



Gregory S. Henderson, MD, PhD, FCAP
The Primary Care Pathologist

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at the side of the primary care physician.*

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Gregory S. Henderson, MD, PhD, FCAP, graduated from Tulane University with a biochemistry major and a philosophy minor before heading to Vanderbilt University for medical school. If his major was a predictor for medicine, his minor was a predictor for “thinking too much”—and in provocative ways. He says this runs in his DNA.

Dr. Henderson is a board-certified AP/CP pathologist who subspecializes in breast and gynecologic pathology. He is president, partner, and medical director for a six-pathologist group outside Seattle, and medical director of the Harrison Medical Center Laboratory. He also cochairs the CAP Member and Public Communications Committee.

Dr. Greg Henderson named his blog (primarycarepathologist.com) in homage to a phrase that Julian Henderson, MD, coined when his son was a resident. His father had been in the private practice of pathology for 25 years when the two attended the USCAP meeting together. When Julian Henderson introduced himself to a group of colleagues as a primary-care pathologist, Dr. Henderson writes, he was greeted with blank stares. “They had no idea what I mean by primary care pathologist,” his father told him later that day. “And unless your generation starts to understand what I mean, our specialty will be obsolete.”

“My dad represented the ‘old, old’ generation, the way it used to be when pathologists really were the doctor’s doctor, and they really did everything,” Dr. Henderson says. “That was just the way he practiced, and there was no question that he was a physician in his mind or anyone else’s. That whole generation demonstrated that they were physicians in their walk and their talk every day.”

The specialty moved away from that model, Dr. Henderson says, when pathologists began to spend all their time in the laboratory. Pathology is now focused on adapting to a new healthcare paradigm that is not really new at all, he says; it’s his father’s generation’s model. “Our new niche is our old niche, right there where the decisionmaking is done at the side of the primary care physician,” Dr. Henderson says, “helping that physician guide the patient testing, menus, and algorithms and becoming a resource to both physician and patient.”

To illustrate his point, Dr. Henderson describes an arrangement he had when practicing in North Carolina, when his office was next door to that of a friend who was a breast surgeon. The two were talking one day, he says, and came up with a novel idea.

“When you have a patient who has the difficult diagnosis,” I said, “why don’t you send them over to my office to look at the slides? Let’s see what happens.”

What happened was something wonderful. “Patients would show up at my office,” he says. “It was usually a half-hour meeting. They would look down the double-headed scope. And I would say, ‘This is normal breast tissue, and these are cancer cells.’ With very rare exceptions the patient would say, ‘I get it now, I know what I have to fight.’ It was a completing experience for them.”

Although payment mechanisms still need to be addressed, Dr. Henderson says, the first goal is to establish a partnership with treating physicians. “The treating physician is under extreme time constraints,” he says. “When he has to go into a patient room and spend valuable time translating your diagnostic information for a patient, he is consuming time that could be devoted to discussing treatment options. Sure he understands the disease process, but we’re the guys who really know it—it is, after all, our specialty to know it; so why shouldn’t we be the ones directly communicating it to the patient?”

“Once you talk to your clinical colleagues and say, ‘Here’s my number, have the patient call me,’ you begin to experience a different relationship,” Dr. Henderson says. “Once you learn how to be the clinician’s friend and have enough clinical knowledge to know what he needs to know, you can answer his question before it is asked.”