Please make a part of the record:

I am a registered nurse manager of a Women's Diagnostic Center.
As a patient advocate I am aware of the advocacy of other nurses such as Judy Wagner. I have some great concerns about the practice of mammography and other breast imaging modalities if we do not make some changes in educational requirements and tracking of competence.

Screening mammography still provides the best defense against a death from breast cancer. However, this is only true when the quality of radiologists reading accuracy is highly proficient. As you may or may not know, studies indicate that doctors need to read minimally 2,500 films each year to stay sharp. The government, however, only requires 480 per year. It is ridiculous to think that anyone can be proficient reading this few per year. At this time the government does not require regulatory agencies to monitor these levels of proficiency. Having the radiology groups monitor internal performance is quite like having the fox watching the hen house. Most radiology department directors have neither the time or the staff to go back and find the false negatives. I run a small center and make it a priority to go back with each new cancer diagnosis and see if it fits into the "false negative" category. This is time consuming but very necessary. To date I have discovered 18 false negatives, read primarily by two radiologists, within the past two years. I work closely with the medical director of the center who has been very supportive. He has helped me get this information to the physician quality committee and has made recommendations to remedy the situation. While we have discovered the actual cases of missed diagnosis I can only wonder how many more patients who were given a benign or negative outcome may have a cancer already.

Several months ago we had a fellowship trained mammographer join the practice. She quickly spotted the above problem and stated that there were two other physicians in the group who should not even read mammography. She stated that this was more of a problem than just the need for a few CMEs in mammography. The cancers that were being missed were, for the most part, not small, difficult to see cancers. It seemed clear to her that there was a real problem identifying what cancer looked like in its early stages. We have the R2 Image Checker which is used and still we have this many missed diagnoses. She left the group after only a few months to go to practice in a large hospital breast center.

As with the majority of community hospitals the radiology group has the hospital radiology contract. They are very good at many things. They rotate several physicians through our center to cover mammography. They do not enjoy reading mammography and are clearly not going to spend time and effort to even go to a visiting fellowship in mammography, (as recomended for correction of deficit) My problem is that once you have had a really good mammographer and see what quality looks like, you can't go backward. I have insisted that they find us another mammographer and so far administration has backed me up. They, of course are dragging their feet because this new person will not generate the same amount of revenue that other physicians in the group generate. My feeling is that there needs to be a new paradigm in the way radiology groups think about practice recruitment and development. Because the average radiologist would prefer not to do mammography/and other women's imaging, the group should be willing to subsidize salaries for those who are willing to do this kind of practice. Women deserve this vital service even if reimbursement is terrible. It should be of some value to a radiology group to have one well trained, passionate person take all the heat in this highly sued specialty. This mammographer could help raise the bar for all radiologists in the practice. Mammographers should be allowed to just do mammography and should not have to keep skills up in other areas as well. Breast imaging is changing so rapidly that it is no longer just mammography. A breast

imaging specialist has to be able to read breast MRI, do minimally invasive breast biopsy procedures, talk to patients and the public in general. He/she should not be expected to take general radiology call as well.

When I confront our radiology group with their individual statistics for all birads categories, FP,FN,TP and TN and when I provide % recommendations ** they tell me that they should not have to be held to the standards. They say they don't read as many per year as mammography experts and can't be expected to reach the same level of proficiency. I say this is bunk!. If I go to a surgeon to have my colon removed should he be able to say to me, "well, I may miss some of the possible cancer because I don't do as many of these as some others do". May it never be!!

At the last NCBC conference this past February I voiced my desire to see minimal reading and CME standards improved.
1.Additionally, we must improve reimbursement for breast imaging. We must find a way to provide incentives for bright dedicated physicians to go into breast imaging.

2. We should encourage radiology groups to recruit breast imagers and be willing to subsidize their salaries.

3. Regulatory agencies must find a way to do more than measure accuracy of equipment in their surveys until such time as physicians can adequately police themselves. In lieu of this, hospitals should be required to have non-physician personnel or consulting physician personnel monitor statistics for reading accuracy.

4. The MQSA needs to become more comprehensive. I am in favor of expanding it to BIQSA.

6. With regard to stereotaxis qualifications, I have no problem with surgeons doing stereotaxis in our center. If the radiologist has done a good job of marking the recommended area for biopsy our technologists have no problem locating the lesion on the computer and preparing everything for the surgeon. He then reviews the mammogram, the stereo set up and marks the area for biopsy. I think when surgeons get into trouble doing stereotaxis is when they interpret the mammogram which was done, perhaps in their office, then expect an aid, other than a registered mammo technologist, to set up the equipment and position the patient.

Recently I read in the Mammography Regulation and Reimbursement Report that the ACR would begin calling the False Negative (missed diagnosis) a 'sentinel event' for the hospital. This would have a big impact on hospital accreditation. I will now be attempting to track our cancer patients to see if they die of breast cancer. If so, the sentinel event repercussions for the hospital are significant. I can see if this happens the individual hospitals will begin demanding better quality readers of breast imaging.

I am only one voice but I am a thorn under the saddle. Each time I find another false negative I see the patient's face. I am the person who will counsel them prior to their first surgical visit. I am the nurse who gives out her phone number to them for questions and comfort. I am the nurse who runs the women's cancer support group. None of them know that their cancer should or could have been caught earlier. It is my job to market our center as a center of excellence. We meet that goal in every single way. We have very high customer service scores and people rave about the quick and compassionate service they receive. Indeed we are a center of excellence in so many ways. It is the physician component that lets us down. In order to keep my job I must fight this battle quietly within the Physician Quality Improvement Committee. It has been of little value to me. Recommendations for improvement are just that. The radiology group has little incentive (other than my constant nagging) to do much about anything.

**Practice Quality Audit goals are quoted from: Diagnostic Imaging, May 2000, Breast Imaging, "Audits Measure Practice Quality of Mammography", Dr. Michael N. Linver, M.D. Percents were based upon review of all major audits in the scientific literature by the multidisciplinary clinical practice guidelines panel on quality convened by the Agency for Health Care Policy and Research of the Dept. of Health and Human Services..

Goals of analysis of medical audit data: This audit divides cases found on screening patients vs symptomatic diagnostic patients.

	Goals:	Current Practice Patterns
PPV based on abnormal screening examination (screening cases only)	5% to 10%	_____
PPV when biopsy (surgical,FNA or Core) is recommended	25-40%	_____
Tumors Found stage 0-1 (Screening cases only)	>50%	_____
Tumors Found-Minimal Cancer (Inv Cancer <1cm,DCIS) Scr.only	>30%	_____
Node Positivity Screening cases only	<25%	_____
Cancers found /1000cases screening only	2-10	_____
Prevalent cancers found first time exams (scr only)	6-10	_____
Incident cancers found/1000 cases follow up exams	2-4	_____
Recall Rate	<10%	_____
Sensitivity	>85%	_____