



DRIVING CHANGE

Leadership Is for Everyone

Leadership Is for Everyone



In times of uncertainty, strong leaders are more important than ever before. To survive and thrive, every radiologist needs to fill gaps in non-interpretive skills. That's where the Radiology Leadership Institute® (RLI) comes in.

Built by radiologists for radiologists, the RLI teaches you the essential leadership and business skills you need to be a change agent in your organization.

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With programming for radiologists who are leading change at all levels, the RLI can help you advance your career and master the challenges ahead.

Be a Leader





IMAGING 3.0 IN PRACTICE

Driving Change Leadership Is for Everyone

Throughout medical school, residency, and fellowship, radiologists receive extensive clinical training that prepares us to deliver exceptional patient care. What's missing in radiology education, however, are other essential skills that we also need to deliver imaging services — things like communication, negotiation, financial management, team building, business principles, change management, and more. In a word: leadership.

In the past, many radiologists believed that, unless their goal was to become the chair of their department or an executive in their practice, they didn't need business and leadership training. Now more than ever, it has become abundantly clear that healthcare isn't just about medicine. At all levels, it's about leading change, driving quality improvement, and implementing value-based care.

Simply put, leadership is for everyone.

In the face of today's unprecedented health, social, and economic challenges, rapidly addressing changing priorities is top of mind for many radiologists. But none of us could have forecasted just how fast those changes would hit.

No matter what challenges you're facing, now is the time to focus on honing your existing leadership and business skills and learning brand-new ones to help you succeed in today's profoundly altered healthcare landscape.

The Imaging 3.0 case studies in this collection demonstrate how radiologists across the country have applied leadership skills learned from the ACR Radiology Leadership Institute® to become change agents.

There's something here for every radiologist who wants to improve their business or leadership skills. By reading these stories of leadership in action, we hope you will better arm yourself with new abilities and fresh perspectives to master the challenges ahead.

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SHARE YOUR STORY

Have a case study idea you'd like to share with the radiology community? To submit your idea, please visit acr.org/Suggest-a-Case-Study.

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Catalyst for Growth

A radiologist uses skills learned through the ACR Radiology Leadership Institute to drive measurable results and implement new service lines.

KEY TAKEAWAYS

- A radiologist participated in the ACR Radiology Leadership Institute after realizing that he needed additional skills to advance his career toward improving hospital operations.
- Leveraging communication, negotiation, collaboration, and other business-centered skills, the radiologist became a trusted resource throughout the hospital, helping to advance his radiology group's prominence.
- The radiologist's efforts led to the development of new service lines, increased patient referrals, and higher employee satisfaction scores.

Shawn D. Reesman, MD, FACR, was attending a peer review committee meeting when he experienced an unforeseen sense of inadequacy. As a partner with Raleigh Radiology at the time, Reesman had joined the committee in hopes of contributing to clinical care improvement at Raleigh General Hospital in Beckley, West Virginia. But as his colleagues around the conference table demonstrated a deep understanding of the hospital's daily operations, Reesman recalls feeling overwhelmed. His internal monologue chided, "This is beyond my skill set. I have no idea what I'm doing. Why am I even here?"

Reesman realized that if he wanted to participate in the discussion and have a meaningful impact on patient care, he needed additional training. In particular, he required the communication skills, operational expertise, and strategic planning moxie that advancing comprehensive patient care requires. To obtain these skills, Reesman participated in the ACR Radiology Leadership Institute® (RLI), which offers online and in-person training on topics ranging from personal branding to negotiation to help radiologists at all career levels lead change and enhance care within their hospitals and practices. "When I heard about the RLI, I immediately recognized that it would provide me with the skills needed to move into the next phase of my career," Reesman says.

As Reesman expanded his knowledge base through the RLI, he took on a more influential role at Raleigh General Hospital. He served on various hospital committees, collaborated with administrators on quality improvement initiatives, formed new partnerships with other physicians, and became a trusted resource for colleagues hospital-wide. Now a partner at Associated Radiologists in Charleston, West Virginia, Reesman continues to apply his leadership training to help solve everyday challenges and give a stronger voice to the radiology



Shawn D. Reesman, MD, FACR, participated in the Radiology Leadership Institute to hone his interpersonal and leadership skills for improved bridge-building between radiology and hospital administration as well as other specialties.

team in today's increasingly complex healthcare environment. "One of the most important things that I learned from the RLI is that you have to embrace change," he says. "If you're not helping develop the direction of the change, then you're left at the mercy of wherever the change winds up."

Getting Involved

While medical and residency training programs adequately cover diagnostic skills, they seldom address the business side of medicine. As a result, doctors rarely leave medical school with the leadership skills required for career acceleration and effective management, including interdepartmental collaboration, negotiation, communication, and problem-solving. "In medical school, the focus is mostly on the disease, diagnosis, and cure processes, but the business aspects of building bridges between specialties and hospital administration are often lacking,"



Reesman explains. “It’s important to develop leadership and interpersonal skills in medicine so that you can help align teams around a vision that benefits patients.”

This became increasingly apparent to Reesman as he began getting involved in hospital operations in 2011. Although he had gained a baseline knowledge of operations from attending one-off sessions at various professional conferences, experiences like the one he’d had with the peer review committee made him realize that he needed to deliberately hone his leadership skills if he wanted to be involved in making critical changes. “I had a cursory understanding of hospital operations, but I needed more robust training to fully engage in the type of decision-making that leadership requires,” Reesman says.

As circumstance would have it, the ACR launched the RLI in 2012 to help radiologists at various stages of their careers further their professional development. Reesman was eager to participate in the program, which explores topics such as the differences between leadership and management, the value of involving diverse opinions, the secrets to active listening, and tips for developing credibility and executing follow-through. He participated in the online, synchronous interactive classroom, listened to RLI podcasts, and attended several RLI Leadership Summit meetings, where he networked with peers and sharpened his skills to better perform in new roles that would benefit the hospital as well as radiology.

“As radiologists, we don’t have a lot of face time with patients or even colleagues because we’re reading films all day,” Reesman says. “In some cases, you are in the reading room for years and few people even know your name. You’re out of sight and out of mind. If you’re overlooked, you’re not being heard. It’s important to get engaged in hospital operations so that you can bring the radiologist’s perspective to the table.”

Building a Reputation

In Reesman’s case, his reliable presence on the peer review committee positioned him as a trusted resource. He says he gained credibility in that position by demonstrating four

“Once you build confidence and find direction, you are able to step out and become a change agent. You become a sought-after resource for other stakeholders.”

–Shawn D. Reesman, MD, FACR

essential traits that he learned along the way: integrity, intention, capability, and outcomes oriented. He also focused on being a good listener. “The RLI taught me to appreciate diversity of opinion,” Reesman says. “This was a major turning point for me because before this, I didn’t always acknowledge the significance of other people’s perspectives.”

As Reesman applied his leadership skills to committee work, he was presented with additional opportunities to get involved in hospital operations. In 2015, for instance, he was elected to Raleigh General’s Medical

Executive Committee (MEC), a governance group that implements the hospital’s culture of safety, drafts and enforces bylaws and hospital policies, ensures compliance with accreditation standards, and considers new medical staff for board approval. “Once you build confidence and find direction, you are able to step out and become a change agent,” Reesman says. “You become a sought-after resource for other stakeholders.”

As a member of the MEC, Reesman leveraged the skills he learned through the RLI to open new service lines, address behavior

Make Things Happen

Shawn D. Reesman, MD, FACR, says these leadership traits have been essential to his career success:

- Integrity
- Intention
- Capability
- Outcomes Oriented
- Active Listener

The infographic features a stylized orange lightbulb with a propeller and a jet engine, flying against a teal background with a large yellow moon and stars. The text is presented in white and teal colors.

and compliance issues among medical staff, facilitate realignment of the hospital's vision, and further the MEC's role as a champion of change. He found the work so engaging that he remained on the MEC through the years, serving as secretary/treasurer, vice president.

Raj Patel, MD, spine surgeon and member of the MEC, says that working with Reesman gave him a greater appreciation for the

operations overall. Radiologists and the hospital share common goals and incentives and are closely aligned, so their involvement is an appropriate fit."

As Reesman's reputation as a change agent spread, individual physicians often approached him for advice and with ideas. Based on these conversations, Reesman developed robust action plans to shepherd the implementation and expansion of new

the lead interpreter and later the imaging director of a freestanding OB/GYN imaging center after a local physician proposed that Reesman's radiology group provide mammography and vascular ultrasound services at their imaging center. "I have been able to build genuine relationships with unlikely colleagues," Reesman says. "I probably wouldn't have had this opportunity if I hadn't taken the initiative to get involved in the RLI and build skills beyond image interpretation."

Reesman also got involved in the Raleigh County Medical Society, serving on its board from 2015 through 2018. During that time, he spearheaded the development of the society's interactive website, allowing remote access to continuing medical education opportunities. "This all happened as a result of getting out of the reading room and taking action. The RLI taught me that while the focus of management is orderly results, leadership functions to produce change," Reesman says.

The RLI has served as a bridge for Reesman, from one stage of his career to the next, and is doing so for other radiologists. The importance of leadership skills can't be overstated, says Reesman. "I went from feeling overwhelmed when I first joined the hospital's peer review committee to a ranking member of the MEC to a trusted leader who is involved in multiple levels of hospital operations. The RLI equipped me with the knowledge and skills to perform at this new level."

By Kerri Reeves

Next Steps

- Participate in the ACR RLI leadership programs and attend in-person and online courses to learn more about the business side of medicine.
- Join hospital committees, and build credibility by regularly attending meetings and listening to the viewpoints of key stakeholders.
- Track and share results data to illustrate the impact of change initiatives and further engage team members.

"The radiologist's voice is one of the most objective voices in the hospital. The level of objective reasoning they have while interpreting images is a valuable asset."

—Raj Patel, MD

unique position that radiologists hold within the healthcare system and the ability they have to impact change across the hospital for the good of patients. "The radiologist's voice is one of the most objective voices in the hospital," Patel says. "The level of objective reasoning they have while interpreting images is a valuable asset to bring to the table for other types of decision-making."

Achieving Results

Patel wasn't the only one impressed with Reesman's work with the peer review committee and MEC. David Darden, MHA, FACHE, former chief executive officer of Raleigh General Hospital, also took notice and invited Reesman to join the physician engagement group, which includes representatives from various hospital divisions who focus on improving both patient and physician satisfaction scores.

"I'm a strong supporter of hospital-based physicians — radiologists in particular — being involved in leadership," Darden says. "Radiologists see almost every patient who comes into the hospital for care, so they can provide guidance to hospital administrators and medical staff about patient care and

and existing service lines, including MRI iron quantification testing, MRI-guided breast biopsies, coronary CTA interpretations, and contrast-based liver tumor evaluation. These leadership contributions helped generate positive outcomes for the hospital, especially in the form of increased patient referrals from cardiology and hematology, which helped bridge the gap between specialties.

As the hospital's patient referrals rose, staff members came to see how their contributions were impacting patient care. The results drove an increase in employee engagement, and during the 2016-2017 year, the hospital boasted its highest-ever physician satisfaction scores, with radiology topping the list as the most satisfied department. "Short-term gains really fire people up. And if you show these gains along the way, people not only stay involved, but they also go the extra mile because they have a better understanding of the meaning behind their work," Reesman says.

Expanding Contributions

Reesman's efforts inside of the hospital led to new opportunities within the community, too. For instance, he became

Dedicated to Pediatric Care

An interventional radiologist leads the creation of a pediatric interventional radiology department at Peyton Manning Children's Hospital.

KEY TAKEAWAYS

- Leveraging skills learned at the Radiology Leadership Institute, an interventional radiologist created a pediatric interventional radiology (IR) department at Peyton Manning Children's Hospital.
- Building a pediatric IR department that met the needs of patients and referring physicians required buy-in and support from the diagnostic radiology group and hospital.
- In its first three months, the department took on more than 80% of the hospital's pediatric IR patients.

Young patients have access to more than 40 pediatric services and subspecialties at Peyton Manning Children's Hospital (PMCH), part of St. Vincent Hospital and Health System in Indianapolis. But before 2016, when children required interventional radiology (IR) procedures as basic as feeding tube replacements, a dedicated pediatric IR department wasn't available to treat them.

Sometimes, these children went to St. Vincent's adult vascular lab — which the hospital system shares with Northwest Radiology Network (NWR), the private practice that provides the system's diagnostic radiology services. Unfortunately, though, the lab wasn't equipped with the dedicated time or resources for specialized pediatric care.

"Without a dedicated workflow for all the kids we saw, the adult lab just worked kids in as it could," says Marc P. Underhill, MD, an interventional radiologist at NWR. "Pediatric IR is different than dealing with adults: You're not just treating the patient, you're also treating the parents. Reviewing treatment plans with both the patients and parents requires more time and flexibility than the adult lab can consistently provide."

As the children's hospital grew and the volume of pediatric IR cases increased, this bottleneck became more evident. "We were seeing more frequent and complex pediatric patients than the adult IR providers were comfortable treating," says Richard K. Freeman, MD, MBA, system chief medical officer at St. Vincent. "As a result, some pediatric IR patients were being delayed or transferred out of our facility."

For Underhill, who was studying business and leadership through the ACR's Radiology Leadership Institute® (RLI) at the time, the solution was obvious: Create a dedicated pediatric IR department to improve the patient experience and keep kids from having to seek care elsewhere.



Marc P. Underhill, MD, interventional radiologist with Northwest Radiology Network, led the creation of a dedicated pediatric IR department at Peyton Manning Children's Hospital at St. Vincent.

Presenting to the Board

In December of 2015, Underhill presented his vision to his group's board of directors — which initially responded with "nice smiles and a bit of skepticism," he says. They understood the hospital's need for this service and recognized Underhill's passion for pediatric care but had plenty of questions about the time, cost, and resources required.

"One concern that always arises in any private practice model like our group is, what are the costs associated with providing this service?" says Matthew M. Jones, MD, a pediatric radiologist at NWR. "Other concerns include: How much dedicated time is this going to take? Is there a set of procedures and patients to start caring for immediately, or will it take a while to ramp up? And how will the group budget its time and payroll to make it worthwhile?" Collaboration was the answer to many of these questions.

W. Kent Hansen, MD, PhD, president and chief executive officer of NWR, says, “We couldn’t promise Marc the dedicated time to do only pediatric interventional services. He had to be willing to sacrifice his time to grow the pediatric department while continuing to provide adult care — and the group had to make sacrifices, too, to help him out. It was critical for him to build relationships and buy-in from the rest of the group and from the hospital because he needed their support.”

Rallying Support

In the weeks following his meeting with the board, Underhill focused on building buy-in and support throughout his practice and the hospital.

Underhill had been casually bouncing the idea of a dedicated pediatric IR department off other clinicians for years. Now, he began asking more pointed questions to understand how often pediatric physicians would use dedicated IR services and to assess how he would manage their patients.

“While the initial goal of these conversations was to gain support, they actually informed how we structured the service line,” Underhill says. “They helped us develop a business plan for standardized care and determine how we would schedule patients, how we would process imaging orders, and who should perform and manage which IR services.”



Richard K. Freeman, MD, MBA, system chief medical officer at St. Vincent Health and Hospital System, immediately saw the value in establishing the pediatric IR department.

Underhill credits the RLI, a professional training program specifically designed for radiologists, with teaching him the business savvy necessary to turn these conversations into a business plan.

“Five years ago, I had no idea how to write up a business plan or how to present that plan to different groups to get buy-in,” says Underhill, who wrote his RLI practicum report about launching this pediatric IR service. “The RLI provided me with the skills I needed to turn my vision into reality.”

After receiving strong approval from hospital providers, Underhill secured a meeting with St. Vincent’s chief medical officer. He presented a list of physician-requested IR services that the new department could offer and laid out a proposal for delivering, expanding, and improving those services to increase referrals over time.

“Dr. Underhill had carefully thought through the problem and the potential solution and had gathered support within his group and among his peers,” says Freeman, who immediately saw the value in filling this care gap. “People often bring problems to me, but rarely do they present such a well-thought-out solution.”

With the support of his practice and St. Vincent Hospital, Underhill opened a dedicated pediatric IR department in shared space within PMCH’s radiology department in January of 2016.

Building the Department

To achieve his objective of improving the pediatric patient experience, Underhill built the dedicated expertise and processes to treat children more effectively than the adult vascular lab.

His initial goal was to acquire at least 80% of the hospital’s pediatric IR cases in the first year. He thought this was a realistic number since referring physicians would have to get used to sending him their pediatric patients.

“Referring physicians had always ordered these procedures in the adult vascular lab, so I knew there’d be a tendency to keep sending patients there,” Underhill says. “But I was surprised by how quickly referring providers adjusted to the change.”



W. Kent Hansen, MD, PhD, president and chief executive officer of Northwest Radiology Network and chairman of diagnostic medicine for St. Vincent Hospital and Health System, says the pediatric IR department’s success depended on collaboration.

Leveraging the relationships and open communication lines he’d already established with referring physicians and other radiologists, Underhill exceeded his first-year goal within three months.

During this time, Underhill attended pediatric rounds, quarterly meetings, and morbidity and mortality conferences, where he continued promoting the pediatric IR department and asking referring physicians how the department could help them. He also gave referring physicians his cell phone number, making himself available for any IR questions or requests.

“The referring physicians really appreciate having Marc as a point-of-care contact,” says Hansen, who’s also chairman of diagnostic medicine for St. Vincent. “They appreciate his accessibility and availability. They have expressed that the department is a great benefit to the hospital, referring physicians, and patients.”

Improving the Patient Experience

Underhill attributes the successful launch of this pediatric service line in part to his accessibility. He meets referring physicians and their patients where they are — whether on another floor or even in another St. Vincent hospital.

"I have made myself as portable as possible and tried to perform cases either in the patient's room, when appropriate, or at least in their hospital," Underhill wrote in his RLI practicum report. "This has included performing cases in tandem with other physicians in the operating room, so a child could be put under anesthesia once and have a series of procedures done."

Because many of the procedures Underhill performs are ultrasound guided, he can often treat patients at their bedsides. This not only improves the patient experience, but it also reduced the administrative burden of establishing the department because Underhill didn't require dedicated space to get started.

"Pediatric surgeons would call me and say, 'Do you have five minutes to visit this patient?' So I'd run up to their clinic and see the patient," Underhill says. "That saves the patient time, streamlining things for a more collegial, team-based approach. It's a more positive experience for the patients, their parents, and the referring physicians."

In his report, Underhill wrote that the ACR Imaging 3.0 initiative inspired his efforts:

"A strong lesson learned, especially in the hospital setting, comes directly from ACR Imaging 3.0. That is: Get out of the reading room. Performing a procedure at the bedside when it is safe to do so not only helps nursing out, but also gives you invaluable face time on the floor," Underhill wrote. "Let the physicians see you are a physician like them. Round on your patients, take an interest in who they are and what they want. Working with your patients will always result in better outcomes, and being seen on the floors and in clinics as part of the treatment team buys collegiality and support if times ever get tough."

This method has established Underhill as a vital part of the care team. "Our pediatric providers overwhelmingly support this approach," Freeman says. "We have seen a higher quality of care and the elimination of patients being delayed or transferred for procedures as a result."

Planning for Expansion

Two years into its existence, the pediatric IR department now sees as many as seven patients a day. The most common procedures include feeding tube changes, biopsies,

abscess drains, and an increasing number of sclerotherapy cases. (Read more about the department's sclerotherapy services in this Imaging 3.0 vignette, "In the Same Vein," at acr.org/Imaging3-Same-Vein)

While most ultrasound-guided procedures are done at the patient's bedside, Underhill also has access to a couple of clinic rooms in the radiology department and even a couple of operating rooms.

Additionally, Underhill is building a larger inventory of kid-sized supplies, including smaller feeding tubes, catheters, and IV access devices. The department also has its own CT fluoroscopy scanner and access to ultrasound equipment. "Marc brought in the latest pediatric IR equipment to make procedures easier, faster, and more effective for these patients," Jones says.

"A strong lesson learned, especially in the hospital setting, comes directly from ACR Imaging 3.0. That is: Get out of the reading room."

—Marc P. Underhill, MD

Underhill continues to meet with hospital executives to plan the department's growth. The next step, he says, is to formalize a process for ordering supplies and to create a dedicated pediatric IR suite for more complex procedures. Eventually, the department may hire additional providers to support him.

"Having another dedicated person here in the near future would be wonderful, but we don't have enough pediatric business yet for a full-time employee," says Underhill, who splits his time 50/50 between pediatric IR and adult biopsies. "The goal is to slowly grow to the point we need to hire someone else to do biopsies, so I can focus exclusively on pediatrics."

Sharing Insights

The most valuable lesson Underhill learned in establishing the department was that, to succeed, he had to train other radiologists to



Matthew M. Jones, MD, pediatric radiologist at Northwest Radiology Network, says the dedicated IR department significantly improves pediatric care.

cover some of his procedures, such as feeding tube maintenance, allowing him to focus on growing the department without burning out.

"Make sure other people can do your job," says Underhill, who now serves on the board of NWR and as president elect of the Indiana Radiological Society. "You really need help from other groups to cover you so that you can grow."

Hansen agrees: "Being a department of one is difficult; you have to understand that it requires a team approach — from both the hospital and the radiology group. It's critical to achieving and maintaining continuity of care."

By Brooke Bilyj

Next Steps

- Craft a comprehensive business plan, including details about the amount of time and resources required to launch and grow the service line.
- Develop and maintain relationships with other radiologists and with referring physicians to identify gaps in service and build buy-in when adding new services.
- Become a vital part of the treatment team by being visible on the floor and readily available and accessible to physicians and patients.

Shaping Your Story

A radiologist in Massachusetts strives to rebrand radiology and winds up simultaneously building her own personal brand.

KEY TAKEAWAYS

- A radiologist at the University of Massachusetts Medical School set out to change misperceptions of the specialty among medical students and clinical colleagues.
- By collaborating on a committee to create a curriculum focused on communicating with patients, she began rebranding radiology and also established a personal brand for patient communications.
- To expand her local brand as a radiology changemaker, she shares her passion for patient-centered care and diversity in radiology at the national level.

When Carolynn M. DeBenedectis, MD, associate professor of radiology and vice chair for education, set out to remake the perception of the radiology department at the University of Massachusetts Medical School (UMMS), she didn't realize she was simultaneously shaping her own story. "My personal brand came about because I wanted to rebrand the way people viewed radiology," she says. "I didn't see it as building my own 'brand.' Instead, I found something I was passionate about changing in radiology and set about doing that. Before I knew it, my enthusiasm for patient-centered care became my own brand."

For DeBenedectis, the initial goal was to reinvent how medical students and colleagues saw radiologists. "I wanted people to see that radiologists care for patients; we don't just sit in a dark reading room all day. That's where my personal brand in patient-focused care originally started. It came out of my love for radiology, my love of patients, and my love for wanting to further the field and make it a better place," she says. "Rebranding radiology in your organization opens doors for you to establish your own brand in a strong, unique way." (Learn more about how DeBenedectis and her colleagues at UMMS strengthened their department's brand in "Rebranding Radiology" at [acr.org/Imaging3-RebrandingRadiology](https://www.acr.org/Imaging3-RebrandingRadiology).)

What DeBenedectis serendipitously happened upon — personal branding — is what many business experts have been advocating for decades. As Tom Peters wrote in "The Brand Called You" in 1997, "You, everything you do — and everything you choose not to do — communicates the value and character of [your] brand." It's this concept that J. Mark Carr, MBA, president of Carr Consulting Group and adjunct lecturer at Babson College in Wellesley, Massachusetts, lectures on for the Radiology Leadership Institute® (RLI). At a recent RLI Leadership Summit, he said, "Personal branding is about taking control of one's own image — just like a product or company would to achieve some professional or personal goal."



Carolynn M. DeBenedectis, MD, associate professor of radiology and vice chair for education at the University of Massachusetts Medical School, says that building her personal brand started with a focus on a passion project — patient-focused communications — and being intentional about taking steps to advance change in her organization.

As DeBenedectis realized that she was developing a personal brand, she took more deliberate steps to become nationally recognized for her commitment to patient-centered care and, more recently, for extending her personal brand into diversity, equity, and inclusion in radiology. "Although my path could be considered to be 'accidental branding,' there's no doubt that my efforts to rebrand radiology have made a tremendous impact on my career trajectory. In addition to gaining national recognition, I was also recently named vice chair for education, the first female vice chair in the radiology department."

Starting Locally

To realize the benefits of a personal brand, it's helpful to know what constitutes as personal branding. As Amazon founder Jeff Bezos once said, "Your brand is what other people say



about you when you're not in the room." And as Carr explains in his RLI Leadership Summit presentation: Personal branding is how others perceive you — a view derived from the actions you take to have "a significant and differentiated presence" in your profession.

Anyone interested in developing a personal brand should start with an honest assessment of who they are and what they want to be known for, Carr says. They must ask themselves: What are my values? What makes me unique? What are my skills and competencies? Can my colleagues clearly articulate what I do and what I'm passionate about?

For DeBenedectis, those answers came easily. "I wanted our med students and hospital faculty to truly understand the value that radiologists bring to patient care and the critical role we play in communicating directly with patients and families," she says. "We're not just sitting on the sidelines reading scans; in many cases, we're at our patients' bedsides guiding them and their referring physicians to get the best care possible. I wanted to change the misconceptions that our med students and other care providers had about radiology."

To advance her passion, DeBenedectis began taking intentional steps to ensure her colleagues recognized radiology's contribution to patient care. She started showing up to medical student events — such as those focused on how to choose a specialty and how to apply to residency — to share her love for radiology and patient-centered care with students. UMMS radiology department chair, Max P. Rosen, MD, MPH, FACR, took notice of DeBenedectis' dedication to direct patient care and asked her to represent radiology on a UMMS committee that was developing a curriculum for communicating with patients. From there, her personal brand was born, and she has been building and evolving it ever since.

To start building a personal brand, DeBenedectis recommends a focused, step-by-step approach. "Start with one group, one goal," she says. "I was initially just trying to convince the committee that radiologists were key in communicating with patients. That's how personal branding begins. Be intentional about one idea and

move it forward every day. Try to help people understand the unique value you bring to a particular issue. Be focused: one passion, one group, then go from there."

Building National Recognition

While DeBenedectis' leadership in patient communication skills started locally at her own institution, it wasn't long before her brand started gaining national recognition. "Personal branding goes beyond creating a name for yourself in your own organization; it's also about finding ways to get yourself out there so that people know you as an expert in the

being invited to join a national committee. "A few years ago, the ACR asked me to join the Commission on Patient- and Family-Centered Care (acr.org/PFCCCommission)," she notes. "A key goal of our work has been to transform the UMMS communications curriculum into a national standard for training radiology residents in patient- and family-centered care."

DeBenedectis followed the same model to build a national reputation in another area as well: diversity, equity, and inclusion (DEI). As she focused on rebranding radiology in the medical school, she discovered a passion for getting more women to join the specialty. "One

"We're not just sitting on the sidelines reading scans; in many cases, we're at our patients' bedsides guiding them and their referring physicians to get the best care possible. I wanted to change the misconceptions that our med students and other care providers had about radiology."

—Carolynn M. DeBenedectis, MD

field," she explains. "Once you achieve success locally, publish a paper about it. Let everyone see it. For my patient- and family-centered care initiative, I published a paper in the *Journal of the American College of Radiology* about our communication skills curriculum. When people read the paper and think of that topic, I believe they will think of my name."

After publishing about patient communications, DeBenedectis was invited to co-author additional articles with people involved in similar initiatives and research. "That builds your brand further because you're considered an expert by other people," she adds. "From there, I started getting invited to speak about patient-centered care at national conferences like those hosted by the Radiological Society of North America and the Association of University Radiologists. It catches like wildfire. If you work at it one step at a time, and it's a good idea, it will perpetuate itself."

As her reputation as a leader in patient-centered care grew, DeBenedectis discovered another path to bolster her personal brand:

medical student that showed an interest in radiology got me into DEI. After initially showing interest in radiology, she decided it wasn't for her because she didn't see any young female role models in the field. After meeting me and other female radiologists, she changed her mind and decided to join the specialty after all."

DeBenedectis adds, "I collaborated with her to develop a radiology paper about her experience — "Do Interventions Intended to Increase Female Medical Student Interest in Radiology Work?"¹ — which led her to get even more excited about radiology, and she matched into the specialty. To advance my passion for getting more women in radiology, I then wrote a paper about the experience, which turned into a national presentation, which led to doing more projects and more papers on diversity in radiology. Based on all these efforts, Dr. Rosen nominated me to join LEAD, a women's leadership program. Now, more people know me for my brand as a diversity expert than for communication skills."

“Never, in a million years would I have thought I’d be a leader in radiology. But everyone can be a leader. You’re a leader just by wanting to change something and taking action.”

—Carolynn M. DeBenedectis, MD

Once DeBenedectis started building her brand, she turned to social media to amplify it. “Social media is not the defining element of your brand,” she emphasizes. “Twitter opens me up to a whole new world of people who follow me and want to talk to me as an expert in particular subjects. But I find that all the hard work of the papers, lectures at national conferences, and the committees are the most important vehicles to build personal branding. Based on my experience, social media helps you showcase your efforts to a wider audience. First, you have to find your brand and then use social media to perpetuate your brand.”

Leading Change

DeBenedectis’ personal brand story started with her seeing opportunities for positive change — and then taking action to make them happen. She credits the RLI leadership programs with giving her the inspiration and tools to lead change locally and nationally. “Change is hard, and most people don’t want to change, so you need leadership training to know how to go about it the right way,” she states. “They don’t teach you those skills in medical school. The RLI and other leadership programs are imperative for every radiologist who wants to make

things better — not only to advance themselves but also to advance the specialty.”

DeBenedectis has leveraged what she learned through the RLI to become an ambassador for change in radiology. As such, she was invited to share her approach to personal branding at the most recent RLI Leadership Summit, where she shared her secret to success: “Your brand has to come from the heart; it can’t be something that’s a cerebral decision. For me, it came because I love talking to patients. I love to show people how important radiologists are to patient care and how we are with them through some of their most vulnerable moments. And I’m equally passionate about getting more women into radiology. My journey shows how you can make a difference by building your brand.”

All radiologists, regardless of their titles and positions within their practices, can follow a similar approach to make change in their organizations. “It is imperative to empower all radiologists to become better

LEADERSHIP ACTION PLAN

Steps radiologists should take to lead change



Communicate

- Understand the needs of those you serve
- Provide clear communication to all stakeholders
- Listen, listen, listen
- Get feedback
- Be open to everyone’s opinions
- Include diverse perspectives



Collaborate

- Identify allies and get others involved
- Find a local champion
- Design creative, results-oriented teams
- Develop relationships with administrators and other physicians



Lead change

- Create a compelling vision and communicate it to the group
- Develop a clear plan for executing change
- Get the right people involved to accelerate change
- Recognize and celebrate small wins
- Create a sense of urgency for change
- Acquire high-quality data that supports change

** This action plan is based on a survey of radiology leaders.*

“The RLI and other leadership programs are imperative for every radiologist who wants to make things better – not only to advance themselves but also to advance the specialty.”

—Carolynn M. DeBenedectis, MD

leaders,” DeBenedectis says. “I was a junior faculty member, one of the newest in my department when I started taking steps to rebrand radiology. Never, in a million years would I have thought I’d be a leader in radiology. But everyone can be a leader. You’re a leader just by wanting to change something and taking action. To improve things, you have to lead the charge. As

radiologists, we must all be at the forefront of change to make things better for our patients and for the specialty.”

By Linda G. Sowers

Next Steps

- Be intentional. Think about where your passions lie and how you want to change things for the better. Focus on one idea or group, then take actionable steps to reach your goals.
- Start locally and build a reputation as an expert in a particular area within your own organization. Then expand your brand by publishing papers, speaking at conferences, and participating in national committees to advance your passion. Use social media to amplify your brand.
- Gain leadership skills to learn how to effectively cultivate buy-in and make the changes you want to see in your group as well as the specialty.

ENDNOTES

1. Yuan ED, Makris J, DeBenedectis CM. Do Interventions Intended to Increase Female Medical Student Interest in Radiology Work? Preliminary Findings. *Curr Probl Diagn Radiol.* 2018;47(6):382-386. doi:10.1067/j.cpradiol.2017.09.003

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ACR RLI leadership
programs!**



**To learn more, visit
acr.org/rli.**



Gain business skills

- Learn what drives the business
- Understand the institution's financial goals
- Get involved with hospital operations
- Engage at the local, state, and national level in radiology
- Implement an effective and efficient governance structure
- Account for non-RVU activities



Ensure continuous improvement

- Develop new skills
- Keep growing personally and professionally
- Build on existing efforts
- Learn from prior mistakes
- Embrace failure
- Quantify performance
- Engage in continuous improvement



Be a leader

- Lead by example
- Focus on value
- Deliver patient-focused care
- Tell the truth
- Be patient
- Mentor the next leaders
- Be enthusiastic, inspirational, and visible

Behind the Curtain

Ohio radiologists collaborate with a patient advocate to implement a direct results delivery program that decreases patient anxiety and gives radiology a face.

KEY TAKEAWAYS

- Cincinnati Children's Medical Center has implemented a direct results delivery program that allows patients and families to discuss their test results directly with a radiologist.
- Providing results directly to patients helps decrease patient and parent anxiety while increasing their understanding of what radiologists do and how the department operates.
- Connecting with patients reemphasizes the importance of the individual behind the image, reinvigorating radiologists' sense of purpose and reducing burnout.

When David C. Mihal, MD, diagnostic radiology resident at the University of Cincinnati Medical Center, began working on his practicum for the ACR Radiology Leadership Institute® (RLI) he knew he wanted to use the opportunity to make a real difference for patients and families. But before Mihal could improve the patient experience, he needed a better understanding of how patients and families perceived radiology.

To that end, Mihal turned to Dianne Hater, patient and family advocate in Cincinnati Children's radiology department, to help him focus his efforts to foster meaningful and positive change in patient and radiology relations. Through her research, Hater found that patients and families were often nervous about their imaging exams and, for some, uncertainty about how to obtain their imaging results increased their anxiety. "Patients and families want answers, so having to wait for results creates a lot of stress," Hater says.

Recognizing an opportunity to significantly improve the patient experience through better communication, Mihal initiated a direct results delivery pilot project that would allow patients and families to review their exam results directly with a radiologist immediately after image acquisition. Since its inception in 2015, the project has drawn praise from patients and families, with 92% providing positive feedback on surveys, and has led to 84% of participating radiologists and technologists reporting increased job satisfaction — leading the department to adopt it as an ongoing initiative.

Patient and Family Perspective

When Mihal decided to embark on a patient experience improvement project, he wanted to ensure the change would be something patients and families wanted and needed, not just what he assumed they needed. That's why his first step was to reach out to Hater for help. "I approached Dianne because she was deeply entwined in patient and family

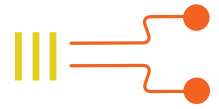


David C. Mihal, MD, diagnostic radiology resident at the University of Cincinnati Medical Center, initiated the department's direct results reporting project to give patients a chance to speak directly with radiologists.

relationships at Cincinnati Children's, and I wanted to make some sort of real difference that would directly benefit them," Mihal says.

Once on board, Hater, who became an advocate for patients and families after navigating the healthcare system during her own daughter's illness, began talking with the hospital's frontline staff, including registration personnel, patient advocates, and child-life specialists, about their interactions with patients and families who had undergone imaging. Many staff members reported that patients and families were often concerned about having to wait for imaging results, and they lamented having few tools available to help minimize patients' and families' anxieties.

Hater also interviewed radiology technologists since they have the most interaction with patients during image acquisition. From these conversations, Hater found that many patients and families were noticeably nervous during and after their imaging exams, and the technologists often felt helpless because they were unable to share results with patients and



“Oftentimes, as radiologists, we get detached from our patients. Speaking with patients is an excellent reminder that we are diagnosing real people.”

—Alexander J. Towbin, MD

families. “We just did the best we could to ease their anxieties with the limited time we had with them,” says Erin Adkins, an imaging technologist and quality improvement coach.

For even greater insight into the patient-and-family perspective, Hater reviewed patient feedback surveys from 2011 to 2015 to see what patients and families themselves had to say about their radiology experiences. That’s when she discovered that patients and families were not only anxious about their results, but some were also stressed because they were unsure how to obtain their results. “Patients and families were saying, ‘We just need answers. The waiting and not knowing is the worst,’” Hater says. “We knew there had to be a better way of communicating results.”

A Face to Radiology

To achieve that goal, Mihal and Hater conceptualized the direct results reporting project. They envisioned it as a natural extension of the department’s existing “difficult news” program, in which radiologists deliver negative results directly to patients and families. Only in this case, the news would be mostly positive. “With the direct results reporting service, the results are often good, so the radiologists are able to immediately relieve the stress that patients and families feel, allowing them to walk away breathing a sigh of relief,” Hater says.

To get the program off the ground, Mihal approached Brian D. Coley, MD, radiologist in chief and professor of radiology and pediatrics, and Bernadette L. Koch, MD, pediatric neuroradiologist and associate chief of academic affairs, about implementing it as a pilot project. Coley and Koch were both excited for the opportunity to reemphasize quality patient care and to give patients a chance to speak directly with radiologists. “This program provides patients with more positive experiences in radiology and puts

a human face to the profession, helping patients understand the important role that radiologists play in their care,” Coley says.

In addition to humanizing radiology for patients, the project also offered the chance for the department’s radiologists to connect with their patients and feel more fulfilled as a result, says Alexander J. Towbin, MD, associate chief of clinical operations and radiology informatics and pediatric radiologist at Cincinnati Children’s. “Oftentimes, as radiologists, we get detached from our patients. We are looking at pictures all day, and we see the body parts and the disease, but we don’t always see the child on the other side of the picture,” Towbin says. “Speaking with patients is an excellent reminder that we are diagnosing real people.”

A New Beginning

With support from the department’s leadership, Mihal began rolling out the project slowly and purposefully. It’s an approach he took in part to win support from his colleagues, many of whom were initially concerned that they would be unable to keep up with the volume of patients opting for the service. In fact, only seven of the department’s 40 radiologists volunteered to participate in the project at first.

To put the radiologists at ease, Koch, who served as a physician champion on the project, reached out and encouraged them to participate in the consultations, explaining that each one takes only about five minutes.

“As the program expanded and faculty saw how little time it actually took, it was much easier to get more radiologists involved,” Koch says. On top of that, Mihal and his team addressed radiologists’ workload concerns by limiting the number of patients who were eligible for the program. “I wanted to identify patients who would benefit the most from this service while simultaneously



Dianne Hater, patient and family advocate in Cincinnati Children’s radiology department, found that patients and families were often nervous about their imaging exams, and for some, uncertainty about how to obtain their imaging results increased their anxiety.

limiting the number of patients to a manageable sample set,” he says.

During the project’s first of four phases, the department’s technologists vetted patients and families, identifying those they thought were most likely to benefit from a direct consultation with a radiologist, such as patients and families who were visibly anxious or those who requested immediate results. Patients were excluded from the service if they were emergency patients, inpatients, had follow-up appointments already scheduled, were in a hurry to get to another appointment, or preferred to receive results from their referring physicians.

After deeming a patient eligible to receive direct results, the technologist would ask the patient and family whether they wanted to speak with the radiologist. If the patient and family opted for a consultation, the technologist located a radiologist from the volunteer pool, assigned the study to that radiologist, and informed the patient that the radiologist would be in soon to discuss the results.

The radiologist would then read the study and deliver the results directly to the patient in the exam or consultation room. Wait time for the patient was typically less than 10 additional minutes. After the consult, the patient would fill out a survey regarding the

“Spending time with patients minimizes physician burnout. It personalizes what radiologists do and allows them to connect more directly with patients.”

—Brian D. Coley, MD

interaction with the radiologist and drop it into a locked box before leaving the facility. This feedback was invaluable in helping Mihal and his team understand what was working with the program and informed ideas for positive change.

Adjustments and Growth

With only one patient per month opting into the program, the project’s first phase did not attract as much interest as Mihal had hoped, so he and his team expanded the inclusion criteria and primary screening method. In doing so, they began allowing administrative staff to offer the service to any patient at check-in who did not have a follow-up appointment already scheduled. This doubled the rates of patients opting for consultation from phase one but was still not quite the volume for which Mihal had hoped.

While low patient participation rates were initially discouraging, Mihal and his team didn’t let it derail them. Instead, they took it as a learning opportunity and made efforts to improve the program. “When you embark on a project like this, it’s important to measure your progress and look for areas of improvement,” Koch says. “You must be open to changing small things to see if those changes will help rather than just abandoning ship.”

For the project’s third phase, the team expanded the program to all imaging outpatients. Patients opted into the program through a self-screening survey, which also included information that suggested a wait time of an additional 10 to 30 minutes. With this approach, only 8% of patients opted into the service — still well below the hoped-for engagement.

In the fourth and final phase of the project, the team tweaked the survey, this time

excluding the reference to the additional wait time, which they found exceeded the actual average wait time for the service and likely caused patients to opt out. As a result, 33% of patients opted into the service, bringing the number to approximately one patient per day.

Program Feedback

In feedback surveys, patients and families were overwhelmingly satisfied with the service and reported feeling relieved and at ease after receiving their results from a radiologist. Comments included, “Made my day!” and “It immediately eased my mind and assured me everything was OK to return to work and school.”

As a technologist, Adkins has been grateful for the opportunity this service provides to help lessen the anxiety that patients and families often feel. “When you see patients and families enter the room who are visibly nervous, you can immediately put them at ease by offering to find a radiologist to speak with them,” she says. “A lot of what we do is so quick, and this provides some closure and more connection with the patients. It gives you satisfaction in knowing that you are part of improving the patient experience.”

In addition to increasing job satisfaction, most of the radiologists and technologists involved in the program report little increase in their workloads as a result. “If anything,” Coley says, “spending time with patients minimizes physician burnout. It personalizes what radiologists do and allows them to connect more directly with patients.”

Towbin agrees and says radiologists owe it to their patients to put in the extra effort. “I volunteered for this program because I strongly believe that families deserve to get results as soon as possible,” he says. “Some families want the results from the pediatrician, and some families want to know whether something is wrong immediately. As radiologists, our job is to meet our patients’ needs.”



Alan S. Broder, MD, consults with a young patient about a procedure.

Plans for the Future

Cincinnati Children's radiologists were so pleased with the results of the pilot project that they have now integrated it into their regular workflow as a permanent and ongoing program for outpatients undergoing radiographs. "It's been wonderful to watch this initiative grow," Towbin says. "Knowing that we are able to provide this service efficiently and help put a face on the radiology department is incredibly satisfying. It really has a positive impact on our day, and we feel like we are doing something special for patients and families. What's more, we're showing others that this can be done."

With this program as a proof of concept, Hater encourages all radiology groups to follow Cincinnati Children's lead and offer to deliver results directly to patients. As someone who's been on the receiving side of care, Hater knows how powerful such interactions can be and how much it can mean to patients and families to have the answers they need, when they need them.

"There's no doubt how much patients and families appreciate it when they can get their results and have their questions answered immediately," she says. "It saves them from so much worry and allows them to move more quickly toward treatment and healing. This kind of patient-centered care is the way of the future, and radiologists are well positioned to lead this effort."

By Chelsea Krieg

Next Steps

- Start small. Look for manageable ways to provide opportunities for radiologists to interact more directly with patients.
- Find others who are excited to implement patient-and-radiologist interaction initiatives. Work together to brainstorm innovative practices and strategies to accomplish goals.
- Don't be afraid to tweak what you are doing if something isn't working. Ask questions and look for ways to alter the project rather than abandoning it.



GET READING

What's on Your Nightstand?

25 Leadership Books that Made an Impact on Radiologists

1. *Fish!: A Proven Way to Boost Morale and Improve Results* Stephen C. Lundin, Harry Paul, and John Christensen
2. *First Among Equals: How to Manage a Group of Professionals* Patrick J. McKenna and David H. Maister
3. *Understanding A3 Thinking: A Critical Component of Toyota's PDCA Management System* Durward K. Sobek II and Art Smalley
4. *Infinite Game* Simon Sinek
5. *Start With Why: How Great Leaders Inspire Everyone to Take Action* Simon Sinek
6. *The Tyranny of Metrics* Jerry Z. Muller
7. *New Power* Henry Timms and Jeremy Heimans
8. *The Art of Gathering: How We Meet and Why It Matters* Priya Parker
9. *Good to Great: Why Some Companies Make the Leap and Others Don't* Jim Collins
10. *High Output Management* Andrew S. Grove
11. *The 21 Irrefutable Laws of Leadership* John C. Maxwell
12. *Team of Rivals: The Political Genius of Abraham Lincoln* Doris Kearns Goodwin
13. *Range: Why Generalists Triumph in a Specialized World* David Epstein
14. *Getting to Yes: Negotiating Agreement Without Giving In* Roger Fisher and William Ury
15. *First 90 Days: Proven Strategies for Getting Up to Speed Faster and Smarter* Michael Watkins
16. *Crucial Conversations: Tools for Talking When Stakes Are High* Kerry Patterson, Joseph Grenny, Ron McMillan, and Al Switzler
17. *Lincoln* David Herbert Donald
18. *Be in Charge: A Leadership Manual: How To Stay on Top* Alexander R. Margulis
19. *How to Win Friends and Influence People* Dale Carnegie
20. *The Seven Habits of Highly Effective People: Powerful Lessons in Personal Change* Stephen R. Covey
21. *Your Brain at Work: Strategies for Overcoming Distraction, Regaining Focus, and Working Smarter All Day Long* David Rock
22. *The Power of Vulnerability: Teachings on Authenticity, Connection, and Courage* Brené Brown
23. *The Art of Strategy: A Game Theorist's Guide to Success in Business and Life* Barry J. Nalebuff and Avinash K. Dixit
24. *Pre-Suasion: A Revolutionary Way to Influence and Persuade* Robert Cialdini
25. *The Practice of Adaptive Leadership: Tools and Tactics for Changing Your Organization and the World* Ronald A. Heifetz, Marty Linsky, and Alexander Grashow



To make it easy for you to find these 25 favorite titles, we've created an RLI Leadership Reading List on Amazon: bit.ly/RLIgoodreads

What leadership books have made the biggest impact on you? Join the discussion and add your own leadership favorites.

Changing for the Better

Radiology leaders use change management strategies from the ACR Radiology Leadership Institute to adopt previously resisted technology.

KEY TAKEAWAYS

- A newly elected president of a struggling radiology practice in Little Rock, Arkansas, recognized that major changes were needed to get the practice back on solid footing.
- After determining that he needed to learn critical business skills to guide his practice through organizational and technological changes, he discovered the radiology-specific leadership courses taught by the ACR Radiology Leadership Institute (RLI).
- Change management skills learned from the RLI helped the new president lead a transition to voice recognition technology and structured reporting, despite resistance from many radiologists in the group.

In the value-based era, radiologists must step out of the reading room and take on new roles to enhance patient care. To succeed in this new paradigm, radiologists need more than interpretive expertise. They also need negotiation, hospital administration, and financial know-how. However, most medical schools don't teach these noninterpretive skills. Without leadership training, radiologists can find themselves in dire straits — with a faltering practice, transitioning leadership, and no one to spearhead change.

In 2009, this was the situation in which Radiology Consultants of Little Rock (RCLR) found itself. After one of its two outpatient imaging centers shuttered due to a lack of profit, the group was in debt and its leaders were struggling. Several radiologists left the group while others blamed one another for the group's problems. "No one wanted to be president," recalls Scott B. Harter, MD, FACR. "We spent a couple of months trying to figure out who was going to take charge of the difficult situation." Several of Harter's colleagues approached him and asked him to take the lead. After consulting his wife and close friends, Harter agreed to run for the position and was elected.

Harter spent the beginning of his presidency stabilizing the group. He helped integrate a new practice manager and spent time re-establishing relationships with administrators at Baptist Health, the hospital RCLR serves. He also developed relationships with the radiology group's various departments, including accounting and billing. Things were improving for RCLR, but Harter worried he still didn't have a strong enough business or administration background to succeed in the position.

In 2012, Harter received an invitation to the ACR Radiology Leadership Institute® (RLI) Leadership Summit and discovered an opportunity to learn the financial, communication, collaboration, and other leadership skills he needed to strengthen his practice

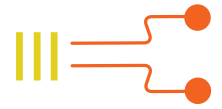


Scott B. Harter, MD, FACR, used change management techniques gained at the Radiology Leadership Institute to guide his practice towards embracing new technology.

and his team. He also realized that the event would provide an opportunity for him to learn from and network with the specialty's top thought leaders and business experts.

"The RLI offers leadership programming tailored specifically to radiology," Harter says. "I immediately recognized that I could benefit from many of the topics presented at the summit, including negotiation and business skills taught mostly by business school professors. It offered me a new perspective that I could leverage as my practice's president — especially since I am someone who believes all radiologists, regardless of title, should be involved in moving the practice forward."

With the business challenges ahead of him as president, Harter asked his group to sponsor him to attend the RLI Leadership Summit in 2012. He considers it one of the most important steps he has taken to advance his career and his practice's transformation from instability to steady ground.



Negotiating for Change

One of the concepts Harter learned at the RLI Summit and valued most was change management, a transformational process that follows key stages to build change over time. It was one of several skills Harter says he has learned through the RLI that helped him make specific improvements within his practice. One of those changes was to implement voice recognition technology with structured reporting into a practice that was a late adopter of that technology.

Starting in 2013, hospital administrators at Baptist Health had approached RCLR about incorporating voice recognition technology into their practice. Although the radiology group knew about the technology, they resisted adopting it, believing it would decrease their efficiency and reduce productivity. Radiologists in the practice wanted to hold onto the status quo — using transcriptionists, with radiologists editing the reports.

“The radiologists had a lot of concerns,” recalls Gerald C. Raymond, information systems manager at Baptist Health. At the time, Raymond was the PACS administrator and spearheaded the hospital’s transition to voice recognition technology. “Some radiologists had used voice recognition technology before and believed it didn’t work well.” Harter says, “Initially we thought that adopting the voice recognition technology would decrease our productivity by forcing us to become transcription editors, and we were resistant to the proposed change.”

Harter knew implementing voice recognition technology would also be an opportunity to initiate structured reporting for the group. Having a standardized reporting process would add value because other departments would consistently know where to look for sought-after information in radiology reports, and physicians could immediately receive clear, significant findings.

At the time, the radiology practice’s process of transcriptionists typing and editing the report before a written copy was sent to referrers left other departments uneasy. “Any time there was a significant finding, the radiologist would give us a verbal report,” explains Wendell Pahls, MD, medical director of emergency services at Baptist Health. “By

the time we received the written report, we were concerned we wouldn’t know whether something changed between the initial and final reports that could have an impact on patient care.” Despite the expected benefits of structured reporting, many radiologists were against that transition, too. “Initially, several people believed their own report structures were better than standard templates,” Harter recalls.

Most departments within the hospital were implementing voice recognition technology, making radiology an outlier. Hospital administrators became somewhat

“Convincing the group to change was smoother and easier because we followed the change management steps, got the right people together, and paid strict attention to the details.”

—Scott B. Harter, MD, FACR

frustrated with the radiologists because they recognized that voice recognition technology would save money and benefit the entire hospital system. Harter worried that RCLR’s resistance made them seem unsupportive of the organization as a whole.

In 2014, the hospital began putting more pressure on providers to align with other physicians and adopt voice recognition technology. Resisting change also made radiology’s image more problematic, says Harter. “Any time information is communicated verbally instead of written down, there is a concern. And by resisting change, they weren’t addressing that,” says Pahls.

Harter says it quickly became apparent that the group either had to take ownership of implementing the technology or be forced to do it. “I knew that this change was inevitable and that I had to convince my colleagues that it was the right thing to do.”



Wendell Pahls, MD, medical director of emergency services at Baptist Health, was a great supporter of the radiology department’s change to voice recognition technology and to standardized reporting.

Applying Lessons Learned

Harter saw an opportunity to put some of the change management skills he had gained at the RLI Summit into action. He determined he would use the lessons learned to overcome resistance, get consistency of buy-in from his group, and plan and execute the transition.

Some of the change management principles that the faculty taught at the RLI Summit were first published in a *Harvard Business Review* article by John Kotter, PhD, business and management thought leader, business entrepreneur, and Harvard professor. In “Leading Change: Why Transformation Efforts Fail,” Kotter lays out a structured design approach to making change and overcoming resistance by those who are holding on tightly to the status quo.

According to Kotter, the steps to successfully leading change are:

- Establish a sense of urgency
- Form a powerful guiding coalition
- Create a vision
- Communicate the vision
- Empower others to act on the vision
- Plan for and create short-term wins

- Consolidate improvements and produce more change
- Institutionalize new approaches

Harter acknowledged that “change is hard, and you often see it fail more than it succeeds.” He was determined to succeed and decided to follow Kotter’s approach to implement the voice recognition system in his practice. “Convincing the group to change was smoother and easier because we followed the change management steps, got the right people together, and paid strict attention to the details,” he says.

Applying Change Management Skills

Following Kotter’s principles of change, Harter initially worked to understand the issue better. He connected with radiologists across the country whose practices had already implemented the voice recognition technology software and solicited opinions about the transition process and using the technology. “I heard lots of people saying it was not as difficult as they imagined to make the transition. Those who were most successful advised committing considerable administrative time toward group communication and to the development of voice recognition templates.”

Harter also talked to several people in his own practice who had used voice recognition — including board members and younger radiologists who had used the technology in

residency. And he recruited people to collaborate with him on the transition group.

From that point, Harter says, establishing urgency was easy. “I went to my board and told them we would continually get pressured to do this and that it was in our best interest to be proactive about it. That way we’d have the most influence in installing the system that worked best for us,” he notes. “Otherwise, we’d be coerced to use a system we were unfamiliar with and might not like.”

With board members receptive to the idea, Harter took steps to further educate his guiding coalition about voice recognition technology. He arranged for board leaders to attend professional conferences and site visits to learn about various voice recognition systems, and the group identified vendors they thought would best fit the radiologists’ needs. “We spent time understanding what different vendors were offering,” Harter explains. “We weighed the pros and cons, and we spoke with practices who had implemented different systems. After narrowing the field, in cooperation with hospital administration, we had a couple of different vendors do onsite demonstrations.”

This education also helped Harter and the board determine their vision for the change process, the third step in successful change management. “With hospital administration, we collectively decided which vendor to use. We understood that implementing voice recognition and structured reports would take

a full year from start to finish, and we knew what physician training for it might look like,” explains Harter. “Our goal was to make the change as clear as possible so that radiologists wouldn’t be deterred by unknowns.”

Convincing the Practice

Next, Harter and the board communicated their vision. In a corporate meeting in January 2015, they explained their decision to the rest of the practice, as well as the timeline. “One of the reasons everyone was so skeptical — and remained skeptical — was that they were afraid of the unknown. So, it was my goal to help explain the technology and process as much as possible,” explains Harter.

For the next year, the voice recognition project was placed on each agenda for every board meeting and corporate meeting to keep the project at the forefront of group members’ minds. “We talked about where we were on the timeline and what progress we’d made. That way, everyone knew the change was coming, and there would be no surprises,” he says.

From there, Harter engaged several colleagues who were familiar with voice recognition software and understood its potential advantages to help lead the change. Harter named a point person, a radiologist who was tech-savvy and could talk about the benefits of voice recognition software. He also got section leaders within the radiology practice involved.

This powerful coalition built structured report templates, which each section leader vetted through their own areas. Harter also arranged training for a transcriptionist on the voice recognition software so that she could provide support and answer additional questions. “Prior to that, she was in danger of losing her job, but we found a way to empower her to find a new role in the practice,” explains Harter. “Our internal IT company associates were also trained in the technology.”

Harter and his coalition also spent time talking to members of the practice who weren’t on board with the project. Knowing it would be more effective coming from multiple sources, Harter asked several members of the practice who understood the technology and were positive about it to allay fears

John Kotter's actions for successfully leading change

ESTABLISH a sense of urgency

FORM a powerful guiding coalition

CREATE a vision

COMMUNICATE the vision

EMPOWER others to act on the vision

PLAN for and create short-term wins

CONSOLIDATE improvements and produce more change

INSTITUTIONALIZE new approaches

in the group and convince them the new technology wouldn't hurt their practice.

Knowing that this change process would take time out of everyone's schedules, Harter gave his team administrative time for these activities. "They were excited about it," Harter notes. "It was a fine opportunity for established leaders to increase their stature and for young leaders to emerge." The approach worked, convincing many skeptical members of the practice that adopting voice recognition technology was the way to go.

Structured reporting implementation took a little more effort. "I had to assert the influence and power of the board — we told resisters it was a mandate, not a choice. In some cases, we really had to give them some tough love if they refused to use the report template. And they would have to explain to me why they believed their report structure was better than the one the team developed," says Harter. "Eventually, all of our members adopted the templates."

Achieving Victory

Due to the collective efforts of the board and the section leaders, more and more of the group signed on to embracing the technology and report templates. Three months before the technology went live in the hospital's radiology department, they installed the voice recognition software in RCLR's remaining outpatient office to get all of the radiologists familiar with using the software. "We made sure every single doctor rotated through the office so that they could experience the technology and could call on IT support if they were stuck," Harter says. "They ended up feeling more comfortable with the technology, and this way, there wouldn't be any surprises to them during the hospital's rollout."

The result of all the communication and the practice was an overwhelming success. RCLR stuck to its timeline and switched completely over to voice recognition software with no transcriptionist backup in one day on Feb. 2, 2016 — moving completely over to the new technology and structured reporting. "Radiology did amazing work. By eliminating the need for transcription services so quickly, they ensured patients would get faster, more standardized results.

Having a quick turnaround, accurate results, and standard formatting are valuable things the radiologists can provide to speed patient recovery, and Dr. Harter helped introduce that here," says Raymond.

Despite their initial resistance, the radiologists were pleased with relatively how little impact the change had. "Over time, productivity actually improved, and we weren't having to spend time after hours signing and editing reports," says Harter. Feedback from the other departments was also very positive. "The perception that we were getting a more thorough read of the report was extremely comforting," adds Pahls.

"Taking on a leadership role was one of the best decisions I ever made, but I couldn't have been as successful without the skills I learned through the RLI."

—Scott B. Harter, MD, FACR

Says Harter: "The hospital was excited that we had been able to accomplish the task and get on board. We were seen as being part of the team, supportive of the hospital, and administration strongly supported us. We received lots of positive feedback."

Looking to the Future

The lessons Harter learned from the RLI don't end with change management. Harter continued to apply leadership skills to ongoing challenges and changes within the practice. For example, Harter leveraged the success of the voice recognition process to continue making changes within the practice, including adding clinical decision support technology in 2017.

Although Harter stepped down from his presidency in January of 2020 to prepare for a move to the local teaching hospital, he continues to advocate for radiologists

learning how to lead. "Taking on a leadership role was one of the best decisions I ever made, but I couldn't have been as successful without the skills I learned through the RLI," Harter says. "The fundamentals I learned through the RLI carried me through my tenure as president and allowed me to lead our practice back to stability. The overall experience was a platform from which I was able to become a more effective leader."

Now Harter is focused on mentoring the next generation, using what he learned through the RLI to inspire his colleagues and empower them to take on leadership positions of their own. In recognition of the value that the RLI provides, RCLR now sponsors a radiologist to attend the RLI Summit each year to build leadership skills in the practice. "The RLI has been a valuable investment in developing new leaders in the practice," Harter says. "The opportunity for new leaders to emerge is embodied by the ascendance of the new group president Dr. Greg Baden."

Harter believes all radiologists should make leadership a priority. "I think it's important for everyone to learn these skills," Harter says. "Radiologists must do more to demonstrate that they're willing to step out of the reading room to lead change and enhance the care we give our patients. Acquiring communication, negotiation, collaboration, and other leadership skills will position radiologists for success well into the future."

By Meghan Edwards

Next Steps

- Identify an issue you'd like to change and contact others who have successfully undergone the same transition to become familiar with processes, potential pitfalls, and opportunities.
- Identify and empower a coalition with diverse viewpoints that will help you understand and master the challenge. Doing so gains greater buy-in and allows other individuals to learn leadership skills.
- Recognize that the leadership skills and business knowledge gained from the RLI can help radiologists at all levels lead change.



CRITICAL
SKILL SETS

What are the most important professional development skills radiologists need to succeed?



Jonathan Breslau, MD, FACR
Chief of Sutter Imaging

LISTEN “Trading 90 Years of Independence for Employment” Episode 3

-)) Listening skills
-)) Humility
-)) Resilience



Catherine J. Everett, MD, MBA, FACR
President and managing partner of Coastal Radiology Associates

LISTEN “Leading with Authenticity” Episode 5

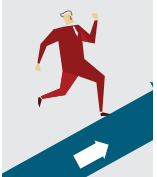
-)) Adaptability
-)) Patience
-)) Outreach
-)) Communication skills



Geraldine B. McGinty, MD, MBA, FACR
Chief strategy officer and chief contracting officer for the Weill Cornell Physician Organization

LISTEN “Leading With Mindfulness and Inclusivity” Episode 8

-)) Curiosity
-)) Avid professional networking
-)) Informed risk taking



Carolyn C. Meltzer, MD, FACR
Professor and chair of radiology and executive associate dean for faculty academic advancement, leadership, and inclusion at the Emory University School of Medicine

LISTEN “Leading to Serve” Episode 11

-)) Self-reflection
-)) Empathy
-)) Humility



Daniel J. Mollura, MD
Founder and CEO of RAD-AID International

LISTEN “Leading by Serving the Underserved” Episode 17

-)) Versatility
-)) Growth minded
-)) Flexibility



Judy Yee, MD, FACR
University chair of radiology at Montefiore and professor of radiology at Albert Einstein College of Medicine

LISTEN “Populations From Coast to Coast” Episode 2

-)) Emotional intelligence
-)) Negotiation
-)) Time management



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