Episode 5: Leading with Authenticity
Dr. Catherine Everett, MD, MBA, FACR
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Geoff: Hello and welcome to "Taking the Lead," a podcast from the Radiology Leadership Institute that profiles radiologists as leaders, seeking insight and inspiration from a variety of perspectives and experiences. I am Geoff Ruben. Today I am speaking with Catherine Everett, [00:00:30] a radiologist who, after growing up on a tobacco farm, has been managing partner of Coastal Radiology in New Bern, North Carolina for 38 years. She has served as president of the group for the past 10 and recently oversaw its acquisition by Radiology Partners. We discuss her decision to attend the Yale School of Management and earn an MBA, all while juggling her senior leadership responsibilities. We also discuss her subsequent engagement with the [00:01:00] American College of Radiology where she has recently stepped up to take on over 50 formal roles.

Through all of these and many other accomplishments, including serving as president and founder of Idetico [SP] Radiology Solutions, she has managed tremendous balance between her professional and personal life as a wakeboarding mother of five. We speak about her career, her love of radiology and her common sense perspective on leadership through identifying and solving [00:01:30] problems. Catherine, welcome.

Catherine: Thank you.

Geoff: I wonder if we could begin with you telling us a little bit about your childhood. What was your life like growing up?

Catherine: I grew up on a tobacco farm [00:02:00] in northeastern North Carolina. My dad had a degree from NC State and went back home to farm the farm that my granddaddy and great-granddaddy had owned. So I grew up working in tobacco alongside my brothers in the fields and in the barns and declared to my dad very early on that I was never gonna do that again.

Geoff: With tobacco farming being so deeply ingrained in [00:02:30] your family what do you think led so many to leave northeastern North Carolina to pursue college and advanced degrees?

Catherine: Well, my dad was one of two children. His father formed and that's the reason he came back. My other family's...the interesting one is my mother's family. There were seven children. Both of my grandparents went to college. One or two-year college but my grandmother went to East Carolina. At the [00:03:00] time it was a teacher's training school. And so education was important to them even though they were born in the 1890s. So all seven of their children went to college. My granddaddy owned farms but it was important to him that they be educated. So they're engineers, teachers, physicians, and then one of them actually came back and farmed.

Education has just been [00:03:30] always important to both sides of my family. Very interesting for eastern North Carolina. I never thought twice about doing anything other than going to college and then doing something beyond that. That was part of my upbringing.

Geoff: Were there any aspects of farm life that you believe informed your approach to your profession today?

Catherine: Two things. Hard work and then I was treated exactly like my brothers were. I was expected to do what they did and [00:04:00] they had the same expectations of me, and I never ever thought there was a difference between men and women other than the obvious differences. I got up in the morning at 4:30 or 5:00 and helped take the barns out and then I went in the fields just like my brothers did. Now I drive a tractor. They worked in the fields on the back of the truck and then some are in the barns, but that was part of our jobs. That was part of how we grew up. [00:04:30]

Geoff: At that moment in time did you have any ideas as to what you would be doing instead?

Catherine: No, I didn't really. There are a lot of physicians in my family. Despite the fact that my dad was a farmer, all my aunts and uncles, including seven on my mother's side, all had college degrees and advanced degrees. So, you know, we were educated. We just lived in a relatively poor area of North Carolina and farming was what was there.

So I knew I didn't wanna [00:05:00] teach. I knew I didn't wanna be a secretary, and that cut out a lot of what women could do back then. But being a physician was in the back of my mind and finance was in my mind. I was a math, economics major in college. I just wasn't sure until I was probably a junior in college what I really wanted to do.

Geoff: And what led you to radiology?

Catherine: I have an uncle that's a radiologist and I got to shadow him some. He started off in primary [00:05:30] care and then went back and did his residency at Chapel Hill and moved to Pinehurst. And so I followed him around and really liked it.

Geoff: Now you're a North Carolinian through and through, grew up on a tobacco farm, Duke undergrad, UNC medical school and residency. What led you to practice in New Bern?

Catherine: I wish I could say I had lofty ideals of radiology, but in fact I wanted to live on the water and New Bern [00:06:00] was a great opportunity. I got a job offer which was...at the time I came out of fellowship. Not many private practices really were interested in women. And so I jumped on it. It was a great place to live and do all the water activities I wanted to. I can go to work within 10 minutes of my house. I just love it.

Geoff: What sort of water activities are you attracted to?

Catherine: Well, I'm a water skier. I have been since I was probably five. And now I wakeboard and [00:06:30] I tried to surf a little bit. Of course that's an ocean activity and I learned that late so I'm not very good at that.

Geoff: It's great that you're able to pursue all of those activities through all that you do otherwise. Now you have practiced at Coastal Radiology for the past 38 years. Can you tell us a little bit about the group and its history?

Catherine: It's an interesting history. When I first came to New Bern I went to work for Larry Addams and Bill Richie, both of whom I knew from my residency [00:07:00] at Chapel Hill. Larry had come to New Bern maybe three or four years earlier than I did and joined a group, and that group ultimately split into two groups. So when I came there were two radiology groups in the one hospital, which was an interesting scenario, I think, on a lot of levels. When I first came in New Bern, Coastal Radiology was Trent Radiology and then there was Coastal, the other group. And it was only the one hospital in New Bern, which is CarolinaEast [00:07:30] Medical Center. Eventually the two groups merged, and we were then going to Carter General in Morehead City and then [inaudible 00:07:40] Memorial in Jacksonville. Since then Coastal has added Martin General Hospital, and the county I grew up in in northeastern North Carolina, as well as a hospital in South Carolina as part of our group even though we're far apart. We share work lists and call and they're part of our group in terms of [00:08:00] financials. The latest thing that's happened is Person Memorial in Roxbury, North Carolina has joined our group. And the last two hospitals were pretty much related to our joining RAD Partners, which we did in 2016. Currently we have basically 16 working radiologists. That's grown over the years obviously from our beginning of like three or four radiologists.

Geoff: So you were the fourth or fifth radiologist in the practice?

Catherine: I was the third [00:08:30] in my practice, which was at that time Trent, and then there were three radiologists in the other group and one joined the year after I did.

Geoff: And New Bern itself, maybe just a little bit about the community, how big is it, how many people are served by the practice?

Catherine: The town is, I think, about 30,000 now. Maybe a few more. But wisely in the '50s when all the counties in eastern North Carolina [00:09:00] were building their own little, small hospitals Craven County, Jones County, and Pamlico County decided to have one central hospital, which was in Craven County. And the end result of that is our population served is probably 100,000 to 120,000 people. So that hospital is a regional hospital rather than just the local county hospital with more sophisticated services obviously than small 25-bed hospitals can provide. [00:09:30] The county has 350 beds according to the State.

Geoff: You have been a strong voice for general radiologists on the ACR's Engage Platform. Are you a generalist or are you a specialist?

Catherine: I have a fellowship in pediatric radiology and I rarely ever come in contact with children. We just don't have that many in our practice. And since I've been in practice I have [00:10:00] specialized by going to a lot of courses, doing a lot of reading, doing a lot of cases in both breast radiology and MSK radiology. I basically practiced general radiology including interventional for the first 15 years, 15 or so years I was here, including angiography, nephrostomies, everything. But then our group attracted one and then two and now three interventional radiologists so that part of the practice I don't do [00:10:30] anymore. As I told one of the interventionists when he came to town, I said, "You know, I've done probably 10 times more nephrostomies than you have yet but I'm never gonna do another one because that's yours now." The more complicated interventional procedures obviously need to be done by people who are skilled and very well trained in that, but the more general skills, I think, radiologists need to be able and willing to do. [00:11:00]

Geoff: So what would you say is the right blend of specialists and generalists for your practice?

Catherine: Because we do have the CarolinaEast, which is the regional referral center, we need three interventional radiologists to work in it at all times. So two would work and one would be off or fill in another slot if need be. Beyond that it depends on how you do your workflow. If you're willing to offsite read then if you have a new radiologist off site somewhere that's reading for [00:11:30] several practices, fine. Or, MSK. Obviously breast radiologist needs to be on site. The biggest issue, I think, though, is no matter how big the group there are still a lot of playing films to be read and there are weekend shifts and

evening shifts that need to be covered. It needs to be somebody who can kind of read everything other than the very complicated stuff and then a backup for complicated things that really need a subspecialist [00:12:00] to read.

Geoff: You described the story of Coastal Radiology splitting into two groups with you joining Trent and then the two groups remerging. What led to that initial split and was there bad blood to overcome in coming back together?

Catherine: Like almost everything that happens when it's not about money, it's about money. The partner [00:12:30] who split off was the younger partner and he felt he had been wronged when he became a partner so that caused the initial split. By the time the group remerged, there were so many people involved that had nothing to do with that didn't have the preconceived notions of what was going on. That was very amicable. We were tired of two people taking call all the [00:13:00] time when there was no reason for it and for the inefficiencies of the work and also for...as small as we were, nobody could specialize in anything. We had one person doing an angiogram, then another person would do one. And everybody was relieved when we finally got back together.

Geoff: With two radiology practices operating in the same small hospital when you first got started, did you feel a constant tug of competition at that point? And if so, what strategies helped [00:13:30] to distinguish Coastal Services from those of the other practice?

Catherine: It's interesting. That would be one of the fantastic examples of radiology 3.0. Believe me, we went out of our way to be available for consultation, available for anything anybody wanted. And, you know, the clinicians sensed that too. So they would play one group off the other, they would threaten to, you know, change groups if you didn't do something to suit them. [00:14:00] Of course, that's a double edged sword because some of the things they asked for you shouldn't be doing. So you had to make sure that you were doing the right thing for the patient.

There was competition and there was inefficiency because the techs would have to see who was actually on the ED that week and go in that office and the other one could be sitting there doing nothing all day. So it wasn't really a good business model but clinicians sort of enjoyed it for a while.

Geoff: What did they enjoy [00:14:30] about it? Just the idea of being able to play one group off the other?

Catherine: Sure. They learned tricks. We actually, as a group, the radiologists, the six of us got along really well. It was just a business thing. So we would

occasionally cover for each other and it got to be more and more that we cover for each other. So finally we just said, "You know, why are we doing this?" And sat down and aired it out and rejoined so that we were one group.

Geoff: It sounds like you [00:15:00] realized a really good solution to it, an ideal solution, in fact. Now it seems unlikely that folks will encounter this specific situation today where they've got two different practices in their hospital, but are there any lessons that you can identify that might be of value in today's practice environment from those days?

Catherine: Well, the main thing is to just cooperate because for whatever reason there are two practices...and I actually think I could see that coming with the new R specialty because I think [00:15:30] there will be R groups that cover multiple hospitals and there will be an, you know, a DR group in the hospital. So the biggest thing is just to make sure you have communication between the two, two or three or whatever groups, particularly in terms of the hospital administration and in terms of departmental meetings and quality and safety protocols, those kinda things. And even today if you think there are a lot of practices that have night time services, [00:16:00] and it's important that the hospital group or practice has communication with whoever's doing their night reads or evening reads.

Geoff: How did you become president of Coastal Radiology?

Catherine: Sorta by default. Larry Adams was the original president and then he retired from the group. So we didn't have a formal mechanism at that point for president or whatever. We just had managing partners. [00:16:30] But people started coming to me and then ultimately we did have an election, and I don't even remember what year it was but I was named president at that point.

Geoff: So this was really a process that invented itself and sort of was a product of necessity?

Catherine: Well, you gotta have somebody that makes the final decision, and even the partners would come to me for things and finally they just said, [00:17:00] "Let's make it official." So we did.

Geoff: Why do you suppose the partners were inclined to come to you?

Catherine: It wasn't just the partners. It was administrators, staff. I got things done. Somebody gave me a problem, I tried to solve it. I tried to look for problems. My philosophy in business is that I don't care how well we're doing. There are better ways to do things. [00:17:30] And I'm constantly looking for

things that we can do to improve whatever it is whether it's billing or whether it's reporting in macro, or our library of templates, our relationships. Anything that we can do, there's always something better. Always.

Geoff: In a recent posting of the Radiology Business Journal's top 100 private practices here in the [00:18:00] U.S., only 4 out of the 100 practice leaders were women. Relative to other medical specialties, does radiology present unique challenges for women to be leaders of practices?

Catherine: I do not think so. I'm not sure why that would be. I certainly think that a radiology group usually is more cohesive than, say, an internal medicine group or a multispecialty clinic. I can't answer that. I don't [00:18:30] know why that would be so low. Except that there are...obviously we know that there are many fewer women radiologists, 23% of radiologists are women and the older radiologists, it's fewer than that. So maybe that reason.

Geoff: It sounds like in your group the people were very, very receptive and in fact encouraging of the fact that you would become president. How many women were practicing in the group at the time? [00:19:00]

Catherine: There were two of us and there still are just two of us that are full time. We've had several part time women and we have several now that read for us as contractors. We're recruiting women heavily. We'd love to have more. The whole group.

Geoff: Are there any particular moments where your experience or perspective as a woman has informed your approach to a particularly [00:19:30] challenging issues for your practice?

Catherine: Well, I think I probably tend to ask more questions and ask more advice than my partners. I don't think I do anything totally one sided. Occasionally I have. I've had to stand up once or twice and say no, but most of the time I get input on any reasonably large decision from everybody. It's casual. I don't do polls [00:20:00] but I talk to everybody before we make any changes. Now our situation is we have a practice leader's board and that's three people. So we discuss everything before anything's finalized, although I'm still the one that ends up all the conference calls.

Geoff: In 2017 Coastal Radiology merged with RAD Partners. What does this merger mean for Coastal Radiology?

Catherine: It means for us support. Recruiting [00:20:30] support, IT support, help with after-hours coverage. We are hospital heavy. So our after-hours

coverage tends to be almost as busy as our day time coverage. And taking some of the burden of the compliance off of the radiologists with, you know, putting it with legal and our revenue cycle management and actually compliance groups, that small groups now just can't afford [00:21:00] and it all falls to the radiologists pretty much, and we just don't have time anymore.

Geoff: Were there any challenges that the merger presented?

Catherine: Yes, there were. We needed a lot of support and it was the year that we joined was the year that RAD Partners acquired so many additional groups. And so there were big, big growing pains. And the support was longer coming than we had hoped. It's really good now. [00:21:30] We're fine. They've hired more people in support staff, particularly IT, recruiting and revenue cycle management. But we struggled for a while and we're still glad we did it. We looked at a lot of different options. We spent a lot of time thinking about what we should do, and that was the best thing for our group. It's not for everybody but it certainly was for our group.

Geoff: Can you describe in a little more detail what is the nature of the [00:22:00] merger? Did Coastal Radiology purchase the practice and now owns the practice?

Catherine: Well, Radiology Partners is the combination of venture capitalists and then the radiologist owners. So we have stock in Radiology Partners. Approximately 40% of the stock is owned by radiologists...of the radiologist owners and then the other 60% currently is venture capital. So yeah, we have a vested interest in it doing well because part of the, you know, part of the...it was an asset purchase agreement. [00:22:30] And then, of course, employment contract. So the assets of what we were doing in terms of office and all that were purchased by Radiology Partners.

Geoff: Recently we had a conversation with Jonathan Breslow up in Sacramento and we discussed how Radiology Associates of Sacramento underwent a similar transition where they had an asset purchase actually by the Sutter Health System [00:23:00] and then an employment agreement. Was there a consideration or an option about health system merger as opposed to merging with RAD Partners? What kind of options did your practice assess at that time?

Catherine: That would've been difficult for us because we work for multiple different health systems. Those smaller systems in eastern North Carolina have not yet merged. The one we obviously would've talked to [00:23:30] is CarolinaEast, but at this time all five of our systems are different. So that would've been difficult. We talked to several much larger radiology groups.

They were interested in us and we were interested in them. It's just, you know, there's an expense there and our group is not young so not everyone was willing to take on the expense.

Geoff: You mean in terms of a buy-in for the radiology practice?

Catherine: It depends on how they're structured, but most of the time you've got a [00:24:00] big group and then you've got the small group. Whether you're gonna bring them in as direct partners, not necessarily. There have to be something or one group talked to us. We would be a call center. So we would pay them X number of dollars and then they will handle some of our...like our IT or our billing or compliance and all those things. But there was still an outgoing expense at the beginning that honestly my group wasn't willing to do to get those services down the road because, again, we're not [00:24:30] a young group.

Geoff: Now the corporatization of radiology is a hot topic for discussion these days. What's your perspective on corporate ownership of radiology practices?

Catherine: I have obviously mixed feelings about it. Even though as most people look at me and say I've jumped to the bad side or the dark side, I do have considerable stock in RAD Partners, and so obviously I want it to do well. So even though I'm an employee by contract [00:25:00] I am a stock owner as well. Other groups can be employed by a hospital. You can be employed just strictly imaging centers that have employed radiologists. I would like to see private practices thrive and I think the larger ones will. But I'm not sure what's gonna happen to small practices and I think employment models are increasingly...you wanna be out there.

Geoff: Right now seems to be a moment in time where practices are merging [00:25:30] just as Coastal Radiology did with RAD Partners and, you know, largely operating within the context of this larger organization as business units, that in the case of Coastal Radiology it sounds like, are largely unchanged. But over time do you sense concern amongst the larger pool of partners and RAD Partners that consolidation [00:26:00] within the practice will affect some of these smaller rural practices to the extent that you're potentially forced to merge together and lose the identity that you originally had when you came to the merger?

Catherine: You know, Radiology Partners, again, is my end of one, but we are locally run in terms of decision about hiring, firing, your income pool is budgeted [00:26:30] by the radiologists. So how do you split the money is pretty much determined by the radiologists, obviously within reason. You can't

understaff on purpose. So in terms of the local hospitals, they really can't see the RAD Partners part of it. So for us, we haven't lost our identity. There are a few things we've given up and, you know, radiology is pretty independent, and when they first came in and started telling us things a lot of us kinda bristled up. But we're fine now and we do have a lot of local control. [00:27:00] I don't think that's the case of all the various big corporations out there that are employing radiologists. I'm not as familiar with the other ones. RAD Partners is really the only one we looked at seriously. So I think the bigger challenge for the small hospitals and small groups really is whether they will be able to find radiologists that can staff them, whether it's a big group acquiring small practices or what.

I was talking anecdotally to Eric Mansell, [00:27:30] who is the president of Greensboro Radiology and a very, very successful practice in North Carolina. He said that their biggest challenge with acquiring the smaller hospitals is that no one in his core group in Greensboro could actually go and sit at any of those hospitals and do what needed to be done there. So he would have to send both someone to headlight our skills or at least some of our skills, and a breast radiologist to the same small [00:28:00] hospital. And that's not supportable when you're talking about a hospital that does, you know, 10,000 RVEs a year. So that's the biggest challenge, I think, in how radiology is gonna handle those hospitals. Are we just gonna give away the procedures and turn them all into offsite reads, basically commodity reads, or are we gonna still try to have a radiologist present at these hospitals?

Geoff: Yeah. That's very well said. [00:28:30] Has there been a process in place where the group consistently reaffirms your leadership? In other words, is the role of president now a term limited role?

Catherine: It was...no, it was Radiology Partners. Now it's defined by Radiology Partners. And again there were three of us on the local practice board and I was just officially named the president of that board [00:29:00] sort of recently. It just...people came to me and I was the one that did whatever it was. So I guess it's not really very spelled out. The only thing I'm concerned about at this point, though, is we don't have the next person in line very well defined largely because we have a relatively old practice and we really need some younger people in our practice to step up to bat.

Geoff: Are you taking any steps [00:29:30] to plan for the future?

Catherine: Yes, our younger people, we're trying to put in leadership positions both in the practice but mainly in the hospitals. Out of our group we've had one, two, three, four people who've been chiefs of staff in one or another of the

hospitals, and two of those served on boards. So we're trying to get our younger people into those roles which are certainly great training for leadership. It's tough right now because we, like a lot of people, are having trouble recruiting [00:30:00] in a practice that expects people have to be able to do more than a single specialty.

Geoff: You mentioned about the local practice board. What is the scope of the local practice board?

Catherine: It's schedule. We handle our pot of money that pays the radiologists and professional staff. It turns out that we do [00:30:30] a lot more advising our practice director than I had anticipated but we don't have to go home and do the specialized work like macro and billing questions and that kinda thing.

Geoff: Is the local practice board something that is related to the RAD Partners merger and connected with that specifically?

Catherine: Yeah. It's the equivalent of an executive [00:31:00] committee, I think, of a...or just a regular private practice. Each of the practices that joined RAD Partners have their own local practice board and it functions pretty much as an executive committee. We don't make major decisions without running them by all the partners but we do make some minor decisions so that we can be agile.

Geoff: So the scope of the local practice board is similar to the scope of what Coastal Radiology would consider premerger or is it [00:31:30] a bit larger than Coastal Radiology scope premerger?

Catherine: I would say it's actually smaller because a lot of the decisions we don't have to make. You know, we don't deal with the billing at all. That's all done at the RAD Partners level. We don't have to make IT decisions like we used to. So those are two big things. And the finance and outside [00:32:00] of paying the radiologists and RAs and PAs we don't have to deal with. So we don't have to hire and fire. And the biggest thing as far as I'm concerned is the HR responsibilities, which are pretty extensive, and I think a lot of people don't realize that when they're starting to run a practice.

Geoff: Upon merging with RAD Partners, were there any growing pains related to leaving the autonomy [00:32:30] of the private practice behind?

Catherine: Yes. Radiologists, I think, in general, are pretty independent, and prior to joining RAD Partners we were fairly loose with... Well, if somebody needs to get off we'll figure out a way to do it. As long as we stay within some

reasonable budget we were okay. We were willing to make changes on the fly. And those kinda things have had to be more standardized. It hasn't been [00:33:00] as bad as I thought it as gonna be. The biggest issues early on were just infrastructure, which we're now happy with.

Geoff: Mostly the infrastructure that RAD Partners was needing to provide to you?

Catherine: Correct.

Geoff: But it sounds like your partners from Coastal were largely rolling with the punches, and that there was not any major crumblings or issues [00:33:30] other than making sure that RAD Partners delivered the infrastructure you needed.

Catherine: Correct. Early on during the practice integration there were some personality conflicts. There were expectations on both sides that were not well communicated, but once we got through that, I think, any time there's a merger, when you've got two very different cultures, one is a corporate California culture and then the other's eastern North Carolina, there are a lot of differences [00:34:00] that need to be worked through. But we did and it wasn't a professional problem. It was just more figuring out what each of us needed and wanted and expected.

Geoff: Recently the devastation of hurricane Florence placed New Bern at the center of the national news. How did your partners and your patients fare through that storm?

Catherine: I personally was fine because I live up high but several of my partners had their houses flooded. A lot of my friends had [00:34:30] houses flooded. So they're still not living in their houses. The town is historical, it was a colonial capital and I'm big on history so you're gonna have to hear this. New Bern was occupied by the Union Army very early in the Civil War in 1861 and my house actually sits on the block where Union Army camped. So the Underground Railroad was very active through New Bern, and because it was under Union [00:35:00] forces there was no destruction of property like there was in Atlanta and with Sherman. I've been told by this preservation society in New Bern that there are actually more pre-Civil War homes in New Bern than there are in Richmond still standing. It's a beautiful downtown historical area, and all that got flooded. We have patients left, our staff left, everybody, and came back to houses that were ruined.

The thing that's been pretty amazing about this community is how quickly our [00:35:30] leaders acted and how many volunteer groups came in, and it's certainly still not back to normal but it's just been amazing how much help we've had and how much people have just rolled up their sleeves and done work and cleaned up a big mess.

Geoff: Was your leadership called in to action during this crisis?

Catherine: Yes. Well, the main thing is, you know, radiologists have to have IT, and when you've got storms coming that threaten [00:36:00] the electricity you have issues. So we serendipitously had the Radiology Partners IT group meeting at our office to discuss a regional issue. So we had all the main players and I just walked in there and said, "Stop. What you're gonna do right now is get us a working disaster plan so we can cover our five hospitals." So they did. They spent three or four hours just figuring out the best [00:36:30] way we could handle things and they are using that as sort of a footprint for the rest of the RP practices. We had to make decisions. Some radiologists had to go spend the night. One actually stayed four nights in one of the hospitals because there was so much flooding and she couldn't get home even after the hospital...you know, she wasn't needed anymore. Luckily we had no IT failures and despite the fact it was a mess. And the main reason is we have generators in our office, [00:37:00] and I have a generator so I could read all the way through the storm.

Geoff: Were there any lessons that you carried away from the management of that crisis and advice that you might be able to give folks when facing a similar crisis?

Catherine: The main thing is to have a disaster plan in place. We think about some of the things like the immediate disaster but what you don't think about is the aftermath. What do you to [00:37:30] staff when the schools are closed and their children are at home? And there were dramatic rescues but then what do you do with people when they don't have anywhere to go after the storm? We still have people that are living in camper trailers in their driveways because they can't get back in their houses. And they're the ones who were lucky because a lot left and haven't been able to come back at all. You need to think about that with your staff, think about that with the hospitals that you have to serve, and even patients. Another biggie which should be [00:38:00] obvious to everyone but I don't think is, is the loss of revenue. Our revenue was down 25% the month of September. But, you know, obviously you still have to pay staff, so you need to make sure you can handle some kind of revenue disaster that comes along with a natural disaster.

Geoff: Yeah. A lot of considerations, a lot of lessons learned. Have you and the practice and the hospital [00:38:30] begun to revise your disaster plans as a result of this latest event?

Catherine: We've worked on ours. I think a big issue with hospitals is just how far do you go to staff a hospital. How big does the hospital need to be, how many services? For instance, you know, we have two very small hospitals. Luckily they were outside the range of where the hurricane was coming in, but it's neither efficient nor safe nor indicated to put a radiologist [00:39:00] sitting, you know, four days in a hospital that is basically closed because the emergency department's not working and the inpatients that were sick have left. We have not finalized any of those kinds of decisions but there are things we're talking about and we will definitely, before next summer, have a plan in place which basically says we need to make sure that you understand that we can't do that and it's not efficacious or even indicated. [00:39:30]

One of the hospitals stayed open. The one that one of my partners spent four nights in. Actually it should've been closed. They should've taken the patients to bigger centers. They ended up with part of the roof missing, a lot of leaks, staff issues because they had staff that were there for days and, you know, you need to leave. You need to shut down if there's any chance you can't function as a hospital.

Geoff: In 2010, after 30 years as [00:40:00] managing partner of Coastal Radiology and 3 years as its president, you earned an MBA from the Yale School of Management. What motivated you to take that step?

Catherine: I'd always wanted to go back to school. I didn't know exactly what I was gonna do. I considered law at one point. But I had five children and a busy practice. So I basically took that 20 years and raised my children. I followed them around whatever they were doing and thoroughly enjoyed it. But then [00:40:30] I knew that I wanted to do something else eventually. And first of all, I'm a math freak and business needed to be a good fit. Plus I thought some of the skills I could learn would help me in the practice. So honestly I'd been to Carolina, I'd been to Duke, and my daughter was at Yale at the time. So I looked online. They had a great program. It was a health program but it was the regular MBA courses. So the people in the class were in the healthcare industry but the [00:41:00] courses we took were the standard courses everyone was taking and that's what I wanted. I wanted a business school, not a health business. So I applied and went.

Geoff: It sounds like it was not so much that you felt like you needed the knowledge and information in order to pursue the leadership role that you were

in, but rather it was sort of feeding the passion that you had to learn [00:41:30] something new. Is that fair?

Catherine: That is fair. That's very fair. I mean, I would keep going. I would go again if I could. I mean, something else but we'll see.

Geoff: I totally understand that feeling. So thinking back to your time in business school. What did you enjoy most?

Catherine: The people in the class and just the learning, the exposure to great professors and the thinking. And I was told the first day in business school, "You will learn to think differently." [00:42:00] And it was absolutely true. I can't tell you how it's different but I can tell you that I approach problems very differently now than I did 15 years ago and differently than my partners do.

Geoff: You and I share the distinction of earning an MBA after 50, and for me the experience was transformative and everything you said about thinking about things differently resonates deeply with me. What takeaways might you offer about returning to school [00:42:30] at that point in your career?

Catherine: Well, first of all, obviously you've gotta have a practice that allows it. I was very fortunate that I was gone every other weekend for almost two years. Flew to New Haven. So I had to have partners that were willing to let me do that. I didn't take extra time or anything, but Fridays are kinda valuable to people and I was gone every other Friday. So obviously support from family. And as I told my friends, I'm just [00:43:00] dropping out for two years. You know, please invite me to your party two years from now but I probably won't be there for the next two years, and I did. I'm a garden fanatic and I let my yard go, everything, because I needed to do the homework but I was bent on doing well and enjoying it, and I did.

Geoff: And Coastal Radiology, you were the president at the time. How did you juggle that?

Catherine: Of those few years it seemed like we didn't have a lot of problems. [00:43:30] We were just getting into all of the regulations, the compliance. All that stuff happened after I finished. So in the older days radiology practices could kinda run themselves. Obviously you had a few little things at the hospitals to take care of. You had scuffles with other specialties about credentialing. But in general there was not the intense need for non-radiology work that there is now. [00:44:00]

Geoff: Can you expand on that a little bit? What sorts of additional effort and challenges do you see coming into the practice today that weren't there even seven or eight years ago?

Catherine: Well, macro MIPS. All of the things that are required for that. MOC, all of the new payment models. Those are the things people have to spend time reading about, making sure they're around when decisions are made. Even the [00:44:30] consolidation of groups, the recruiting, trying to find people that fit your group well. Night time coverage, which really wasn't an issue 15 years ago. You know, you had night hawk and playing films weren't read and now those kinda things affect small groups and take a lot of effort to get working correctly.

Geoff: What about your time at the Yale School of Management? Have you found to have the most lasting value in your day-to-day work? [00:45:00]

Catherine: For me networking which sounds interesting to you I'm sure, but when I went to Yale I felt like I was just an eastern North Carolina radiologist kind of out of the loop with everything and basically had not been doing much of anything outside of going to work and raising my children for 20 years. So just the fact that I was meeting all these interesting people made me [00:45:30] bolder and more able to interact with lots of different intellectuals and people that I just had no idea I'd ever have conversations with. So it gave me a lot of confidence.

Geoff: Putting your MBA hat on for a moment and stepping back and saying 60% of RAD Partners is owned by venture capital. If you were in their shoes and thinking about how would you create the most [00:46:00] efficient radiology operation you might try to pull as much of the reads away from those small hospitals to a central reading facility as possible and just leave a skeleton crew on site essentially, you know, resulting in groups contracting and being much smaller and even potentially looking at a labor pool of radiologists that are locally based but assigning them to go to [00:46:30] centers just to be able to, you know, fulfill having the one radiologist, for example, in person. I mean, is that a little bit of a dystopian future that I'm describing or is that a reality?

Catherine: I actually think that might be the reality and I've been thinking about that for a long time. I think in our practice we're down pretty much to seats where someone has to be. Even 15, 20 years ago we pulled everybody out of the individual hospital, even the bigger hospitals, [00:47:00] and had offsite reads within our group with one person which at that time we called the consulting radiologist. It's changed a little bit now but that person obviously has to do procedures. But we were fortunate in that our group, the neuro-radiologist

is really good at breast radiology and she can do a liver biopsy and she can drain an abscess. And those people, they're hard to find these days. I'm hoping we will address that issue [00:47:30] because, you know, I don't want it to go to hospitals by just hiring PAs to do the light RR and then, you know, radiology just gets read by whoever gives them the lowest price.

So in terms of RAD Partners, if I were running it, I would do exactly what you said. I'd have a pool and they wouldn't have to be...obviously wouldn't have to all live in El Segundo. They could be anywhere. But I would...the most efficient way to read MSK is to have somebody [00:48:00] who does it all the time read it. The same thing with neuro and then you have the local people who can do the breast procedures, so the RR procedures at the various places and then have another pool of those type physicians who would be credentialed at multiple RAD Partner sites and be able to fill in for vacation. So if you have one RR guy in a group and that's all you need but obviously he needs to have vacation [00:48:30] time, then you have a seamless RR person coming from the Radiology Partners pool to fill in. I think that's a true economics of scale that you learn about. But anyway, [inaudible 00:48:43] why did that get there? I don't know.

Geoff: Imagine some medical students listening to our conversation and the medical students who are interested in radiology. How would you contextualize this [00:49:00] possible reality in order to encourage them and to, you know, give them hope and enthusiasm for the specialty?

Catherine: Frankly I think that a lot of our young people today are extremely excited about technology and I know they're worried some about artificial intelligence and all that, but radiology's just been the cutting edge of progress and medicine [00:49:30] forever. It's not stopping. And if you really wanna be out there it's challenging. Everything is interesting. As I say to people when I talk to residents, I say, "You know, every single day I go to radio pedia, and don't laugh, I know that's not the austere journal but that means every day I have a question that I get answered." And when I quit doing that then I don't wanna practice anymore. That's what's the fun. That's the most [00:50:00] exciting thing about it. Everybody's not cut out to take care of diabetic patients. That's a whole different kind of medicine, obviously, as important, but I would encourage anyone right now, even with the business models a little bit in flux, the specialty is still great.

Geoff: I hope this next question doesn't seem too redundant but I'm gonna ask it again because I'm really seeking your insights on your [00:50:30] leadership. Both when Larry Adams retired and then again when Coastal Merged with RAD Partners you described subsequent formal leadership positions being the

result of people coming to you because you were able to get things done. And that sounds almost like a passive approach with leadership positions finding you rather than you seeking them out. But when you look at all that you've accomplished as a leader for your practice, for the hospital, for your [00:51:00] business, for your family, do you recognize something innate within you that makes you the logical choice to lead?

Catherine: You're right about that, about the passive. That is interesting and I've taught about it a lot particularly after I went to business school and truly gained confidence. I always felt like...maybe it's part of the imposter syndrome. I always felt like that I really wasn't up to the task but when the [00:51:30] task was given to me I usually got it done. I still didn't learn from that and I would approach things the same way. And I think over the last 10 years I finally reconciled with myself that I do have assets, I do have some strengths and I have a problem-solving ability and I accept that now and actually relish it and take on roles. I know it doesn't sound like that with the RAD Partners [00:52:00] situation. But again as I mentioned earlier, there was a miscommunication somewhat when the integration with RAD Partners occurred, and I actually aggressively pointed out that I was the practice leader because there was an assumption that someone else was because of a title within the practice. [00:52:30] Again, this was a funny miscommunication and it bothered everybody for a while until we finally just straightened it out. Despite the way I sound today I was not an aggressive person on the surface probably until 10 years ago.

Geoff: Catherine, you don't sound like an aggressive person today. You do accomplish a lot, and I think what I'm hearing from you is that you're feeling increasingly more comfortable [00:53:00] going after leadership positions, understanding that you do have this innate ability and skill, and that you are a really good leader, and that you should be taking on these leadership positions.

Catherine: I think that's true. As you know, I was appointed to the Council Steering Committee and, again, thought, "Why me? Why would anyone put me in such a leadership position?" [00:53:30] By the time I finished my first two years I decided to actually run again for the position. I have a mortal fear of public speaking but I managed to do it and I, you know, won the position again. By the end of the two years, my first two years I felt like I had done a good job. I've worked hard. I had actually added something. I was in private practice. I was female and I was from the south. So I had a little bit different perspective from [00:54:00] a lot of people on the CSC.

Geoff: As best as I can tell your introduction to formal leadership within the American College of Radiology began seven years ago with your appointment

as an alternate counselor for the North Carolina State Chapter. By 2015 you were chapter president and have since held 52 distinct leadership appointments within the American College of Radiology. What's up with that?

Catherine: Yeah, again, I call it my Rip Van [00:54:30] Winkle years. I decided early on that I wanted to participate, and right after I was...did my fellowship I did a little bit, but then my children came first. And whenever the radiology...the state chapter was meeting I had a soccer tournament or I had a ballet recital or something. So I always knew I was gonna return to it. I just didn't know how and how much time. Well, when you've got five children and all of a sudden you have none at home, you have more time. So I started at the state level and [00:55:00] I kept volunteering at the national level, and then I got a call one day that asked if I would serve on the Council Steering Committee which I jumped at. I mean, I looked around and my husband started jumping up and down. I said, "I can't believe this." It's been fun, it's been fun to give back, it's been amazing to meet all the people and it seems that there is a niche for me as a private practice radiologist and female and I've enjoyed the work. [00:55:30]

Geoff: How has your membership on the Council Steering Committee influenced your view of the profession?

Catherine: The key thing to me is, it is just incredible to sit in a room with such smart people. When people start talking, the conversations and the input is amazing. This was another reason that I would encourage people to go into radiology, just amazing people you meet. Obviously the ACR has strong [00:56:00] leadership. I mean, it's fun. It's a lot of fun to work with them.

Geoff: Amongst those many roles that you have taken on, you're the chair of the ACR Senior Retired Section, what insights have you gleaned about radiology career's latter stages from that role?

Catherine: That role, I'm really trying to beef up a little bit right now. We started the Senior Retired Section when we were still having the big annual meeting, all members meeting. And so there were a lot of [00:56:30] older radiologists there who could network while they were there. So we had the reception and a few other things. Well, once that stopped unless...obviously unless you're a counselor or an alternate counselor you won't be going to those meetings. So we lost a lot of our seniors on site. So we're kinda having to regroup and get this going again. One of the things I very much wanna do with the seniors is the institutional [00:57:00] memory. The ACR will have its 100th birthday in 2023, and there are so many giants in radiology that the younger people don't know about. And we're hoping that the seniors can contribute to

that memory. We're not sure what yet and, you know, we've gotta work with the ACR and the appropriate committees, but that is a big goal for several of us in the senior's group right now. [00:57:30]

Geoff: Is there anything that the college can or should be trying to do to help the senior members particularly as they contemplate a transition to retirement?

Catherine: I'm not sure what the college's role is in that frankly, but there are ways to offer opportunities to seniors, and I think a big one is Red aid or international volunteering or even volunteering in other areas. [00:58:00] Mentoring obviously. We talk about that. I think it's hard to have a senior retired person mentor a younger person. I think there has to be a connection between the two because, you know, we old folks like to tell people what to do and the younger ones don't always necessarily think we know what we're doing. So that would have to be structured a little bit differently I think. The biggest [00:58:30] thing is just offering somewhere volunteerism, I think.

Geoff: Is that an active component of your committee's work?

Catherine: We actually talk about it some and we've had a couple of meetings at the annual meeting. We had people talking about volunteer opportunities. It's not a formalized process right now, but again we're sort of regrouping and trying to figure out [00:59:00] things that we can do without meeting personally, and that's certainly on the list.

Geoff: Over the summer you posted Coastal's final MIP score of 97.35 with the commentary, "Little disappointed. We should've gotten a 100." Are you a perfectionist?

Catherine: Sure. But we should've gotten a 100. I sent it to Lauren Golden and she said, [00:59:30] "Yeah, you should've gotten a 100." But, you know, a lot of practices did get a 100 so we weren't satisfied with that. Before we merged with RAD Partners, we spent an inordinate amount of time making sure that we had as good a MIP score as we could get. We use a lot of structured reporting. In fact, we are a structured reporting practice. We have a library and our radiologists pretty much use standardized reports and a lot of the [01:00:00] MIP's requirements were within the report or you couldn't sign the report unless you put the appropriate words in there. So yeah. We were a little disappointed that we didn't get a 100.

Geoff: Well, I think you should be proud that you got 97.35. I think it's tremendous. I also appreciate, you know, that you're someone who really strives for perfection. Sometimes [01:00:30] that can be difficult for mere mortals to

achieve. How do you keep your staff motivated to keep improving, you know, without, you know, potentially discouraging them when they find that a 97.35 isn't good enough?

Catherine: Yeah. That is the challenge, period. And I think you're kind of alluding to burnout maybe. It's a challenge because I think everyone is having to produce more now [01:01:00] than they used to have to produce and they have to do it within guidelines that are more structured than many radiologists would like. And as I tell people now, we're kind of on shift work, and I think that is hard to keep people motivated when you're...you know, you just walk in, start reading and then you leave. One of the biggest things that helps, in my opinion, is some patient contact. Certainly [01:01:30] for me it's the breast patients or even going in and do an arthrogram, or as much as everybody bashes barium, just going in and talking to a patient a little bit when you do a barium study. You know, you feel like when you talk to a patient and they're grateful that you've got a good reason to go to work that day. And we need to strive to do that even though it's hard.

Geoff: I'd like to ask you about Idetico. What is that?

Catherine: The name is...we [01:02:00] went into the dictionary and found this. It has something to do with bright light and we keep thinking we're gonna change it but we haven't gone to the trouble to go to the lawyer and, you know, spend the money to do it.

Geoff: So after founding Idetico Radiology Solutions nine years ago you served as president. Do you not have enough to do?

Catherine: Well, it's my idea. We basically...at the time we had three hospitals, four hospitals, and [01:02:30] everybody was still using transcription. So we decided that based on talking to a group in central part of the state that had done a similar thing we decided to approach the hospitals to say, "Look, we'll buy the VR systems. And we'll maintain you. We'll do all the reporting. You can get rid of your transcription services and you just pay us some price for doing this." Again it was economies of scale because we could buy one system instead of each of these hospitals [01:03:00] buying their own. We would be bought into the system. They wouldn't have to make us go transcription-less. And it's worked, it's worked very well. Everybody's been happy with it.

Geoff: Let's just maybe rewind a moment and take a little bit of a higher level field of view on Idetico and maybe you can just, you know, give an overview of what Idetico produces and what is the size [01:03:30] and scale of the business today.

Catherine: There are two parts of it. The part that is functional now and produces income every month are the radiology reports. We get paid per click by the hospitals. We maintain the software. We maintain the report library. We maintain the overall worklist. We were able to replace some functions at the hospitals, as well as transcription. We also replaced [01:04:00] their system for doing...for accounting for critical values, which was costing each of our hospital systems $20,000 a year. And we replaced that as part of our product and they were quite happy with it frankly. It saved them a lot of money and it does make a small profit for us.

The other piece of it is our report library. One of the things that occurred in 2010 when we formed Idetico is all of the radiologists agreed [01:04:30] to a single report library. We would not do our own just individual reports. We would do a single one and we would all contribute to the library and we would edit them so that everybody was happy with them. To this day we've maintained that and all the radiologists love it. The reports are pre-populated as soon as I open a case. I open my dictation system. Normal report populates. So when I'm working [01:05:00] in emergency room probably 75% of the time I just click, send, and the report goes. If I have changes to make obviously in a CT abdomino-pelvis, if there's an appendicitis, I go to the appendix and fix it and then put it in the impression and send it to the emergency department.

Geoff: So Idetico provides report templates that essentially automatically populate in [01:05:30] your third party dictation system? Is that...?

Catherine: Well, we own the dictation system. We own a single...we own the [inaudible 01:05:39] dictation system. None of the hospitals own their own. So we own that and it's tied into each packs. We open the packs. We have a single work list through Clario, which can open multiple packs. So if I'm reading from CarolinaEast I hit the case on my [01:06:00] work list. It opens the packs, opens the fluency dictation system, and then populated in that is if it's the CT abdomino-pelvis with contrast and I hit the template that has the normal CT abdomino-pelvis with contrast. It has all the technique, it has all the things we need for macro. All of that is pre-populated in the report. So I'd use it as a checklist and then I change anything that needs to be changed to abnormal, put it [01:06:30] in the impression, and it goes back to that hospital.

Geoff: That's amazing. How many hospitals or practices would you estimate are using Idetico's solution?

Catherine: Not many. I think NYU has at least a couple of departments that are doing it but I don't know of...and then also Greensboro Radiology, which is

where we got the idea in the first place, own their own transcription, I mean, [01:07:00] own their own dictation system for their multiple hospitals but they don't go to the extent we do with structured reporting.

Geoff: Approximately how many employees do you have in Idetico?

Catherine: It's the radiologists and we have two other part time.

Geoff: I see. And so with everything else that you're doing, how much time do you need to devote to running this company?

Catherine: Initially it was extremely radiologist [01:07:30] intensive because we have about 600 or 700 templates in our library. That's a lot of work and really can only be done by radiologists. I think that's one reason that structured reporting hasn't taken off because it's gonna take just some basic scud work and the only people that can do it are the people who are creating the reports. But anyway, once we got the library pretty well set up now we spend time editing. [01:08:00] We try to do that whenever we see an error or whenever we need to update or we try to...each of us tries to do that. Again it can only be really done by radiologists unless it's a grammatical problem. And then we have one of our employees who's an IT person, helps us periodically when we need to change the macro lists or change a technique or change a contrast or something like that. [01:08:30]

Geoff: I see. You know, that's really quite an added dimension. As you transition to RAD Partners, did that affect the relationship with Idetico, or is Idetico really...Idetico's customer really CarolinaEast?

Catherine: Carolina's customers are the hospitals and we were very careful when we did our asset purchase agreement to keep Idetico out. You know, [01:09:00] we had made...all the radiologists had made the capital purchase of the software and the hardware and everything we needed for this system and we felt like that it was a separate entity anyway. We had already separated out as a...you know, with a different tax number. So we kept all of it separate from RAD Partners. But they're...you know, they knew about it of course, but they were fine with that.

Geoff: Sure. So is Idetico [01:09:30] owned by all the radiologists in Coastal Radiology?

Catherine: It's owned by the current six partners. We had two additional partners who are no longer there who...once you're not a partner anymore the ownership goes away and it's a buyout. But in a sense it's more like a

subscription. There's really no capital assets to speak of that haven't been depreciated.

Geoff: I see. Do you anticipate when new people join the [01:10:00] practice that they'll become partners in Idetico too?

Catherine: They could if they're interested in it. Again it's hard to value, and one of the things we're actually looking at now...we've had some interest from some companies about purchasing our report library, which we would be certainly interested in doing. Again it's labor intensive and it has to be done by someone who knows what language goes in the [01:10:30] reports. So it's hard to value but it's certainly not something that everyone has.

Geoff: Yeah, I imagine 700-plus report templates is a valuable asset.

Catherine: We think so. We've had new radiologists come in and start using it and one said to me, "This is great. When I get home at night I don't feel like [01:11:00] I've talked all day long." Our goal is to use as little of the VR as possible so that the fewer words you just have to say the fewer mistakes you make.

Geoff: The VR, what do you mean by VR?

Catherine: The dictation system.

Geoff: Okay. It must've been a very proud moment when you and your daughter graduated from Yale together. You with the MBA and she with a bachelor's degree. How did having five [01:11:30] children impact your career? And conversely, how did your career impact your mothering choices?

Catherine: Well, again, in my career I didn't do...I'm a contemporary of Bill Thorth [SP] and yet I didn't become a fellow at the ACR until 2015. Basically I didn't do anything in the ACR until then. And I was quite happy to put that off but it was a...I did my work a lot later than my contemporaries did. [01:12:00]

As far as my children, I had excellent help at home and I don't think anyone, father or mother, went by to working outside the home can survive without good support. I was extremely lucky. The same woman who was here when my fourth son was born...he's now 32, is still working with me and she's now helping my mother who's [01:12:30] 95. So she helps me a little and she helps my mother. If you find someone like that it's just tremendous. And you can't do it without. I missed some things my children did but my group is very family oriented and we try our best. I'll cover for somebody when it's...the other

morning one of my partners has a daughter who has a beautiful voice and she was singing at 8:30 at school, and so I was the late shift that day but I just went in and sat in his spot for a couple of hours so [01:13:00] he could go hear her and we do that without any, "Well, you gotta pay me back or what..." That kind of thing. So, you know, we still are a local group despite all the corporate stuff going on.

Geoff: That's a special relationship. Everybody in the group should feel fortunate to have that. You talk about postponing and waiting to take on some of these additional roles until your kids were grown but... I mean, you were a full time radiologist [01:13:30] through all that and so, you know, that certainly represents a substantial career commitment and, you know, in and of itself. So it's impressive to, you know, be raising the five kids and to manage your radiology practice to the point where you were the logical choice to become president of the practice.

Catherine: Well, you know, it's hard work. I put a lot of it on my DQ experience. You know, you work hard and you play hard and you don't [01:14:00] waste time. And, you know, you do things that are important to you when they are. And if you have to put some things aside like, for instance, my garden for two years, you do what you can do and what makes you feel good and happy.

Geoff: You describe your 20 or so years raising your kids as your Rip Van Winkle years, but you served on the Medical Executive Committee and were the Radiology Department chair at CarolinaEast Medical Center through much of the 1980s, and subsequently an officer [01:14:30] of the medical staff culminating in becoming the first woman to serve as chief of the medical staff and then onto the board of directors. So you really were deeply involved in healthcare leadership from almost the beginning of your practice. How demanding were those roles within the context of raising your family and practicing radiology?

Catherine: The chief of staff years were pretty demanding. And I hesitated to take that position but [01:15:00] when asked, I thought, "Now this is an opportunity and you shouldn't turn it down." It was out of my comfort level but I did it and learned a lot from that position, particularly the board years.

Time wise, I think department chair early on was harder because we were making a lot of decisions. Since we had gone back to one group we had a lot of departmental decisions to make, to make [01:15:30] the department more standardized. I had more time during the day. As you know I think radiology was a little bit more leisurely in the old days. You had to put a few films up and

you got to talk to a lot of referring physicians but the volume wasn't there that is today and I used to...could find half an hour here and there to take care of things in the department.

Geoff: It's fair to say that Rip Van Winkle was really not [01:16:00] sleeping.

Catherine: Only for the ACR.

Geoff: Okay. All right. That's excellent. That's fair. Do you believe that your children have gained through your example and in particular your commitment to leadership?

Catherine: I have great children. They're all just super. I have one that's actually applying to medical school now, the one that went to Yale. After she tried to save the world for five years she's now decided she's gonna do it through [01:16:30] medicine. But anyway, I think they are very different but they're self-possessed, they handle themselves beautifully, they have great manners, they're all smart, they all have good jobs, and they're used to making independent decisions because I wasn't always around to mother them. And they made some bad decisions but they're making great decisions now and they're truly adults, and I like to see that.

Geoff: Photos of you wakeboarding, [01:17:00] riding a camel in the Sahara, thank yous from grateful patients or posts on patient care, physician well-being and meaningful leadership. Your Twitter feed exudes passion for seizing all that life has to offer as well as for the field of radiology. How do your passions inform each other to produce the woman that you are?

Catherine: Well, again, you know, work hard, play hard. I have several young friends [01:17:30] who ask me how I've traveled so much and I say, "Well, you know, I didn't even have a passport until I was 42 years old." You talk about delayed...arrested development. But I love to travel and I do every chance I get. So I don't like to waste time. When I'm home I work or I work in my yard and when I'm gone I go somewhere fun. Unless it's, you know, radiology meetings which are fun but in a different way.

Geoff: What do you see as the role of social media in both your professional and personal lives? [01:18:00]

Catherine: Professionally I've learned so much being on Twitter with radiologists. I have to be careful because I spend a little bit too much time on it. But just reading everybody's thoughts and reading the papers that are out there. It certainly broadens your perspective and your knowledge. As far as other

social media I reconnected with a lot of my cousins and older friends through some of the other social media. Again I try to stay off of it. I get a little [01:18:30] bit too involved. I do a lot of things, as my husband would say, whole heart and so I have to watch myself on that.

Geoff: But as a whole it sounds like you would say that social media has been a good thing in your life.

Catherine: Yes, absolutely.

Geoff: You recently tweeted, "Renew your vows with the radiology you fell in love with," in response to an ACR education course that you were taking, referring to it as exhilarating and mind expanding. [01:19:00] Would you expand upon these sentiments and how they might encourage professional joy and contribute to a strategy to reduce physician burnout?

Catherine: Again, I think, going to a course like that or any really good course, it reminds you of why you went to radiology in the first place. I mean, the learning...particularly the one I went to was prostate MRI which is not exactly my field of interest or expertise but it was such good faculty, such good cases and [01:19:30] the visual of radiology. That's why you went into it. You like to look at things obviously. And doing that a couple of times a year, going to some intense course really gets your mind revved back up into why you did it in the first place. You didn't do it to manage diabetes. That's not what you're doing. You're doing it because you like the imaging. Every day I look up something. Even if I've gotten to the end of the day and I've read a case and I remembered something about it that I wanted to see a couple more things. [01:20:00] I go to anatomy books or actually online, but I look at anatomy all the time. Despite the fact I do MSK a lot, I can't always remember every single muscle in the hand and I have to go look those up, but I'm getting there.

Geoff: So as you reflect on your career to date do you have any fundamental philosophies that you feel have served you well?

Catherine: One is, as I said, I always think there's a better way to do things and it can be small things. [01:20:30] But there's always room for improvement. Never sit back and think, "Yeah, I got it done." Because you don't. It's always something out there you can do a little better. Realize that one has to work hard. That's just...it is but you also have to enjoy your work. If I didn't like what I did I can't imagine how miserable I would've been over the last 30 years. I tell my children that. If you don't like what you're doing, I don't care how good it seems on paper, you've got to do something else. [01:21:00]

Geoff: Solid. Solid advice. Looking back, is there anything you would have done differently?

Catherine: You've got me now. I can't think of anything that I would've done differently. I know that I missed some things with my children. I know that, you know, I started the ACR late and may have missed some opportunities there but I think overall, I can't think of anything that [01:21:30] I would change in my career. Would like to be a little younger maybe, but even that, you know, I'm making the best of it.

Geoff: You definitely are. What would you say is from your perspective radiologists' biggest challenge in the near to midterm future?

Catherine: I think the consolidation of practices is gonna be tough. [01:22:00] Small practices are really gonna have to evaluate where they stand and if they can maintain. If they can, I think they should. I think what we're gonna do to...how we're gonna train generalists again to do...to take care of small hospitals. I think radiology is gonna have to decide do we wanna keep those positions and train people to be there or are we willing to give them up and centralize everything with [01:22:30] the idea that we are giving up procedures. I know there's a lot of concern about AI. I think that's just exciting. I think done correctly it's gonna be another whole dimension for us to make us a better radiologist. So I don't see that as a threat. I see that as a future.

Geoff: Are there any words of encouragement that you would like to impart on women radiologists in particular [01:23:00] who might be in the throes of raising a family at this moment based upon your experience?

Catherine: I mean, a key one is to trust your own instincts. Your child doesn't have to do everything that everybody else's child is doing. The family unit is the most important thing. Children are resilient. If mama or daddy's not there, there's someone there, that's okay. When I go to some of the [01:23:30] meetings with the young residents and young professional radiologists, it worries me that they're so uptight and so tense and so seems like worried. And, you know, we've been mothers forever and daddies forever and children turn out okay. Just I think you need to relax a little bit, enjoy your career, enjoy your children, and don't feel like every single decision is earthshaking. [01:24:00] Relax.

Geoff: Super. That's great, great advice and a voice with a lot of experience. Well, Catherine Everett, you are an inspiration for your example and for your passion and for your zeal. I can't thank you enough for taking the time to talk to us today and joining us on "Taking the Lead".

Catherine: Thank you. [01:24:30]

Geoff: Please join me next month when I speak with Norman Beauchamp who, after 14 years as professor and chairman of the department of radiology at the University of Washington in Seattle, stepped up to the role of dean of the College of Human Medicine at Michigan State, a university in crisis after the growing public awareness of Larry Nassar's abuses while providing healthcare as a trainer for U.S. gymnastics and Michigan State athletics. [01:25:00] In the wake of the tragedy and subsequent firing of the university president, Dr. Beauchamp has led an effort to restructure healthcare delivery at Michigan State within a newly created role as associate provost and assistant vice president for health affairs, addressing the delicate balance between healing wounds of the past while driving innovation and optimism for the future. "Taking the Lead" is a production of the Radiology Leadership Institute and the American College [01:25:30] of Radiology. Special thanks go to Anne Marie Pascoe, senior director of the RLI and co-producer of this podcast, to [inaudible 01:25:40] for production support, Megan Gian Papa [SP] for our marketing, Brian Russell for technical support, and Shane Yoder [SP] for our theme music. Finally, thank you, our audience, for listening and for your interest in radiology leadership. I'm your host, Geoff Ruben from Duke University. We welcome your [01:26:00] feedback, questions, and ideas for future conversations. You can reach me on Twitter @geoffruben or the RLI @rli_acr. Alternatively, send us an email at rli@acr.org. I look forward to you joining me next time on "Taking the Lead." [01:26:30]