplines, the resident also works with Unit-Based Clinical Leadership teams.

Executive Mentorship: The track assigns each of its residents with an executive level leader in the health system, meeting monthly to discuss either the Capstone project or an assigned Harvard Business Review article. In many cases, the mentor is in a different specialty, allowing him or her to offer a new perspective.

My executive mentor is Dr. Ronald Barg, the Executive Director of a physician group practice in primary care called Clinical Care Associates. We have weekly or biweekly phone calls during which he provided insights on moving my project forward or overcoming obstacles.

Capstone Project: The resident synthesizes the knowledge and experience in the HLQ tract in a quality improvement project, starting from refining the question, obtaining data, and ending in the implementation of a systemic intervention.

My capstone project involved implementing an inpatient shoulder-to-shoulder radiology consultation service which is resident-initiated and resident-run. In this service, we have a dedicated radiology resident for the inpatient general medicine practice. We were able to show in a preliminary analysis that 40-60% of the time, the clinical team's discussion with the on-floor radiology consult yields a change in management.

Howard Chen, MD MBA
PGY 5, Diagnostic Radiology
Hospital of the University of Pennsylvania

Contrast Reaction Training

Contrast reaction are one of the few medical emergencies that radiologist must be prepared to manage. Statistically every radiologist will have to treat a patient for a serious contrast reaction at least once in their career. Severe reactions to contrast agents can be life threatening, and although they are rare, effective recognition and management are essential to improving outcomes.

As physicians, we were all required to become ACLS and BLS certified. Does this prepare us for the different scenarios we are faced with as radiologist? The average radiologist's knowledge regarding contrast reaction management is deficient in multiple crucial areas, especially regarding the dosage of epinephrine and route of administration.

Simulation training has unique benefits. Multiple research studies show that knowledge retention increases when the learning experience is similar to the clinical scenario. It also offers an opportunity to strengthen teamwork as you train side-by-side with faculty members, trainees, technologists, and nurses.

Our residents developed our contrast reaction course incorporating both an online curriculum as well as interactive simulation scenarios. Participants performed a series of online modules, which were educational for contrast reaction recognition, treatment, and medication dosing. Follow the online modules, participants preformed actual contrast reaction scenarios, such as anaphylaxis and severe bronchospasm, using simulation manikins. The simulation rooms were set up in such a way that mimicked our radiology department.

I can truly say that after participating in this course I feel more prepared and confident to effectively recognize and manage serious contrast reactions. Even if your residency or practice does not have access to simulation materials - there are many excellent resources available. The American College of Radiology guidelines on contrast reactions is an informative place to start.

One of the most well-known resources can be found at the Mayo clinic- where they offer the Advanced Radiology Life Support Course – composed of a series of DVDs and online course material. At the very least I encourage you to become comfortable with your contrast reaction box and the medications in it.

I think being more prepared for these life-threatening events will allow us to provide better care and improve outcomes for our patients.

Hayley Oligane, DO
PGY 4, Diagnostic Radiology Resident
University of Pittsburgh Medical Center

Radiology Resident Debt

The average national radiology resident salary is $57,000 a year. Well over one third (37%) of entering residents have over $200,000 in debt, and over one fifth (22%) have $100,000-$200,000. For radiology residents, 1- or 2-year fellowships are almost necessary, which not only adds years to the length of training but also cause compounding of interest on debt. In 2014, the average resident debt from educational cost alone was $183,000 (medical education and premedical education debt).

In inflation-adjusted terms, resident compensation has been essentially unchanged for 40 years and Congress signed specific language into law exempting teaching hospitals from antitrust litigation.

Radiologists are working beyond the traditional retirement age. This continuation of work into later life results in fewer job openings. Further, decreases in salary and 12 reimbursement cuts since 2005, raises the cost of providing services and stagnates hiring.

Perhaps, it is time for healthcare reform to include financing medical education and financing resident education debt. Medical student and resident education debt could serve as a source of revenue for the healthcare system as well as increased flexibility for financing, repaying and incentivizing medical students and residents. The radiology community could be proactive about our professional expenses, as well as re-evaluate resident compensation, recruitment and education. Of course, the larger lingering question is how to detangle and demystify the tidal wave of changes, mostly to reimbursements as we shift from a volume to value based system and how to accommodate young radiologists into that framework.

Daniel Mizrahi, MD
PGY-5, Diagnostic Radiology Resident
Thomas Jefferson University

"Business of Radiology" – Lecture Series/Curriculum

At Penn State Hershey, we have a unique lecture series called the "Business of Radiology" incorporated into our 2-year lecture schedule and coordinated by two of our attendings.

This lecture series is more than the name implies and goes thru various stages in the career of a radiologist focusing on non-interpretive topics.

We have discussed the differences of various career opportunities from academics, private practice, to tele-radiology, in respect to realistic expectations of work hours, call, vacation, type of work, academic time, etc. In addition, finding the right job or best fit for you and making compromises in certain areas such as location versus pay or vacation time.

We have gone through the steps of applying for a job, getting the job, and contract evaluation. We have had local private practice attendings come and discuss how they hire, what they look for, and what they did to get hired. In addition, attendings from our own institution have discussed the process of getting an academic position. We have discussed how to evaluate job listings, finding "non-listed" jobs, contacting alumni relations, faculty relations, directly contacting hospitals in areas of desired employment, and the pros and cons of "headhunters".

We discussed life after getting the job. How to be successful by finding your place in a group, so you can thrive and not just survive, whether it be leadership, quality and safety, research, academic development or practice development. If you can find your niche, you can be that much more successful. We also discussed entrepreneurship as it relates to radiology, practice development and making partner.

An important topic of discussion was strategies of retirement planning with various attendings and financial planners - an area in which most physicians are lacking, and can lead to delaying retirements into late life and/or financial crises in life.

Additional unique topics are "how to deal with problems at work".

We had a guest lecturer, who was a physician and now is a lawyer specializing in medical law, talk with us and lead a mock trial. He focused on radiology and how it relates to medical law. In addition, we discussed how to cope with the aftermath of a law suit and the effects on your career and life outside of work. We read excerpts from "To Err is Human" and discussed the human nature of humility. Unfortunately, many physicians especially residents do not think about how to deal with an error until it is too late and possibly just don't like to think about it. But it is important to know how to deal with errors both analytically and emotionally. It is important that we learn from our errors but at the same time not allow them to consume us.

We also had an addiction specialist speak with us. Addiction, like error, is an important topic that physicians tend to shy away from, whether it is their own addiction or the addiction of a family

member, friend, or colleague. Fortunately, there is a lot of help for physicians dealing with addiction. But, it is important that we know about and take advantage of the help available, before it is too late.

Last we discussed knowing when to move on from a job, including exit strategies to move on when things are just not working out at a practice. Sticking around at a job where you are not a good fit, cannot only be detrimental to your career, but also may affect those around you and the patients you are serving.

Barry J. Amos, DO
PGY-4, Diagnostic Radiology Resident
Penn State Hershey Medical Center

RADIOLOGY LEADERSHIP INSTITUTE:
2016 LEADERSHIP SUMMIT

I stared intently at my friend and partner for the exercise, suit jacket impeccably pressed and his smirk taunting me to make that final observation. "And you took your nametag off. I think. Did you wear one?"

The Pennsylvania Radiology Society sponsored a resident's tuition and cost to attend the Radiology Leadership Institute summit, and I had the immense fortune of traveling to Boston's Babson College for a week of hands-on leadership learning.

One of the earliest sessions focused on the human nature of change resistance. To make a point, the instructor asked us to pair with a partner, with one playing the "observer" and the other playing the "changer." With the back of the "observer" turned, the "changer" modified five things about his or her appearance. The observer would name as many differences he noticed as she could before switching roles. Despite formal training in diagnostic radiology, we as a group fared less than splendidly, scoring an average of 3 detected modifications out of 5.

But observation was not the point of the game.

After spending several minutes of discussion on observational skills in the face of subtle immediate changes, the instructor asked a simple question, "in the course of the past few minutes, how many of you have already changed all 5 modifications back to the way they were?"

A nervous chuckle washed over the conference room as almost all the hands rose into the air. We are resistant to change, even if it was as unremarkable as putting a pen in a different place.

The RLI Summit offered numerous opportunities to engage in hands-on exercises and small-group discussions. In some scenarios, we offered insights from our own academic, private, or residency settings. In others, we were asked to play different sides. The topics of discussion were germane, and I met many excellent established radiology leaders through this experience.

Overall, the seminar topics ranged from the personal level to the organizational. For instance, one session focused on the immunity to change and how to overcome the human inertia against change. Another session emphasized the importance of making decisions under uncertainty and amongst constant economic and political change. Yet another session focused on radiology issues specifically and discussed the challenges of creating a value-based performance system by drawing on a lesson from orthopedic surgery. The week closed on a negotiation exercise when we assessed our styles and learned how well-structured deals can maximally realize everyone's potential.

The RLI weekend ended on a high on Sunday, leaving the attendees with a thought-provoking question: "What happens Monday morning?" I, for one, left Boston with a few ideas.

Howard Chen, MD MBA
PGY 5, Diagnostic Radiology
Hospital of the University of Pennsylvania

LEGISLATIVE UPDATES

Harrisburg: Legislative Update

Overview

The Society maintains a constant presence in Harrisburg on behalf of our interests. While the state's Medical Society works on issues affecting all involved in medicine, the PRS, through its Committee on Legislative Affairs, and our lobbying efforts, can concentrate on issues that directly affect radiology. Our firm is proud to have served the Society for over 20 years. Over time, we have become the face of the PRS in the halls of the capitol. Representation also takes place in front of regulatory agencies and other sections of the executive branch.

There are other specialties besides radiology that have a specific presence in Harrisburg as well. Groups such as oral surgeons, pediatricians, psychiatrists, plastic surgeons and many others, have their own interests being represented.

Legislative Session

The current two-year legislative session will end on November 30, 2016. After that the new session will begin in January, 2017. This new session will begin after the November, 2016 elections for all 203 state house seats and 25 seats of the 50 member senate. There will likely be some new faces in the capitol. We will ensure that the newly sworn in members are aware of the Society and our work.

Since the session is winding down this is a relatively quiet time in Harrisburg. There will be a flurry of activity in the final days to pass some bills but none that will have a great impact on citizens.

General Elections

As stated above all house seats are up for election and half of the senate seats will be contested. Currently the Republicans hold a 30-20 seat margin in the senate and a 35 seat advantage in the house. While there will be some changes, we don't predict a change in the majority. In fact, because of Pennsylvania's changing demographics, there could be an increase in these margins.

Legislation

In the upcoming legislative session issues such as credentialing, insurance (Mcare), liability and telemedicine will take stage.

On Mcare, this important component, managed by the state, must be monitored closely to ensure our members are sufficiently insured and that premiums are fair.

Telemedicine, a topic very familiar to all radiologists, will be scrutinized more closely by lawmakers next year. With the great advances in technology, patients are now able to receive diagnoses, consultation, treatment, and follow up care remotely. Radiology pioneered much of this technology and leads in many areas. One of the issues involved in telemedicine has been, and continues to be, the requirement of the provider to be properly licensed in the jurisdiction of the patient's primary care provider. A bill detailing licensing and other requirements was introduced in June 2016. The language in the first draft of the bill would have had a negative impact on radiology. The specific language would require a one on one relationship with the patient. Dr. Keith Haidet, chair of the Committee on Legislative Affairs and I met with legislative staff and discussed our concerns. As this bill progresses next session we will ensure language is included which will exempt radiologists, allowing them to continue their current work. This is an example of the committee in action and responding in a timely fashion.

We sincerely appreciate the support of the Society and look forward to further updates like this in the future.

John Kline,
Executive Director
Pennsylvania Radiological Society

Pennsylvania Medical Society: House of Delegates

The Pennsylvania Medical Society's House of Delegates Meeting and Educational Conference was held October 21-23 in Hershey PA. Several of the topics reviewed at the meeting may have direct implications for radiology. First, the House of Delegates voted in favor of the Practice Options Initiative, which will create Clinically Integrated Networks as well as Management Services Organizations to provide options and assistance for physicians to succeed in the error of QPP and alternative payment models. Second, a commitment was made to "advocate for more consistent and transparent insurer processes." An executive summary can be found at https://www.pamedsoc.org/advocate/topics/general/HOD2016Overview.

Joshua G. Tice, MD
West Reading

GENERAL, SMALL AND/OR RURAL PRACTICE (GSR) COMMISSION REPORT

The General, Small and/or Rural Practice (GSR) Commission is a specialty Commission of the ACR. It is comprised of the following 7 Committees:

-Economics (Chair, Catherine Everett)

-Quality and Safety (Chair, Bryon Dickerson)

-Network (Chair, Eric Friedberg)

-Emergency Radiology (Chair Michael Bruno)

-Practice Parameters and Technical Standards (Chair, Sayed Ali)

-Education (Chair, Steven Birnbaum)

-Human Resources (Chair, Michael Donner)

The Chairs of the Emergency Radiology Committee and the Economics Committee also serve with the Patient Family Centered Care (PFCC) Commission.

The Scope of the Emergency Radiology Committee is responsibility for all aspects of Emergency Radiology, from solo practice sites, to every tertiary center in the US. This committee has a large "footprint" in Radiology. To recognize the ER Community, the GSR Commission name will be changing to GSER.

In Pennsylvania, and throughout the US, there are many small and/or rural practices as well. Our Commission serves to identify and respond to your needs. Watch for our recently updated Purpose/Goals in the next Bulletin, and on the ACR Home page.

The greatest challenges to the GSR Commission currently involve compliance with MIPS/MACRA, as well as other issues, which will be reported in future Bulletin articles.

PA Radiology practices are strongly encouraged to visit the MACRA Resources site on the home page of the ACR.

Please join the ENGAGE GSR Community Forum, for online discussion of pertinent topics.

If you would like more information, please contact Bob Pyatt, MD, FACR, Chair, GSR Commission, at: bob_pyatt@hotmail.com

Bob Pyatt, MD, FACR
Chair, GSR Commission