HEALTH CARE REFORM, RESTRUCTURING PREDOMINATE AT MID-WINTER MEETING

Committees and Board of Trustees feel effects of socioeconomic concerns about health care costs at biannual meeting in Seattle

WHILE PROVIDING AN OPPORTUNITY for councils, chapters, committees, and the board of trustees to talk business, the SNM Mid-Winter Meeting in Seattle, February 3-8, revealed some of the wide-reaching ramifications of the health care reform movement. Perhaps most exemplary of this trend was the formation last fall of the Commission on Health Care Policy (CHCP), which had its first general meeting in Seattle. Replacing the former Office of Health Care Policy, the Commission was formed in response to the complex social, political, and scientific issues arising from the public's growing concern with health care. CHCP's three-pronged structure represents these complexities and how SNM plans to tackle them for nuclear medicine: Practice Guidelines and Communication, chaired by Robert E. Henkin, MD; Technology and Outcomes Assessment, chaired by Henry D. Royal, MD; and Health Care Reform, chaired by Henry N. Wagner, MD. Howard J. Dworkin, MD, chairs the commission and its steering committee.

A New Commission with a Mission

As the health care reform movement gains momentum, nuclear medicine practitioners have grown vigilant over how increased belt-tightening and the backlash against specialties may lead to cutbacks in nuclear medicine and affect patient care (see *Newsline*, November 1993, p. 32N, and February 1994, p.13N). In Seattle, CHCP set forth its goals, committee by committee, and presented a strategy to ensure that reform will not leave nuclear medicine in the cold—primarily through monitoring health care policies, educating nuclear medicine professionals on key issues, developing quality standards and practice parameters, and recommending ways to increase its cost effectiveness. CHCP also planned to hold a categorical seminar on health care reform, June 4, 1994, at the SNM annual meeting to address the most pressing health care reform issues facing nuclear medicine.

CHCP Chair Dr. Dworkin, director of the Department of Nuclear Medicine, William Beaumont Hospital, noting that health care reform is not new, described recent changes in the medical industry, like the decreasing role physicians play in decision-making as insurance companies step in, and the increasing importance of practice guidelines in selling sound medical practices to these corporate decision-makers. Dr. Dworkin emphasized how SNM must take the initiative to develop guidelines and carefully monitor reform activities so these guidelines will fit reform's final shape.

Each CHCP committee presented its objectives. The Health Care Reform and Practice Guidelines and Communication committees will focus primarily on sociopolitical issues, while Technology and Outcomes Assessment will concentrate on scientific methods. Health Care Reform Chair Dr. Wagner, division chief, Nuclear Medicine, Johns Hopkins Medical Institutions, emphasized the importance of monitoring reform at the state level, at which most policy will be executed, thus creating much nationwide variability in administered health care. Since decision-making on reform is shifting away from physicians to professional policymakers, nuclear medicine practitioners need to develop relationships with policymakers at all levels to create a wedge for nuclear medicine. In practical terms, these general goals translate into forming nuclear medicine physician alliances, developing intersociety relationships, and tackling relevant technologist issues, education and research, and regulatory affairs.

Practice Guidelines and Communication Chair Dr. Henkin, director of Nuclear Medicine, Loyola University Medical Center, said that his committee and Technology and Outcomes Assessment will draw up draft guidelines, which all three committees will review and comment upon. Dr. Royal, Technology and Outcomes Assessment Chair and associate director, Division of Nuclear Medicine, Mallinckrodt Institute of Radiology, presented some of his committee's objectives, such as the development of procedure standards and of scientific evidence supporting nuclear medicine procedures. This committee also met formally and separately from the rest of CHCP for the first time in Seattle, presenting some of its projects in

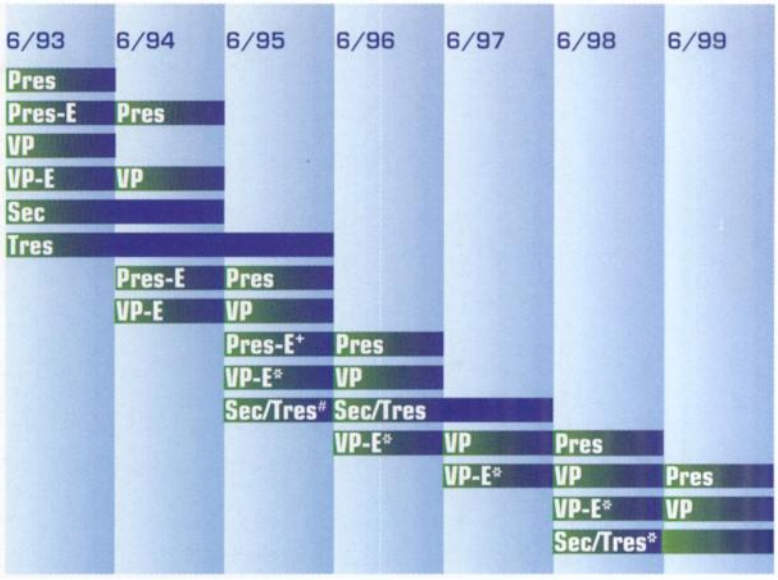
more detail. One of the most salient goals of the committee—along with Practice Guidelines and Communications—will be to develop practice guidelines for the discipline (see box). A related concern is the development of a procedure standardization process. Dr. James Fletcher's method to standardize the performance of brain SPECT offers a model for the consensus process—for obtaining expert opinion. Other standardization projects in the works are for thyroid imaging, myocardial perfusion, and captopril.

Responding and Restructuring

Health care reform made an impact on the SPECT Project meeting in Seattle. Peter C. Vermeeren will head a task force to devise recommendations on restructuring the Project so it may work with the CHCP on a comprehensive nuclear medicine response to reform. Health care reform was also felt indirectly even in the Radiation Effects of Ionizing Radiation (REIR) Committee. Most of Seattle's REIR meeting was dedicated to heated discussion of how SNM should respond if the recent public outcry about government radiation experiments (see *Newsline*, March 1994, 9N). The committee has planned a symposium at the SNM annual meeting on this issue in June.

Restructuring may be a type of "reform," but the Society has been working for years on restructuring itself to better serve its members (and help them provide better care). The Board of Trustees meeting in Seattle made significant progress toward completing that process by approving the restructuring plan. The new bylaws will change the entire officer succession schedule (see *Newsline*, September 1992, p. 38N; December 1992, p. 32N; April 1993, p. 25N; October 1993, p 26N; and December 1993, p. 32N). Over the next five years, as the new officer succession comes into effect, there will be a period when the old system will overlap with the new until the new is completely in force. At the Mid-Winter Meeting, this transition was clarified with an illustration of the officer succession schedule through 1999 (see Figure 1). The new bylaws now only have to be approved by the general membership at the Annual Meeting in Orlando this June. Other items the Board of Trustees approved in the Business Session included budgets for the SNM Commission on Health Care Reform, relocation, ACNP/SNM Joint Office supplementary funding request and approval of the proposed PET policy statement, site selection for the year 2000 SNM annual meeting (Baltimore), and the SNM Strategic Plan. ■

OFFICER TRANSITION SCHEDULE



+ Interim Pres-E, Scientist
* According to Revised Bylaws
# Interim Sec/Tres, Sec only first year

HOD/BOD TRANSITION SCHEDULE

1/95-6/95	6/95	1/96	6/96
Councils (15) & TS (3) Elect HOD	HOD Complete* New Officers Councils TS	Hod Elects 7 BOD	BOD Complete Restructure Complete

* Intermin BOD = Old Ex Comm

Figure 1. Officer Transition schedule and House of Delegates/Board of Delegates Transition Schedule.

GUIDELINES FOR DEVELOPING GUIDELINES

A paper by Steven Wolff, MD, MPH, offers a fair representation of both committee's goals, philosophy, and caveats for developing guidelines. Wolff presents a scientific view of guidelines by citing several studies on the actual effects of introducing guidelines into clinical use. He concludes by taking a cautious approach to practice guidelines. Problems arise not only when policymakers set guidelines according to economic rather than scientific considerations. In addition the physiology and disease expression of each patient can vary drastically, and part of clinical practice is to determine these undefinable variations and adjust care accordingly. Too strict guidelines may either confine the clinician's options or lead to inexact treatment—the bane of widely feared "cookbook medicine." Disseminating and enforcing guidelines pose problems of their own in that wording may be too narrow or vague, clinicians may or may not pay attention to guidelines once received, and enforcement could increase cost of care. Still, because scientific studies of guidelines' effects on clinical practice are the only way of approximating their utility, Wolff emphasizes limiting enforcement to guidelines that meet clinical and scientific measures of quality. His final recommendations are "a respectful approach to guidelines, which gives clinicians the freedom to use that information as they wish"; "more sophisticated approaches for disseminating guidelines"; and consideration of the fact that "physicians are more likely to change practices when they perceive new norms for professional behavior than when they simply receive new information." He concludes, "the most important question is whether practice guidelines will improve the health of patients." ■