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Promoting Management and Leadership

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Management in Radiology Annual Scientific Meeting Review

Bologna in Italy was the setting for this year's Management in Radiology (MIR) annual gathering. A roster of distinguished speakers from Europe and the United States discussed, debated and mulled over key topics for radiology leaders and managers, including value, quality, strategy, globalisation, imaging biobanks and communication. Delegates went away encouraged to try something new in their own radiology department.

Prof. Moshe Graif (Israel) set the scene by looking into the future prospects of radiology in 2020 [see page 44 for an article based on this presentation].

Value

The value of radiology and radiologists was discussed from the viewpoint of the U.S. and the UK, by Dr. Geraldine McGinty and Prof. Erika Denton respectively. Prof. Denton is the National Clinical Director for Diagnostics, NHS England, and she argued, with examples from the NHS England Diagnostic Imaging Dataset, that data is essential to effect change and monitor results. Denton observed that strategic thinking is needed to manage the overwhelming sense that radiologists are being overworked. It is important to count what radiologists do, and count the impact of what radiologists do, beyond the "technological silo" that radiology can tend to focus on.

McGinty, Chair, American College of Radiology (ACR)'s Commission on Economics, outlined the ACR's Value 3.0 proposition, and urged delegates to start demonstrating value. She listed six actions, which radiologists could do right now:

1. Maximise reimbursement under the current system;

2. Maximise participation in quality programmes;

3. Get educated about your wider world;

4. Educate your community about what you do;

5. Get involved in system governance;

6. Find a way to connect differently with your patients.

Communication

Prof. Charles Kahn and Prof. Leonard Berlin discussed the technical, ethical and medicolegal aspects of reporting "actionable findings". Kahn served on the ACR's Actionable Findings Work Group, and he took delegates through the categories: communication within minutes, within hours and within days, as well as discussing where IT can assist. Berlin had a plethora of legal cases at his fingertips, where the radiologist was held liable for not communicating findings. Failures occur when the information exists, but is not communicated. Berlin recommended that direct communication of findings, whether in person or by phone, be documented at the time. He asked, "Wouldn't the radiologist, if he/ she did not communicate findings, not only be liable to legal consequences, but feel guilty?"

Berlin also spoke about disclosing and apologising for patient errors. Surveys show a gap between aspiration and practice: physicians believe they should disclose errors, but few do. An apology has four parts, explained Berlin: acknowledge, explain, express remorse, reparation. Ineffective apologies involve a failure of one of those elements, e.g by saying, "Mistakes were made" vs. "I made a mistake". Berlin advised radiologists, when apologising, not to speculate about cause, blame others, disclose information prematurely or clutter an apology with excuses. Berlin's presentation prompted some lively discussion around the difference between errors and complications, and the influence of the increased workload of radiologists.

Social Media

Social media can make radiologists more visible, according to Dr. Pablo Rodriguez (Spain), Dr. Lorenzo Faggioni (Italy) and Dr. Jon Bell (UK), who encouraged delegates to get involved in social media, and take advantage of the educational and communication benefits, while being careful to separate the personal and professional. Dr. Peter Pokieser (Austria) described an innovative course at the Medical University of Vienna, which uses social media in blended learning in an interdisciplinary course on emergency medicine.

EHealth in Europe

Dr. Stephan Schug, Chief Medical Officer of the European Health Telematics Association (EHTEL) spoke about the widespread deployment of telemedicine in Europe from the perspective of an eHealth stakeholder. Key actions of the European Commission's Digital Agenda for Europe include to "propose a recommendation defining a minimum common set of patient data for interoperability of patient records", undertaking pilot actions to equip Europeans to secure electronic access to their electronic health record. There are several models of teleradiology: a single facility uses it for home-based radiologists or to obtain second opinions; multi-professional care teams support patients at home, facilitate self-management and patient empowerment. The Association recommends that patient access be part of the standard set up, and that digital literacy and training in eHealth tools is needed for all health professionals. In addition the identity of a health professional providing a service should be transparent, systematic monitoring of the value of the telemedical service should be monitored before inclusion in guidelines, and telemedia should not replace human encounters. Celine Deswarte, from the European Commission, outlined the legal approach to telemedicine in Europe: the focus is on licensing, registration, professional qualifications, data protection and reimbursement. Physicians don't necessarily have to move to the country of their patient, but have to comply with authorisation and registration requirements of their member state. There is a project to produce a "European professional card", to accelerate recognition procedures and validation by the host state. Regarding data protection, it is prohibited to process health data except in case of patient consent, to protect vital interests, for health purposes or research purposes (data must be pseudonymised). As to reimbursement, the member state decides what to reimburse.

Dr. Remy Demuth (President, European Union of Medical Specialists (UEMS) Radiology Section) explained the UEMS' views on free movement and training requirements - "quality in mobility". Objectives are to promote free movement, with the vision of setting standards for specialist medical training and quality assurance. As different specialities have reached different levels of quality, harmonisation should aim higher than the highest achieving entity. To modernise training requirements, medical training should be duration- and competence-based.

Promoting Safety

Safety in radiology has many facets, including appropriate imaging and decision support, communication with patients about radiation dose and implementation of European Union directives.

Professor James Brink (U.S.) Mass General spoke about decision support for radiologists and referring physicians. He noted that algorithms have been published for incidental findings, but doctors don't always use them. These algorithms need to be tuned to patient populations.

Communicating with Patients

Professor Davide Caramella spoke about communicating about radiation dose and contrast media (see article on page 48). Dr. Jurgen Jacobs (Belgium) outlined how his department is implementing the European directive on radiation protection, which requires justification, optimisation and limitation of radiation exposure. Exams must be justified, based on evidence-based guidelines. In his department they constructed a generic framework. The next step will be working on its implementation and integration in workflows which currently exist. The data collected will contribute to business intelligence for statistical analysis, etc. Jacobs urged radiologists to start harmonising protocols. Clinical audits should assess care quality and resources effectiveness. Information is there, but is not closely analysed. Jacobs pointed out that the same dataset is of different value to people, depending on their interest and specialities. Tools should save time ultimately, unless they are only seen as a compliance tool. For improving quality, the investment is beneficial. It simplifies the optimisation process. Prof. Caramella pointed out that by using tools passively (disregarding alerts and malpractice), you are collecting evidence against yourself in the case of litigation!

Prof. Peter Mildenberger (Chair, MR) with Dr. Geraldine McGinty

Prof. Leonard Berlin, Prof. Charles Kahn

Discussion revolved around how to bring referring physicians on board. Prof. Brink said that they need to understand that the new system will not be punitive – at his hospital (Massachussetts General) they have incentivised physicians to participate. Local variations will of course require modification to suit local practice patterns. That's the only way to keep referring physicians on board. Prof. Caramella noted that a potential weak point is that adverse events could come from following guidelines from new decision support systems.

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