

Breast imagers find that work expands, but pay and time don't

Three prominent radiologists talk about becoming the primary care physician, feeling overwhelmed, and staying focused on patient care

By Rebekah Moan

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Women's imaging is moving and shifting in seemingly predictable ways, but that doesn't mean practice has become easier.

Three prominent practitioners in women's imaging told Diagnostic Imaging they are becoming primary care physicians, though they can't bill for that. Dr. Marcela Bohm- Velez, president of Weinstein Imaging Associates and a clinical assistant professor of radiology at the University of Pittsburgh; Dr. Ellen Mendelson, a professor of radiology and director of breast imaging at Northwestern University; and Dr. Stamatia Destounis, an attending radiologist at Elizabeth Wende Breast Care in Rochester, NY, all said they are doing more than just reading mammograms.

While also getting more involved with their patients' lives by acting as primary care docs, the radiologists are constantly "on call." All three practitioners provide patients with their cell phone numbers and thus receive calls after work, on weekends—basically all the time.

It's hard to keep up with it all because of so much to juggle, so there is a backlog of work. Obviously, some sites are worse than others, but many women have to wait longer and longer for their screening mammograms. Below, the radiologists talk about how practice has shifted.

SHIFT CHANGE

Q: How has practice changed for you?

Destounis: We spend half an hour talking to these women—examining them, doing the ultrasound, and performing biopsies. But there's no billing for doing all this work. I've become their primary care doctor. They're calling me instead of the doctor when their infection is back, or if they're allergic to the antibiotic that I put them on for their abscess. I've become their primary care physician, but I'm a radiologist. I communicate with their husbands and themselves when they have a diagnosis of cancer. I'm speaking to them more than any of their doctors, but I'm still treated like a lab, and I cannot bill for services that I'm performing, which is examining them and taking care of them.

Mendelson: The direct patient care and the management of patients is our responsibility. And in many places— Northwestern is one—we go from screening all the way through histologic diagnosis. So there is really an important relationship that you forge with the patients. When you have high volume, you have a lot of phone calls to make, people to see, lots of talking, lots of advising, many questions, and that's primary care.

Bohm-Velez: Patients come to me because they want that special attention [they get from a private practice]. I do the mammogram, I do the ultrasound. I talk to them. When I go in the room nowadays, they will ask me questions about something like, “I take hormones, do you think I should take hormones? When do you think I should do my densitometry?” All these issues have to do with women's health, so I need to be educated about that. I try to keep on top of what's going on with the new hormone replacement therapy. Patients ask me about it. I go into the room, and they say, “Look, I'm taking arimidex, it's causing me joint pain, what do you think I should do?” The gynecologists are probably overwhelmed.

Not only am I referring the doctors, the breast surgeons, where to do the MRI, where to do the studies, but I also recommend how to follow the women. I call them with the results as soon as they come back. I recommend the breast surgeon, so they think of me as a primary doctor. The problem is when you spend that much time, there's also only so much you can do.

Q: Are you experiencing a backlog of work? Bohm-Velez: No. If you call

and say I have a palpable mass, you will be seen that day. That's just our philosophy. Mendelson: Asymptomatic women may have to wait a few months for a screening mammogram, but for an urgent or emergent problem, they can be seen promptly that day or within the next two days. There is a backlog, but it's not specifically ours.

There's no place for a few extra. I mean we pushed ourselves to the limit before, and you can't exceed the limit; it's not good for patient care if you do that. We all work hard, and we are an academic site. We need to make time for teaching, which is one of the important goals that we have in terms of our section and for some research.

Destounis: As breast imagers, there's more and more technology and more and more information, but it's all time-consuming, and we're the limiting factor. We need to clone ourselves. I'm getting to work at 7 a.m., and I'm there until 7:30 p.m., and my patients are calling me all weekend because I have my cell phone, and they can find me even here.

Bohm-Velez: When I do any type of procedures, I give them my card and my cell number. I tell you, they call me.

In Pittsburgh, we have three offices, but the one I work in most of the time, the patients are very educated. The universities are nearby, and the patients are very needy. They call me. "By the way, I wanted to ask you, I spoke to so and so about X. Well, what do you think about this?" Of course, I answer the phone call. Particularly after I do a procedure, I don't want them, if they have any questions, to ask anybody who doesn't know what the procedure is. I don't want them to show up to the emergency room—they wouldn't know what kind of procedures I do. I say, "Call me for anything." And they do call me.

Q: What other changes are you noticing?

Bohm-Velez: The role of breast imagers has really changed in the past 10 years. It used to be that you would do batch reading. You'd sit in a multiview, and you'd just read mammograms and mammograms. Then ultrasound came along, which helps, but it takes time. If you have a question about something on a mammogram, you do an ultrasound. In most places, the tech will do it, the sonographer will do it, but if there's specifically something that a doctor is looking for, most doctors will go

and scan. That takes time.

When you're in there, you talk to the patient. You exam the patient, ask her a question. And then you yourself, the breast imager, decide if you're going to do a biopsy or any procedures or not. And then you also decide are you going to an MRI. If you do an MRI, then you have to know how to do the MRI-guided biopsies.

Mendelson: It's harder to do women's imaging at an academic center or in a setting where you have departmental turf issues. Ob/gyn is doing the ultrasound, so you've lost that. You may in your nuclear medicine section have some mild, mild issue with those people who want to do the breast-specific gamma imaging and the PET scans. So it's sort of an organ system versus modality kind of competition in your own department. And it just makes it much more difficult.

Our own volume at Northwestern, for example, makes it impossible to do anything else with those patients. I mean we could introduce osteoporosis imaging and include that. [But] there aren't enough of us, and we just can't. So there are components of women's imaging that we really can't satisfy and we can't practice. It's just not feasible. I think that's also the case at many large hospitals, community hospitals; we have all these sorts of competitive forces, and it just makes it too difficult.

Destounis: Mammography is high-resolution imaging. It's been the last one to go filmless. In the last five years, since the American College of Radiology Imaging Network study results, the Digital Mammographic Imaging Screening Trial, where digital has been shown to be better, there's been a big push for the radiology breast imaging practices to go digital. Before, we used to be able to just pick up the chart, hang the film on a viewbox, read it, put it back in the chart, and off they go. Now, everything is on a workstation or multiple workstations, depending on what you use in your facility. You're sitting in front of a monitor, at a workstation, and you're there all day looking at digital images.

It's very good for the patient because we're getting to look at those films in high detail. When you look at them in full resolution, the images are quite large on each monitor, and you really are seeing very subtle changes. But the bad thing is it's either doubled or tripled the amount of time it takes us to read it. So every single mammogram has taken us a

lot longer to read.

Everything takes time. Searching for the patient by name or birth date or number, the accession number, annotating on the films if you want your technologist to do extra views, if you wanted to see the patient and her screening. We're now sitting in front of monitors, and it's taking us a lot longer to read every case. So it's good for the patient, but it's bad for the radiologist. It's slowing us down.

Q: What can be done about that?

Destounis: You have to educate your patients. When you educate your patients about why we're moving into a filmless world, they are very willing [to wait for test results] and very happy. You just need to tell them what you're doing and why you're doing it.