Episode 27: Representative Leadership
Johnson B. Lightfoote, MD, MBA, FACR
October 22, 2020

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Dr. Rubin: 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. As we celebrate the second anniversary of the "Taking the Lead" podcast, I find myself in the midst of my own leadership transition. After 10 rewarding years at Duke University, I am headed west for an exciting opportunity to lead the Department of Medical Imaging at the University of Arizona and Banner University Medicine in Tucson. I hope to speak more about this and other leadership experiences with our community in the future, but for this month, I am delighted to once again lean on the tremendous talent of Geraldine McGinty to serve as our guest host. Geraldine is president of the American College of Radiology and chief strategy officer for Weill Cornell Medicine and will be speaking with Dr. Johnson Lightfoote, for what I am certain you will find to be a fascinating and wholly unique leadership conversation. Without further delay, I will hand the microphone to Geraldine to introduce our guest.

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Dr. McGinty: Good morning, good afternoon, everyone. My name is Geraldine McGinty and I'm the president of the American College of Radiology. I'm really thrilled to be guest hosting the RLI's leadership podcast this month, trying to fill Geoff Rubin's very big shoes. Having been the subject of this podcast in the past, it's a fascinating exploration of one's own leadership journey. And I could not be more delighted to have the opportunity to interview my guest today. Dr. Johnson Lightfoote is a fellow ACR board member. He is the chair of our Commission on Women and Diversity and has held a number of different leadership roles, both in organized medicine as well as in his practice. Johnson, welcome to the RLI leadership podcast.

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Dr. Lightfoote: Good morning, good afternoon, Geraldine. Pleasure to be here.

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Dr. McGinty: So, Johnson, we are going to take a leisurely meander through your life story and I'm hoping to learn about your particular approach to leadership and who are the leaders who have inspired you during that journey? Maybe we'll start with a general question. What are the qualities that you see as being important for a leader?

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Dr. Lightfoote: I think representation has to be one of the top priorities that all leaders give. Being responsible for a practice, or a family, or a medical society, or a nation, we are representing the needs, interests, and aspirations of our flock, for lack of a better word. So, I think the willingness to represent our constituents, if you will, is really one of the most important characteristics. Secondarily, of course, and really quite important is the ability to inspire, to find a vision, an idea, a project, a program, a goal that your flock, your society, your country, your family can get behind. I think that's really almost as equally as important as the primary task of representing the needs, wishes, and aspirations of those whom we're called to lead. So, it's really kind of a servant-leadership philosophy that I have.

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Dr. McGinty: Well, certainly having had the honor and pleasure to work with you over many years now at the college, I can say that you live those values. I'd like to take you back and understand where your own values and what shaped you as a leader. So, where were you born?

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Dr. Lightfoote: I was born in Lake City, Florida, back in the hundreds.

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Dr. McGinty: And is that where you grew up, Johnson?

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Dr. Lightfoote: I spent the first five years of my life in Lake City. My parents were both teachers, school teachers. They were graduates of Tuskegee Institute, now Tuskegee University, and they both graduated back in the 1930s. And they had just begun their teaching careers in Florida in Lake City, Florida, central Florida. My mother was actually the first African American school supervisor in the State of Florida and my father was also a school principal. And they began their family in Florida and we moved back to Tuskegee. They moved back to Tuskegee when I was about 5 or so. So, I grew up most of my life, early life in Tuskegee. And Tuskegee, as you may know, is a very educationally-oriented community. It's the home of Booker T. Washington and George Washington Carver and we were steeped in that tradition. In fact, my father actually was sitting around the house one day and didn't have anything to do and decided that he would add an E to his name.

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So, we're the only light flicks with an E, the E to stand for education. It was that central in their lives that they educate again, not only their community, but their children, their family as well. So, I spent my early childhood there through middle school in Tuskegee. And it's a community that, as I said, really centered on education and really around the university itself. Even the elementary school kids, and primary school kids, and high school kids would spend a lot of time at the university at various seminars and summer courses. So, that's really the core of my origin, I think, is that extra E that my father decided to tackle into his name and mine.

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Dr. McGinty: So, as the child of educators, where did you...do you remember when you first thought about becoming a physician?

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Dr. Lightfoote: Yes. I was initially interested in the sciences. And again, I think I got that from my parents. They were not primarily scientists, but because they were so interested in teaching us, those were the subjects that excited me the most at the time. And so, in college, I actually majored in engineering and applied physics. But I was coming through college at the time the Apollo program was closing down and I thought that perhaps there was a little more future in biomedicine bioengineering. So, I decided to go to medical school really somewhat late through my college career, but it was my science orientation that I developed in the Boy Scouts, frankly, and hanging around Tuskegee University, Tuskegee Institute that by science orientation is how I ended up in medicine going through physics and engineering first.

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Dr. McGinty: So, Johnson, I don't wanna get too far ahead of ourselves because you actually went to high school in the Northeast. Talk to me about that decision and that journey and what it was like to go from Alabama to the Northeast, Massachusetts.

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Dr. Lightfoote: My parents, as I said, were profoundly dedicated to and interested in education. And they researched educational opportunities for their children, not only their direct offspring but the kids that they were teaching in their various high schools and elementary schools at the time. And they came upon the concept of boarding schools. And I applied to several boarding schools in eighth grade and ended up going to Andover Phillips Academy in Massachusetts. This was after a substantial amount of research by myself and my parents about what this was all about. And none of us had ever lived in the Northeast. My parents had actually got their master's at Columbia. So, they

were familiar with the Northeast at least that much, but not further North to new England. And so, as a ninth-grader, I went off to Phillips Academy and it was similar and different. It was similar in that this too was a learning community, a community dedicated to education, school, academic excellence, and the like. But different weather, obviously, radically different, and I happened to be the only African American in my class. I believe we had a class of about 140 ninth graders and I was the only African American.

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Well, that actually was not quite as traumatic as it may have sounded. This was 1964 and schools like Andover, Harvard, Princeton, all the Ivys, all the New England boarding schools had really adopted as part of their mission to improve America's social equity by educating some African Americans. Previously, schools like that, the Ivys and the seven sisters had had single or two at most African American kids in their classes. Well, around 1964, 1965, 1966, with the advent of the civil rights movement, that's when these leading institutions decided that they should lead, that they should lead America and train substantial numbers, reasonable numbers of African Americans to advance really social equity in the United States. So, I was certainly a beneficiary of that.

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Dr. King's movement had reached a zenith of sorts about 1964, 1965. And so, that's how and why I believe schools like Phillips Academy, Exeter, Deerfield, Mount Hermon began to admit substantial numbers of African Americans. And Andover actually doubled the number of African Americans that were matriculated there every year that I was there. So, it went from like 2 in the whole school to 4 to 8, to 16. So, much more substantial numbers. Now, Andover graduates probably...about 20% of its class are people of color.

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Dr. McGinty: And, Johnson, you've remained involved with the school, I see, as part of the alumni and have been, in fact, decorated as a distinguished alumnus by the school. So, you clearly made a difference while you were there and beyond.

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Dr. Lightfoote: Yes, indeed. It was such a transformative experience. I think, you know, many of your listeners who've gone to a prep school like that think that it was quite transformative, not always positive, but in my instance, it was. I have been an alumni interviewer for Andover since 1984. And I think I've got the longest standing career for interviewing applicants for Andover. I've served on Andover's alumni admissions committee for, as I said, decades and on the

alumni council. And as a result, I was given the distinguished service award, which is given to alumni who served the school. I've also been active in organizing regional events for alumni that have graduated and moved on to Los Angeles, for example. And I've been president of our local alumni association here.

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We sponsor visits from the school by the school leaders, both teachers and the head of school. Used to be called headmasters, now they're called simply head of school because Andover had its first female head of school about 20 years ago. So, yes, indeed, I am grateful for what Andover did for me and also what it does for its current alumni of color. It's a great place to be from I tell them all. So, I give back, not substantially treasure, but quite a bit of time.

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Dr. McGinty: So, moving on, you decided to stay in the Northeast for college and you went to Harvard and we'd love to hear about the experience of being a student during a time when student activism around the Vietnam War, around civil rights was particularly important in the national discourse.

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Dr. Lightfoote: Indeed. I did go about 26 miles south from Andover to Harvard and enrolled. And thanks to Andover, I actually was able to get advanced placement. So, I actually spent only three years there. And I somewhat regret that because college experiences, as most of us remember, can be very gratifying. I kind of, in retrospect, I wish I'd stayed the full four years. But as you point out, Geraldine, this was a time of very active involvement of students, student leaders, student bodies in protest primarily around the Vietnam War and civil rights. I was there at the time that students were killed at Kent state, you may recall, were actually killed by the national guard at Kent State. And at Harvard, we took over a building a couple of times, I believe extensively to have Harvard divest its ownership of stock that was invested in South Africa.

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I remember one winter, we planted 500 black crosses in Harvard yard in the white snow. So, that was a great photo opportunity that appeared in many newspapers across the country basically pointing out and claiming that universities like Harvard and many corporations were active in supporting Apartheid. Eventually, that divestiture did occur, but I'm not sure that it was in direct response to our student protest. But Harvard did eventually divest of its investments in companies supporting South Africa.

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Dr. McGinty: It's interesting we're seeing universities now being pressured to divest their investments in fossil fuels. So, you know, definitely, sort of different issues, I guess, although some of the issues you were protesting against are very much front and center now for students.

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Dr. Lightfoote: Indeed. And along the same lines, universities, notably Yale and Princeton, Harvard as well, possibly less so, had substantial investments in slavery. They owned slaves, they profited from slave when slaves were a major asset, a national asset. And so many of those universities are making reparations in some way not direct cash payments, but trying to correct that history. The Dean of Radcliffe Institute, which is a Harvard Institute, Tomiko Nagin-Brown has as her main mission, the discovery of Harvard's involvement with slavery and a way to mitigate or repair some of the damage that that did 150 years ago. So, it's a very similar recycling of social responsibility. And, you know, I think schools like Harvard are fortunate that they have members, faculty members, leaders, alumni, board of trustees that do have a sense of social responsibility. They don't see their sole mission as merely being educational, but also a sense of social responsibility as well.

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Dr. McGinty: Thank you. So, you decided not to become an astronaut and decided to go to medical school, which you also did at Harvard. Tell us a little bit about that experience and specifically tell us about some of the role models for physician leadership that you encountered as a student.

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Dr. Lightfoote: Dr. Alvin Poussaint was our dean of students, recently appointed and again very much in the wake of the civil rights movement. Dr. Poussaint is a psychiatrist who has written extensively on adolescent black psychiatry, practicing psychiatrist, only recently retired actually, 50 years ago, was given the charge of increasing enrollment of African American minority students at Harvard Medical School. And he was one of the first medical school deans of students that were given that charge. And we recently celebrated his success in that with 50 years of diversity at Harvard. There was a convocation and he and his wife who happens to be a neuroradiologist prominently featured and celebrated by the Dean of Harvard Medical School, George Daley. So, Dr. Poussaint was an inspiration for me. He had been a freedom rider, graduated from I believe Cornell, and went to the south and participated in freedom rides in Mississippi, and then was called back to Harvard to become a leader in increasing the diversity of enrollment at Harvard Medical School and also really around Boston. Many of the other deans followed in Harvard's footsteps back in about 1970, 1969, 1968. He was quite an inspiration.

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I guess my medical school experience is similar to most. Medical school is as I'm sure, you know, Geraldine, is such an intense experience that you don't have time to look up or hear yourself think very much. And it's very much a self-remaking process. It certainly was for me. Voluminous amounts of information you have to learn during your preclinical years and then, of course, during the clinical years with long stretches of time spent in the hospital and learning to deal with uncertainty, beating back on certainty, and being absolutely sure that you are doing the best for your patients, learning how to care and to put the patient's best interest as an absolute first, absolutely secondary to nothing. And that process I think was, you know, transformative for me and one that I still, you know, obviously, take quite seriously. Most of us doctors do.

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Dr. McGinty: Johnson, I think we are having an important conversation in healthcare right now about structural racism, and inequities, and disparities, and outcomes. I agree with you that as medical students, I think we are overwhelmed by information, but do you remember a realization about that? Was it something that you'd been exposed to growing up that you saw compounded or academic medical centers have certainly not been immune from that?

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Dr. Lightfoote: Indeed. I became aware of health inequities in the sense that as medical students in urban centers, at academic medical centers, usually, the patients that we got were less well off than the patients who went to the private hospitals and were cared for by the attendings rather than the rookie medical students and interns. And that was something that I became aware of and I'm sure most medical students do. It's not something that we can directly do a whole lot about, and I don't think I was active in fixing that, but it was something that, sort of, you know, stuck in my craw, if you will, and something that I noticed. I did write my thesis, actually, in medical school about the under-representation of blacks in medicine. I took a history of medicine course and one assignment was to write a thesis. So, I actually researched the under-representation of blacks in medicine, which at the time I started medical school, about 2% of physicians were African American. By the time I finished medical school, enrollment in medical schools of African Americans had increased to about 6%. So, it was a bit better. It's improved a bit since then, as you know, but still has a way to go to reach population parity.

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And unfortunately, as I'm sure you've read, Geraldine, the enrollment of African American males in medical school is the same now as when I graduated 40 years later. That under-representation is a substantial inequity because as you know, when we are at the table, when one is at the table, as a leader, as a physician, practicing, teaching physician, we can impact the priorities of the organization. I think that's the main effect that I want to see, that I work for is having more people like me, who look like me, think like me at the decision-making tables to set priorities for larger healthcare systems, whether they be the American College of Radiology, Harvard Medical School, or Pomona Valley Hospital. That representation is a key element of improving inequities.

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Dr. McGinty: Couldn't agree more and definitely lots of work still to do. We know that African American students are more likely to choose primary care specialties with a real sense of wanting to give back to their communities. When did you decide to do radiology?

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Dr. Lightfoote: I actually did do primary care. After I had finished medical school, I did internship in internal medicine at Stanford, which was a pleasant change from the snow of New England to the eucalyptus driving through Palo Alto. And I spent a year there doing internal medicine. I owed the U.S. Public Health Service two years. Back in the day, the National Health Service Corp would fund medical school attendance for medical students if they would agree to give back a year-for-a-year service at an underserved community on behalf of the U.S. Public Health Service or the National Health Service Corps. So, I was fortunate enough to be able to give my time back two years in Tuskegee. And I returned to Tuskegee and practiced primary care at John Andrew Hospital, name for a Massachusetts Governor who funded the hospital there at Tuskegee Institute. It was still Tuskegee Institute, I believe at that time, was a community hospital of 50 beds and it took care of the community in Tuskegee. So, I was stationed at that hospital, did primary care, drove to rural communities of 50, and immunized children with DPT and polio vaccine twice a week. And that was an enjoyable experience, but I missed the technology and the hard sides, if you will, the physics, the engineering that I'd come to like and love so much in college and even before.

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And so, it was my two years of family practice, general practice that perversely enough convinced me to go into radiology. I enjoyed family practice, but as I said, I really missed the technology and the engineering.

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Dr. McGinty: So, we're going to come back to radiology, Johnson, but so, we have you practicing in Tuskegee, Alabama. And when we think of the shameful history of the way in which our healthcare system has treated communities of color, Tuskegee is a name that stands out. We also know that for communities of color to have physicians who, as you said, look like them, can be a critical trust factor in driving better health outcomes. How did what happened in Tuskegee influenced the way you practiced or what was the legacy of it in terms of the patients you treated there?

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Dr. Lightfoote: I was there just after the Tuskegee experiment had been discovered. Because as you recall, there were about 400 African American men who were continued on non-treatment or placebo after the discovery of penicillin, men who had syphilis and were getting only salutary treatments, not the definitive cure of syphilis. And the lawsuit had just been settled. While I was there, there was created a bioethics commission that is now cited at the old John Andrew Hospital facility. The Tuskegee experiment was indeed a source of distrust. When it was discovered, it outraged the community. And what was so ironic is that many people in the community, sort of, saw it hiding in plain sight, if you will. Mrs. Rivers was one of the nurses whom I knew and, you know, she was a community nurse, but no one knew that this experiment was still being continued when it should have been discontinued in 1945, or even earlier. That experience, the issue of Helen Lacks, who, as you know, was a lady with cervical cancer, whose cervical cancer tissue has been universally used across the globe as tissue culture and her legacy has only recently been properly recognized, her contribution to global science.

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So, communities of color do have substantial mistrust of major medical institutions resulting from experiences like that. I view my role as do most of the other black physicians I know as being a focus of trust, dispelling the mistrust, to the extent that I would and could go out into the communities and immunize the kids. I was a trusted physician in those communities. I had that opportunity in Tuskegee where I gave talks at churches and I remember making house calls. One of my patients paid me in tomatoes, which was fine. And so not only there, but subsequently, I view my role as a representative and really a bridge between organized medicine, organized healthcare, and a community from which I came, which can clearly benefit from better health care, but nevertheless is somewhat mistrusting.

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Dr. McGinty: Work that I know that you continue to do. So, tell me about training to be a radiologist. Johnson, I know that, you know, our trainees today

who are working in an entirely digital environment may never have seen an IVP. It's a very different world. So, tell me what it was like to be a trainee in the early '80s.

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Dr. Lightfoote: Indeed. This was before God made computers, if you will. And as you point out, it was not digital at all. I began training in 1979 at UC San Francisco. And I'll never forget my first day I came in and there was an alternator. Some of your younger listeners may not know what an alternator is, it's a giant machine that would hang up four to six large sheets of film, side-by-side, and mechanically move them on 50 different panels so that we had an MV 300 that could contain 300 large sheets of film 14 by 17, on 50 different panels. And these panels would rotate from patient to patient. You'd put one patient on one panel and those images...well, not images, those films, those sheets of film would rotate from panel 1, to 2, to 3, up to panel 50. And the residents were assigned an alternator and each resident should come in in the morning, review the cases of the 50 odd patients that were loaded on the alternator physically, of course, because these are films, and would come up with their diagnosis, and then we would later readout with the attending who would join us at 10:00 or so and would go through the 50 odd patients.

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I was on the left alternator and Dr. Bill Bradley was on the right alternator. Dr. Bradley, who is another one of my role models was sitting on the right-hand alternator. And his first instruction to me was how to hang up a chest x-ray. I had the lateral backwards and had the previous films on the wrong side as opposed to the right side. So, I was fortunate enough to be at UCSF when Dr. Bradley was a second-year resident. I was a first-year resident. And Bill gave the first lecture on NMR, nuclear magnetic resonance to the residents, to his fellow residents and everyone went to sleep. It was so incomprehensible. But those of us who had the pleasure of knowing Dr. Bradley remember him as one of the most enthusiastic teachers of MR. He had encyclopedic knowledge, both deep and broad, but he also had an ability to make it clear and plain. He also was very much an applied scientist as well. He did quite a bit of primary research. He also applied his knowledge. He, as you may recall, came up with the discovery of the unidentified bright objects. That's what they would call back in the day, deep, white matter small vessel disease is what we recognize those both side T2 and flair signal abnormality. And he gave a clear explanation of what they came from. He also was the first to explain to us how hemorrhage evolves in the brain. So I've remained friends with Dr. Bradley from, as I said, 1979, when I started there at UCSF, until his untimely death a couple of years ago. But he was definitely one of my inspirations and good friends.

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Dr. McGinty: What a giant in the field. So, you certainly seem to have been able to combine that love of physics, and science, and you were at the cutting edge of technology. You were already beginning to take on leadership roles in radiology. You served as chief resident and you initially pursued an academic pathway, but in 1989, you decided to do your MBA. That's something, obviously, that was a part of my career. And I'm interested to know, tell me about that decision and what was it that you felt that that MBA contributed to your career?

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Dr. Lightfoote: Yes. I finished my residency at UC Irvine and stayed on their faculty for a couple of years, but then went into private practice. I had a business opportunity. And back in those days, this would have been 1984, 1985, we were setting up imaging centers. This is the advent of imaging centers. This was the first time that imaging centers were developed. And that seemed like a very exciting idea. It was an opportunity to purchase great equipment, really top-of-the-line equipment, still with no computers, but excellent equipment, and provide care in a private practice setting. And I did that for about 8 to 10 years.

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I did go to get my MBA, Geraldine, primarily out of interest. I had always had at least a theoretical interest in business and economics. And physicians were often criticized as not having a good business sense or a good business understanding. And I really, you know, wanted to dispel that notion. I thought it was important for doctors to understand balance sheets, and profit and loss statements, and accounting, and strategic planning, and marketing, just as much as the hospital administrators did. And like you, I'm sure, I think it's important that when we go into a C-suite, chief executive officers and chief financial officers, that we be able to speak their same language. Even though we don't practice on a daily basis business at their level or their specificity, it's important that we be conversant in what's important to them. Certainly, CEOs think strategy is important, strategic planning is important. CFOs, of course, look at cash flows and the bottom line. As physicians, for us to be fully respected, if you will, by non-physician counterparts, we need to be able to speak their language. So, that was the primary motivation for doing that.

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Dr. McGinty: I noticed, Johnson, as you've moved through your private practice career, you've typically held a medical director role of being in the leadership of the medical staff. Talk to us about the importance of that

relationship between physicians and hospital leadership and what you've learned, how you've managed that relationship over the years.

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Dr. Lightfoote: I have, as you say, been a Medical Director at Beverly Hospital here in Montebello, a small hospital now, and Pomona Valley Hospital a larger one or at USC University Hospital. And as such, my role is to represent, again, as a leader, to represent my, our medical staff, the physicians in our department, radiologists, of course, typically, to represent the aspirations, interests, needs, and priorities to the C-suite, to the administrators, to the hospital, financial leadership. And that remains my goal. That's why I'm there is to make sure that my physicians, our group is well-represented. For example, with regard to equipment, the imaging equipment, quality, maintenance, technology advances, that's important for the hospital administration to understand, for the health system administration to understand. And again, that's really a fusion of the roles of being a representative of the radiologist, as well as being able to speak the language, the return on investment, for example, to the hospital administration. So, that's sort of duplex role, if you will, I've enjoyed undertaking and been generally successful at it. It is always sometimes a challenge and that's what keeps one up at night as I'm sure you know.

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Dr. McGinty: Johnson, I'd like to pivot a little bit and talk about the importance of professional communities because you are part of many and you've been a contributor to many radiologic societies. You were, as I mentioned, the chair of our Commission of Women and Diversity elected last year and you were a founding member of the commission, you were incoming president of the California Radiologic Society. You chaired the National Medical Association, the Section on Radiology. Tell me about why you've chosen to take, you know, out of your busy schedule and devote time and effort to these communities.

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Dr. Lightfoote: Right. People will often ask me what my hobby is and the short answer is just what you reported. That's my hobby. I think it's important for us as physicians to exchange information, exchange positions, exchange, and network. And that's where I see my main role as a leader in these various medical societies. At the NMA, for example, the Section on Radiology, we have an active effort to network with and have outreach to all the black radiologists across the country. And I would imagine that we're about 50% of the black radiologists will actually come to our annual meetings, at least before they were virtual. During the virtual meeting, we actually had about 80 black radiologists online in July 2020, likewise California Radiological Society. Each

state has its unique challenges and opportunities. And I think it's important for radiologists up and down the state to network, exchange ideas and insights.

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In California, in particular, we have lots of residency programs, UCSF, UC Irvine, USC, UC San Diego. And so, it's important to orient these graduating residents and fellows to the importance of networking. And so, I think I've taken on roles of leadership in these societies to promote the concept of professional collegiality and exchange of ideas. At ACR, for example, we have the ACR Engage website and that's an important forum for exchanging ideas, sometimes a little more heat than light, but that's okay too. So, again, I see it primarily as a function of representing my constituents, our constituents, and bringing us together so that we can exchange ideas.

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Dr. McGinty: It's been an interesting time, hasn't it, Johnson, in terms of promoting dialogue when we can't see each other in-person, and a big issue that was a discussion at our 2020 ACR meeting was the idea of how we recognize advanced practice providers in radiology. And certainly, the pandemic has opened up scope of practice for those providers, which they are not really looking forward to giving away or giving back when the pandemic ends. And I know that in California, you've had recent significant discussions around this issue. Talk about how we interface with other specialties and our place as radiologists in the house of medicine, and, you know, what your activities have been in that regard.

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Dr. Lightfoote: Right. Here in the State of California, we did have a specific and unique challenge that we only partially overcame. Assembly Bill 890 provided for a significantly expanded scope of practice for nurse practitioners. Nurse practitioners have been given...recently, the law was signed by the Governor Gavin Newsom have been given, in essence, the ability to practice medicine within the scope of their abilities. And there remains to be settled How that scope will be determined. There will be a board of nurse practitioners, and they will determine how nurse practitioners will be certified or allowed to do various medical procedures, including examining patients, prescribing. And the bill was passed over the objection, over the vehement objection of all of the major medical societies, notably California Medical Association. The bill gained political traction as a result of active, aggressive lobbying by the nurse practitioner, community of state legislatures, and as a result of the pandemic, there was a perception, and I don't think this has ever really been documented, but there is a perception that there's a shortage of primary care physician and particularly in rural areas there's a shortage. That phenomenon, I don't think has

ever been adequately documented or proven. The legislature, however, bought that concept.

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California Radiological Society saw this coming, unfortunately. The bill actually passed 53 to 1 in our assembly so that there was no hope, if you will, of getting the bill not passed at all, even though it was vehemently opposed by all the medical associations. We, sorta, knew this was going to happen. That's because we have, I like to say, the world's best lobbyist. Our Administrative Director Mr. Bob Ackerman has been with California Radiological Society for several decades and he has his finger on the capitol pulse in Sacramento. Bob saw that this was going to pass. And so, Bob worked with the author of the bill to get imaging essentially excluded from the scope of practice. There's a clause in 890 that gives nurse practitioners the right to use the results and findings of imaging studies, but not to perform them or interpret them.

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So, we were able to carve out a tiny little bit of turf, if you will, for radiology that other specialties were not. CRS was criticized for taking that position. And this is one of those instances where the making of politics is very much like sausage. We knew that the bill was gonna pass. So, we had this was the best compromise that we could get. I think in the end, we remain on good terms with the other medical associations. The CRS took a no position on the bill. That is, we did not oppose it because we knew that we were trying to get it slightly rewritten and we did the best we can. So, politics is the art of the practical and we definitely exercise that art in this particular bill, again, to only partial effect. But as I said, you know, we did the best we could. So, that's an example of how collaboration among physicians, in this case CRS, led to a fair outcome, not perfect, but fair.

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Dr. McGinty: Indeed. And artfully navigated. I do want us to spend some time on your work with the commission which has been just luminary, but I have to ask you very briefly about another society that you remember of called the Boulé. Could you tell us a little bit about that?

[00:36:29]
Dr. Lightfoote: Yes. Sigma PI Phi fraternity is the oldest African American Greek-letter fraternity. It was founded in 1904, back in the day when African Americans could not go to hotels or restaurants, could not have balls or parties. And so, four African American professionals, two doctors, and a dentist, and a pharmacist got together in Philadelphia and founded this fraternity that continues today. And the fraternity was, for a long period of time, somewhat

secretive, but in recent years have recognized the importance again of leadership and representing the community. It's primarily a social fraternity. And one of the main features is that the fraternity replaced the kinds of functions that one could have at hotels and ballrooms by having them in one another's houses. And back in the day, when we could not go to the Waldorf Astoria, we would go to one another's houses and have Christmas parties. Since that time, the fraternity has evolved substantially to become much more socially active.

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There's a foundation with multiple scholarships. There are about 130 chapters across the country with about 6,000 members. I've been the secretary of our local chapter here since 1997. They won't let me get out of that job. So, that's been my hobby also. But I find it particularly gratifying to be in a fraternity with like-minded gentlemen. It's a fraternity, but it also involves families so that the wives are involved in the group as well. Recently, we had a convention, a virtual convention where one of the main discussions was returning to school during the pandemic. And many of the wives of the fraternity members are physicians. Three of them actually brought on the panel and they presented the scientific evidence about returning to school and how the guidelines should work. So that while it was founded as primarily a social organization, now it's become much more socially active. We have many forums about, for example, getting more blacks on boards, on corporate boards, again, the representation imperative. So, it's both the test, but it's also very enjoyable for all the social functions that we get to enjoy.

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Dr. McGinty: Well, I loved, in my reading about it, it's described as a council of noblemen. And when I look at the luminaries who've been members, including Dr. Martin Luther King Jr, the late Congressman John Lewis, Arthur Ash, I certainly think that you're aware of the member of that group. Let's talk about the Commission on Women and Diversity. I actually joined the board in 2012 when then Board Chair, Paul Ellenbogen established the commission and you were the founding member of the committee on diversity, and as I said, was elected as chair of the commission just last year. The work that you've done has been published and certainly, would direct our listeners to that. But what do you see as the main accomplishments of the commissioner, and what's left to do?

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Dr. Lightfoote: Right. As you mentioned, Dr. Paul Ellenbogen was chair of the board when the board decided to establish this commission. I'm very grateful to him for having that insight. I think our main task, the center of our task is hearts and minds. It's important that physicians, radiologists, community leaders

recognize that diversity and inclusion are core elements of being at an excellent organization, that if we're gonna be an organization that serves our public well, that diversity and inclusion are essential parts of that. And that's really, sort of, a hearts and minds concept. And so, many of the tasks and programs that we've undertaken have been primarily to educate our constituents here in the entire American College of Radiology, all of radiology, and to a lesser extent, all of medicine, to the extent that we can get to all physicians about the importance of diversity, the lack of diversity to date, how a diverse physician workforce helps provide better care, how to exploit the talent and resources that would otherwise go unrecognized and unused without including women and minorities in both planning process and healthcare delivery. How setting priorities for a healthy population require all elements of that population to be studied, accounted for, represented.

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As you mentioned, we have published quite a bit and because this is a hearts and minds project primarily, that's been one of our main products. We've reviewed the state of diversity in radiology, various subspecialties, we've talked about how women have been disadvantaged for any number of reasons because they are primary caregivers, for example, for their families. More recently, we're talking about health equity. Because the pandemic has exposed health inequity, it's important to recognize the degree of those inequities and talk about methods of mitigating them. So, as you point out, our commission's work is not even done, not at all done. During the pandemic, since we're not meeting face-to-face, we're having quite a few webinars and those are excellent opportunities for radiologists to come together, exchange ideas, and to learn from one another.

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Most recently, for example, we had a webinar about health disparities in breast care. I'm a breast imager as are you and I know that's near and dear to both of our hearts. Because women of color, including Asian American women and Pacific Islander women, are diagnosed with breast cancer at a younger average age, the guidelines currently calling for beginning mammography at age 50 disadvantages them. It underserves women of color.

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Dr. McGinty: I'm going to interrupt you then correct that to 40, but...

[00:41:54]
Dr. Lightfoote: Yes. Well, the guidelines from USPSTF...

[00:41:56]

Dr. McGinty: Oh, I see. [crosstalk 00:41:58] My apologies.

[00:41:59]
Dr. Lightfoote: Right. That's right. The ACR's guidelines, of course, recommend starting at age 40, but the...

[00:42:05]
Dr. McGinty: I'm obviously [crosstalk 00:42:05] program, Johnson.

[00:42:07]
Dr. Lightfoote: Oh yeah. Right. the USPSTF guidelines that recommend starting at age 50 underserved minority women. So, there are campaigns that we've mounted along with the Hawaii Radiological Society and the Missouri Radiological Society to have that guideline lowered, corrected to correspond the ACR guidelines to start screening at age 40. Somewhat a fine point for those not in mammography, not in screening, but it makes a big healthcare difference for women of 40 and over where the majority of breast cancers in women of color occur between 40 and 50. So, the years of life lost are much greater at that younger age. And so, as I said, we're focused not only on under-representation and lack of diversity, but increasingly on health equity.

[00:42:56]
Dr. McGinty: Johnson, our time is almost up and it has been just an illuminating journey through your career. And I thank you for sharing so many great insights with us. You grew up in the crucible of the civil rights movement and, you know, have been exposed to caring for patients all through the country. You came into our specialty at a time when we were discovering things like MR and the possibilities. As you look to the future, what makes you hopeful? How do you feel about our specialty? What would you tell a medical student today thinking about radiology as a career?

[00:43:32]
Dr. Lightfoote: I tell my residents and medical students that I chose my parents and my profession very well. I am very happy in radiology and think that it is, you know, certainly, a profession that they will, would enjoy being a member of. We're blessed with some of the best technology that's ever been imagined in human history. And further, we're blessed with the probability that will continue to develop even more better, more faster, and we can apply it in very practical ways to improving human health. For example, digital mammography is much more effective than film. Screen mammography is more easily deployed, it can be deployed more widely than the old film screen and film processor technology. Telecomputing, which is, of course, computers, and telecommunication, and high-resolution displays, and solid-state detectors have

really revolutionized radiology, much better than the old film screen days when we hung up our 300 films on the giant mechanical alternators. We can go through films much faster with much greater accuracy. And, of course, artificial intelligence and advanced data sciences offer even greater opportunities for radiologists to leverage our strength. It's not going to replace radiologists, it just will make us faster, better, stronger, and more accurate.

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So, I believe that radiology's future is brighter than it's ever been. And medical students, I do encourage to consider radiology if that's the kind of profession that they'd like to be involved in. In fact, I'm sure, Geraldine, you may know about our peer program, which is a program specifically to identify and recruit promising minority medical students and introduce them into the radiological sciences. That's been a very successful program. We just finished his fourth year, virtualize this past year, unfortunately, but we expect to create a new cadre of specifically minority radiologists through ACR's pipeline initiative for the enrichment of radiology, the peer program.

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Dr. McGinty: Well, yes, an absolute signature program for the commission and for the college. And Johnson, thank you so much. You talked about representative leadership. You certainly lived that. It's an absolute honor to serve on the ACR's board with you and to count you as a friend. Thank you.

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Dr. Lightfoote: Geraldine, thank you very much, and I look forward to our next board meeting, whether virtually or in-person

[00:46:02]
Dr. Rubin: Please join me next month when I speak with Ezequiel Silva, an interventional radiologist and member of the board of directors of South Texas Radiology Group in San Antonio, Texas, for over 17 years, a medical director of radiology at the Methodist Texan Hospital since 2017. He is the immediate past chair of the American College of Radiology Commission on Economics and is a founding board member of the Neiman Health Policy Institute, currently serving on their advisory board. Dr. Silva is co-chair of the AMA Digital Medicine Payment Advisory Group, he is also a member of the AMA/Specialty Society RVS Update Committee and serves as Chair of the RUC Research Subcommittee. I hope you will join us for a conversation exploring Zeke's leadership journey and his expertise on the economics of medical imaging. If you've enjoyed this podcast, I invite you to do three easy things. Subscribe to the series so you need never miss an episode, share the link

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