The Rules of Radiology

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To my lovely prize-winning author wife, Rachel, for her support, tolerance, and damn fine editing skills. This book wouldn't be in your hands without her.

Preface

Hello and welcome to this book.

If you have bought this book then you are either a radiologist or someone who is interested in radiology. Or possibly my mother (Hi Mum!). Irrespective of who you are, hopefully you'll find much in the following pages that will be directly relevant to your personal and professional life. It may even raise a dry smile: Lord knows that those have been in short supply recently.

This book addresses what I see as the most important issues in radiology. To be specific, it takes a critical look at the day-to-day practice of radiology and teases out the important bits. Not always the popular or topical bits, but the nitty-gritty of what radiology is actually all about. These are the topics that radiologists know intuitively but actually rarely discuss. I explain why these topics are so important and should be discussed.

It isn't a textbook by any stretch of the imagination; there are plenty of those already. Nor is it a manifesto; I'm no politician. It isn't just a critical look at the world of radiology but it gives considered guidance about how radiologists and others can not only survive but also thrive amidst the tricky modern medical world.

In that respect, it is a letter to my younger self. Apart from saying, "sit down, shut up and get a haircut", this overlong letter contains all of the scraps of wisdom I've gathered thus far in my time on this planet. By presenting these as Rules to be obeyed, it makes up an unofficial curriculum for young radiologists starting out into the world. For others it provides a reality check; a mirror to hold themselves up against. It is an extensive critique of modern radiology but it also conveys a valuable message of hope in these turbulent times.

You will note that this book deals with Rules of Radiology #1-50 but there are multiple references to Rules #51-100. These are listed in Appendix 1. My intention is write a second volume to cover Rules #51-100. However, I am contractually obliged to not do so for a year from the publication date of this book otherwise my wife says she will probably leave me. Given that I'm rather fond of her, you will have to wait for the second volume, I am afraid. But hopefully it will be worth the wait.

Bristol, UK — Paul McCoubrie

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Several individuals have offered support and constructive comments. I'd particularly like to thank Barry Kelly but also Adrian Brady, Giles Maskell, Philip Ward, Guy Burkill, and last but not least, my father, Malcolm McCoubrie.

Contents

Chapter 1
Rule #1 / / Obey The Rules

Your reason is to knowingly breach The Rules isn't good enough. It never will be. It is also forbidden for someone familiar with The Rules to knowingly assist another person to breach them.

—

The average reader will look at the introductory paragraph and be slightly baffled. Of all the medical specialities, why does radiology need Rules? And why do radiologists have to obey them? Furthermore, why do radiologists have to insist that others obey the Rules in a similarly rigid fashion? And more to the point, who is this McCoubrie chap and why the hell does he think he can tell others what to do? So many questions, such anger, such perplexity.

Before anything else, I should point out The Rules are my opinions. They aren't a legal document. I'm not going to instruct counsel to prosecute you in the event of a transgression. But if you don't obey The Rules then I will do what all right-thinking Britons do when severely provoked. I will fix you with a hard stare and tut quietly.

The other thing is The Rules is predominantly a work of satire. You may quote them freely but they aren't evidence-based or in any way binding. So, for God's sake, don't quote me in anything serious. I'm not appearing as an Expert Witness on the back of one of my assertions. But I am being perfectly serious in my satirical aims. My goal is to first make you laugh then make you think. As George Bernard Shaw once wrote, 'My method is to take the utmost trouble to find the right thing to say, and then to say it with the utmost levity'.

By way of introduction, I'm a middle-aged male white British radiologist (Fig. 1.1). I've specifically tried to avoid any cultural bias but if some unconscious bias has crept in, I apologise. This said, The Rules apply to all radiologists irrespective of age, gender, cultural heritage or country of residence.

The book is about radiology. Not radiotherapy or anything to do with radios. If you aren't medical, radiology is sometimes known as the 'X-ray department',

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Fig. 1.1 "By way of introduction, I'm a middle-aged male white radiologist"

'roentgenography' (only in the US) or the loathsome 'medical imaging'. Radiology is a post-graduate medical speciality. Like Anaesthetists, patients are often surprised that we are doctors and not some technically-trained Surgeon's handmaiden.

Admittedly I am writing about it from a medical perspective but The Rules equally apply to those involved in working closely with radiologists. There are many members of the radiology team. The most numerous of which are radiographers (in the UK) but elsewhere they are 'radiology technicians' or similar. Radiologists work very closely with radiographers. The two trades are interdependent. Radiographers explicitly have to obey The Rules too.

I can reassure you that The Rules have been thoroughly thought through. They are formed from over twenty years as a radiologist and considerable introspection. They are also formed from listening to people a lot more intelligent than me and then stealing their ideas.

Like *La Gaza Lardra* (The Thieving Magpie), I have rapaciously collected the sparkling wit and collective wisdom of the Great and Good of Radiology. I've

taken old radiological maxims, heuristics, and aphorisms then buffed them up, ready for general viewing. I even wrote quite a few myself.

This isn't a radiology textbook, you will be reassured to hear. There is very little in here about the day-to-day interpretational aspect of the job. I'm not here to spout about how to read X-rays or CT scans. Plenty of people have done this already. This is about the other 50%. The bits of a radiologist's job that isn't looking at black and white pictures. Like talking to other doctors. And occasionally patients too.

Okay, I hear you say. It is a book of radiology axioms. With clever-clever words to explain them. But why present them as Rules that must be obeyed? That is a more complex question that will take a little explanation.

Firstly, radiology is different to most forms of medical practice. All the old adages don't translate to our way of working. This is largely because we have historically been 'back room' doctors. Radiologists, like pathologists, are largely the 'doctor's doctor'. Our primary goal is to help the patient by helping their doctor. But unlike pathologists and other back-of-house staff, radiology is increasingly front-line and patient-facing. We still help the patient's doctor but we have a public face too.

Secondly, radiology is increasingly homogenous. Rather being culturally-driven, radiology is technically-driven. And in the modern global economy, the technology is the same the world over. Naturally the health systems in each country vary hugely. In some countries there are several different health systems. The number of scanners and access to them varies widely. And the precise numbers of staff, training of the staff, the background of the staff, the style of employment of the staff varies hugely. But a scanner is a scanner. The machines are the same whether they be in Tipperary or Timbuktu.

It is this common technology that binds the global radiology community together like glue. We speak a global radiological language. Day-to-day radiological practice is remarkably similar the world over. A fully trained radiologist from, say, Manchester would find themselves eminently employable in Moscow and Manila alike.

Thirdly, radiology is in a state of flux and needs direction. It is a massively changing speciality, almost unrecognisable from the speciality I entered over twenty years ago. I don't think any other speciality has seen either such fundamental changes in its practice or such huge growth. And it doesn't show any signs of slowing. I suspect radiology in 2040 will be quite, quite different again.

Half of the procedures that I did as a new consultant radiologist no longer exist. I admit that I miss some of these very dearly. The beautiful simplicity of an intravenous urogram, done properly, is a thing of singular beauty. If Shakespeare had lived in modern times I am sure he would have written sonnets about the graceful curves of the calyceal system.

Some of these procedures, I must admit that I don't miss at all. And if you asked them, neither would the patients that had to endure them. Lower limb venograms and barium enemas were not far off being instruments of medieval torture.

They firmly belong upon the dungheap of medical history. The only thing worth writing about them is laws to ban them ever coming back.

But perhaps the biggest change is massive expansion of cross-sectional imaging. I remember the scanner appeals of the 1980s, where each hospital faced the uphill battle of funding their first CT scanner. Only twenty years ago, MRI scanners were rare beasts; space-age tech that us mere mortals rarely got to see close up. As a very young radiologist, I might have drooled once or twice, such was my slack jawed wonder.

These days each hospital has several of each type of scanner. And they are much, much faster. It takes longer for the patient to clamber into the saddle of the scanner than the ride itself. Twenty years ago it was very very different. On a good day we would scan fifteen patients in CT and be working flat out; now it is more like four to five times that. Back then CT scanners were slower than MRI is now. MRI was glacially slow and the images were murky smears, more like an abstract painting than a depiction of human anatomy.

Lastly, and perhaps most importantly, most mainstream radiology practice makes sense to the casual observer. But when such practice is critically examined, it is often found on to be based on rather shaky logic. Just occasionally current practice makes no sense and is actually counter-productive. For example, many hospitals are now waking up to the fact that the radiologist looking at the most complex scans on the sickest patients needs quiet uninterrupted thinking time. Whereas this couldn't be further from what actually happens.

So. We have established several facts. Radiology needs Rules as it is doesn't already have them; it is different from mainstream medical practice; it is a increasingly homogeneous on a global scale; it is changing so rapidly and much of our practice doesn't bear close inspection.

But you might still be asking about such strict adherence to arbitrary Rules. I don't blame you. Most folk don't like being told what to do. And doctors are particularly fond of their clinical autonomy. The classic notion of persuading a group of doctors to behave uniformly is like trying to herd cats.

So, why should you obey The Rules. It isn't a case of 'I know best, listen to me'. That isn't my style at all. The reason is fairly simple. Read them. Read them all. Then, after due consideration, decide if you agree. And if you do agree, you must obey Rule #1.

Chapter 2
Rule #2 / / Smile

Those who complain the most, accomplish the least. And remember, nobody likes a whinger.

—

There is an saying that it takes forty-three muscles to frown but only seventeen to smile. There is a lesser-known misanthropic addition which points out that it takes just four muscles to slap the smart-arse who comes up with annoying sayings.

The point is that smiling is supposed to be simpler than frowning. Except this isn't necessarily true. When the whole face animates with a full beaming and radiant smile, it often involves all forty-three facial muscles. Yet only six muscles are needed for quite respectable frown. To make matters more complex, you need just four muscles for a rictus grin (left and right *risorius* and *zygomaticus*). And if we are to follow the argument through to the end, a proper slap actually involves around fifty six muscles.

You might think I am missing the point through anatomical pedantry. But radiologists tend to be pedantic. I'm not apologising for this; pedants don't apologise. They just pity the less pedantic individual. They know the warm glow of superiority and truly wish others could have it too, if only they would apply themselves a little more. Plus, if I know my target audience, they'll welcome a brief discussion on the complexity of physical exertion in differing forms of non-verbal communication.

Anyway, this Rule is to encourage cheerfulness *en generale* and discourage moaning. At this point, several questions might arise in your mind. Most pertinent is why should radiologists be cheerful? They aren't paid to be happy. They are here to get on with reporting scans and so forth. You may agree that cheerfulness is a Good Thing. But you may argue that, given the pressures most radiologists are under, being cheerful is distinctly difficult. You might also point out that some individuals are by their very nature dour and that persuading them to be cheerful is a forlorn exercise. And lastly, you might argue that blowing off a bit of steam and having a moan to a colleague is highly therapeutic.

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I will hopefully persuade you that these questions have answers. Yes, radiologists should be cheerful and that there are many very good reasons for this. Not only that but anyone can do it, even the most miserable sod. And also that having a proper moan is probably the worst thing you can do. Let me explain by painting you a few verbal pictures of grumpy personality types that can be found in radiology departments.

The first is the 'Marvin'. Marvin was a robot with 'a brain the size of a planet', from the *Hitchhiker's Guide to the Galaxy* series. Marvin was labelled a 'paranoid android' but wasn't actually paranoid. He was, however, the personification of pessimism. Marvins are useless colleagues—their negativity stops any activity dead in its tracks. They are emotional black holes that drain all the fun, all the humour, all the life out of anyone or any situation. Their constant moaning and grumbling is grinding. They are very difficult colleagues to be around.

On the other end of the spectrum of sullenness, I introduce my second character, the 'House'. Named after the fictional character 'Dr. Gregory House' in the eponymous series, these individuals are curmudgeonly arses. The fictional Dr. House was a flawed genius, a nonconformist who spoke the truth and didn't care what people thought. I should point out that fictional characters are quite different to real-life colleagues. Lovable and endearing grumpiness is far more attractive on screen than in reality. The day-to-day lack of social graces and endless biting sarcasm grates on the nerves, completely outweighing any occasional stroke of genius.

The last character in this gloomy pantheon is the 'Psychopath'. These radiologists give our sainted profession a bad name as they are the bane of a junior doctor's life. I'll give an example. When I was a young doctor, my boss always wanted his scans performed by a particular radiologist. It was my job to get the scans organised. This involved regular trips to the radiology department to find this particular volatile radiologist. I never knew what mood he would be in. Sometimes, I knocked on his door and he would effusively call, "Ah, come in my dear boy, how can I help". Sometimes, I knocked and before I could utter a word, he screamed "Get out! Get out! Out! Out!".

These unpredictable characters are usually unrepentant about anger-management issues. Even when challenged about their unacceptable behaviour, they blame others. The alarming thing is that such behaviour is tolerated. It is tolerated as these attacks of social incontinence aren't witnessed by the appropriate people. These characters are often sweetness and light to their senior colleagues. They reserve their episodic sociopathic behaviour for those lower down the medical hierarchy.

Having summarised this grouchy group of characters, I hope you don't recognise too many of these characteristics in yourself. And if you do, I hope you are admonished. They aren't flattering. I suspect that you'll recognise traits amongst your current or former colleagues.

It is very important that you don't tackle their behaviour head on. This leads to a World of Pain. Part of being socially incompetent is that you fail to recognise the problem, overestimate your own abilities and don't recognise those same skills in

others. It is called the Kruger-Dunning effect. Tackling them doesn't work; they deny the problem and often fight back. Save your energy.

I would advise treating these individuals as 'Time Thieves'. I've found it a very useful way of protecting myself from the antisocial antics of particularly toxic individuals. You will be all too aware that you only have so many hours, minutes and seconds on this planet. You will be all too aware of wanting not to waste this time. You will, in fact, be specifically keen on spending time doing life-affirming and joyous things. A Time Thief steals your time and gives nothing back. Every precious second in their company is one you cannot get back.

Thus you should insulate yourself from these people. Spend the absolute minimum of time in their company. And don't give them a second thought. Cut off any emotion, thoughts, or worries. By doing this, you don't waste time thinking about them either. Try it; you'll thank me afterwards.

But let us focus on the positive message of this Rule. Let's look at the benefits of smiling and acting cheerful.

First off, cheerfulness benefits you as an individual. Any therapist will tell you that if you behave in a cheerful fashion, you feel more cheerful still. That is, pretending to be cheerful actually works. If you deliberately employ cheery words, deeds and actions then you feel happier. The reverse is true. Giving voice to a tirade of negativity actually makes you feel worse. Negative body posture and facial expressions reinforce the misery. Thus moaning and whingeing is something to be avoided at all costs. If you find yourself starting, just stop. Sit up straight, put your shoulders back and force a smile. It is curiously effective.

Before long, you'll find yourself happier. This is a goal in itself. We know that happiness in a radiologist is associated with several positive outcomes. Happy radiologists are productive radiologists. Happy radiologists are healthier. Happy radiologists are less likely to burnout or retire early. No one knows if happier radiologists make fewer mistakes but I'd wager that is true too.

Cheerfulness also benefits those around you. For a radiologist, this is most often your colleagues and other members of the radiology department. And patients like a smiling doctor too. Happy patients and happy staff are the markers of a well-functioning department. A well-functioning department is a good place to work; it can recruit and retain staff, it is popular with clinical colleagues and standards are generally high.

But being cheerful isn't always easy and sometimes you have to pretend. You might want to take the request card being proffered by an interloping clinician and insert it forcibly up their least favourite orifice. But instead, you should force a smile and say, "Sure, no problem. Leave it with me".

This ability to remain cheerful in the face of adversity is not something that comes naturally. Well, there are some folk that are curiously pathologically happy. I suspect them of having being dropped on their head as a child. The rest of us normal mortals have to learn it as a skill. And it all starts with a smile. Practice smiling when you least feel like it and, before you know it, your life and that of those around you will have improved immeasurably.

Chapter 3
Rule #3 / / Keep Your Cool

Losing your temper always makes things worse. Anger reveals weakness of character. Equanimity is hard but worth it.

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This Rule is the corollary of Rule #2. This Rule additionally demands that a radiologist should not lose their rag: they should be phlegmatic not choleric.

You may well laugh and think that I am just posturing. Maybe I am a little but I rarely lose my temper in the workplace. Like many, I've been sorely tested and failed to hide my irritation. I've been irked by thoughtlessness and failed to conceal my exasperation. But I've never descended to a bestial level; I've never shouted, I've never lost control at work.

This is quite deliberate, quite intentional. As my family will tell you, I'm not naturally imbued with calmness. I suspect that one's spouse and offspring are quite different to work colleagues. They know exactly which buttons to press and which raw nerves to tweak. And like a Skinnerian rat pressing a button for a pellet of food, they cannot help themselves, impulsively poking until their spouse/parent explodes.

I strive for calmness in the workplace and advocate the same for very simple reasons. Firstly, like most unspoken goals in life, I've been influenced by both negative and positive role models. I've encountered some needlessly aggressive senior doctors: I swore would be nothing like them. I also encountered some particularly calm and stoical senior doctors: I swore I would strive to be more like them.

I advocate this as I realised that not everyone shared my passion. Indeed, I've encountered modern-day radiologists who had no filter, no check to their words or emotions. They feel it completely acceptable to flip mid sentence from an austere Abraham Lincoln to a raging Genghis Khan. Sometimes the slight was real, sometimes perceived. Nevertheless, they'd be off. All toys out of the cot and the dummy spat. A gratuitous overreaction.

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The raging radiologist is totally blind. They completely fail to appreciate the destructive effect on other people and their feelings. They completely fail to appreciate that everyone thinks they are a complete and utter prat.

I've met many radiologists who have clear gambits to avoid such spiralling rage. Some recognise the surge of adrenaline but physically divert themselves into a displacement behaviour. Some feel the pupils and nostrils dilate but mentally pull themselves up short, pause to mentally rearrange themselves, and continue calmly. Some turn their emotional excitement into humour.

Now turning potential anger into humour can work but is a risky strategy. The best strategy I've seen uses the heightened state to channel a particular self-effacing humour. This gambit is successful as the focus of the joke is moved onto the radiologist. It is non-threatening; a serious point can be made humorously and no one gets upset.

Another strategy that can occasionally work is the comedic rant at a third party not present in the room. This third party can be a single person, a group or even a concept. The only way this works is to point out something wrong: an injustice, something ludicrous or an amusing paradox. Berating something or someone that is innocent makes you look bitter and jealous. When fluent and lucid this technique can be funny and constructive. But it is very risky. It is a fine line between an sparklingly fluent critique and a fulminant spitting tirade.

The worst strategy I've seen turns the focus of the humour onto a specific individual that is present. This doesn't work. It always belittles and undermines the other individual. At worst, this is bullying. It is embarrassing to admit but anyone who works in any healthcare system has experienced this in some form. There is no excuse for it. It leads to tears, resentment and formal complaints.

There is a more persuasive reason to encourage radiologists to be more affable, aside from being a better person and not getting sanctioned. It is simply that civility saves lives. It isn't that incivility directly kills patients. It is just that incivility is part of a recipe for poor medical care. There is now overwhelming evidence that if someone is rude to someone else, a whole web of unpleasantness unfolds.

The main effects are on the recipient of the uncivil behaviour. They take it personally, becoming stressed and anxious. They lose time worrying about the rudeness, they reduce their commitment to work, they avoid the offender, reduce their time at work, reduce the quality of work and take it out on patients.

But also the witnesses of the uncivil behaviour are affected, both other staff and patients too. The performance of those nearby also suffers and they become less willing to help others. Patients feel more anxious and less enthusiastic for those giving care to them.

So, as you can see, not being rude isn't about being loved and avoiding trouble, it is about good medical practice. Faced with such overwhelming argument, I hope you will agree that a quick and easy temper is clearly a sign of an inferior and uncultured radiologist. Whereas a steadfast and unflinching radiologist is part of the solution for modern healthcare.

And this is where equanimity comes in. This is a concept worthy of exploring and adopting as your default option in times of stress.

In 1889, Sir William Osler's famous address 'Aequanamitas' captured the *zeitgeist* of the late Victorian era. A medical man at that time (and they were virtually all men) was supposed to be a sober and upright citizen, in complete physical and mental control. It was a philosophy of life encapsulated in a single word, from the Latin for 'with even mind'. Coolness and presence of mind in all circumstances was seen as the premier quality of a doctor.

In Osler's day, physical control or imperturbability was important to ensure clear judgement and to maintain the patient's confidence. One didn't want to appear flustered or panicked. Given that medical practice in those days largely concerned the rather inexact science of clinical diagnosis and the even less exact science of prognosis, maintaining the confidence of one's patient was paramount. Confidence was important back then. Losing the patient's confidence often meant your services weren't retained and you didn't get paid.

Mental control, or equanimity, was seen as equally vital to physical control. Calmness and inscrutability allowed clearness of judgement in moments of grave peril. This attribute was nurtured in young doctors and medical students through encouraging patience and persistence. In full development, such as that seen in an older colleague, it was seen as akin to a divine gift, a blessing and a comfort to all who came in contact with them.

Of course medical practice at the time was very different to today. Whilst great strides were being made in the understanding of disease, the investigative arts were basic—pathology was king and radiology didn't exist yet, although Röntgen's famous discovery followed 6 years later.

This said, there are still similarities to Osler's time despite the technical sophistication of modern medical practice. Life is still uncertain, truth is still fragmentary and the demands of successful medical practice are still challenging. But a number of false assumptions have arisen about equanimity. Equanimity has become a negative and outdated concept. This implies an imperturbable doctor is emotionally constipated, hierarchal, haughty, uncaring and inhumane. The spectre of a white male authority figure is raised, complete with frock coat and alarming facial hair.

A few things. I should stress that Osler didn't want his young colleagues to deliberately fake this emotional state. He didn't want them to construct an artificial emotional barrier to hide behind. He stressed heavily that imperturbability is derived from wide experience and an intimate knowledge of disease. Such expertise affords protection against circumstances that would normally disturb the mental equilibrium.

This resonates with me. A deep knowledge of the conditions I am scanning for allows me an inner calmness. I am on familiar turf. I've seen it all before. Even when something unusual crops up, I can handle it safely and calmly. But it is difficult to mask the sense of unease when I'm out of my depth, on unfamiliar ground and struggling to make meaning of an unfamiliar scan.

Osler then expounds on how this isn't the same as hardness of demeanour. An uncaring attitude was a criticism of the medical profession even then. Osler only advises 'insensibility' or immunity to emotion when 'steadiness of hand and

coolness of nerve' is needed. He advised cultivating a cheerful calmness and that doctors meet the trials of practice with courage and 'a smile, and with the head held erect'.

Again, this makes sense. You don't want to bottle it half way through a procedure just because a smidge of 'house red' (i.e. blood) gets sprayed up the walls. You don't want to burst into tears in front of a patient just because you see liver metastases on the ultrasound. You don't want to be unable to complete a report because you are so upset about the greyscale tragedy unfolding on the screen in front of you. Acknowledge the emotion but you must press on and finish the task.

One of Osler's little observed points is a misquote from Shakespeares *Antony and Cleopatra*, 'from our desolation only does the better life begin'. Life inevitably contains disappointment, perhaps failure. You cannot avoid such matters. But he advises that by standing up bravely against the worst and, irrespective of victory or defeat, emerging cheerful is the making of a wise, peaceable and gentle doctor. And who wouldn't want that?

Chapter 4
Rule #4 / / Work Hard

It is the radiological trump card, "Yes he may be a sociopath with BO that makes paint peel but he works hard." But don't work too hard. You only have a finite time on this planet.

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Not long ago I organised a teaching day for our local radiology registrars on 'Becoming a Consultant'. Looking for a job after 5 years of radiology training can be a matter of considerable anxiety. This anxiety is misplaced. Consultant radiologist vacancies across the UK are widespread and unlikely to change anytime soon. It is widely acknowledged that if you have the FRCR exam, a spine, a pulse and at least one good eye, you are in. And most employers are not that fussed about the spine to be quite honest, although no invertebrates have applied just yet.

Anyway, we'd dragged the great and good from around the region to say a few short words. Being a bright-eyed bunch, the assembled acolytes listened assiduously to the advice of the assembled authorities.

One particularly sparky colleague started his talk by asking the audience, "How long does a consultant interview last?". There was brief muttering and murmuring before sporadic replies of "thirty minutes", "forty-five minutes" and "one hour" came back. After a short dramatic pause, he smiled knowingly and answered, "five years; it has already started".

Suitability as a future consultant radiologist is judged throughout training. As the majority of radiology trainees end up working in the region where they trained, it is important to nurture a good reputation from day one.

If a radiologist wants to be popular with non-radiologists then they cultivate what is known as the 'Three As'. These are (in order): 'Availability', 'Affability' and 'Ability'. Being immediately accessible is number one by some margin. The importance of having a radiologist on tap is something that clinicians, clerical staff and others want first and foremost. Next, they want someone pleasant. They want a radiologist who will not just listen and be reasonable but be welcoming,

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