

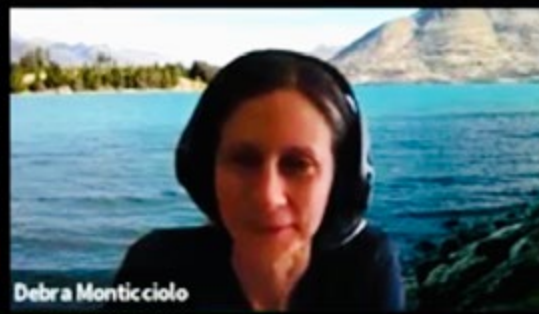


SBI NEWS

The Member Newsletter of the Society of Breast Imaging

INSIDE THIS ISSUE:

- Legislative Update: MARCA and Averting Further Medicare Provider Payment Cuts
- Method of Detection: The Missing Piece in United States Cancer Registries
- Difficult Conversations With Technologists and Administrators: Practical Tips for the Early-Career Breast Radiologist



SBI Young Physician Section webinars "Difficult Conversations with Technologists and Administrators: Practical Tips for the Early-Career Breast Radiologist" and "Why Academic Breast Radiology?," September 2021.

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President's Column

OUR SBI MISSION:

To save lives and minimize the impact of breast cancer

OUR SBI VALUES:

Patient-centered and evidence-based care

Excellence in education

Scientific integrity

Collaboration and collegiality

Respect for diversity and inclusiveness



Emily Conant,
MD, FACR, FSBI
President of the SBI

As the pandemic stretches on, we continue to be challenged by the unknown, and as a result we find ourselves in limbo planning for the upcoming winter and spring. However, increasing vaccination rates and the promise of booster shots suggest that we are moving toward a new, and hopefully more optimistic, norm by the time of the spring 2022 SBI symposium. In anticipation of this, and especially based on the incredible success of our 2021 meeting—which attracted more registrants than ever before—the SBI board has voted that the 2022 symposium will be a hybrid meeting, offering in-person as well as online attendance. We hope that merging the best of both formats will maintain (or increase!) both national and international attendance. I assure you that the symposium, with a theme of “Moving Forward: New Approaches in Breast Imaging,” will contain high-impact educational content while also fostering important networking opportunities for all!

In other important news reflecting our society's continued commitment to diversity, equity, and inclusion (DEI), SBI has partnered with Dr. Nika White of Nika White Consulting (NWC), a management consulting firm that is nationally recognized as an authority in strategic diversity and intentional inclusion. We hope that through the consulting process, we will not only obtain

important feedback from our membership but will also be able to implement impactful DEI processes. Each of you have been sent an invitation for an anonymous survey conducted by the NWC team. If you haven't already, please take a few minutes to complete the survey so that we may critically assess your views and suggestions for important and strategic DEI improvements. In addition, in the coming weeks, many of you may be randomly selected by NWC either to join focus groups or to engage in one-on-one interviews. I encourage you to participate, since your input will guide us in determining opportunities to strengthen SBI's cultural responsiveness. Thank you in advance for your time and commitment to this important work.

Finally, a note on our increase in membership dues. As our society grows, we hope to attract more members with diverse interests and needs, and we also hope to increase our support of research projects and community outreach—central missions of the SBI. The increase in dues will help accomplish these important goals.

Thank you again for your resiliency, support, and commitment to the SBI and to breast care. It's a great honor to be able to work with you all toward our shared goal of improving our dynamic field of breast imaging.

Best regards,

A handwritten signature in black ink that reads "Emily F. Conant MD".

Emily Conant, MD, FACR, FSBI
President, Society of Breast Imaging

Editor's Note

By Vilert Loving, MD, MMM, FSBI

Many breast radiologists, technologists, and trainees have a mission-focused mindset. Our mission, which we've chosen to accept, is to diagnose breast disease and facilitate treatment. The SBI's mission is "to save lives and minimize the impact of breast cancer." The institution for which you work almost certainly has an overarching mission statement.



Vilert Loving, MD, MMM, FSBI

During one's career and personal life, it is often easy to become burdened with impending stressors: a seemingly endless list of screening mammograms, project deadlines, important meetings, wedding planning, or a cross-country move. Sometimes these stressors may be a source of motivation to succeed, while at other times these stressors may contribute to burnout. The latter is especially true when compounded by factors outside one's control, COVID-19 being an omnipresent example. Whenever these stressors become overwhelming, I find it helpful to zoom out and refocus on professional and personal high-level missions. For breast radiologists, this mission entails decreasing breast cancer mortality and morbidity. It is why we choose to do what we do. Refocusing on long-term missions can help keep things in perspective and prevent impending stressors from becoming disproportionate sources of mental fatigue.

Peter Eby, MD, FACR, FSBI, one of my SBI newsletter editor predecessors, established the mission of the SBI newsletter: "To empower and expand the diverse global breast imaging community through honest journalistic coverage of significant events, personal perspectives, scientific discoveries, and inspirational stories from all facets of our field for our members." As the new editor, I commit to the SBI membership to continue to deliver on this mission, as did my immediate predecessor, Shadi Shakeri, MD, FSBI. Importantly, this newsletter requires a group effort. Joining me are the new associate editors, Randy Miles, MD, and Nidhi Sharma, MD. The SBI Newsletter Committee also includes Dawn Derenburger, RT(R)(M), Amina Farooq, MD, Robyn Hadley, RT(R)(M), Elizabeth Krupinski, PhD,

Anita Mehta, MD, Sophia O'Brien, MD, Sarah Jacobs, BS, RT(R)(M) (CT), Amy Patel, MD, Hannah Perry, MD, Eric Rosen, MD, FSBI, Jean Seely, MDCM, FRCPC, FSBI, Danielle Sharek, MD, and Mary Scott Soo, MD, FACR, FSBI. Additionally, the committee is critically supported by Kesha Willis at the SBI. This stellar team will continue to deliver interesting and practical stories that keep you apprised of myriad topics impacting the worldwide breast imaging community.

To that end, this edition features stories that will appeal to all facets of the breast imaging world. Looking for advice on having challenging conversations with technologists? Check. Searching for methods to promote emotional wellness? Check. Unsure how to engage with the breast imaging community at home and abroad? Check. Confused about legislation affecting the field? Check. In particular, I encourage everyone to review an important article from the Screening and Emerging Technology Committee of the ACR Commission on Breast Imaging. Their suggestions for improving cancer registries in the United States, if properly implemented, could have a long-lasting impact on breast cancer screening conversations.

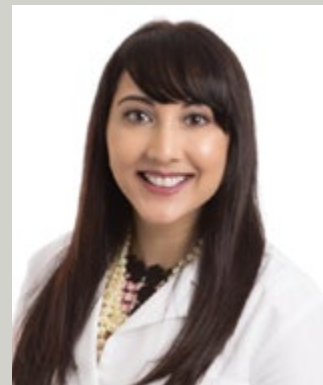
Finally, I appreciate you, the SBI newsletter reader. Part of my mission with the newsletter is to continuously search for new ways to serve you better. Let's accomplish this joint mission together. If you have any suggestions for how we can improve the SBI newsletter or if you would like to submit a potential article for publication, I would love to hear from you: vilert.loving@bannerhealth.com.



Legislative Update: MARCA and Averting Further Medicare Provider Payment Cuts

By Amy K. Patel, MD

Recently, the Medicare Access to Radiology Care Act (MARCA) has been a forefront issue in the field of radiology. MARCA is a bill that has been fine-tuned over multiple years with the following provisions: Centers for Medicare & Medicaid Services will reimburse registered radiology assistants (RRAs) “under radiologist supervision” (specialty-specific language) at 85% of the Medicare physician fee



Amy K. Patel, MD

schedule, RRAs will not be reimbursed for independent services or work performed for other specialties, and the scope of services will be defined by state law and certification. The ACR is cognizant of multiple reports of RRAs being dismissed from practices because of the inability to bill Medicare for services in which they participate and being replaced by physician assistants and nurse practitioners. As of May 26, 2021, there were 595 RRAs (including radiology practitioner assistants), nearly 140,000 physician assistants, and over 325,000 nurse practitioners in the United States. The American Society of Radiologic Technologists, American Registry of Radiologic Technologists, and Society of Radiology Physician Extenders have continued to support guidance that RRAs perform no image interpretation, work exclusively with radiology practices, and do not practice independently.

However, the standing argument is that if this bill finally passes (after unsuccessful attempts in 2018 and 2020), RRAs could potentially gain control of interpreting and billing for imaging studies that the overwhelming majority of clinicians feel should always be in the hands of radiologists, experts with years of extensive training and the clinical knowledge to ensure that patients receive high-quality care. An additional question is whether technologist groups will continue to maintain their positions or turn to independent practice in the future. Currently a task force is being created to address radiology physician extenders and MARCA. This effort aims to guide the final position of leading radiology groups (like the ACR) on MARCA.

In 2021, RADPAC (the ACR’s bipartisan political action committee) and the ACR Radiology Advocacy Network have not lobbied lawmakers about MARCA at all, despite false claims and information disseminated via various channels. MARCA was also not included among legislation discussed with federal elected officials during the ACR’s virtual Capitol Hill Day in 2021.

If you are asked to give your opinion in the future, whether through a survey or through any other form of communication outreach, I encourage you to let your voice be heard. The ACR

has heard loud and clear the concerns of radiologists from all over the country at all career levels, and many will be working both inwardly (behind the scenes) and outwardly to ensure that the future of radiology is bright and prosperous for young radiologists.

Finally, many radiologists have recently received correspondence regarding impending 2022 radiology reimbursement Medicare cuts. The ACR Government Relations team was successful in mitigating potentially devastating Medicare cuts to achieve budget neutrality as part of increased reimbursement toward evaluation and management codes, which subspecialties such as radiology, radiation oncology, and pathology do not typically use. Because the ACR Government Relations team formulated a coalition of support from over 60 organizations, including the voices of radiologists, these cuts were decreased from 10% to 3.75%. Unfortunately, additional cuts are looming in 2022. It is imperative that the radiology community respond to call-to-action emails or directly contact the members of Congress representing their congressional districts. Two physicians in the US House of Representatives (Ami Bera, MD, and Larry Bucshon, MD) are garnering support from others in Congress to delay additional cuts until 2023. Drs. Bera and Bucshon make the case that COVID-19 has negatively impacted radiology, particularly in patient care and access, furthering the already concerning disparity in patient care. Their goal is to ensure that patients receive good radiological care regardless of geographic location.

We will continue to soldier on as health care becomes increasingly competitive and at times contentious. However, united we stand, divided we fall, and it is crucial, now more than ever, that we band together to defend and protect our patients and profession.

Further Reading

The Medicare Access to Radiology Care Act (MARCA). American College of Radiology. Accessed September 8, 2021. <https://www.acr.org/Advocacy-and-Economics/Legislative-Issues/MARCA>

Method of Detection: The Missing Piece in United States Cancer Registries

By The Screening and Emerging Technology Committee, American College of Radiology Commission on Breast Imaging: Debbie Bennett, Mythreyi Chatfield, Toula Destounis, Sally Friedewald, Sujata Ghate, Ed Hendrick, Regina Hooley, Maxine Jochelson, Dan Kopans, Sharp Malak, Amanda Mayne, Diana Miglioretti, Donna Plecha, Jocelyn Rapelyea, Rob Rosenberg, Dana Smetherman, Rita Zuley, Peter Eby (chair)

The American College of Radiology (ACR), United States Preventive Services Task Force (USPSTF), and American Cancer Society (ACS) agree that annual screening mammography beginning at age 40 years will save the most lives.¹⁻⁴ However, the same organizations disagree over the balance of risks and benefits of screening mammography and recommend different frequencies and ages to initiate early detection of breast cancer in the United States. The results of randomized controlled trials conducted between 1963 and 1990 from multiple international sources provide strong evidence that screening mammography significantly reduces deaths from breast cancer.^{5,6}

The results of the randomized controlled trials have been reinforced and supported by modeling studies inside the United States and observational research from national databases outside the United States. Shortly after the data from randomized controlled trials confirmed the benefits of early detection, many developed nations instituted population-wide breast cancer screening programs. The United States did not. Administrators of many national health programs outside the United States had the foresight to track the initial method of detection (MOD), such as mammography screening or clinical examination, for decades for every patient with a new diagnosis of breast cancer. In examination of data from a large subset of screening-eligible women in Sweden, for example, researchers reported that women attending screening had a statistically significant reduction of 41% in their risk of dying of breast cancer within 10 years of diagnosis and a 25% reduction in the rate of advanced breast cancers compared with nonattenders.⁷ Similarly, other nations tracking MOD, such as Australia and Canada, have reported reductions in breast cancer-specific mortality exceeding 40% as a result of mammography screening.⁸⁻¹⁰

Knowledge Gaps

Many national, state, and local databases in the United States, such as the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program, the Centers for Disease Control's National Program of Cancer Registries, the American College of Surgeons' National Cancer Database, and the ACR's National Mammography Database, collect specific data for every patient with a new diagnosis of breast cancer. However, MOD has never been included in any United States breast cancer registry. The North American Association of Central Cancer Registries does not require registries to document MOD. Thus, among developed nations with high rates of breast cancer, the United States critically lacks the fundamental ability to directly link breast cancer outcomes to MOD and address the ongoing debate over screening. Without patient-specific data on initial MOD, national organizations (such as the USPSTF, ACS, and American College of Physicians), when examining the impact of screening, still turn to models based on

historical data and variable assumptions that are subject to bias.^{1,2,11} The lack of contemporary, patient-specific MOD information has permitted ongoing speculation and fostered disagreement about the risks and benefits of screening in the United States. This disagreement leads to conflicting recommendations that confuse patients and clinicians and missed opportunities to save lives.^{11,12}

Defining and Determining MOD

The initial MOD of breast cancer is defined as the first test or clinical event to trigger the workup leading to the histologic diagnosis of breast cancer. When national service screening programs and registries were built in the 1980s and 1990s, the choices for initial MOD were limited. Screen-film mammography was the only image-based screening test. Today, initial MOD can include multiple other image-based screening modalities. Screening with full-field digital mammography, digital breast tomosynthesis, ultrasound, magnetic resonance imaging (MRI), and other tests can now provide the earliest evidence of breast cancer. Self-examination and clinical breast examination, which detect lumps, thickening, or tenderness, can also be the initial MOD leading to a diagnosis. Patients may trigger detection of breast cancer when they seek care for nipple discharge, erythema, pain, dimpling, or skin ulceration. In addition, other imaging or laboratory tests not designed to evaluate the breast, such as abdominal computed tomography or brain MRI, may identify metastases that lead to a diagnosis of breast cancer.

Benefits of Collecting MOD

If MOD were assigned and collected accurately and without bias for each patient, we would have new primary data rather than models based on historical data that may no longer accurately represent the diversity of our screening-eligible population or advances in screening technologies. Concrete, patient-specific data could bring the ACR, USPSTF, and ACS to consensus recommendations for screening. We could employ the MOD-inclusive data to answer numerous national population-based questions about how screening relates to efficacy, equity, treatment, and breast cancer:



- What are the relative contributions of screening and treatment to reducing mortality from breast cancer?
- Should the treatment of stage I cancers detected by screening be the same as treatment of stage I cancers detected clinically?
- Do patients with screening-detected cancers have different treatment or mortality outcomes compared to patients whose cancers are detected clinically?
- Do tumors that are detected by screening have different molecular signatures compared to tumors that are detected clinically?
- Are there racial disparities in screening that impact outcomes?
- What percentage of breast cancers are not initially detected on screening, and how does this vary by personal risk, breast density, age, or other factors?
- Are there differences in initial staging for breast cancers initially detected with image-based screening versus those detected with clinical examination or self-examination?
- Do MOD and outcomes vary with geographic location, and can we use that information to improve access to screening at the local level?
- Are supplemental screening options (MRI, ultrasound, etc) improving treatment, morbidity, or mortality from breast cancer?

Barriers to National Collection of MOD

National service health care systems outside the United States are less than perfect, but they provide a uniform system for delivering care and collecting data. The United States health care system provides cutting-edge care with comparatively brief wait times and less regard to cost, but data are collected by a patchwork of public and private entities funded by numerous private and public payors. Moreover, these heterogeneous entities compete at the local, regional, and national levels and are stitched together with different electronic medical records of heterogeneous patient populations. Nearly every state has a tumor registry responsible for tracking valuable information such as incidence, stage, race, and mortality for every case of cancer diagnosed. Currently, patient data from some state registries are deidentified and then sent to SEER. However, 33 states, including Texas, Florida, Illinois, Michigan, Ohio, and Pennsylvania, are excluded from the SEER cancer incidence database (https://seer.cancer.gov/about/factsheets/SEER_Overview.pdf).

Assigning MOD Accurately

Abstractors employed by state, local, and hospital registries currently gather information related to a new cancer diagnosis from clinical reports. Most of the information regarding cancer type, size, grade, and receptor status is quickly abstracted from succinct and standardized pathology reports. However, abstractors may turn to the tedious and time-consuming strategy of sifting through other clinical notes. We cannot expect abstractors to retrospectively read multiple radiology and pathology reports to recreate the clinical history to determine the MOD. In addition, if abstractors already know the patient has breast cancer, will they be able to avoid unconscious

bias when assigning MOD? It is imperative that assignment of initial MOD be accurate, unbiased, easily discoverable by abstractors, and correctly transferred to registries for future scientific investigation.

Additional Methods of Demonstration

It is essential to distinguish initial MOD from additional methods of demonstration (AMOD). AMOD are defined as any additional method, following initial detection, which further characterizes or re-demonstrates a cancer. A cancer may be additionally demonstrated by any of the same diagnostic exams used for initial MOD. However, initial MOD must be distinguished from subsequent AMOD. For example, a cancer may initially be detected on screening mammography and then further characterized on ultrasound and MRI. Ultrasound and MRI would be considered AMOD.

Summary

The Screening and Emerging Technology Committee (SETCOM) within the ACR Commission on Breast Imaging is actively exploring how to help United States registries accurately collect initial MOD specific to every woman with breast cancer. The SETCOM is dedicated to helping clinicians and patients understand the current impact of breast cancer screening and early detection in the United States. Breast radiologists are the experts on breast cancer screening and the SETCOM wants your ideas, input, and help. Please post your ideas and comments on the SBI Engage forum or send an email to Peter.eby@virginiamason.org.

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Gratitude: The Key to Personal and Professional Well-Being

By Sarah Jacobs, BS, RT(R)(M)(CT)



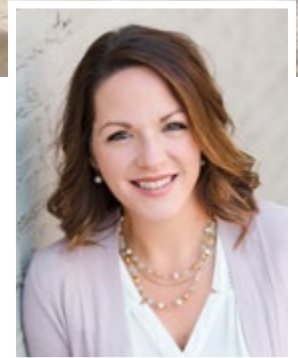
Practicing gratitude, the quality of being grateful or showing appreciation, is not just an act of politeness. Gratitude can foster a positive outlook and goodwill, which have been increasingly in short supply and difficult to maintain in the past year or so. Of the many things the pandemic has taught us, we've learned that our bodies and minds can only be tasked with so much before we start to bend and break. We take on more than we can handle out of the goodness of our heart or, in some cases, because we're required to. When balance is hard to come by and burnout among health care teams is at an all-time high, it is important for us to take a step back and focus on gratitude. Gratitude can be accomplished by implementing specific practices that can re-energize an exhausted imaging department. Now more than ever, it is imperative that we focus on healthy ways to cope, teach, and inspire others. Many of us have heard of gratitude practices but are unaware of the true impact of establishing these habits in our daily lives.

Embracing a Gratitude Practice

We are constantly hearing about the warning signs of burnout as health care professionals. Practicing gratitude is one of the most effective and easiest ways to decrease burnout in the health care profession. Gratitude is linked to well-being and resilience.¹ The health benefits are undeniable: lower stress, increased cardiovascular health and emotional wellness, and a boosted immune system.² Starting a daily gratitude practice can be challenging because of our busy schedules. However, 1 simple practice may be all you need: take the time to focus on something you're thankful for, even if for just 1 minute. This act can be all that's needed to feel less overwhelmed and more disconnected from stressors. The impact of this practice can be monumental, helping health care professionals work at their highest level and improving patients' perception of the quality of care they are receiving.

There are many easy and efficient methods of adopting a gratitude practice. The most effective is to build these methods into your normal routine³:

- Journal or meditate as you are enjoying your first cup of coffee or tea in the morning.
- Reflect on 1 person you're grateful for before turning on your computer and checking your email.
- Before you walk in to work, think of 3 people that need you to be the best version of yourself that day.



Sarah Jacobs, BS, RT(R)(M)(CT)

- Set a calendar reminder on your phone or office computer that goes off at the same time each day to remind you of 3 affirmations that bring you gratitude.
- Focus on genuinely thanking 1 of your colleagues each day for a specific task, rather than just verbalizing the word "thanks" as you're going about your day.
- Before you leave your parking spot and start your drive home, reflect upon 3 things that brought you joy during your day.

Leaders must lead by example, so don't be afraid to share your routine and ideas with others. If you haven't established a routine, start small and create habits that you can stick to. Gratitude is contagious and should be encouraged. Enlist the help of your technologists, leadership team, and anyone willing to participate in creating a gratitude program/practice at your institution.

Expressing and Accepting Gratitude

Practicing gratitude is a method of demonstrating your core values to others at work while fostering a safe, supportive, and inclusive work environment. Instead of focusing on things outside of our control such as late patients, add-on examinations, equipment malfunctions, and unexpected staffing changes, we need to focus on the things we can control, such as how we treat others and how we respond to stressful situations. Our colleagues learn by our example. Make an effort to carry out activities that demonstrate kindness and gratitude:

- Purchase extra coffee or tea for colleagues. While you're there, pick up doughnuts for the entire team!
- Recognize the good work of others; write thank-you notes.
- Food works wonders: purchase lunch for your team.
- Smile at a stranger in the hallway every chance you get. Yes, masks make it difficult, but you can see their eyes smiling.
- Greet employees and patients when you walk through the front door of your facility.
- Check in with your colleagues by having genuine conversations. Ask "What can I do to help?" or "What can I do for you?"

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Ways to Get Involved With the Breast Imaging Community as a Trainee

By Sophia O'Brien, MD; Amina Farooq, MD

As a radiology resident, whether one is learning the radiology lexicon as an R1, balancing demanding call duties as an R2, or studying for boards as an R3, it may seem like an insurmountable task to become involved in the breast imaging community in a meaningful way. However, there are numerous opportunities for trainees to become active participants in the breast imaging world locally or worldwide, based on their available time and personal interest.

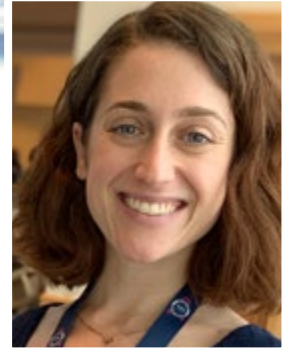
Local Breast Imaging Community

Reaching out to the breast radiologists at one's home institution is a great initial step. Multidisciplinary tumor board, radiology-pathology concordance conference, interesting case conference, and journal club participation are among multiple avenues to learn and express interest in the field. Trainees can assist their faculty with clinical research or quality improvement projects and participate in breast radiology education for medical students, junior radiology residents, or nonradiology health care practitioners. Trainees can get involved in local breast cancer awareness activities like screening education community outreach efforts, local breast imaging legislative efforts, and health initiatives such as organized breast cancer awareness marathons. A local breast imaging conference or something as simple as a home program's Mammography Quality Standards Act review is a great opportunity to participate and learn more as a trainee.

National Breast Imaging Community

There are multiple opportunities to dig deeper and become further involved at state and national levels with research, teaching, and legislative opportunities. Original research from one's home institution can be submitted as educational exhibits, posters, or oral presentations to annual national meetings such as the [Radiological Society of North America \(RSNA\) Annual Meeting](#) and the [SBI/ACR Breast Imaging Symposium](#) and can later be submitted as manuscripts for publication. For a less time-intensive option, interesting cases can be submitted to the [Journal of Breast Imaging \(JBI\) Image Spotlight](#), [ACR Case in Point](#), or the [RSNA Case Collection](#). Even if not personally presenting, trainees can attend annual national meetings like those of the RSNA and SBI. National conferences are great venues for networking with peers and breast radiologists from other programs and helpful forums to learn about current hot topics in the field.

Trainees can serve as peer reviewers for medical journals, enhancing their academic experience. Journals such as the [JBI](#), [Journal of the American College of Radiology](#), and [Academic Radiology](#) have ample opportunities for trainees who express interest to be involved in the process at an early career stage.



Sophia O'Brien, MD

Multiple [SBI committees](#) accept trainee members, including the Social Media, Newsletter, Resident and Fellow Section, Mentorship, Membership, Patient Care and Delivery, and Inclusion Diversity Equity Alliance Committees. As committee members, trainees work closely with other leading national SBI members, networking within the breast imaging community and creating ideas, events, projects, or guidelines with far-reaching impact.

International Breast Imaging Community

There are numerous opportunities to assist with international education, training, and outreach initiatives as a volunteer with the [RAD-AID Breast Imaging section](#). The time commitment varies, with options to contribute from home or on-site when able. SBI members can apply to the [RAD-AID SBI Global Breast Imaging Program](#) for the opportunity to travel with the RAD-AID Breast Imaging section, assisting with international breast imaging outreach and access projects.

Through the [Health4TheWorld](#) initiative, radiology residents can help organize and moderate international grand rounds on breast imaging and can submit videos teaching specific breast imaging topics in the Residents' Corner.

Joining the Conversation

Involvement in the breast imaging world can be as simple as observing or contributing to the larger virtual conversations in the community. On Facebook, groups like RadChicks, American Radiologists, and Learning Breast Cancer are great resources for trainees. There are numerous handles to follow on Twitter, including SBI (@BreastImaging) and the SBI Resident and Fellow Section (@SBIRFS), and on Instagram, including SBI (@earlydetectionsaveslives), ACR (@radiologyacr), and RSNA (@rsnagram), as well as many other professional breast imaging

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Cara Sapida

By Danielle Sharek, MD

DS: Please tell me about yourself and your background.

CS: I'm a 39-year-old mother of two. I have a 3-year old daughter and 6-year old son. I've been a television news reporter in Pittsburgh for 16 years. I shared my breast cancer journey publicly in hopes of encouraging women to get mammograms during the COVID-19 pandemic.

How were you diagnosed with breast cancer?

I was diagnosed last year at 38 years old. I was reaching up to stretch my arm muscles after recently joining a boxing gym for exercise. While stretching, I felt a lump in my breast. I am grateful for those pulled muscles, otherwise I'll never know how long I would have gone before noticing my lump. My cancer was aggressive.

How did you feel when you learned of the news?

When I learned I had triple-negative breast cancer I felt rock-bottom devastated. I was a healthy vegetarian who exercised and took good care of my health. I was at a level of devastation that, as a writer, I can't quite find the right words. My diagnosis left me in the fetal position for a long time.

What was your treatment process? Did you face any treatment obstacles? How did you overcome them?

I did 12 weekly rounds of Taxol [paclitaxel], with carboplatin every 3 weeks, followed by 4 rounds of adriamycin/cyclophosphamide and atezolizumab immunotherapy every 3 weeks. One week out of the 16, my neutrophil counts were too low and I couldn't get treatment, which was an interesting experience. I realized I was sad I couldn't get my chemotherapy because I was grateful for the medication which was shrinking my tumor. I also underwent bilateral mastectomies.

What motivated you during your diagnosis and treatment process?

My children were my biggest motivation. After I shaved my head, the first thing my then 5-year-old told me was that I was still beautiful. We spent many days cuddling in bed. They constantly drew me pictures, and I hung them around the bedroom. I think there's a misconception that you'll be sick all throughout chemotherapy. There were days I was horrifically ill, but I had many decent days that were spent playing with my children.

What did you learn from your experience?

I learned to appreciate the ability to grow old. I remember 2 years ago dreading the big 4-0. I feel beyond blessed to be here to celebrate that milestone. I feel blessed that I'll get to see my

son go to kindergarten next week. You won't catch me taking life for granted. I pray hard that I'll be a grandmother some day, and thank God that I'm here to tell my story.



Danielle Sharek, MD

How has this diagnosis impacted your life?

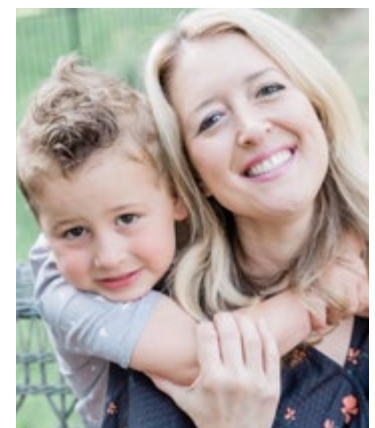
Breast cancer has forever altered my life. My short-term memory is still terrible. My anxiety is still high. My outlook on life and what's important versus what is trivial has never been more clear. A therapist once told me that something many of her breast cancer patients had in common was putting themselves last. I'm working on making sure my physical and mental health are both a priority.

Are there any lessons that you think the breast imaging community can learn from your experience?

One of my best friends is an ultrasound technologist, so I've experienced a loved one and a lot of strangers performing my breast ultrasounds. I've noticed there's compassion and kindness in the profession. The amount of anxiety that I feel during imaging is off the charts. I know that radiologists and technologists can't medically offer any reassurances, but the kindness and positive energy is noted and much appreciated.

What advice would you give to other patients who are going through the diagnosis and treatment process for breast cancer?

The diagnosis stage is the hardest. I called it the "dark days." It gets easier after you have a treatment plan. Remember that there are new medical treatments and advancements every single day. Also remember: faith over fear, and you've got this.



Cara Sapida and her children

The Canadian Society of Breast Imaging

By Jean Seely, MD, FRCPC, FSBI, FCAR

One death is a tragedy; one million is a statistic.

Anonymous

We are now in the fourth wave of the COVID-19 pandemic in Canada. This resurgence is highlighted by variation in vaccination rates and diverse public health care measures, all managed differently in separate provincial and territorial health care jurisdictions. The impact of different public health measures and government policies on COVID-19 vaccination rates and trends is seen in rates rising in some provinces more than in others. By the date of this writing (September 17, 2021), 74% of Canadians had received 1 vaccination dose and 69% were fully vaccinated. The provinces with the lowest vaccination rates were Alberta (67%) and Saskatchewan (66%), as compared with the 2 most populated provinces, Ontario (74%) and Quebec (76%).¹ On September 17, the province of Alberta had the same number of new COVID-19 cases in the preceding 7 days (10,000) as the provinces of Quebec and Ontario combined, with populations of 4.5 million in Alberta, 14.8 million in Ontario, and 8.5 million in Quebec. The health care impact in Alberta has been declared a public health emergency.

The heterogeneous public health measures for COVID-19 are familiar to those of us involved in breast cancer screening. The quote at the beginning of this article is not a pleasant one but, unfortunately, is increasingly relevant in 2021. It could describe the number of women who are underscreened in Canada because of variable screening policies in the public screening programs. We have different approaches toward the age to begin screening, screening intervals (annual vs biennial), and the age at which screening invitations stop. For example, British Columbia's screening program begins screening women at age 40 years, screens every 2 years, and screens only within the provincial screening program. Ontario's screening program begins screening at age 50 years, screens every 2 years, and allows for screening outside the provincial screening program. Some programs, including Ontario's, also screen women with dense breast tissue (defined as $\geq 75\%$ fibroglandular tissue) annually. Assessing the impact of the various screening policies is increasingly important, and an evaluation of interval cancers—cancers diagnosed between screening periods—is a useful outcome metric. A study of 144,000 women in Canada evaluated the impact of annual versus biennial screening policies in women with dense breasts. The study demonstrated that jurisdictions that screened annually had 40% lower interval cancer rates than those that screened

every 2 years.² It is well recognized that interval cancers are associated with a higher stage of cancer at diagnosis and worse outcomes. Therefore, various policies for screening correlate with different outcomes, as with COVID-19 health care policies.



Jean Seely, MD, FRCPC,
FSBI, FCAR

In Canada, most organized screening programs follow the recommendations from the Canadian Task Force on Preventive Health Care,³ which recommends against screening women in their 40s. Although some provincial screening programs invite women in their 40s, the most populated provinces, Ontario and Quebec, deny these women the opportunity to participate in organized programmatic screening. Coldman et al evaluated data from over 2.7 million screening participants in Canada aged 40 to 74 years.⁴ The results showed that average breast cancer mortality among those who participated in programmatic screening was 40% lower than expected for those who did not participate.⁴ This reduction was seen across all ages, including women aged 40 to 49 years.

The Canadian Task Force on Preventive Health Care has chosen to ignore newer observational studies such as the Coldman et al study and instead relies on older randomized controlled trials such as the Canadian Breast Cancer Screening Studies. I wrote about the importance of work on the Canadian Breast Cancer Screening Studies in the summer 2021 edition of the SBI newsletter (*SBI News*. 2021;[2]:22-23).

Collaboration with various societies and public health groups is a key priority for the Canadian Society of Breast Imaging (CSBI). Providing timely breast imaging updates in the face of rapidly evolving changes related to the COVID-19 pandemic has been important for public health measures. In 1 year, in collaboration with the Canadian Association of Radiologists (CAR), the CSBI released statements on screening and COVID-19,⁵ vaccination and adenopathy,^{6,7} and screening and tomosynthesis.⁸ The CSBI also worked with the Canadian Partnership Against Cancer, an independent organization funded by the federal government, to accelerate action on cancer control to identify the problem of rising abnormal recall rates in Canadian screening programs despite no change in cancer detection rates. The Canadian Partnership Against Cancer published a report, endorsed by the CSBI, on a framework to address the abnormal recall rate.⁹

Continued on page 15 >



Technologist Engagement, Part 2: Enhancing the Radiologist-Technologist Partnership

By Sarah Jacobs, BS, RT(R)(M)(CT); Robyn Hadley, RT(R)(M)

Radiologists and technologists typically play the key clinical roles in a successful breast imaging practice. As with any effective partnership, the team members are responsible for the success of this alliance. Mutual respect, open communication, and a professional approach with the goal of keeping patients first lays a strong foundation for an excellent breast imaging team. To maintain a strong partnership, radiologists and technologists should focus on effective communication, a solid understanding of mutual patient-centered goals, and empathy toward colleagues.

Communication

The radiologist-technologist partnership relies on open communication among all clinicians within the department. To create a thriving environment while demonstrating a culture of engagement and safety, both groups must feel comfortable offering solutions to problems and processes, working toward a common goal of patient care.

The technologist plays a vital role as a liaison between the radiologist and the patient. Breast imaging is a high-anxiety setting because most patients recalled from a screening examination are nervous about the result. Technologists must ensure that the way they talk about the radiologist instills confidence in patients and makes them feel safe and well attended. “Managing up” is a common tool used during the introduction process and is essential to help create a positive first impression. Managing up teammates and departments allows patients to feel more confident in their caregivers and comfortable with the coordination of care. For example, when greeting a patient undergoing biopsy, the technologist can say, “[Doctor’s name] is performing your biopsy today. [He/she] is excellent at what [he/she] does and truly cares about [his/her] patients. You are in great hands today.”

Technologists also exercise their role as liaison when presenting diagnostic cases and pertinent patient history to the radiologist. As stated in the American Registry of Radiologic Technologists Standards of Ethics, “The Registered Technologist acts as an agent through observation and communication to obtain pertinent information for the physician to aid in the diagnosis and treatment of the patient.”¹ It is extremely important for technologists to obtain a focused clinical history, assess and document physical findings, and accurately deliver the information to the radiologist in a clear, concise manner.

Offering effective feedback is an essential tool that contributes to productive communication. Requests for additional imaging because of poor image quality, artifacts, or positioning errors should be viewed as opportunities for improvement.

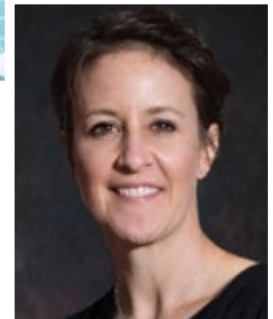
Radiologists and technologists can turn such interactions into positive learning experiences by encouraging open dialogue regarding the reasons for the technical callback and expectations for optimal outcomes. The radiologist-technologist partnership must recognize that a positive patient experience centered around compassion and empathy begins with the technologist.

This interaction may determine if a patient returns for additional screening or follow-up imaging. Suggestions for improving communication include the following:

- Encourage open lines of communication while establishing a safe environment where it is acceptable for all team members to speak up. Welcome ideas for improvement through a suggestion box or anonymized surveys and set goals for the team with morning huddles and weekly or monthly discussions.
- Model the behavior and communication style that you wish to see in teammates.
- Promote accountability through effective feedback to strengthen the level of trust between radiologists and technologists.

Mutual Goal

All staff members on the breast imaging team should work together toward the mutual goal of providing optimal patient care by acquiring high-quality images. Radiologists have a valuable opportunity to encourage and engage their technologists through quality image assessment. Enhancing engagement and motivating technologists can be accomplished with simple words of gratitude such as “Great work!” or “Fantastic images!” or “Thank you!” This



Robyn Hadley, RT(R)(M)



Sarah Jacobs, BS, RT(R)(M)(CT)



can easily be accomplished by implementing a process of feedback and gratitude with a simple form (Figure) that can be printed, filled out, and exchanged between staff members or by setting up an online anonymized feedback form. Announcing a monthly caregiver champion who worked hard to provide exceptional patient care is another well-received award. Other ideas include the following:

- When a diagnostic workup or biopsy report yields a cancer diagnosis, share the case with the technologist(s) who obtained the patient’s images, offering words of gratitude for the quality images that allowed the critical diagnosis to be made.
- Share interesting cases, new technologies, and updated practices that have the potential to inspire staff members to perform their best work.
- Support opportunities for continuing education for technologists, such as hosting an annual continuing education conference with topics geared toward technologists.
- Invite technologists to departmental educational seminars, interesting case conferences, and journal clubs and provide lunch as an effective team-building experience.
- Establish and allow access to a shared teaching file.
- Invite staff to tumor board meetings.

Members of the breast imaging team often enjoy participating in activities such as these to promote team engagement. Finally, enlist the help of a lead technologist or manager to implement these ideas and to symbolize that these engaging activities are a priority for the team.

Colleague Empathy

As members of a caregiver team, radiologists and technologists hold themselves and their colleagues accountable for treating patients with a high level of compassion and empathy. However, team members sometimes neglect to treat each other in the same way. They focus on anticipating the needs of the patients to display empathy. In the same regard, they should anticipate each others’ needs to create a stronger partnership.

- If a team member (radiologist or technologist) seems stressed or just not themselves, simply asking “Are you okay?” or “What do you need from me today?” and listening with empathetic understanding builds a long-term and successful partnership.
- Understand the team’s needs and actively troubleshoot during difficult diagnostic workups or challenging procedures.
- Encourage wellness with consistent breaks to recharge and reenergize.

As individuals, our daily lives are filled with external life stressors that are mentally, physically, and emotionally challenging. Everyone has an underlying story that others are not aware of. To feel supported with a positive mindset based on learning, radiologists and technologists should treat each other with compassion and understanding. When radiologists lead the team and model empathetic behavior toward technologists and nursing colleagues, the technologists appreciate this behavior, which in turn strengthens the entire team. When empathy is displayed, communication comes from a place of gratitude and the common goal remains high-quality patient care. The foundation for high-quality imaging services is established by constructing a partnership between the radiologist and the technologist, resulting in the highest level of patient care.

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Figure. Image feedback form

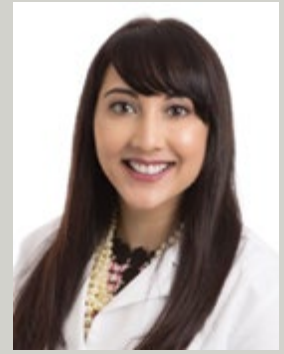
Difficult Conversations With Technologists and Administrators: Practical Tips for the Early-Career Breast Radiologist

By Kimberly Beavers, MD; Amy Patel, MD

The early-career breast radiologist faces many challenges when adjusting to a new role as an attending radiologist. Among these challenges is navigating relationships with technologists and administrators. Recently, Dr. Amy Patel hosted a forum discussion



Kimberly Beavers, MD



Amy Patel, MD

with Dr. Kimberly Beavers, Amy Mathis, and Alina Oramas to facilitate a practical approach to navigating these potential relationship challenges. The forum is posted online via SBI platforms. Each of the forum participants brought a unique perspective and background. Dr. Beavers is a first-year attending radiologist at AdventHealth Orlando. Ms. Mathis is a technologist with over 25 years of experience in mammography technology and works with Dr. Patel in the Kansas City, Missouri, area. Ms. Mathis has also served in an administrative role as manager of their Breast Care Center for over 10 years. Ms. Oramas, a computed tomography technologist by training, has been an outpatient site manager for multiple mammography sites within AdventHealth Orlando and is now senior manager of outpatient imaging operations.

Throughout the dynamic discussion, several themes emerged as being critical to successfully engaging in conversations with technologists and administrators. These themes included trust, compassion, teamwork, reinforcement/repetition, and culture.

The most important theme that was revisited with each topic was trust between the radiologist and the technologist. For early-career radiologists, establishing relationships in a new practice can be challenging, especially if the technologists are very experienced. While many early-career radiologists may see this experience differential as a negative, in nearly every scenario it can be a positive. Not only can the early-career breast radiologist learn from seasoned technologists and administrators, but the latter can also learn from the former. Establishing trust is a 2-way street. Many technologists will have years, or even decades, of experience in their field. Opening a dialogue with technologists from the beginning, establishing a relationship of respect and honesty, and giving and receiving feedback are key. In breast imaging, clinical practice techniques are variable. Other radiologists or technologists may use techniques or methods that are well within BI-RADS and Mammography Quality Standards Act guidelines but may not be the way that the early-career radiologist was trained. As long as a technique meets the patient care criteria that we strive for in breast imaging, creativity and being open to new methods are assets. It is important to know when to “pick your battles” in the early stages of forging the relationship.

If things don't seem to be flowing well with particular technologists, the radiologist would benefit from asking them how they're used to doing things and learning their perspective. You don't have to agree on everything, but creating an environment where everyone's opinion is heard is vital. Approaching this team dynamic with humility and curiosity goes a long way in developing trust and establishing positive relationships.

Another overarching theme was teamwork. Teamwork is vital to breast imaging as all team members, including the schedulers, receptionists, medical record keepers, technologists, and radiologists, are necessary to provide excellent patient care. Hand-in-hand with teamwork is flexibility by all team members, including the radiologist. Learning more about each team member's role can be particularly helpful. Closely observing each team member's daily workflow, hearing their feedback and challenges, and seeking input serve to strengthen the team, improve empathy and understanding from the radiologist, and improve patient care.

Reinforcement and repetition of concepts was also a recurring theme during this discussion. While flexibility is important in many patient scenarios, a background of standards and expectations strengthens patient care. Establishing standardized protocols and ensuring adequate and repetitive education are critical to quality. However, establishing such protocols is a fruitless effort unless there is buy-in from the technologists performing the work. For example, if a process is cumbersome for them, decreases efficiency, or decreases the quality of patient care, being “standardized” is not enough to ensure that the process is good policy. Having the technologists involved in these decisions, with continual feedback on how the process is working, is paramount.

As part of the SBI's continued commitment to facilitating excellence in breast imaging, this multidisciplinary discussion is a valuable tool for breast radiologists of all career levels, with a particular focus on early-career radiologists. SBI members are encouraged to view this discussion on the SBI website.



Wellness Column: Gratitude: The Key to Personal and Professional Well-Being (continued from page 8)

Ultimately, there is no perfect way to adopt these practices, but it's important to integrate them into our daily lives. Even if we can't control what is happening in the world around us, we can create habits to support emotionally strong and engaged teams. The reward of consistently practicing gratitude far outweighs the effort and may even be life changing.

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Member-In-Training Column: Ways to Get Involved With the Breast Imaging Community as a Trainee (continued from page 9)

organizations and individual radiologists. [SBI Connect](#), a virtual and active community with multiple specific discussion groups for SBI members, is a great starting point.

Joining the breast imaging community on social media allows one to see and interact with larger conversations about new research, educational initiatives, legislation, and other pertinent topics in real time. Trainees often write regarding their research projects, publications, and experiences on social media, engaging the community during their training journey.

Keeping a Finger on the Pulse

[SBI News](#) is a quarterly publication and the [SBI YouTube channel](#) is an outstanding resource of professional webinars, e-learning resources, and highlighted research presentations. Review of the tables of contents of major journals like *JBI* can help trainees identify specific articles of interest, keeping abreast of new, innovative research and ideas. The breast radiology cases in ACR Case in Point or the RSNA Case Collection are additional useful quick learning resources. The [ACR Bulletin](#) provides updates for practice and management criteria and is a great educational tool.

Regardless of the avenue chosen, interest level, and time commitment, trainees have ample opportunities to engage in the breast imaging community. Trainees' involvement in the community will inevitably grow and change with evolving professional interests, educational foundation, and time availability as their careers advance. It's never too early or too late to get involved!

Canadian Corner: The Canadian Society of Breast Imaging (continued from page 11)

Recognizing the role of tomosynthesis in reducing recalls for abnormal but benign results, the CSBI/CAR statement on screening with digital breast tomosynthesis⁸ is anticipated to support this framework while increasing cancer detection rates.

Collaboration continues with the CAR; establishing a working group on artificial intelligence in breast imaging is the next step. The CSBI is also working with the Canadian Association of General Surgeons and the Canadian Society of Surgical Oncology to produce 2 joint webinars. The first, "Approach to the Axilla in Breast Cancer," was held on September 29, 2021, and the second, "Breast MRI Surveillance and Screening," will be held on October 28, 2021, at 7 PM EDT.

The CSBI's mission of providing trusted education for patients, referring physicians, and health care providers who access breast imaging has never been more important or relevant. Saving just 1 life from breast cancer is more than a statistic.

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MARK YOUR CALENDAR

Upcoming Events

Some events may be tentative, depending on the status of the COVID-19 pandemic. Please check event websites for updates.

October 4 – 29, 2021

Virtual

European Society of Breast Imaging 2021 Online

<https://www.eusobi.org/congress/>

November 5 – 6, 2021

Seoul, Korea

International Congress on Magnetic

Resonance Imaging 2021

<https://2021.ksmrm.org/abstract/?sn=2>

**November 28 –
December 2, 2021**

Chicago, IL

Radiological Society of North America

Annual Meeting 2021

<https://rsna.2021annualmeeting.org>

Please visit the SBI Calendar of Events at www.sbi-online.org for a complete listing of events.