EDITORIAL

The 4 A's

When interventional radiology (IR) first began to become a victim of its own success, many people thought we could compete with other services by simply providing superior service. They preached the 4 A's—affability, availability . . . I can't really remember what the other ones are, but it basically boils down to being a nice person to referring clinicians. This concept worked well except when referring clinicians stood to benefit by referring their own patients to their own service. Then the whole thing fell apart. Nonetheless, these are good rules to live by and my IR colleagues and I make a conscious effort to follow the 4 A's . . . whatever they are.

Being nice to a clinical service can be foreign in a university setting, especially in diagnostic radiology where studies keep coming no matter how obnoxious you aspire to be. There are a few reasons why diagnostic academic radiologists get irritated with clinical services. First, their salary often isn't closely tied to their output. Unlike the situation in many private practices, for academics, more studies equate to more work for the same pay. Another reason is that some clinicians in referring services have the erroneous opinion that they can read studies better than radiologists. Many of these nonradiologists fall into the "100% sensitivity, 0% specificity" portion of an ROC curve. Actually, most of them aren't even on the curve. I'm sure nearly everyone has had the experience of some clinician pointing to 100 different normal structures on a CT to finally get to the one abnormality. You sit there and say things like, "No, that's the diaphragm, not a lung mass," or "That's a renal cyst, the mass is on the other side." You can see the pride in their eyes when they "make the call." God forbid the radiologist miss the abnormality—this only reinforces the misperception that the nonradiologist is competent to interpret diagnostic imaging studies.

I have become the de facto "go to" guy in my hospital when it comes to vascular studies. It is one niche that I feel comfortable filling and I have unique qualifications that neither my diagnostic or interventional colleagues have. I either officially read or unofficially double read the majority of vascular studies in our

hospital. I try to follow the 4 A's even when I cover abdominal imaging although sometimes it is difficult. The other day I was called by one of the residents in the ER and asked to read a chest CT on a patient with chest pain.

Me: Abdominal Imaging, this is Brian Funaki.

ER Intern: This is Dr. Johnson. Could you take a look at Mr. (Insert HIPAA violation here)'s chest CT. He has an aortic dissection.

I don't mind residents calling me by my first name. It makes me feel younger—particularly since I graduated from med school when current interns were still playing kickball in the schoolyard. (Well, maybe not the ones here. Students here walk around with shirts that say, "The University of Chicago—Where Fun Comes to Die.") I always wonder though, what interns are thinking when they call me by my first name, then refer to themselves as Dr. Insert Name Here. In my opinion, this tendency is related to illeism and for me immediately conjures up images of Ricky Henderson, Karl Malone, and Elmo from Sesame Street.

Me: I don't see a dissection. What do you think is abnormal?

Incidentally, this is one of the problems with the current picture archiving systems—nobody ever comes to the reading room to go over studies. Instead, residents call you and tell you what they see. You have to figure out what they are misinterpreting because they can't point to the normal structure.

ER Intern: In the ascending aorta, there is a dissection.

Me: Oh, I see what you are referring to. The line above the aortic root—actually, that is an artifact caused by motion at the aortic root. It isn't a dissection.

ER Intern: My attending says it is a dissection.

I've heard this argument dozens of times and I'm never sure how to respond. I want to say, "well, your attending is a moron" or "maybe your attending should do a radiology residency" or how about "then 80% of the people who got chest CTs today also have a A dissection. Have you treated all of them?" I like to have face-to-face discussions with referring clinicians, I sometimes find things I've overlooked and enjoy the

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interaction. I tend to read studies as “yes,” “no” or “I have no idea.” Like most IRs, I don’t like to hedge—I’d rather tell someone I simply don’t know one way or the other than list a differential of 10 different things. I leave the differentials to my wife who is a thoracic radiologist. On occasion, clinicians remain unconvinced when I’m certain of my interpretation. I usually offer to bet a case of imported beer that I’m correct. For some reason, that is usually more convincing than my signed report. Once, I offered to bet a particularly irritating resident his entire yearly salary that I was correct (he didn’t bite on that one).

Me: You’re going to have to take my word on this one. That isn’t an aortic dissection—it’s an artifact.

ER Intern: Can I have your name?

Me: Brian Funaki.

This can get a little annoying because this is akin to, “Can I speak to a manager?” On the other hand, I understand that these residents need to document who says what and when. Also, they may want to know which Funaki they are talking with although my wife’s voice doesn’t much sound like my own. Occasionally though,

things go to ridiculous extremes, like when the resident calls back 5 minutes later.

Me: Abdominal Imaging, this is Brian Funaki.

ER Intern: Hi Brian, this is Dr. Johnson, again we just spoke about Mr. HIPAA violation’s study. Look, I’ve discussed this with my attending and he wants an *attending* to read and report the study.

Me: A different attending or the one you’re talking to now?

ER Intern: Uh . . . never mind, that should be OK.

I don’t argue with people anymore. What’s the point? I’ve found the most effective route (other than wagering alcoholic beverages) is to tell them that they *could* be right but my report was going to say what *I* thought was correct. If they wanted to ignore my report and explain their interpretation to a plaintiff’s attorney, they could do whatever they wanted.

I like diagnostic radiology, but I’m glad to be an Interventional Radiologist.

Brian Funaki, M.D.¹

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