Episode 30: Leading Innovation
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Geoff: Hello, and welcome to "Taking the Lead," a podcast from the Radiology Leadership Institute that profiles radiologists as leaders, seeking insight and inspiration from a variety of perspectives and experiences. I'm Geoff Rubin. Today, I'm speaking with Giles Boland, president of the Brigham and Women's Physicians Organization in Boston, Massachusetts, and the Philip H. Cook Professor of Radiology at Harvard Medical School. As president of the Brigham's Physician Organization, Dr. Boland directs the strategic work of the organization and guides key operational activities, including finance, ambulatory operations, business and network development, information technology infrastructure, decision support, quality, compliance, and wellbeing and professionalism efforts. A former chair of radiology at the Brigham and vice-chair for business development and founding member of the Radiology Consultant Group at the Massachusetts General Hospital, Dr. Boland has been a pioneer in driving cost-effective patient care through practice and workflow redesign, quality improvement, outcome-enhancing information technologies, patient and employee wellness, new market development, and systems integration. Giles, welcome.

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Giles: Thank you, Geoff.

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Geoff: You were born in Edinburgh, Scotland. Did you spend your childhood there?

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Giles: I lived in many countries actually as a child. I spent two years in Scotland, a little bit in England, then my formative years in South Africa before coming back to the UK in my teenage years.

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Geoff: I see. Formative years in South Africa. Whereabouts in South Africa?

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Giles: In Cape Town. My father started a business school in Cape Town in 1965. We went out by boat. That's what you did in those days. And I was there for about eight years.

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Geoff: I see. And started a business school. Was that connected with a university or a freestanding business school?

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Giles: No. It was the University of Cape Town and they needed a business school. And so he started the Graduate School of Business, which is at least in Africa, the sort of go-to business school. I know the Johannesburg Business School would probably question that statement, but it's generally recognized as the top school in Africa.

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Geoff: That's remarkable. And so he was a university professor in advance of heading down there.

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Giles: Yes, he was in Cranfield Business School in the UK. He actually went to Harvard Business School in 1961 to do his MBA. He became Dean of that business school in Cape Town. He then, by the way, became a physician at the age of 50.

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Geoff: Really? After he completed his time as the founding Dean of the business school in Cape Town, he went to medical school.

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Giles: He went to medical school. Yes.

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Geoff: Do you have some insights into the backdrop around that?

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Giles: Yes, we actually were in med school at the same time, actually. There were some programs in the '80s, Ph.D. to MD programs in two years. They were generally run with offshore schools and he did his, actually, in Juarez,

Mexico living in El Paso, then did residency in St. Agnes Hospital, medical residency, Saint Agnes Hospital, Baltimore. He then went into public health and got an MPH at Hopkins after that and ended up in an international labor office in Geneva and many other things.

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Geoff: That's remarkable. I mean, that sounds like quite a heterogeneous set of activities for one's dad to be engaging in as one is growing up. I mean, you mentioned your formative years being in Cape Town. Was it a relatively stable upbringing during those years?

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Giles: In Cape Town it was. As you can imagine, I was always playing catch up with him. He was always about eight steps ahead of everyone. And so he was a true innovator. And I think I owe a lot of my success, frankly, to him constantly challenging me to think differently, think out of the box, push the system, don't accept the status quo, and innovate.

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Geoff: Any specific examples during your childhood days where that message came across, particularly with respect to innovation? That's a concept that we usually don't fully understand till later in life.

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Giles: Well, as a child, I guess, it was sort of adapted to my childhood. But one thing I remember very well today wouldn't resonate with the folks who have been upbringing now because everyone learns to type because it's so ubiquitous, the computer and etc. But when I was 11 and typewriters existed, computers didn't exist, essentially, he said, "The future is in typing. You need to learn to type." And during my summer vacation, he said, "You're going to typing school." And I said, "What? It's my summer vacation. I wanna be outside running around and playing..." I was just learning to start to play golf and my friends, etc. So I was sort of reluctantly dragged to a month of typing school at the age of 11, which was pretty unusual in those days to have a kid to learn to type. In fact, I would say I was probably the only person of my peer group who did learn to type and sure enough I did. And to this day, I'm a 10-fingered, pretty fast typist.

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Geoff: Very handy. I wish that I had been sent to typing school at an early age. I can assure you of that.

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Giles: Yeah. The point I'm trying to make is he saw where the future was going and wanted to give me the tools. As I said, today, it wouldn't resonate because all the residents around me, not only knows 10-finger type, they don't even need to look at the keyboard, etc. They just type away at 100 words a minute.

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Geoff: Yeah.

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Giles: I'll just go give you one more piece. When I was 15, I was at a English boys boarding school and he said, "You know what, you're too insular and inward-looking. And in three weeks you're going to a French boarding school for a year out of the group." And I did. I went to Grenoble in France, lived with an elderly couple, and was put in the deep end in a French school, and I learned fluent French.

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Geoff: Wow. That is fantastic. He seems like a real take-charge guy. And your mom?

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Giles: My mom lives in the UK. She was always trying to play catch up too. Unfortunately, my dad died about this time last year, age of 93. My mum is 87 and managing on her own with COVID, which is a bit of a struggle because I haven't been able to see her for a year due to the shutdown in travel.

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Geoff: That is rough. Back to your upbringing though. Your mom was basically keeping the household going through all of your dad's activities or did she work outside the home too?

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Giles: Well, in South Africa, at least, this was during the apartheid years. She actually worked at the business school when you could do that when couples could work in the same workplace and she was an administrator there. I was essentially brought up by maids in Cape Town. We had two maids and, you know, they had a busy life, my parents. It was, you know, the '60s and a lot going on in Cape Town in the university and I was at boarding school too. In that sense, I had a traditional boys boarding school upbringing where you only occasionally saw your parents. Anyway, the long story short is why I went back to the UK. My parents went their separate ways and I went back with my mum. My dad stayed in Cape Town for a little bit before going to med school.

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Geoff: I see. And brothers and sisters. Did you have any?

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Giles: I had a brother. He died at the age of 19, unfortunately. But my dad remarried and I have three half-brothers who are 39, 36 and wait for it, 25.

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Geoff: Bravo. Bravo. Are you close to them?

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Giles: Very close. I just got off a weekly Zoom with them. We've been doing that during COVID.

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Geoff: Excellent. Do you recall what your first job was growing up?

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Giles: I do. Remember, I said I went to France. Well, not only did my dad say, "You're going to this school in about three or four weeks," we happened to be in Paris on vacation at the time. He was out... This is typical of my dad. My brother was with me at the time. We were in a hotel and he was nowhere to be seen in the morning when we woke up. Several hours later, he came back and said, "I have a job for you." And it was a sort of a way to ease me into French. And so I worked in it for a month. I remember for 50 Franks, which was about

$7 or $8 in those days a day, in a restaurant, essentially cleaning all the tables, 100 tables for the night before as revelries and resetting them for the lunch and then feeding them after lunch and then preparing them for dinner as well. It was a hard job.

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Geoff: I would imagine so. Anything from that first job that still resonate with you today in terms of lessons learned?

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Giles: I think it was how to survive in the deep end and how as a sort of 15-year-old left in Paris on your own, essentially, how you sink or swim. And the lesson is you better swim because, you know, that's life.

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Geoff: Yeah. You start paddling as hard as you can even if it isn't necessarily the most efficient stroke.

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Giles: Exactly.

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Geoff: Returning to your brother for a second, was this a younger brother or an older brother?

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Giles: He was a little younger than me, 18 months younger than me, and unfortunately he died by suicide.

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Geoff: It must've been a very difficult time for you and the family.

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Giles: If it's appropriate to talk about it, for those who may hear this or have experienced it before, you never get over it because as you get older, you

realize all the things that you missed. And you miss his potential partner and maybe they might've had children. My children, my four children, might've had cousins. They might've had an uncle and so on.

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Geoff: Yeah. I can only imagine. You started medical school at the London Hospital Medical College just before turning 20. It seems a bit older than I would have expected. What did you do between secondary school and college?

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Giles: Well, there's a story behind that too. There's a lot of stories behind my upbringing. So I went to France. As I said, in the end, it was an epiphany, an enlightenment for me to go to France to recognize that I was just really part of a culture, which was as good as any other culture. Up until then, you know, for thousands of years, the British and the French were adversaries. And the British like to think of themselves as superior and vice versa, or at least that was the impression. And that goes on a little bit today, what with Brexit. So I went into France thinking, you know, the UK had a better view of life, etc, but I came out and said, "You know what? It's just another country. Everyone has their values and opinions and no one's necessarily better or worse than the other." And that was an incredible lesson that I learned about having a worldview and that really, I was sort of like a world citizen.

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The reason I share that a little bit is because when I came back to the UK, I was a misfit. I didn't fit back. I felt I couldn't fit back into the late teenage rhythm of my peers and in the school. So I didn't go back to the school that I left. I went to a...in the UK it's called a sixth form college, which was basically a senior year sort of technical college for trying to get my A levels. And then that didn't work out for three months. And a friend of mine from the previous school in the UK I was at, he left at the age of 16 and went to what's called a comprehensive school, which was what in the U.S. we would call a public school. Many people know that a public school in the UK is actually a private school, but state schools, comprehensive schools are the same as public schools here in the United States. And I ended my last six months there.

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So I only had about seven or eight months of education to take my A levels, which would have been the equivalent of SATs and other such examinations

here in the U.S. when it typically would have taken two years. So in the UK, it's still, to this day, they take what they call A levels. You needed three or four A levels to get into university and relatively high grades to get into medical school, and I took those examinations in seven months instead of after two years. Well, I got three of the four. Actually, I got two of the three. I added French. So I had four. I did pass the French, but I failed the physics because I had only had a few months of A level physics. So I went to a different college for a year to do physiology. And a friend of mine said, "Why don't I set up an interview with the Dean at my med school?" Actually, the friend actually had turned out to be my wife-to-be. She got into the medical school a year ahead of me and she said, "I wonder if the Dean might see you and sort of completely, you can't do it today. It wouldn't happen."

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So I bypassed the usual sort of matching process. And he interviewed me and he said, "Oh, my word, your story is pretty incredible. I'll tell you what. If you get a certain grade in physics in three months in what they call the retake exams, you got to place next year in medical school." And I did, and I passed, and that's how I got into medical school. And that's why it was a year later than others might get to medical school. And when I got to medical school, because I'd actually went... I'd been to 13 schools in my time, Geoff, in my upbringing. When I went to medical school, I said, "This is such a privilege. I'm never gonna waste this. I'm never going to ever take it for granted." So I was top of the class, not because I'm particularly bright, but just because I felt it was such a privilege and I wanted to do well.

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Geoff: And so you spent your medical school years focused on your studies and concentrating on maximizing the experience to its full extent.

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Giles: Absolutely. But I didn't quite take the traditional route even after that because you can probably get the gist by now that I haven't necessarily followed the traditional way of doing things. So after medical school, in the UK, you have to do what's called CALS jobs, which would be equivalent to internship here. And then I went with my now wife, Judith, to Nepal for six months volunteering. I worked in a government emergency room and she worked in a leprosy hospital. And we thought, "Why not? Let's go to the United States." And we both happened to match to an internal medicine program, a three-year residency in Waterbury, Connecticut. And we went there for a year.

However, those were the days in the mid-'80s where end-of-life hadn't really been sorted out in the U.S. It had in the UK. And for those of us who are old enough, you'll remember being in the intensive cares essentially trying to keep people alive, even though they may have metastatic malignancies and they're 93, etc, and we were very despondent. And so we both left to go back to the UK wondering what to do, but there's a silver lining in this story. And the reason I'm talking to you today, Geoff, it's just when CT and MRI were coming in. And every day we'd go down to the radiology department and the radiologists were having such fun. Everyone wanted their opinion. Everyone came down there. They had these amazing machines which could produce these cross-sectional images. This is now about 1986. And I said, "There's something in this."

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So when I went back to the UK, I wasn't quite ready to make the jump into radiology. I was still sort of formulating in my mind, I thought I might've wanted to become a GP. So I did six months of OBGYN, and then I thought, "You know what? I'm gonna do radiology." But in the UK you had to be boarded in internal medicine, essentially, to get into radiology. So I did some internal medicine and got internal medicine boards. I then applied for...it's called MRCP in the UK, a member of the Royal College of Physicians. And essentially, radiology in the UK was becoming pretty competitive and you had to have that as a sort of ticket, at least to apply. So I started applying and because I was a bit of a non-traditional candidate, the first three interviews were, "Well, you're a fine chap, but you don't quite fit the bill. Thank you very much." The third interview I had, which was at the Hammersmith Hospital, which many people will know. In fact, it was the first hospital to have a PACS in the world. I went through the interview and they... In those days in the UK, you all interviewed back-to-back on the same afternoon. You all sat in a room, you all saw each other, and you had to wait for the end of the day, and then they would say who was the successful candidate.

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Well, this time they came out and said, "We'd like to interview Dr. Boland." And I believe it was Dr. Bell. Again, "Everyone else, thank you very much. Goodbye." And so they interviewed Dr. Bell and me. When I went in and they said, "What did you watch on TV last night?" So they wanted to see if I was an okay guy. Well, this is either embarrassing or a good story. I happened to be watching a program on Baroque architecture. So I told them, and they thought, "This guy, well, he's way too serious. You know, he's obviously a bit of a nerd. We're not having him." So they gave the job to the other guy. As I left, one of

the interviewers, a professor there came to me and said, "I'm terribly sorry. That was all a bit embarrassing. When you apply somewhere else, I really think you should get that, and I'm happy to help in any way I can." I interviewed at Guy's Hospital subsequently where I was successful and I did my three years of... Well, radiology is what they call a registrar and then a senior registrar. Essentially, it's a five-year residency there. I did the three years and took the equivalent of the ABR. It's called a Fellow of the Royal College of Radiologists, and then came over to the United States for a fellowship in GI radiology, abdominal radiology at Mass General, and have stayed ever since.

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Geoff: Wow. Thank you for recounting that full, rich, complex set of interactions. And I love the personal story. I was just waiting for the advice to come to you that next time before you interview, you should watch "Monty Python" the night before, instead of the "Baroque Architecture" show.

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Giles: Exactly. Well, again, a silver lining. I'm glad I didn't go to the Hammersmith, not because it wasn't a great program. It was, but I was very fortunate to go to Guy's Hospital. And as many people know, like the Hammersmith, it's a wonderful hospital organization and I loved it there. So it served me well in the end. And I think it's one of the lessons that I've had in life is now when I mentor people because I'm getting to that part of my life where, you know, we start mentoring and sponsoring as opposed to the other way around, I say, "Be patient. Hang in there. You know, something will come along and the immediate offer or potential offer may not be the right fit anyway." So I'm a sort of a cup half-full person and be patient and it'll come.

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Geoff: Yeah. Sound, solid advice. That's great. I am really struck by the general theme of moving around and the idea that your wife and you decided to just head to Nepal and do what must've been a really unique period of healthcare. You, as the doctor in charge of the emergency room, I think it was in Pokhara and then saying, "Okay, you know, after that, let's go to the United States and work in intensive care, and then we're going back to the UK." Were you and your wife just completely aligned in this somewhat sort of nomadic experiential approach to getting your early medical training?

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Giles: I think so to some degree. We were both on a bit of an adventure, obviously. And I met her at that school I talked about, the final school I went to and it was a very parochial town. And I think she saw in me someone who is up for a bit of adventure and I'd like a piece of that. So we were aligned. Until I was doing my radiology at Guy's, my wife did a full GP general practice residency program and loves general practice and still does, but something had to give. We couldn't both fully pursue our careers in the way we wanted to because we were still on that adventure. So we came over to the United States initially to only do the fellowship for two years, but then opportunities arose. And we started to have children and Judith went to do ER and urgent care, which she still does. In fact, today is her very last day in urgent care. After today, in theory, that's it for medicine, but I think her passion, ultimately, would have been general practice in the UK. And her family is there, but we've had our four kids here and this is home and all's good.

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Geoff: Yeah. I mean, I think it's really an interesting dichotomy that once you landed at Massachusetts General Hospital and in Boston, that suddenly the nomadic existence was left behind. And you set down roots and as they say, the rest is history. That's fantastic. You had a fellowship for 2 years at MGH and then followed by 22 years on the faculty as an abdominal imagery. You must have really liked it at MGH.

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Giles: I did. But the nomadic story didn't quite end there, I have to say, just if you wanna keep the interesting story and going here, or it may be interesting, maybe not. I was a fellow in abdominal radiology, abdominal interventional radiology, out of Peter Mueller, who has definitely been one of my mentors in life who recently retired. And many people will know Peter Mueller. But a hospital opened up in Scotland with venture capital money out of the United States of which Harvard put in about $50 million and the radiology was franchised to Massachusetts General Hospital. And the idea was that international patients traveling particularly for the Middle East who would either go to Germany or London could go to a U.S.-style hospital based in the UK and have U.S.-style medicine. And so radiologists franchised the Mass General. They had surgeons from the Lehi Clinic, from Oxford Clinic, from Hopkins, etc.

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They built a large, I think 300, 400-bed hospital, $350 million of venture capital money, and they then needed to staff it. And there was a lot of hubris involved because relatively shortly before opening, they realized you can't just be an American physician and walk into the UK and practice medicine. They hadn't really thought that one through. So Jim Thrall, who the majority of people will know, another one of my mentors, said to me one day, "Giles, can you go to Scotland?" This is where the building was built. And I said, "Well, that's funny. I was born there and it rains every day and I'm not going back," kind of thing. "Well, I need your help. It's been franchised to us and you have a license to practice medicine in the UK. Can you go?" And this was in 1993 when there was the first go-around with Hillary Clinton's healthcare reform. And for those of you who were practicing medicine in 1993, you'll remember that there was a lot of concern about healthcare dollars and expense. And at Mass General, there was a hiring freeze and folks were even furloughed. Peter Mueller wanted to hire me, but he couldn't because there was a hiring freeze. And Jim Thrall said, "Well, if you go, there's a job when you come back." And that's what happened. And so I went and then I finished the fellowship when I came back and then had a job as a staff member after that

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Geoff: A really interesting story. Now, when you initially went over there, was it to just provide clinical service, or was it in some managerial leadership capacity?

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Giles: So the leader was Reggie Green who was a chest radiologist from Mass General in radiology, but this was essentially a startup company. They needed to find patients. And so very quickly, I realized that this isn't just about clinical radiology and they had very few cases to start, frankly. So I got involved with a lot of the business development line, and this is relevant because that is what I got into when I got back to Mass General. So I would be in a lot of the C-level meetings of strategizing how to get patients, where to get patients, how to market, how to build brand, and so on and traveled around the Middle East to sort of drum up business if you will. And when I came back to Mass General, finished the fellowship, and then became a staff member, I said to Jim Thrall, "You know, I learned so much there about the business of medicine. How can I help?"

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And it occurred to me... And this was just my choice, the way of looking at the world, and it's not for everyone. I said, "You know, frankly, a well-trained abdominal radiologist can read a CT. And there are many of us, but not everyone has had the business inside experience to medicine and radiology and/or radiology." So I said to myself, you know, "I don't need to be reading CTs MRIs all day. Other people can do that just fine. Thank you very much," although I enjoyed it, and hopefully I was pretty good at it. But this is fairly unique and I want to explore this with Jim Thrall." And hence, that was the beginning of us taking off and starting the teleradiology program, the consulting program, what we call the drug trial program, which was essentially secondary readings for drug trials before they went to the FDA and so on.

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And that's what I built in the department of radiology in MGH. And I started the imaging centers too as part of that, which are now still very, very successful. And I think we were bringing in through those business development ventures about 50% of the revenue to the department of radiology, professional revenue at MGH at the time. I give Jim Thrall a huge credit here because he was the one who had a lot of the vision and I worked with him to implement it. So that was a good part of my 15 years or more than that, maybe close to 20 years, at MGH doing clinical work at the same time.

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Geoff: That's a great story to tell. And there's a lot to unpack in that. I don't wanna let your mention of Jim Thrall go by without shouting out the fact that Jim was our guest on episode nine of the podcast and one of our most popular episodes at this point. And it sounds like he was very impactful on your journey, your leadership, and it's understandable why. How would you characterize his impact on you as a leader?

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Giles: Well, it had a profound impact and still does. And I was, from my point of view, very lucky to have been mentored by Jim. I think many people said to me, actually, at the time, "You are so lucky to be mentored by Jim from outside of Mass General." Jim was an innovator. You can tell from the stories we've been talking about. And it's interesting, it ties back to my dad right at the beginning. I had a father who was an innovator. I sort of locked onto Jim in a way. I could see, "Wait a minute. Here's someone who I could align with because I can learn from him and he's gonna do things differently to the mainstream in my life with whatever I do to some degree," you can't be sort of

too far out of the box. I've always wanted to think about challenging the status quo of the system because medicine, of anything in life, in my opinion, should be constantly challenged to see how do we do better, how do we deliver better care for patients, how do we do it more cost-effectively, and how do, we essentially, get out of the way of ourselves as providers and physicians and start with the patient first and work backwards as to what we should do?"

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And Jim was very much like that too. He sort of cut the sort of complexities and the people sort of out of the way, if you will, to think, "How can we redesign our care pathways? How can we rethink radiology, and how can we rethink it for ourselves? How can we make it more efficient, effective, and etc?" And very early on Jim and I, again, I give him credit, we set up a weekly sort of business meeting very early on in the '90s as to how can we be more effective, efficient, drive more volume, expand the hours of operation? And MG, I think, was one of the first us hospitals to go full PAX. In 1997, we went full PAX. We were the first hospital to test voice recognition. And, in fact, it started in my little shop in teleradiology. We were one of the first hospitals to implement clinical decision support.

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And so on and on, Jim was an innovator and I learned a lot from him, how to challenge the status quo and rethink how to do things around this sort of concept of let's start with the patient and work backwards. And then we, as radiologists or other providers, need to adapt accordingly and change the way we do things for the better care for patients. And in that sense, many folks in medicine don't really like to see it this way. In that sense, I do see that we are like a business. Now, not a traditional business, but we have a product and we have customers. And, obviously, the customers are our patients and to some degree referring physicians. So how do we continuously innovate to deliver a better product, which is what traditional businesses do to stay ahead of the game? And I use this as a metaphor, and some people have heard me say this. In 2005, I believe it was, Steve Jobs came out with the first iPhone, which was an incredible thing at its time, and it still is, frankly, I think. It could have played music. You could take pictures. You could send emails and so on. Did Apple say, "This is such a beautiful thing. Let's just stop here because it's so amazing and people love it so much that we're done?" No. They just said, "This is a beautiful thing, but we can continuously do better and make it better." And here we are on iPhone 12 or whatever it is with all the gizmos and additional features.

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And that's kind of the way I see medicine. We have amazing providers. We have amazing treatments. We have incredible radiology and radiologists, but we can always do better. And if there's any one arena where we need to continuously challenge ourselves to do better, it has to be healthcare. It has to be around the patient because we're talking life. We're not talking about buying a car or even buying a phone or buying a kitchen appliance. We're talking about the human experience, human life, human happiness, human health, and everything that goes behind that. And that in my construct means we have to continuously challenge ourselves. How do we think out of the box? How do we challenge ourselves to not just do it because we think that's what's best for the patient as opposed to the other way around? And many of us know when we've become patients for one reason or another, you soon learn that sometimes we're not so good as we think we are and that we could do better in terms of the experience, communication, timeliness, and so on.

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Geoff: Yeah. It's a brilliant perspective and one that often the drive for innovation is influenced by environmental factors when you look at the field as a whole. And when the environment is one of, essentially, guaranteed payment and relative stability that supports the status quo in a profitable operating environment, then there's less of an impetus to innovate as a field. But we're in the midst of this pandemic that has just upended the way we deliver healthcare and provided an environmental disruption that would seem to be a profound catalyst for innovation. And I'm curious, you know, as somebody who has innovation in their DNA and somebody who has been thinking about and driving innovation for many, many years, how do you view this last year within that context, and do you see it as a fundamental accelerant of innovation?

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Giles: Yes. And it's interesting it's happening as I'm sure many, if not all of this audience to be will have read, it's happening in almost every industry. I read somewhere that the online delivery system... Obviously, Amazon has been at this, but it's been brought forward by about 15 years because of COVID in terms of some of these businesses who are using the online platforms. In other words, COVID has sort of accelerated the inevitability of what some businesses were going to get to and those businesses that were not ready to adapt or used the older platforms have, frankly, gone out of business during COVID. But it's happening now as opposed to 5 or 10 years from now. So innovation, it is across the board and very much in medicine, of course, and in radiology. And I

think the big part of the innovation is the virtual platforms, which radiology was always particularly well-suited to. So like many organizations around the country, when COVID hit, our job was to try and keep people safe as you all remember, Geoff, and I'm sure this was... You were doing this too, pretty much put workstations in everyone's homes and we sort of said, "Get outta here."

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Now, we had to keep some people in the hospital, of course, because we needed that face-to-face necessity for the providers were there, but it wasn't just about remote reading. Now, the impact of remote reading, of course, is now we can think differently how to provide the care. Now, it's a tricky balance between radiologists who are absent, sort of out of sight, out of mind, which is the very thing we were trying to get away from over the last two years. We were trying to get back into the center of the clinical delivery system, which is where we provide value. And you and I know, Geoff, we talk about value all the time, and one of the ways we provide value is to be present and to be part of the conversations in clinical conversations. Well, COVID sent it back the other way. Everyone started to read out of home. However, because we needed to innovate getting back to what COVID has done, and I think only some hospitals been able to do this, but we were able to do it at the Brigham where I now am. And I give credit to Ramin Khorasani and Stephen Ledbetter. We put cameras at every workstation through Microsoft Teams and developed a product where now, just at the click of a button, a referring physician can dial into the exact radiologist they wanna talk to and real-time synchronized scroll up and down on the images. You can see the radiologist and the radiologist can see the referring physician. There's audio and all the rest of it.

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So we've really sort of leapfrogged or maybe like what other industry's done. We brought 10 years forward, what we were gonna get to anyway, in terms of being almost in the room, but virtually. And so that has now... I would be very uncomfortable if all we did out of COVID was to spend half our week reading CT and MRI, for instance, at home and just be there I think that, ultimately, people would understand why we're doing it during COVID, but as we come out of COVID, if we had sort of just done that, it would have been a challenge. But because we've now set up these video cameras and, essentially, made it instant access to be able to speak to your referring physicians and more than that, they can actually see you, so, "Oh, that's what Dr. Boland looks like. Oh, I hadn't seen him or her before, etc.," I think as we come out of COVID, we're gonna need to come back into the hospital because that's what we need to do, maybe not in the same way we did before. And whether these video cameras

and virtual consultations, etc. will continue when someone's physically in the hospital or whether you're at home, it doesn't matter so much.

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We've also been able to figure out education virtually. Now, before COVID, most of us would have said, "No, you can't really educate residents and fellows if you're in two different locations. You have to kind of be side by side with each other to sort of scroll up and down the images." Well, now you can see the resident or fellow. You can scroll up and down the images. You just happen not to be in the same place. Now, I'm not saying it's ideal for all occasions, but it's certainly an innovation that's gonna stick and I think appropriately so. One of the interesting things I've noticed as well is around grand rounds and conferences for visiting professors. Well, obviously, we can't have visiting professors because of COVID, etc. But probably in most institutions, one is always a little bit disappointed by the number of residents, fellows, and faculty who show up to a guest speaker from wherever they are because everyone's busy and it's middle of the day and etc. Well, now, I find there's 150 people on our video conferences for a guest lecturer from...whenever you come to guest lecture, Geoff, you'll get the whole house because it's easy to be sort of where you are, dial in, and watch the lecture. And, of course, Zoom has changed everything in terms of conferences, video conferencing, and so on. So that's just a snippet of what we've learned in COVID with innovation. All of it's gonna stick. I think the challenge for us is to balance as we come back, just have enough actual physical presence with the amount we do virtually.

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Geoff: Great. A great description. And turning back to the clinical solution and the immediacy of the online real-time consultation, I can't help but think of what essentially was a bit of a progenitor of that principle that was also, I think originated from MGH, which was the positioning of a radiologist in the clinic and to have that radiologist there to real-time consult both with patients as well as refers. But, you know, thinking about having this as a parallel pathway to reading cases on a daily basis, being available to consult, talk a little bit about the operational model here. How does a radiologist balance the demand for immediate consultation through this video link versus reading the list and just how much is that opportunity being accessed by referring physicians? How many consultations are your radiologists experiencing through Microsoft Teams as you describe?

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Giles: Yeah. There's the rub, right? The yen and the yang is as you provide availability, people will use it. It's been incredibly successful because the referrers themselves say, "Look, I don't wanna walk down." And for those of you who know the Brigham, it's a very sort of a distributed campus. You can actually spend 10 minutes walking from one part of the building to the next. And I'm sure that's the same for many people who will be listening to this session, that you might have to walk across the street, etc. So they love it because they can be in their office or even in their clinic and they can just immediately dial in. And so, you know, the rub there is because I can immediately dial in, I'm going to. Now, the way I view this, you got to balance it, but I would say this is exactly what we've been talking about for the last 10 years or so, Geoff, and you've been right in the thick of this conversation yourself.

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How can we as radiologists, basically, get ourselves back into the clinical care teams because we had sort of gone into the dark rooms, if you will, and read our cases? And, you know, the worst of us had shut the door and said, "Do not enter" when a referring physician to come around. But essentially, we were pretty worried that our value was being diminished so much so that about probably seven or eight years ago, there was a real threat from many places that everything was gonna go to teleradiology companies. Not everything, but a good chunk of it. And these teleradiology companies were taking away the business. They took over a lot of the off-hour work, as we know, and they started clawing their way into the day work too. Me and you, very much part of this discussion, Geoff, would say, "Uh-oh, you know, where's our value here? If we can't demonstrate value to our host institutions, then they're gonna take our business away and give it to the cheaper, more cost-effective, if you will, at least perceived cost-effective teleradiology companies."

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So I think we've done even, pre-COVID, tremendous efforts as radiologists to counter that trend because the American College of Radiology and many thought leaders have said, "Come on. We got to be front and center of the discussions of the multidisciplinary teams, of the strategy of the hospital. We need to be there. We need to be a strategic force, etc. We need to show relevance, and therefore value." So the mindset is there, but the challenge for radiology, of course, is we're often in these rooms reading cases all day in front of computer screens. I would propose that what COVID has done by fast-tracking this virtual consultation service, despite the fact that we are being interrupted potentially more than we might otherwise have imagined, has to be

a good thing because look at it the other way. If no one is bothered to talk to us, all we do is write a report and we never talk to a referring physician. We never get any feedback. We might as well just send it to the teleradiology companies. So this is a good thing.

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And I would say to those who are struggling a little bit with this, with potentially increased consultations, is to say, "Bring it on." Because that's what referrers want. That's good for patients. But here's the thing that I've heard and have had feedback from, from radiologists. Because they can see the referring physician, because they can talk and they can scroll up and down with the images, they've actually started to enjoy their job more. That they're not left alone in a reading room and maybe get someone who would walk down and consult from time to time. So it's had a very positive effect. That being said, there's no question it's disruptive. And as we all know, radiology is getting busier and busier. Obviously, it collapsed during COVID, but we're back to pre-COVID volumes, so we're just as busy as ever on MRI and CT. I mean, at the Brigham, we're gonna do about 100,000 MRIs this year. That's a lot of MRIs for one year.

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So it's very busy and we're now sort of looking at productivity and benchmarking RVUs to national benchmarks using SCARD. You know, we're making sure we're not overheard or underheard. So people are very busy. And then, so where's the balance between getting that work done and then managing these virtual consultations, etc.? There's one more piece to this, I think, which has helped to a degree, but we'll see where it goes. Because people can now read out of home and we've given people more flexibility, they don't have to commute, etc., they can just sort of take the day a little bit differently, how they wanna do it, it's had a bit of an impact on wellness and burnout. It sort of has taken the strain and the stress out of that busy workday to some degree and so people are beginning... COVID aside, people feel miserable during COVID, of course, and we all do, but if one can sort of park the COVID element of it, people are beginning to have a little bit more work flexibility and are able to adapt to this fact that they can now be disrupted, if you will, by referring physicians in a way they may have pushed back on before. So we'll see where it goes. I think it's early days. Once COVID's over if volumes keep going up and up, which we'll see what with VNM code changes and pressures on imaging to reduce costs, etc., we'll see where this goes. But that's where we are right now. So I guess it's still a work in progress.

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Geoff: Yeah. Fantastic. Thank you for sharing that. You know, I wanna return to the topic of the focus of your career, particularly while you were still at MGH, and just to, once again, reflect on the combination of experience and serendipity that led you to be in Europe and helping to get this startup hospital going right out of fellowship. You had the license, but you also had the experience from your father. You had the mentorship from Jim. And when you came back, there you were, director of teleradiology, then director of outpatient imaging, vice chair for business development, and then founding member and principal of the Radiology Consulting Group. And that's where I'd like to spend just a little bit of time talking about. If you could tell us a little bit about the Radiology Consulting Group at MGH and what was its scope of activity.

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Giles: Well, talk about serendipity. I mean, I think that was a big leap and privilege, I think, in my career. So it was another innovation from Jim Thrall. What happened was, his story goes... I hope he doesn't mind me telling this. But the story goes some visitors came from overseas to Mass General because, you know, Mass General was well-known and they wanted to see how radiology was done. And this was in the late 90s. So what happened, Jim organized a sort of roadshow for these folks for two days. They were there and they came around. They saw everything. They asked the questions of everyone. They probably saw 20, 30 people. And at the end of it, they said, "Thank you very much, Jim. This has been a great couple of days. Here's a cookie jar or something." It was just a sort of some sort of candy or cookies as a gift.

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Now, it turns out that those people who were coming were paying what was then Bear Stearns, who went bankrupt in the 2008 crash, probably tens of thousands of dollars, if not hundreds of thousands of dollars. And Jim said to himself, "Wait a minute. This isn't how it should work. We're giving all this intellectual property away and I get a few cookies and someone else is pocketing all the money." So because I was vice-chair for business development, we got our heads together. And another individual, John Chorus, who is now running hospitals in Florida, we started and actually Keith Dryer was on the scene at the same time as well. So we started tentatively this consulting company to say, "Hey, we can do this. We can advise practices, private practices, academic centers on a whole range of emerging challenges and problems." PAX was just coming in, productivity, efficiency, operations is coming in. It was all about radiologists trying to get technical out of outpatient

imaging centers. So how do they joint venture? How do they build imaging centers? What's the appropriate staffing?

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It was really becoming into the fore. How can we advise on that? Strategic development, relationships with hospitals, with the C levels and C-level folks in the hospitals, how do we build, you know, a joint strategy with the chief operating officer or chief CEO of the hospital. And then, other practices who were having challenges with their radiologists over professionalism, etc. And professionalism is an interesting one because, often, people feel a bit skittish of challenging or at least doing the right thing of saying, "You know what? Cut that out," particularly from leaders. So there was a very large opportunity to go into these practices to sort of objectively, if you will, interview all the stakeholders and it might've been a chair of radiology, by the way. That's particularly challenging, you know. Do we have a chair of radiology in a private practice or academic main center right or who's wrong here? Could you come in and arbitrate? And then, we scaled that internationally as well. And it actually turned out the first, one of the first, at least, engagements we had was with a hospital in Tel Aviv, a pseudo hospital who really wanted to understand about efficiency, modern-day practice of radiology, the opportunities, what they were missing, etc.

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And after that, it was off to the races for a good number of years. And I actually, probably, in my time visited well over 100 hospitals, at least. Now, here was the privilege and serendipity piece of it. This goes for all consulting companies. One of the sort of unknown sort of secrets, if you will, certainly, people who have been in consulting, they know this well. Is actually you're going to these other places and you're learning as much about how to do things in different ways as you are, hopefully, trying to help them. So it's a two-way street. I had this amazing experience of going into these 100-plus hospitals and seeing how to do things differently and you know what? That works over there. I think we need to do that, as well. That's the sort of irony of consulting. It's very much a two-way street. Obviously, the client is thinking they're getting a data dump of intellectual advice, property, and thoughts, etc., but what's not often appreciated is I'm getting a data dump of the landscape of the future of where we're going, the issues in radiology. And it wasn't just radiology we were doing, but it was mainly radiology. And what is happening in that segment of the market? How are people dealing with that particular issue?

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And as you do this more and more, you start to get a much better picture, frankly, of where is the business or industry of radiology going? Yes, we, at the time at MGH and many other hospitals too, were pioneering a lot of the now which are standard activities, whether it was PAX, voice recognition, etc., but plenty of other places were doing great things too. And so I was very, very fortunate to have this inside sort of look, if you will, invited in to give advice to these hospitals, but at the same time, constantly learning about best practices. And it goes on to this day. And I was just very fortunate to be able to have that opportunity.

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Geoff: In some respects, it's a bit about how I feel getting to speak to so many fantastic leaders such as yourself through this podcast, being present and participating, listening. I mean, you are on the ground and helping people work through their problems. It is a two-way street. You give a lot. You gain a lot. No doubt it was a transformative experience. Are there any general lessons that you take away from your many practice evaluations? Any sort of summary observations that you might be able to share?

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Giles: I think, and this is no news to anyone, sort of all politics are local, right? I know that's sort of often banded about, but what may be a particular solution for one organization may not be for the other. There will be some fundamental principles around patient care, which are non-negotiable. You can't have one organization say, "Well, it's okay if you have two-month waiting lists for patients with cancer to see whether they're improving or not." No, you've got to do that as quickly as possible. But in terms of the politics, the strategy, the forces you need to align with, the prominence and advocacy within radiology, within those different organizations, it's all sort of contextual to where is that organization going. And that varies from one organization to another. So I remember having a number of conversations, for instance, and in retrospect, this is a no brainer, of course, in the heyday of radiologists building their own outpatient imaging centers, etc., and keeping all the technical, everyone wanted to do the same because for every $2 you might get in professional revenue, you can get $5 on the technical side kind of thing. So everyone wanted to join that bandwagon.

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But some organizations would say, "Wait a minute. That's taking away my business, the hospital. You can't do that." And other organizations would say, "Well, let's joint venture. That sounds great. Let's align our vision. If you work then and run it very efficiently and drive the technical, etc., and, by the way, have a more convenient place for our patients, a better patient experience, we're on for it, so let's joint venture." Or some organization said, "You know, we've got other priorities. We've got to build a cardiovascular center, or a new wing, or etc. We haven't got the time or money to build that. You know, please go ahead." In fact, that was kind of the Mass General experience. There was a lot of capital flowing into other parts of the organization but there were many other priorities. And when Jim Thrall went to the president at the time, he said, "Look, we can't get the patients done enough. We haven't got enough machines yet. Can we go and build imaging centers? Do you wanna do it? Do you wanna joint venture with us?" And the hospital said, "You know what, Jim? It sounds like a great idea. Tell you what. Why don't you go and do it?" And, for instance, to this day, about 35% of our patient imaging at MGH is done through the radiology practice and they keep it technical. But, you know, it's all contextual. Teleradiology and nighthawk stuff, it's all contextual. Everyone wanted to get on the bandwagon of outsourcing of our work. Well, be careful what you do because not every organization is gonna like that. They want you to do it. They want you to be there. So if they want you to be there, you better be there. Other places said, "You know what? That's fine."

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So I think one of the big lessons is it all comes down to understand who you work for. Understand your organization. Understand how decisions are made, and you certainly understand how they view you and how, particularly, we should be helping the organization to forge ahead. Work it out with the CFOs, the COOs, and the CEOs. How can I scratch my back and you scratch mine? Too often in radiology, and I think we're much better at it now than we were, say, 10 years ago, it was, "We're just gonna do our thing and we're gonna build these imaging centers. We're gonna outsource all our night radiology. We don't want all that hard stuff to do. We just wanna do all the good stuff and make a lot of money at the same time." I'm being a little sort of over-emphasizing just to make a point. And that didn't go down too well with many hospitals' CEOs. But now, I think we've come back a long way towards how can we make it work for the hospital, and then they will make it work for us? So how do we find that sweet spot?

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Geoff: Yeah. Excellent. Now, I'm curious, with all of this perspective on organizational relationships for radiology, the heterogeneity of conditions that you just described, and some of the fundamental standardized questions and relationships that are core to understanding in order to be successful within the organization, within the context of all of that, what is your perspective on the growing role of private equity in radiology practice? And how do you see the practice evolving within the construct of all that you saw and experienced through the consulting practice because of this new dynamic?

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Giles: So there are some precedents possibly as to that dynamic and what effect it can have. Australia became corporatized. You probably know this, Geoff, by about four venture capital companies and they essentially bought out every practice of radiology in Australia. And they were pretty lucrative, actually, for the radiologists. They certainly lost control, but it turns out that it was an unsustainable business. And I don't know the latest, but the whole thing unraveled to some degree. It was a great idea at the time from a business perspective, but it essentially unraveled. So that's one experience, what happened in Australia. I would say, and this is probably contextual, again, what works in one part of the country or practice may not work in another. I have a bias around this, very much an opinion, that the more we control our own destiny as radiologists, or you could be an orthopedic surgeon, or etc., whoever you are. Now, if you are in a situation where you're about to go bankrupt, or you might be out of a job, well then, maybe, you know, it makes sense to get bought out by private equity, etc.

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But the problem is with private equity, again, and this is an opinion, you won't be able to really call the shots anymore. And, in fact, because it's private equity, what drives private equity? At the end of the day, it's money. And the challenge here is that medicine, it is very much about money, no margin, no mission. I get it. But particularly in radiology here, it's very easy for people who...or from the outside sort of private equity to say, "It's a widget. It's like filling seats in an airline. It's like doing as many MRIs and CTS and etc.," but there's so much else that goes on that can't be monetized. So the multidisciplinary clinics, the teaching and the education, the quality and safety, medical staff meetings, and so on, those are the things where we actually add enormous value. Often, it's a sort of paradox. The things where we often add most value are the things that we actually don't get paid for or not paid well.

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Now, of course, we add huge value in the interpretation. That is our primary value of diagnostic or performing interventional radiology. Dn't get me wrong. But the risk with private equity is they're gonna focus on the money side of it. How do we generate as much cash out of this particular organization? And let's squeeze out, which is therefore potentially squeezes out, all these other value adds to the organization. We're at conflict. So for every multidisciplinary clinic we do which doesn't get paid for, I can't read another CT or MRI. And I'm exaggerating the point. I'm not saying that private equity insists on only churning out the cases. They do understand that there are other non-monetized activities that we do, but because it's focused around generating profit, you know, you work to how you're paid, frankly. And so there's a tension there, let alone not being able to control your destiny.

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So I personally, to take a brief step back, I do think... I know we will have many, many private practice folks listening to this podcast. And, again, it's contextual. Maybe that is appropriate for where you are because you're in a relatively remote small environment, etc. But increasingly, organizations are becoming systems, and systems are needing to work together and rethink how they do business and are employing radiologists. Now, again, that's losing some of the autonomy. You think you had as a private practice. But if you play your cards right, you can still have a lot of autonomy if you are able to align with the strategy and vision of the hospital and help work with them and make it a win-win. I think we are gonna become increasingly employed, but I would like to be seen that we're being employed by our own host hospital organization because then we're aligned as opposed to a private equity.

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Geoff: There's a lot to unpack in the topic, but I really appreciate your opinion on that. About five years ago, you moved across town to chair the Department of Radiology at the Brigham. After so much management experience at MGH, so much exposure through the consulting group, were there any surprises left for you upon arrival at the Brigham?

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Giles: Oh, there's always surprises, anyone who's in leadership management. I think the only thing I would say is never be surprised what you might find tomorrow because there's always something that could surprise you. So one of the things leaders learn or should learn is that don't freak out when something

happens which you weren't expecting because it will happen. Now, the classic example is HR. And I have to say, my previous job at MGH, I'd done some HR. But any chair of an academic department or a large private practice will know that a good chunk of your time will be spent in HR. And they come out of nowhere. You could be merrily having a wonderful day and then suddenly you get a phone call from your HR person. And someone's doing something or said something or etc., which completely, you know, changes the whole course of the day, the week, or even a month, etc.

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So surprises will happen all the time. What one needs to learn is to not say to oneself, "I wish that never..." Well, I guess you could say, "Wish it had never happened." We never want HR issues to happen, but don't sort of say, "Never gonna expect that. What on Earth do I do?" Because it's gonna happen all the time. I think one of the things I learned going over to the Brigham, this is well known, so I don't think I'm sort of sharing inside stories here that, frankly, the Brigham and the MGH radiology departments really didn't do much together when I came. I knew it, actually, so it wasn't really a surprise. But one of the things that Jim Brown who's chair at the MGH and I have tried to do over the last four years, we are part of the same organization, after all, now called Mass General Brigham, is to really start working together and to make that happen. I guess the surprises were how difficult it is to do that because we're talking about... Well, it wasn't really surprising because I'd done all this consulting and that's why it was such a benefit. But it's really hard to change culture and the way people are doing things and their expectations, and their dignity, and what they're passionate, etc. And you want to leverage the good things and take away the things that get in the way of doing better things for patients.

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I like to think I did a lot in my four years as chair. We changed a number of the divisions. We worked very closely with MGH over the last four years such that we're almost sort of becoming, from a patient's perspective, the same look and feel. I changed the comp plan. The comp plan was all over the place. What I did was... And I didn't expect that coming in. I really sort of found it when I came in. I personally believe in equal pay for equal work. So if you are the same seniority level, the same years out of practice, out of residency, the same administrative level, leadership level, the same academic rank, you should get paid the same. It doesn't matter who you are. And so that's one thing I did. And some people had to lose significant revenue in that process. Fortunately, only 2 out of about 130 radiologists left. It gets back to where we started, Geoff,

innovate, constantly. You do one thing, but don't just sit and park there and say you're done forever.

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You've got to continuously evaluate it. You've got to measure it. If what you put in place you think is gonna work, well, look at the metrics. And if it isn't going the way that you think it's going, why? Ask yourself the questions. You got to get the data, of course, and then change accordingly. And you got to go everywhere in the department and do that all the time. Of course, I have great people who can help me do this, great people who will help give me the ideas. And that's a key leadership tenant here, of course, at least in my viewpoint. I don't know it all, I can't do it all, and I can't think it all. The successful leaders are able to say to your trusted teams, you know, "This is kind of what we need to do. How do we get that? Give us the ideas, etc. And then through effective management, let's find the right people and the right teams to deliver it. And, by the way, if it doesn't work, we're gonna measure it and we'll change it."

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I will say this. There's nothing like actually doing the job to actually really start to learn. So it's all very well that I've had an amazing experience at MGH. I've run the consulting practice. I built the teleradiology. I built all these outpatient centers, but you go to a different organization with a different culture, you come with some of ideas which you wanna do. And, by the way, don't come with ideas that are so baked that you're just gonna implement them, irrespective of what other people say. That's not gonna work either. But I think it's, once you get there, and you start trying to implement these changes with the teams, getting input and advice and all the rest of it, that you really learn how to do it. And it's adaptability, flexibility, nimbleness, accountability, timelines, and action.

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Geoff: Amen, brother. That's the gospel. I hear you. Absolutely. Excellent. When COVID hit last spring, you were tasked with establishing a secondary hospital to handle the surge. Can you tell us about that project?

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Giles: Yes. So Massachusetts was hit particularly hard in March and April. We had sort of fall in the heels of New York City and we were one of the worst, if not the worst, state after New York City in terms of per capita death rates and

infectivity. So the hospitals were getting filled rapidly in March. The ICUs were filling up. We shut down outpatient practices. This got to why radiologists were sent home, etc. We got down, by the way to about 30% of our business in radiology. So that was a huge hit. People were redeployed to care for the COVID patients on the med surge floors and in the ICUs, but then we're filling up the ICUs? Where are these patients gonna go for all of Boston? And we pretty much reached full capacity. And so the vision was, and it started in New York where the Javits Center was, we need an outlet for once patients recover but they're not ready to go home, either because they're still COVID positive or they have a number of either chronic or ongoing non-life-threatening conditions, which would typically we would send patients to a skilled nursing facility, a SNF. Where are we gonna send them? And so this was the idea of building a field hospital and the field hospital led by the governor of Massachusetts, Charlie Baker and Marty Walsh, the mayor of Boston, who's now gonna be labor secretary under the Biden administration said, "Let's take the convention center in Boston and turn it into a field hospital." It was one of the most thrilling three months of my life, I have to say.

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On a Friday, I think it was April the 3rd, there was a concrete floor in the convention center. By the next Friday, there was nothing there on that Friday. By the next Friday, there were 1,000 beds with oxygen, with nurses, with physicians, with all the wraparound services, food, security. All the fire inspections had been done. We were ready for business in one week with 1,000 beds. Now, 500 of those were for the homeless or those who needed shelter, if they were COVID-positive, have a safe place to stay. And then, there were 500 sort of skilled nursing facility type beds. And essentially, I ran it with three others. General was, sort of overall command, Jack Hammond with his chief operating officer, Mike Allard, Jeanette Ives Erickson who used to be chief nursing officer at Mass General, and me. And Jeanette and I were essentially around the whole clinical operations, along with the logistics with the other two I mentioned, and we were all doing something none of us had ever done before. The general had military experience, but not medical military experience.

[01:02:48]

And so every day was a new day. And every day we had huddles for an hour to say, "What's the problems of the day? Who's gonna fix it? How are we gonna fix it? What resources do we need? Who do we need to call? When do we need to elevate it up the chain? And how do we do this in a safe way for patients and ourselves?" Because we knew nothing really about COVID at the time. It was rapidly developing. I'm pleased to say in the three months that we were there to

where we didn't need it anymore because the surge abated, we never had one significant quality and safety event with hundreds and hundreds of patients that we cared for. That's pretty staggering considering it was like a pickup game. And, by the way, all the staff that came, came from many different organizations. You know, typically when you're in an organization, you know the rhythm, the cadence of how that organization works, the rules, the roles, the policies, the responsibilities. People were coming from all over the state, all over Massachusetts.

[01:03:43]

So the nurses were from here, there, and everywhere. The physicians were from here, there, and everywhere. And so to be able to come away without a significant safety quality event and be able to discharge these patients effectively back to home, no deaths at all in those three months. We had about six or seven who needed to return to the hospitals because they de-compensated, usually, for, oh, two reasons because they got pneumonia, etc. I think it was a pretty staggering outcome. And the reason it was so enjoyable... And I'm not sure enjoyment's the right word, but it was so meaningful, or at least it was desperately needed during this COVID time, we provided tremendous value for the system for all hospitals. And all hospitals referred in Eastern Massachusetts to this field hospital. It wasn't just Mass General or Brigham hospitals. So we provided tremendous service. But the teamwork and the commitment from everyone, from the cooks, to the security, to the police, to the physicians, to the nurses, and to the logistic folks and so on and so on, to get that done in that timeframe with that dedication to each other and patients, I'd never seen it before my career and I don't think I'll ever see it again. It was just an incredible experience.

[01:04:55]

And we wrote it up actually in HBR. There's an article, which several of us wrote, "Howard Business Review," about the 10 lessons learned about dynamic leadership, nimble leadership in the COVID field hospital, and how we might be able to use and translate some of those back into our regular hospitals now that we're back. And it's really around effective, nimble leadership, finding the right teams, challenging ourselves to the status quo, course-correcting rapidly if we're going the wrong direction, delegating tasks to the right people, expecting everyone in the organization to have a say, and to help us deliver the best practices. It's a sort of bottom-up type of environment where we're looking for any idea that will help us, and engagement in the teams. It was a truly wonderful experience.

[01:05:43]

Fortunately, even though we're back in this horrendous situation nationwide with the next surge, we haven't had to go back to that field hospital. Two other field hospitals have been started up in Massachusetts. But what we're seeing around the country, as awful as it is, for every patient who has COVID, we're seeing less deaths because we know how to treat it better and manage it more effectively than we did back in March and April where there were more deaths per COVID patient than there are now. So we've been able to manage this surge, at least in Massachusetts, a little bit more effectively, actually, a lot more effectively than we could the first time around. But I know in many parts in the country, as awful as it is, they're seeing this really massive wave kind of for the first time in some parts of the country. And so it's a big struggle. My heart goes out to them.

[01:06:30]

Geoff: Yes. Most recently you transitioned from being the department chair to become president of the Brigham and Women's Physician Organization. What are your responsibilities within that role?

[01:06:41]

Giles: So all the department chairs report up to me and the president of the hospital, Betsy Nabel, and the role has somewhat morphed a little bit from its previous role because the chairs didn't report up, actually. We had a 20-hour review at the Brigham about the roles and responsibilities of the president. And so now, there are kind of three main areas of responsibility. There's a system role. Mass General Brigham is pivoting very much towards working as a system and aligning all hospitals in the systems around common practices and workflows. I have a major role there and I'm in the senior leadership team for Mass General, Brigham to think about strategy, future, and opportunities. Then there's the hospital side, if you will, the Brigham as having a leadership role throughout the Brigham Hospital itself, Brigham and Women's Hospital working with Betsy Nabel, my president. And, in fact, we have daily huddles with the chief operating officer to think, "What are the issues of the day? What do we need to fix? How do we go at this?" So it's kind of an operational role helping to run the hospital.

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And then, there's the physicians themselves. How do we onboard people? How do we work at wellness programs? What policies do we implement around

hiring people? Then there's a network development role. How do I work with a central network development team to expand practices, particularly for physician groups? Business development, how do we build new practices, which benefit the physicians' organization, but not in counter to the hospital direction and organization to contracting with the payers and so on? So it's actually many multiple roles depending on which sort of area, whether it's a system role, a hospital role, or a physician role. And, of course, the primary role is president of the physicians' organization. So it's about the physicians, but to help the physicians be effective, you have to be effective in those other domains too because if the physicians are running counter to the hospital direction and imperatives and the system imperatives, well, that's not gonna work. So I see a big part of my role is to help align the physicians with where the system is going and the hospital, to some degree, and how do I advocate for the physicians and its leaders in developing the strategy and direction as we all move forward?

[01:08:55]

Geoff: Yeah. It sounds like a very exciting and broad role. What skill sets are needed in this current role beyond those that you relied upon as the department chair?

[01:09:05]

Giles: Well, one has now a much bigger portfolio and many, many more stakeholders. So it's about pivoting. Now, in any leadership job we've always got to pivot from one stakeholder to the next. You could be talking to the division chief one minute, to an administrator the next, to your hospital president the next, to a technologist the next, etc. Here, that is just amplified and magnified. I might be having a call with the CEO of Mass General Brigham for an hour of a $14 billion organization. The next hour, I'm talking about wellness for the physicians. So you have to be able to rapidly pivot and move within a given day and adapt to the issue at hand, the importance of the issues, and what agenda is at hand. That's not for everyone. It takes, I think, a particular patience and skill to be able to rapidly move and change the conversation, if you will, and the thinking, depending on who your audience is, which could be 8 or 10 different types of people in any one day.

[01:10:03]

Another big tenet I have is do a lot of listening. Because there are so many different stakeholders, because they have so many different agendas, and all of those stakeholders are important people with important things to say, I make

sure I can do as best as I can to listen to them, hear them, and where there are good ideas, bring them up to the surface and to other leaders around the system because that's gonna be helpful. And where the ideas may sort of run counter to where the system or hospital is going is to help educate, help those understand that, you know, the timing of that idea or thought is probably not the right time, and for these reasons. Another piece like all leadership is to lead as best as you can by influence. That's always the best way to lead if you can. But occasionally, we have to do an executive statement or mandate. Hopefully, not too many of those, but if there's something we have to do, and there's a lot of this going on in COVID, of course, one of the things I noticed with the PPE rollout early on is, you know, there's rules and regulations about that.

[01:11:04]

And we're not gonna break those rules because, otherwise, it's mayhem. We started to see this a little bit with vaccines with people saying, "Wait a minute. I should be at the front of the line," when the rules, the regulations said, "No, you're not patient-facing. You have to wait for the wave three or four, etc." So you have to be pretty top-down in those types of environments. But in others, you know, as much as we can, we lead by influence, try and get all the best ideas possible, and then integrate them into making the solutions. The more we can get people involved in helping us develop the solutions... You know, a number of people will complain. They will say, "There's a problem with this. It's having this effect." And it's very easy to complain. In fact, I had a conversation with a chair this week who was complaining about a particular issue. And I said, "I get it. Thanks. What would you do about it? Help me think. I don't know all the answers here. Let's come with solutions."

[01:11:53]

So anyone listening to this podcast, I would suggest to you, if you have something that's not working well and you want to bring up the issue, I don't have a problem about bringing up the issue. You should. If there's something that can be fixed, bring it up. But whenever you bring up an issue or a problem, think the next step ahead. Try and think, "Well, how would I fix it? How can I contribute to the conversation in a positive way to help make it work better?" Too many people just present the problem and stop there. What I would like to encourage everyone is to, certainly, present the problem and say, "Hey, here's some thoughts and ideas I had around fixing this." Now, they may not be right. They may not work, but at least you're thinking. And I'll tell you what? A lot of the time they will work because you're the person complaining and if you've figured out a way to fix it, presumably, that will work for you, so let's try and work with that.

[01:12:47]

Geoff: That's sound advice. A lot of what you have just been describing in terms of managing such a broad portfolio, the pivots, the interactions is tactical and day-to-day and so fundamental to a role such as this. When you take a step back and look at it from a strategic perspective, what do you hope to accomplish on behalf of the physician organization over the next few years?

[01:13:14]

Giles: So you're right. Many of the day-to-day conversations are tactical, but I try to bring a strategic outlook to any conversation I have. Now, I don't wanna overstate that, that I start getting into strategy when we're talking tactics, but I want us to think one step ahead of the tactic. Okay, we're doing this now. We're implementing something, and this gets back to innovation, which has been a theme throughout this conversation is, okay, we're doing this now. We're doing it pretty well. And depending on the conversation, I could pivot that towards strategy. Now, I don't wanna derail the tactic. That's not what I'm saying, but the reason I'm saying this is I want us all to think about next steps. Yeah, we're doing this and it's working pretty well. Like, how can we do it even better? So in terms of answering your question, what I'd like to continue to encourage in myself and others is, certainly, to implement the solutions that we are devising for whatever task at hand.

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Whether it's a COVID issue, whether it's a through-put issue in the OR, whether it's a staffing issue, continuously think that step beyond that because I think if we're constantly looking out ahead, we change our thinking from one of, "Let's just get this done and let's pause and sit down and just do the job." And there's nothing wrong in that. But inevitably, someone's gonna come along and say, "We need to change that because a new best practice has been developed, or there's a new boss, or there's a new strategic director in the hospital." What I'm really getting at, and this gets back to Jim Thrall, and Jim Thrall was very good at this, change became part of the culture in the department of radiology at Mass General because he was always bringing new things in and challenging the department to think differently such that when we went to voice recognition, which was a huge problem for many hospitals when voice recognition came in, because they said it slowed us up. They had to get used to it. In their defense, it was a little clunky, the voice recognition to begin with. I'm not saying it was all sweet and light, if you will, when we started voice recognition. But because we had a mindset of how can we do things better,

change is inevitable, change is coming, when that voice recognition came in, it was like, "Okay, here it is. Let's adapt. Let's make it better. Let's move ahead."

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And so I'd like to think that we can continuously look to the future because there will always be better ways to do things. The flip side of that, of course, is burnout. I and others have to be very sensitive to this notion of change, of what's the impact to the person, their ability to get their work done, their meaningfulness at work. And one of the big burnout drivers is change itself. My thinking is to try and help people to actually find change stimulating. And that is actually something we want to do because it'll make our life better and it will make the patient's life better. And so how do I sort of reframe change from one of, "Oh, here we go again. I'm being told what to do. Can't you just leave me alone to get on with my job," to one where, "Give me all the tools. I need to get my job down. That's the sort of the deal here. And I'll change. Give me the resources. Give me the tools. Give me the leadership opportunities. Give us the framework, the right people to work with, and I will change." If we ask people to change with the same old, same old group of people and the same old way of doing things, they're gonna push back and they're gonna get burnt out. And I agree with that. I understand why they get burnt out.

[01:16:44]

So how do we develop a whole culture, whole infrastructure, both of mindset, resources, and tools to ensure that when change happens, as it inevitably should, because it gets back to this idea of human health, etc., how can we continuously improve that, that we do it in a way that people respond to say, "I want a piece of that. I wanna be part of that because I can actually help do it and it brings more meaning to me." So that's sort of a grand philosophy, if you will, of where I would like us to go at the physician organization, the balance between allowing people to do their work without stressing them out too much, but helping them to adapt and see change as something positive for themselves and for patients.

[01:17:28]

Geoff: I love that philosophy. And helping to imbue the culture with a spirit of change as an engine of satisfaction, of success, of wellbeing is laudable. It's a fantastic direction. How does the Brigham Physician Organization operate within partners? I'm sorry, Mass General Brigham integrated healthcare system, I should say. And why aren't the physician organizations of MGH and the Brigham merged?

[01:17:56]

Giles: Well, that's a good question. And that is actively being discussed. And that may actually happen. For now, it's not on the table. But so many things have happened in Mass General, Brigham in the last year or so that that could be a conversation that's brought to the front of the agenda in due course. In fact, many people are openly saying that it is inevitable. Why hasn't it happened yet? Because I think there are many reasons to advocate for that to say that it's the right thing to do. I would say a lot has happened. This gets back to change again. A lot has happened at Mass General Brigham in the last few months, in fact, and COVID itself has accelerated some of these. For instance, we now have a central chief operating officer, which didn't exist six months ago, who's responsible essentially for all operations across all of Mass General, Brigham, and all COO's, whoever they are, including the physician organization COOs and the hospital CEOs, now report solid line to that person and dotted line to their own hospitals.

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So big change is happening. So that is a bold move. And so I think the organization, the board, the COO, and others are being bold and taking, I think, the right steps to help us be more efficient, effective, aligned across the system. But I think there are as well, we have to respect the existing culture, legacies, and histories of these great organizations, whether they're the community hospitals, academic medical centers, and how fast is fast. Yes, it may happen. Who knows when, but it's just really a matter of timing and pacing as the system changes. And there's probably only so much a complex, multilayered, large organization can take in one go, and this COO role was a massive move for our organization. So let's get that right and then we'll move on to the next opportunity, which may be the physicians' organizations.

[01:19:50]

Geoff: Giles, how do you unwind? Do you have any hobbies or activities that you pursue outside of work that re-energize you?

[01:19:57]

Giles: Yes. So maybe the most important question you've asked me in the last hour and a half because I can't do any of this stuff unless I'm able to unwind, and I would say that for everyone. Like most people, I work hard, but I definitely have to unwind. One of the ways I do that, I think a lot of people

struggle with this and I noticed a lot of my chairs struggle with this, is when I get home and evening, I pretty much shut off. Yes. I might look at emails, but if I see an email that thinks, "Oh," I say, "You know what? I'm gonna answer in the morning. I'm not gonna do it tonight." I decided pretty early on in my chair job to write very few emails on the weekend, if any, at all, because if I'm writing an email to someone, particularly if I'm their boss, they're gonna feel compelled to respond on the weekend/ And then, you get this whole email train going. And the next thing you know, two hours of your weekend has gone because you asked what might've been a fairly benign question over the weekend.

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So long story short on that one, I try and protect my off time as much as possible. Now, I can't do it all the time, and, of course, there are some emails or telephone calls that I need to take. I will always answer my president's phone call, for instance. That's what you do. You don't ignore that. But when I come home, it's gonna be me and my family or whatever it is. So that's one. Pretty basic. I work out. I do find exercising tremendously benefit for my spirit, for my health, and I feel better. I've got a bit crazy on this. I've run a lot of marathons in the last few years and an Ironman on top of it last year. So that may be too much, but it's given me exhilaration and thrill to be able to do that. The other thing I do is draw, and today I've done two hours of drawing. I sit there and I take my time and I'm told my work is...people like it. So that's a nice thing. I spend as much family time as I can with my wonderful four children. They're sort of scattered now. I like a bit of sport, to be honest. I enjoy that. I think the overall thing here, Geoff, is that I try and shut off once I'm away from work. I've said to myself before, "You can throw me anything between the hours of 7:00 and or 6:00 or 7:00 during the day. You can make it as busy as you like, but when I get home, I want my time because then I can go the next day and do it all again."

[01:22:07]

Geoff: Yeah. Very important. One final question for you. What advice would you give to a young scientist or physician who's inspired by your journey and would like to pursue leadership?

[01:22:20]

Giles: One other thing I mentor people with is to say, "Be patient." You may think you're ready for something or you're hungry for this, that, and the other. And ambition is a good thing. There's nothing wrong with it, but the timing

may not be right. The fit may not be right. So that's one thing. Be patient and continuously tell yourself to be patient. The other thing is find out what your leaders are thinking, whether it's a chief executive-level or your division chief, whatever it is. Find out what's important to them and how can you dock into that and help them be successful because they may not tell you this. But if you work for them and help them, you make them successful and in turn, if they're a good leader, they will then make you successful. And so find out what they want. Find out what they need.

[01:23:07]

And I always encourage people when they ask me about what can I do, where can I go, I say, "Go and see your leader." And, in fact, I often say, "Go and see two or three leaders above." So if you're a junior faculty member, let's say, and you're an instructor or whatever it is, certainly go and see your division chief, but go and see your chief. Go and talk to the chief of the department. If you are a division chief, etc., go and speak to the chief medical officer. Maybe even go as far as speaking to the chief executive officer. I remember when I was vice-chair of radiology at MGH, I remember scheduling a couple of times to go and see the chief executive of what was then partners. So a vice-chair in a department went and spent time with the CEO of this $14 billion organization? What's that about? Well, I didn't go in there with hubris and sort of cockiness, but I asked him, "Where's the system going? How can I help? I'm interested, etc."

[01:24:03]

So seek advice, counsel from your leaders and not just your most immediate leaders. Working hard, you know, I'm sorry to say is a prerequisite for success. We need a bit of luck. I will say that. And, you know, we've talked about serendipity here on today's call. Hard work is, well, we need it. We don't become successful by not going at it. And, you know, at the end of the day, be a team player. Be a good person. Emotional intelligence, you know, it's so important. Read the room. Read the people you're working with. Read the situation. Read the strategy, and think and adapt and be humble. I once heard a very senior leader say, "This person's never gonna get higher than they are because they're such a jerk." You know, that person's career was kind of stuck there because they were seen as not particularly helpful. So just be a team player. And I'll end with this, I think, Geoff, and this is a well-known leadership tenet. It's nothing that people haven't heard before. It's amazing what you can do if you don't care who gets the credit. And if you take that philosophy, if you help make something successful, the people will see that you've been successful and help them make them successful. And they will start doing things for you to

make you even more successful and work your way up in the organization into more higher leadership positions.

[01:25:21]

Geoff: That's marvelous. Giles Boland, I can't thank you enough for spending time on a Sunday afternoon to have this conversation and to have our community benefit from such a rich experience and rich set of perspectives, the priorities toward innovation, toward enabling the change in a manner that is sensitive and attuned to the characteristics of the organization, and particularly the individuals that comprise that organization. It's really been very enriching for me and a true inspiration to have this conversation with you today.

[01:25:59]

Giles: Well, it's been a pleasure, Geoff. And you know that we've worked closely for many years and I've learned a lot of you too. And it takes a village. It takes all of us to help each other, to support each other, to win appropriate advisors. And that's what's so exciting about this career. And I've never got up in the morning and said, "I don't enjoy my job." I've been very, very lucky. I've enjoyed every single day of it. It's such a privilege to be in medicine, such a privilege to be in medicine. And I think sometimes we lose sight of that. What a gift it is to be able to do what we're doing in radiology and medicine. And part of that is because of the people we work with, the people we learn from, and the collaborative spirit we all have to try and do things better for patients and each other.

[01:26:57]

Geoff: Please join me next month when I speak with James Borgstede, professor and vice chairman of radiology at the University of Colorado and immediate past president of the Radiological Society of North America. An enthusiastic supporter of international radiology, Dr. Borgstede has personally supported the purchase of ultrasound equipment and training of personnel in the Philippines and Cameroon. He is a past president of the International Society of Radiology, past president and board chair of the American College of Radiology, past president of the American Board of Radiology, past president of the Colorado Physician Health Program, and past president of the Colorado State Board of Medical Examiners. We explore his path through a remarkably diverse and impactful slate of leadership roles, culminating in an exploration of the tremendous flexibility and innovation required in achieving the COVID-induced unprecedented pivot to deliver the 2020 RSNA meeting remotely.

[01:27:56]

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