EDITORIAL

On Chaos: Codes and the RSNA

I remember the first time I saw a "code" in medical school. In my short white coat, I was struck by what appeared to be complete and utter disorganization and chaos. My first thought was: *you've got to be kidding me*. My second was: *don't ever bring me here if I'm sick*. The spectacle didn't do much to inspire my confidence in medicine. In the subsequent 15 plus years of my career, I've practiced at several different hospitals in different locales and I've seen a sizable number of codes. I have many long coats that I never wear. With increasing experience, I've come to realize that my initial assessment was, well . . . pretty much exactly correct. To date, I've never seen an organized resuscitation effort, even in the IR suite. You would think that codes in IR would be the easiest of all to run—every patient is monitored, vascular access and airway support are already in place, and necessary medications are in the room when the code team arrives. Still, when a code occurs in my IR section, the dog and pony show begins. The code team comes barging into our room, people begin screaming out orders to no one in particular, and running into a million directions at once. It's amazing that anyone survives these things.

The RSNA reminds me a lot of a code—except for the lack of chest compressions and screaming. It's overwhelming. People are running in a thousand different directions, half of them look like they haven't slept in days, and no one really seems quite sure of what they're trying to accomplish. In some ways it is even more of a dog and pony show than a code, particularly given all the colorful ribbons that hang on the badges of some of the faculty. Personally, I hate the RSNA meeting—not because there is anything wrong with the meeting or because I don't get a whole bunch of colorful ribbons. Quite the opposite, it is one of the best attended and well run meetings on the planet. But for me, my hospital is ~10 minutes away and I face the dilemma of both taking care of patients while trying to lecture to people how they should take care of patients. Every time I begin to speak, voices in my head say, *"Hey genius, don't you think that to best take care of patients, you probably should be present in the hospital, not lecturing 10 miles away."* These voices tend to be very distracting.

For the past few years, I've spoken in courses that use the audience response system. At first, I really liked this, and if used correctly, it can be a valuable learning tool. On the other hand, it does present challenges, and it is difficult to optimize the pacing and content of a lecture that incorporates this system. One problem is that some speakers create questions that take too long to read, much less answer. The audience reads about half the question, becomes bored because reading the rest will take too long, and takes a wild guess leading to a random distribution of answers. A second problem occurs when a speaker asks a question and fails to provide any type of answer or explanation. As an audience member, this is really irritating because you never find out how you did until much later—kind of like the oral boards. On the other hand, some members of the audience are just as distracting. In my presentation, all of my questions were numbered with four possible choices. In every question, someone in the audience chose option 5, 6, or 7.

Along with other faculty who live in Chicago, I typically moderate a scientific session on Friday. This is usually pretty awkward. I'm sure very few of you have ever been to an RSNA scientific session on Friday morning. Here is the scenario: It starts with me and eight other people in the room. I welcome the group to the session, ask people to stay on time and turn off their pagers, and introduce the first speaker. He or she gives his or her talk and then grabs a suitcase along the wall and hurries out of the room for the 2-hour trip up the Kennedy "Expressway" (now there is an oxymoron) to O'Hare. This continues until just me and the last presenter are in the room. Invariably, the last presentation is a dialog.

I think Chicago gets a bad rep among radiologists who've never been here outside of the RSNA. I guess I

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feel the same way about Louisville. This meeting is a boon for the city, and the Chicago politicians will do almost anything to keep it here. Why you ask? Chicago is a truly great city—it has everything anyone could ever ask for such as world-class restaurants, semiprofessional sports teams, art, culture; pretty much everything except for habitable weather. Politicians want the RSNA to stay here because no one else in their right mind would visit Chicago in the first week in December. I also believe that this is the reason that the RSNA is among the best attended meetings in all of medicine. It is always 72° and sunny in McCormick Place.

A lot has changed at the RSNA in the past 15 years——mostly for the better. Without doubt, the best and most significant change was the addition of the bridge that goes from Lakeside to West Buildings. I'm still old enough to remember going elbow-to-elbow with 20,000 other people in a hallway 8 feet wide trying to cross Lake Shore Drive. At the most recent meeting, if you looked closely at your name badge, you could see an embedded RFID card—I guess that means our movements were tracked by someone who would be interested in that kind of thing. Maybe it means industry can get an accurate count of people who visit their booths. Maybe it means no more cheating on CME? Maybe they can equip the card to allow me to send an electric shock to the guy who chooses 5, 6, or 7 during my lectures. Now that would be an improvement.

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