

# Education in Professionalism: Saurabh “Harry” Jha, MD

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Radiologist Saurabh “Harry” Jha still recalls the first time he was on call for radiology in the United States. He received simultaneous emergency requests for a head computed tomography (CT) and chest CT, both in the same patient, to rule out stroke and pulmonary embolism. The indication for the examinations was the same: syncopal episode. Jha was flabbergasted. “I thought to myself, there is no way we would do both examinations in the United Kingdom, so I called the ordering physician. I asked, ‘What are the patient's oxygen saturations, d-dimer results, and Wells score?’ She sounded amused, and simply responded, ‘How is that going to help you find pulmonary embolism?’”

Jha's perplexity stemmed in part from the fact that, after graduating from a British medical school, he trained in surgery in the United Kingdom for three years and then practiced for a year in Australia. In those systems, resources were less plentiful, and radiologists were expected to be vigilant, asking hard questions to verify the appropriateness of imaging examinations. Now a faculty member at University of Pennsylvania, he has come to believe that the US health system encourages excessive rates of diagnostic testing, partly through its health care payment and medical malpractice systems.

Jha recalls another encounter that further illustrates this distinctively American approach to diagnostic testing. About 10 years ago at a state radiologic society meeting, he trumpeted the potential value of magnetic resonance imaging (MRI) in the diagnosis of cardiac diseases. Seated next to him was a radiologist who shook his head sarcastically. “Are you kidding?” the man asked. “In the 90 minutes it takes you to do one cardiac MRI examination, for which you will not be paid, I could do six knee MRI examinations and get paid for every one. Who would want to develop cardiac MRI?”

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To Jha, such stories are emblematic of one of radiology's greatest contemporary challenges. "Simply put," he says, "we radiologists have priced ourselves out of doing anything. We have let the equation, 'volume times price equals revenue' so dominate our outlook that we have relinquished our role as true professionals." Consulting with referring physicians to make sure that patients get the most appropriate care has often taken a back seat to generating as much revenue as possible. "And this," says Jha, "is causing radiologists to lose control of imaging."

Jha is referring to the fact that, in many radiology departments today, radiologists play no gatekeeper role, instead performing more or less any study as it is requested. In this situation, radiologists do little to ensure that imaging is used appropriately. The radiology department comes to resemble the pathology laboratory, which analyzes without question any blood or urine samples sent to it. Radiology tests are simply "ordered," and the radiologist becomes little more than an image interpreter, having forfeited an important professional prerogative to ensure that imaging is used appropriately.

What is the solution? One important challenge, Jha believes, is for radiologists to reassert their control over imaging. "We can solve this problem overnight if each day larger groups would designate one or two radiologists to step out of the high-producer model and instead devote their time to meeting patients and consulting with referring physicians. Inevitably, radiologists who did so would be chided by their colleagues—"While you were off schmoozing, I read 60 chest radiographs!"—but in the long run, radiologists could again show that they are in control of imaging."

Part of the problem, Jha believes, is an excessive emphasis on the radiology report. "What we need," he says, "is to focus less on the report and more on clinical dialog." Radiologists should not be saying to patients and referring physicians, "Leave me alone so that I can maximize my productivity," but "Let's spend some time discussing this case, so that I can learn from you and you can learn from me." The goal, he says, "is to get some real back and forth, so that we really understand the case. If we did that, radiologists would be happier, because they would be contributing more to patients."

Unlike many contemporary health policy makers, Jha is not so naive as to suppose that the problem here is a purely economic one. It cannot be solved simply by rejiggering the financial incentives. Another important factor, he believes, is cultural. Britain, he says, is a relatively guarded and pessimistic culture, whereas the United States is considerably more optimistic and operates with a powerful “can do” attitude. This is reflected in the fact that many American trauma victims are alive today who simply wouldn't be walking the streets of England, India, or China.

When presented with a severely injured trauma victim, physicians in other countries are much quicker to say, “This patient is too far gone, there is nothing we can do.” But in America, the attitude is, “We might be able to save this person,” and no resources are spared in doing so. Jha sees trauma as especially significant because patients tend to receive the same level of care, regardless their ability to pay. “It is no accident that the US was the first country to put a man on the moon. If something seems even remotely possible, Americans believe they can do it.”

The downside, Jha points out, is a strong bias toward overdiagnosis and overtreatment. “The fact that we might be able to save a life carries tremendous weight here. In no other nation on earth would physicians reason, as they do here, that overdiagnosing or overtreating 10 breast or prostate cancer patients is a price worth paying if it enables us to prevent a single premature death.” He likens it to a criminal justice system that would sooner let 10 guilty people go free than convict one innocent person.

Jha recognizes that there are radiologists who disagree, sometimes strongly, with his perspectives. Yet, he is convinced that the quality of professional discourse in radiology is not what it should be, and this places on him an ethical responsibility to speak out. “We need a more robust professional dialog, more give and take, and more debate and disagreement. Our biggest threat today is not dissension among radiology's ranks, but rank conformity, the sense that anyone who voices an opposing point of view is guilty of some kind of betrayal.”

Such conformism is one of Jha's greatest fears. One type is economic, the view that every choice in life should be decided by its return on investment. At some point, he believes, we need to look beyond strictly financial returns and think about other forms of benefit. Work can be highly profitable but utterly uninteresting—for example, the practice of radiology on an industrial assembly line model. “Radiologists whose hearts are in the right place,” he believes, “will trade some economic gains for a deeper sense of professional fulfillment.”

“Consider American obituaries,” Jha continues. “When we think about what a person's life has amounted to, we do not talk about how much money they made. We talk about their community service.” America places a huge value on contributing at the local level. “People from India are always startled when they move here because as soon as they move in, their neighbors bring them pies. The people here are not indifferent to money, but there is a deep voluntary dimension of American life that has very little to do with economics. We need to revive this same community spirit in radiology.”

Jha finds the same conformist principles at work in recent debates over maintenance of certification. “The idea of improving practice is a good one,” he says, “but we need to recognize that people learn for different reasons, and we do not always need someone telling us to. There isn't just one way to learn, any more than there is just one way to teach. And most people do not need a gun held to their head or a carrot dangled in front of their eyes to do it. The best people learn and improve because they want to. Adding incentives and disincentives only confuses things.”

Following the Austrian economist Friedrich Hayek, Jha is a big believer in the dispersion of knowledge. “When you begin concentrating knowledge in a central agency far from where the work is actually taking place, you also begin concentrating power. This enables centralized power holders to push their agendas, and as they do so, they inevitably begin making generalizations that make the situations worse. The nuances get squeezed out, and pretty soon, everything depends on how closely you conform to the generalizations.”

Jha argues that, wherever possible, we need to move away from central platforms and back to individual discretion. “First,” he says, “this enables decisions to be made by the people who know the situation best. Second, it ensures that people remain decision makers, instead of mere decision implementers, which undermines dignity and morale. And third, keeping authority local helps guard against the tendency of power to corrupt those who wield it. Only by adhering to such principles,” Jha believes, “can radiology secure its status as a profession.”