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The Management Decision I Most Regret and Why

Six Top Radiologists Share the Lessons they Learned

Each year, top Chairmen from medical imaging departments across the world get together at a dedicated management congress where an innovative tradition is evolving. Dubbed simply the "Management Forum", a select number of medical imaging managers gather before the audience to share their unique professional management strategies in an interactive session, which is then opened to the floor. The aim is to highlight and debate what works and what doesn't, in a practical and experience- sharing way that is useful for other medical imaging managers in their daily working lives.

In this report, IMAGING Management presents the results of the most recent Management in Radiology / MIR congress Management Forum, where leading experts in medical imaging address the topic of "The Management Decision I Most Regret & Why". Here, in their own words, they offer up the hard-earned pearls of wisdom from errors they made that they feel have enhanced their overall professional experience. In the words of Forum Chair Philip Gishen / UK, "We all learn from experience - most of us only get to our level of experience from the mistakes that we make." In this spirit, we also publish the results of some of the post-presentation talks and audience comments, which may also be useful for you.

Hiring & Firing

Carefully research the profile of any new candidate in the department

Stephen Baker / US

The problem I'm going to talk about is not particularly unique, though it is the one that has bothered me the most. Firstly, let me give you some background. Twenty years ago I joined a new institution, the New Jersey Medical School. This was in 1990. I started as Radiology Acting Chairperson for six years before I took the job as Chairman. Twentysix candidates had already turned down the position – it had a reputation as a 'mediocre' facility. I accepted the Chairmanship with the realisation that there was no place to go but up. I was given adequate resources for equipment and funding for five new personnel. In my new role I recruited five additional radiologists, did not renew ten and hired their replacements.

I was also given the brief to hire an individual with an international reputation as a clinician, investigator and teacher. The idea was to establish a research programme that would be considered up and coming by dint of this individual's decision to join us. Unfortunately, this person turned out to be lazy, had forgotten how to do general radiology, and was a grandiose bigoted malingerer who declared that he "no longer had research interests"! Needless to say, I regretted the hiring decision.

The situation in the department got worse; he retarded the growth of a section, badmouthed those he didn't like. During his tenure, he suffered a stroke, and was not fully rehabilitatable. When he recovered sufficiently, he resisted coming back to the department for six months. To solve the problem, I offered him a part-time position doing general radiology, but he protested. He attempted to subvert activities in the department, acting out his anger at his new disability.

The later consequences of this unsettled situation were that he sued the department, and me. In-house legal staff were not able to mount a strong defense, so outside counsel were hired. After a six-week trial, the department paid 100,000 dollars to cover this, although they had won. This was not the end of the matter – for seven years after this, I received two death threats and menacing emails. Then he died. The lessons I learned were:

- Investigate fully before hiring;
- Build the department from below as part of an ethos of faculty development;
- Hire for the department, and not for everyone else, and
- Get a workhorse not a showhorse!

Discussion

Prof. Philip Gishen kicked off the post presentation talks by highlighting the differences in hiring and firing between the U.S. and UK: "In the UK there is an interview process where you are not supposed to know the details of the background of candidates – you just get a CV and that's it. There is much less success in discovering these types of individuals." Prof. Baker responded by stating "I call up about everyone I hire. I found another candidate the other day that is a felon. We do background checks on everybody. It is the opposite of the UK. Even mild crimes are uncovered and we try to get as much information as possible."

Dr. Howard Galloway stated that he has experienced a similar situation where they "... don't have the luxury of terminating people" and asked Prof. Baker what do to with resistant team members when one is not permitted to terminate.

Prof. Baker stated that this is not a situation he finds acceptable, adding "Not being able to terminate employees means you can't perform one of the functions of your appointment" and that he wouldn't take the job. He added that he has fired over 30 people over the 30 years he has been working. His advice is to "marginalise destructive individuals in some way so they can't harm the department". He added a word of warning to the other Chairmen present: "There are certain statements made that are alarm bells when I hear them said about a team member: "The department is dysfunctional", or "Morale is low here". Usually, this is a fairly reliable sign that I have to get rid of that person."

Prof. Gishen rounded up the discussion by stating that hiring and firing is "A problem throughout the EU. There is little opportunity to terminate people, and it's very difficult". His own advice is "Never go to war with a colleague – it is much better to marginalise that person, put them out of harm's way so the department can continue to run efficiently, otherwise you are left with an intractable problem."

New Building Construction

Consider any long-term consequences from outsourced agreements
Michel Claudon / FR

I was very surprised to receive an invitation to discuss a regrettable management decision - regret is not a word one is used to hearing in management courses! To open, I want to make a definition of the word to elucidate what I am going to speak about. For me, this is a feeling of distress and disappointment about something one wishes was different. Let me also preface this talk by asking attendees, "How can I evaluate my management and why? Who should evaluate regret? Is it a self-evaluation? Should the patients or the institution's manager perform this evaluation? And when should it be done: A day, week or even a year after the decision?

As we may all have heard, everything happens to you for a reason. Sometimes the reason is very minor – but even small decisions can have huge consequences. For example, I didn't note an appointment on my agenda a few years ago regarding a meeting with hospital managers to choose the location for a new CT scanner. It became clear that I should have been there to favour my hospital for the location. On the evening when this meeting was taking place, my mobile phone rang, and it was the Vice Dean of the hospital ringing to ask me "Where are you?" As I hadn't noted the meeting on my agenda, I was very embarrassed - I immediately went to the meeting, apologising to those present. However, the next day I learned that unfortunately the conclusion of the meeting was different to the one I had expected – the location of the CT scanner was not our institution. Our team was disappointed. However, after a few days I tried again to appeal to those in charge in a stronger way than before and won. So, it came out okay and the 'mistake' had a positive ending.

However, my second regret was more serious. It was regarding a vote for the construction of new buildings. In 2007 I was elected by colleagues to represent them at a meeting regarding a decision to construct a new building to allow us to work with different departments. For the other, smaller hospitals, this would surely improve their organisational efficiency. The final agreement was to be a leasing contract with an external company who would own the building for three years, and who would be paid six million euros a year for the construction. In 2008 our new general manager calculated that the deficit caused by the construction would be to the tune of 20 million euros. He calculated that the financial advantage offered by the construction of these new buildings would save two million euros a year, so by paying six million euros a year to the external company for its construction, we were left with an additional deficit of four million euros per year. Obviously, though I voted for this decision, I didn't know that this would be the outcome. As time passed, restrictions in our financial income prompted the hospital to develop a strategy to include more outpatients with a diminution of 50 percent in the number of beds and increased capacity within all existing buildings. Finally, this allowed us to offset the deficit by generating new income. I would wrap this up by stating that it can be difficult to predict what's going to happen in the future, but that management is an ongoing process and solutions can always be found. In the words of Victoria Holt, "Never regret – If it's good, it's wonderful. If it's bad, it's experience".

Recruitment Challenges

Avoid departmental inbreeding
Luis Donoso / ES

Our radiology service is less of a traditional department, and more of a 'group'. It consists of over 100 radiologists, nuclear medicine professionals, plus 300 other staff, and is part of a big group working in a network with 10 other hospitals. It is quite a 'nice mess'! To prepare for this talk, I asked myself what are the classical questions in decision-making? For me, these are:

- What are the options?
- What consequences might they bring?
- How likely are they?
- How desireable are they?

Searching in the literature, one finds in addition to these important cognitive considerations, that there are strong emotional factors in decision-making. I discovered that the emotion that has received the most research attention from decision theorists, is regret. Why is regret so important in decision- making?

One interesting article states that a bad outcome resulting from action seemed to be less regrettable than the same bad outcome when it was the result of inaction. (Connolly T. and Zeelenberg, M. – Current Directions in Psychological Science 2002 11: 212). Importantly, people that are asked to recall real-life regrets tend to recall omissions more frequently than commissions. Regrettable actions hurt more than omissions in the

short run, but when looking back, people experience more regret over inactions. People may regret inactions more than actions in the short term also. To add to this confusion, some people might experience high self-blame and regret even when the outcome is good. For example, suppose that you leave a party somewhat inebriated and decide to drive home rather than take a cab. You arrive home safely (good outcome), but the following morning you are racked with regret as you think back on your decision. What we can deduce from this is that a good outcome is not always the best result in terms of decision-making.

The overall feeling of regret at some decision is a combination of these two components:

- The outcome is poorer than some standard (often the outcome of the option you rejected), and
- The decision you made was, in retrospect, unjustified.

If we can anticipate the regret, we may engage in "thoughtful" decision-making. These regrets can be the result of:

- Delays in major organisational changes due to search for impossible consensus;
- Maintaining organisational structures that are not consistent with the current structure;
- Not showing firm commitment to strengthening the role of technicians;
- Overestimating department member's involvement in management issues;
- Insufficient attention to the deployment of quantitative and qualitative methods in the assessment of clinical skills/competence/performance, and
- Paying too much attention to those who complain while ignoring valuable elements in the department. Complaining is good – but we spend too long on it.

The most regrettable one for me is inbreeding in the recruitment of new staff! Why? If you are trying to change your corporate culture, bolster diversity or bring in new skills or talents, it's harder to do if you're hiring clones of your current workforce. Not just doctors, engineers, physicists or biochemists, new staff members in any area of the department can bring new flavours. It's risky, but the inaction in not doing so was far more regrettable.

Discussion

Following his presentation, Prof. Gishen asked Prof. Donoso "How actively do you go out to recruit new staff?" Prof. Donoso responded that there is a "... shortage of radiologists in Spain, especially in Barcelona – we have to act like football coaches, sourcing team members from other organisations that may improve or enhance the current line-up."

He added that "Informal information from colleagues of a potential candidate when hiring is important. While the human resource personnel won't commit opinions to paper, they may speak to you over the phone, informally. Informal information is crucial to hiring."

He added in reference to the previous discussion on hiring that in Spain one may hire someone on a few years contract basis before taking them on permanently, which gives you a great opportunity to view them in action before taking them on for a long-term basis.

Mergers-

Change management
Jarl Jakobsen / NO

During my career, I've been through five or six major mergers. In Oslo, we created a new hospital from several public hospitals. The end result included over 20,000 employees spread across Oslo and the surrounding areas. In regards to the merged imaging departments, there were four departments eight different locations of which I was heading two of them.

Resources for the new imaging unit:

- 550,000 visits to exam rooms per year;
- 700 employees – 120 radiologists, 60 residents;
- Budget of 80 million euros;
- Approx. 120 modalities incl. 15 MR, 16 CT, 11 angio, etc., and
- Part of a division consisting of "medical services' – (lab, pharmacology, pathology, microbiology, immunology).

The challenge was to create one homogenous organisation in as horizontal a fashion as possible, given the eight different geographic locations. We were also charged with the job of cutting costs by 2.5 million euros in 2010. Previously we had been competitors with one clear leader in academics. The challenges were that each hospital had different cultures, with different preferred vendors in each entity and demanded the combination of five RIS/PACS systems.

The numbers were getting bigger – we had a lot of patients and employees to take care of and the budget was not big enough. There were also many machines to account for, which now became part of a holistic medical services division, which was being spoken of as a resource. However, behind the theory of mergers, there are several typologies of mergers and becoming part of a medical service the division that offers totally unrelated services is more a challenge than a resource.
What happened? My first regrettable management decision was that I agreed to be the new chairman for all of this. I was partly running my own unit while also working as project leader (two full time jobs for a while) for the new organisation in Q3 and 4, 2009. From Q1, 2010, I was formally

the new leader for the new department.

This new organisation was up and running from May 2010, in which there were eleven units making direct reports and 42 different units on the lower level, for example sections for neuroradiology. This new organisation chart was debatable and controversials and it was not organised the way I primarily preferred it. My administrative staff became centralised, and my business manager was on a level 'above' me. My formal authority became reduced, and I had was no investment or authority in radiological IT, as one example. I also experienced a management culture different to where I come from. What do you do then? I implemented a proper decision-making process. Finally I ended up with two regrettable decisions: Firstly, becoming chairman, and secondly, stepping down.

However, when I examine what happened, I ask myself why I might regret these two actions? In terms of becoming the chairman, there were certain positive experiences:

- I got new challenges that taught me a lot;
- I got more power, more influence, and
- We succeeded with the merger though not in 'my way'.

On the negative side, the tools needed to practice good management were removed. There was incompatibility between our set of human and leadership values. With regards to stepping down as Chairman, my regrets were:

- I made a mistake in the first choice of accepting the job without proper agremeents up front;
- I experienced feelings of loss;
- It changed my relationships with colleagues, and
- It changed my working situation with a loss of power.

However, the most important question is: Was it worthwhile and right to make the regrettable decisions I have outlined here? I can say that I felt I was true to my own set of values and experiences. In addition, my own reaction to feelings of loss is something I have to handle myself. You have to take care of your own life and handle what happens to you in the best way. I can still be true to my education, experience and interest in management – I have a degree in management and I am a member of national and MIR organisations, so it was important when I stepped down that these years were not spent in vain. I followed those authentic interests. I am now refreshing my academic radiology and clinical radiology – thus, I have the best of both two worlds. My conclusion? Regrettable decisions may be worthwile.

Choosing a PACS System-

Ensure the future stability & long-term prospects of the vendor

Jose Vilar / ES

I feel a certain sympathy with the other presenters. Many of the mistakes discussed sound familiar to me, but I have managed to choose one out of the undoubted hundreds that I have made. Just for background, I work at the Valencia "Hospital Univeritario Dr. Peset", a 520-bed hospital performing 220,000 exams per year, linked to the University of Valencia. During a previous 'Management in Radiology (MIR) congress that was held in Parma, in 2000, we presented our experience in the development of a local teleradiology network, which we developed working with an external group of informatics specialists, as a complementary tool to be used in the Valencia Community breast cancer screening programme. At that time we had no PACS system and were accordingly very proud of this new IT programme that allowed us to be early adopters of the new means of sending images from one centre to another. A few years after the project gave us this initial experience in implementing teleradiology to share images and data, it was decided that we were going to invest in a PACS for the purposes of improved image management. A tender was initiated for the purchase of a PACS system that would be implemented for the whole community of Valencia within the different hospitals. 1,200,000 euros was assigned for investment purposes for the large hospitals and 600,000 euros for smaller hospitals. We were considering whether to go for one of the large manufacturers of PACS in the European market, versus our own internally developed system.

As mentioned, we had this small group of IT specialists who developed an early system of teleradiology and who had already defined a PACS, so we had to choose between them and a new provider.

Our own system was a work in progress that was not fully developed – there was no large firm behind it, it had only a few personnel working on it, but they were very enthusiastic. We had to make a decision! The additional problem was that the politicians in power decided that since we already had our own system in development, they would cut our budget by 50 percent - this was certainly detrimental to our hospital. Finally, I went with our own system. It was a mistake. Afterwards, this small group was absorbed by a large IT group in Spain – this large company was again absorbed the next year by a bigger national IT company, which had little specialised experience in healthcare IT such as PACS.

The consequences were as follows:

- We had an unreliable system;
- We were faced with continuous changes;
- Our system was slow with a loss in efficiency, and
- There was a negative influence on our radiologists and other personnel.

So the lesson to be learned when acquiring any IT system is never to choose a product that hasn't been fully tested or confirmed – probably this is very obvious to you but it was not at the time, either to me or my team. We lost a lot of time and now we are ready to buy another system and will decide completely differently.

Discussion

Dr. Maurizio Centonze stated following the presentation that "In Italy, when we have to make a decision about, for example, PACS or MRI, we have to perform a technology assessment as part of process management – the problem with this is that there is insufficient time to really investigate as much as one would like".

Prof. VIlar responded "This is true – radiology is difficult to Chair, not only can it be hard to find the time to make decisions, but despite the experience you acquire you have to be always prepared for new things, with no precedent, and you are not enough prepared for it."

Prof. Donoso then raised an excellent point - whether such a major decision "Should be taken by the Chairman of a radiology department?" Said Prof. Vilar "No, I assumed the decision was mine, however, it should be more than just the radiology department involved – PACS is something for entire hospital with an impact on the larger organisation."

Following this, David Koff / CA asked about the role of Managed Equipment Services (MES) and asked for reactions from those users present. "In Canada we may be first to move to this type of managed solution. To research it, we went to the UK to see how MES is working there to find out if it is of benefit – we have the impression it can be beneficial, since for us underequipment is a serious problem. This could allow us to have a higher level of equipment and maintenance".

Richard Fitzgerald / UK responded that "Eight years ago we moved to a new department built under a private finance initiative, using a private provider. The great advantage is that needed equipment is being renewed at seven year intervals so there is no problem getting any equipment one wants. There are two downsides. The first issue is that you are locked into contract for 20 or 30 years – and locked in at a time when you Also, he stated, "Not all manufacturers – no matter now good they are – will be "top of the pops" for every single modality or application you need and that is a downside. Prof. Jarl Jakobsen added "You will spend lots of your time on SLAs (service level agreements) – be aware that it is not the case that vendors "know your dreams" - you have to put it into writing and you have to keep your competence as a buyer. You can't just outsource and then switch off so my advice to anyone considering this is to consider the resources you will need for these SLAs and be a competent buyer."

Setting up a Teleradiology Company-

Ensure you have the support of all shareholders when setting up a teleradiology service
Jan Schillebeekx / BE

I'm a consultant radiologist and past Chairman in a big community hospital in Belgium. As this session's oldest speaker, perhaps I have made the most mistakes of all! However, I have decided to talk about a fairly recent one, which is the one I particularly regret. Let's talk about teleradiology. In 2001, faced by the ever-increasing demand for medical imaging services, we started up a company providing outsourced teleradiology services in Holland and in Belgium. We had good intentions, because it was a company started by radiologists for radiologists. However, from the day I began working in this company, suddenly for many people I was the big enemy - and if you find out you have this kind of strong opposition, you have to admit to yourself that there must be a foundation for such a negative reaction. I must point out that despite the worries of radiologists that we were unfair competition, we clearly said we would not push our services on those doing a successful job, but to deliver service when there is a need - for example, where there was not enough capacity of radiologists. Here I can add that there is an overcapacity of radiologists in Belgium, with a total of 1,500 radiologists for 10 million inhabitants. In contrast, there are only 2,000 radiologists in the UK with a population of over 50 million and in Spain there is generally considered to be a shortage.

There were two reasons why I believe it was a bad decision to get involved in a commercial teleradiology company: We were not able to bridge the gap between the reporting radiologists and the management - our radiologists felt they were not paid enough and were overloaded with their work, while the management felt these radiologists were overpaid and not committed to the job.

As a radiologist and manager you feel yourself squeezed between the two parties who both have their rights and wrongs. If you employ radiologists and you work with those colleagues as their manager you come into constant conflict with your colleagues, because their position is that they may feel that they are overworked and underpaid. The lesson is this: competitively the project was very successful financially but the lesson I learned is to never try to make money on the back of your colleagues.

Then there was another problem that cropped up between the company and the local radiologists working cross border - our management felt we were helping the cross border local radiologists - but these local radiologists felt threatened by this new company, that they would be marginalised or that we would somehow 'steal' their business. The company and these outside colleagues from countries where we delivered the service did not have the same perception of our role. We were unsuccessful in bridging the gap between the company and the outside family of radiologists. So, finally I have realised that the message is not to start a major project or service such as this, if you don't have the support of all stakeholders concerned.

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