ifornia PET Imaging Center (Sacramento, CA), discussed methods of increasing patient throughput in the clinical PET center and decreasing tomograph time and imaging costs. He examined the stages of a PET study: transmission acquisition, tracer uptake and localization, emission acquisition, and tracer decay time, with pre-injection transmission acquisition making the most demand on total instrument time. He suggested three ways to increase throughput: through creative scheduling, 3-D data acquisition, and post-injection transmission measurement—the last two recent developments that he felt could reduce imaging time. Tomographs with retractable septa have made possible 3-D or volume data acquisition, which increases detection efficiency and allows 50% reduction in emission acquisition time—though not decreasing total cardiac imaging time, which depends more on ^{13}N decay time. But postinjection transmission measurements allow use of the tracer decay for transmission acquisition and thus reduce instrument time. A survey of the three ways of increasing throughput showed that scheduling strategies or 3-D data acquisition alone did not significantly increase throughput, but 3-D acquisition combined with postinjection transmission acquisition allowed one more study per day.

K. Lance Gould, MD, professor of medicine, University of Texas-Houston Health Science Center, discussed using noninvasive PET and medical reversal for low-cost management of coronary heart disease. Scientific trials and Dr. Gould's clinical experience showed that 50-80% of patients that undergo arteriography, bypass surgery, or balloon dilation can be managed by PET diagnosis of coronary artery disease followed by a vigorous risk factor management at cost reductions of 20-50%. Risk factor management includes lowering cholesterol by low-fact diet and cholesterol-lowering drugs, stopping smoking, and establishing an exercise program. He offered his regimen as an example of why PET reimbursement would be cost-effective.

Putting PET within the context of the marketplace, Daniel S. Berman, MD, covered competing modalities in evaluating coronary artery disease, like SPECT, MRI, and ultrafast CT. PET's competitiveness was also significant in the neurology session, as when Sid Gilman, MD, professor and chair of the Department of Neurology, University of Michigan Medical Center (Ann Arbor, MI) discussed PET's utility in neurological disorders. PET can give information about neurological functions like metabolism and blood flow, as MRI and CT cannot, and so may reveal the abnormalities of dementia, or biparietal hypometabolism of Alzheimer's disease, when anatomical imaging studies are normal. Though no one contended that PET should or could displace other imaging modalities, as Heikki Minn, MD, senior physician at the University of Michigan Medical Center, pointed out with head and neck cancer and lymphoma, the complementarity of PET studies with MRI and CT can sometimes be critical in a diagnosis. This might best sum up the conference's theme of PET in the medical marketplace: as a modality that will not displace others but should serve an ever more vital function in diagnostics to cut costs, forego unnecessary procedures, and increase the quality of care. ■

PET would have curtailed many cardiac interventions and saved money

COMMENTARY

LINES FROM THE PRESIDENT

Richard C. Reba, MD

ONE WOULD NEED TO have been living in a very remote province not to be aware that health care reform, in some still-to-be-determined form, is upon us.

When President Clinton delivered his administration's Health Security Act of 1993 to Congress on October 17, a process began which will affect all of our personal and professional lives. Like any of the precedent-shattering events we've witnessed over the past four years, this legislation brings with it hope, uncertainty, even fear. In a sense, health care reform is medicine's Berlin Wall: it sometimes seems as if medical practice will be dismantled, stone by carefully laid stone, until nothing recognizable is left of the way most of us have practiced medicine throughout our careers.

And what will the future look like after the wall has fallen between past tradition and future reform? One thing is certain: No one can with confidence describe the detailed outlines of healthcare in the twenty-first century.

What we can do, however, is first analyze the Administration's complex program with the detailed care it deserves. Then, we must come to the national and state bargaining tables pre-

pared with knowledgeable, cost-effective proposals which are in the best interest of the Nuclear Medicine community.

I can report to you that the Society of Nuclear Medicine has already embarked on the first of these steps. On November 5, during the evening preceding the Executive Committee meeting, I convened a special ad hoc commission to begin addressing how the Health Security Act might affect nuclear medicine and how the Society might best respond. In analyzing the Act as well as documents supplied by other organizations in medicine, the commission identified a series of key questions—

- How will nuclear medicine ensure representation as health care reform reaches the planning stage?
- How can the profession influence research funding?
- What strategies can we use in approaching reformed specialty distribution?
- How can nuclear medicine collect and deliver manpower data?
- How can practice guidelines be used to promote the most effective use of nuclear medicine procedures?
- The commission discussed these and other questions, such as the positioning of the profession under managed care, and agreed to my proposed expansion of the SNM Health Care Policy Committee to address these issues more fully.

Because the process will only be initiated during the remainder of my term, I asked President-elect James J. Conway to analyze how the SNM Health Care Policy Committee could be restructured to assist the SNM membership to ensure that nuclear medicine practice will be accepted as a valuable part of the new health care system. The Executive Committee approved Dr. Conway's proposal to restructure the Commission on Health Care Policy (CHCP). The CHCP will comprise three groups—a Scientific Committee, Standards Implementation Committee, and Health Care Reform Committee. The role of the Scientific Committee will be to continue ensuring the scientific validation of practice guidelines. That of the Standards Implementation Committee will be to guarantee a system of chapter or state representation as health care reform moves onto the regional level. Finally, the Health Care Reform Committee will initiate a broad-based analysis of issues likely to affect the Society of Nuclear Medicine.

As I noted, it is too early to determine the precise outlines of health care reform. Yet one thing seems clear: any reform will probably favor managed care. If that is the case, there will be substantive and far-reaching changes in the practice of nuclear medicine, as well as in education and research.

Whether or not primary care physicians become the "gatekeepers" much heralded in the media, physicians and allied health professionals in medical specialities may discover that their relations to referring physicians have greatly altered. At the same time, medical education quotas by specialty—if these are established—will change the human profile, and the numbers, in our field. The training of young nuclear medicine physicians will inevitably respond to this evolution.

I feel that another clear theme in health care reform will be that "research" will be come synonymous with "outcomes research." This is an eventuality for which the Society needs to be prepared, and one for which the CHCP's Scientific Committee must immediately address itself.

Of course, the nuclear medicine community spans many diverse areas, not the least of which are the industries whose health is joined to our own. For these companies, an uncertain future may mean a prudent reduction of some current expenditures. Advertising revenues in the Society's journals, as well as exhibitor funding, may suffer in the short term. More crucially, industry funds for research could shrink.

The economic environment for nuclear medicine, then, shows signs of growing leaner. The Society will need to view budgets in terms of declining income and expanding responsibilities. New projects will be subject to meticulous and penetrating budgetary scrutiny.

The reality, in terms of the Society's health in the near term, is clear. To maintain current activities—let alone expand into new areas—new sources of funding will be needed. Facing the threats and opportunities afforded by health care reform will mean sacrifices—in time, talents, and in money. An increase in Society dues—an anathema to all of us—may well be necessary to bolster shrinking revenues and to mount an effective response to nationwide reform.

In September's column, I drew from Dr. William Strauss's Plenary address in which he described the twofold connotation of the Chinese character for "crisis"— "danger" coupled with "opportunity." The Health Security Act of 1993, whatever its final form, has shaken the dust from a host of long-held preconceptions.

Our opportunity is now to view health care reform with freshened vision, using our talents and our intelligence to analyze the many proposals vying for attention. Then we must discover the ways nuclear medicine will fit within the revived health care system of twenty-first-century America.

Our only real danger is to shrink from that challenge.

Richard C. Reba, MD

COMMENTARY

GOVERNMENT RELATIONS UPDATE

REIMBURSEMENT

Relative Value Update Committee (RUC). HCFA evaluated 497 relative work values (physician work component) for new and revised 1994 CPT codes that the RUC recommended. HCFA says that 75% of these values were either accepted or increased in value, and the other 25% decreased from the orig-