
H. William Strauss, MD

Lines from the President

Although for most of us the Society of Nuclear Medicine (SNM) is most visibly represented by the journals and the Annual Meeting, behind the scenes the Society is a dynamic organization employing 37 people who work throughout the year preparing educational programs, interacting with government agencies, maintaining liaisons with sister organizations, publishing a range of books and pamphlets and developing a thriving web site. All of these activities help to ensure the continued visibility of nuclear medicine.

To give you an idea of how your dues go to strengthening our profession and your practice, here are a few of the areas on which Society leadership and staff are currently concentrating.

Meetings

Even though the Mid-Winter Meeting happens in February and the Annual Meeting in June, preparation for those and other meetings goes on year-round. The process of planning the Annual Meeting, for example, begins as staff and Scientific Program Committee members review comments from attendees and exhibitors on the Annual Meeting just past. As committee members and staff consider possible improvements, a detailed plan is being developed for programming the "meeting mainstays" —continuing education, interactive sessions, scientific presentations, exhibitor functions and the plenary session. Among the improvements that will be noted at the 1998 Annual Meeting in Toronto will be an increase in the number of interactive sessions and less overlap between the categorical courses and continuing education sessions. Meeting planners are also making a specific effort to make the meeting particularly useful to practitioners.

Government Relations

The NRC has decided to rewrite 10 CFR Part 35—that part of the *Code of Federal Regulations* dealing with the medical use of byproduct material. To increase the likelihood that this rewrite will reduce government intrusion into medical practice, the joint ACNP/SNM Government Relations Committee presented testimony to NRC staff writing the draft. Testimony at open hearings emphasized the practitioners' perspective on what constitutes reasonable regulation for the medical use of radionuclides. While the outcome won't be known for several months, our members should periodically check the NRC web site (www.nrc.gov) to note the commission's progress in this area. The Government Relations Committee also worked with members of Congress to develop language for insertion in the FDA Modernization and Accountability Act of 1997 to ensure that radiopharmaceuticals prepared by regional radiopharmacies are not subject to FDA regulation.

Commission on Health Care Policy and Practice

Through one-day "roadshow" seminars presented at SNM chapter meetings and other sites, the Commission on Health Care Policy and Practice (CHCPP) is working to inform our membership about changes in health care coding that affect reimbursement.

In response to proposals by the Health Care Financing Administration (HCFA), CHCPP is targeting physician supervision as a key area of concentration. HCFA has proposed three possible levels of physician supervision:

- Personal: Physician must be in room with patient during procedure.
- Direct: Physician is in general area of examination but need not be in the same room as patient.
- General: Physician is available by telephone and is not in immediate vicinity of examination.

HCFA insists (as does the NRC) that personal supervision is needed for the administration of radionuclide therapy, and the proposed standard for diagnostic studies when this issue went to press was "direct" supervision. Clearly, if direct supervision becomes the standard for diagnostic studies, payment for procedures will be contingent on meeting that level, whether or not this is feasible or appropriate for many practitioners. SNM is working with sister organizations to define the actual standard of supervision required for high-quality patient care, and the resulting recommendations will be discussed with HCFA.

On another front, the CHCPP Guidelines Committee is reviewing practice guidelines proposed for the use of nuclear medicine procedures by other organizations. These recommendations will be published for our membership.

We are all agreed, I'm sure, that the quality of nuclear medicine is only as good as the laboratories performing the tests and the knowledge of the practitioners supervising and interpreting examinations. Because of this, the Society has agreed to be a co-founder of an intersociety commission for the accreditation of nuclear medicine laboratories, and a parallel effort is under way to develop parameters to evaluate the competency of practitioners. The goal of the SNM Physician Evaluation Program (SNM PEP) is to ensure the continued improvement of the quality of nuclear medicine practice. SNM PEP will evaluate each physician who applies for self-assessment, utilizing uniform standards for qualifications and performance. This program should be available at the 1998 Annual Meeting. The first modules slated for development are cardiac, bone, lung and thyroid.

As for longer-range goals on behalf of the profession, the Society would like to understand which procedures are performed for specific indications and what the patient outcomes are for those procedures. To accomplish this, SNM has begun a utilization database, with initial efforts being devoted to determining the number of studies done in each of the participating institutions. The institutions will be selected to mirror the range of outpatient clinics, inpatient services, aca-

(Continued on page 24N)

Clinical PET

(Continued from page 16N)

performing these studies. Coincidence camera systems may be demonstrated to be useful for many of these studies. Certainly, studies for lung cancer staging and SPN evaluation will need to be distributed over a larger number of instruments and PET centers. In addition, the utilization of FDG-PET imaging for other indications is also increasing and will cause even greater clinical demands.

Another major issue is the availability of FDG. In 1996, FDG was available for 25,000 studies. The majority of PET centers have a cyclotron and produce the FDG they use. Several centers have recently formed partnerships with industry sources to provide FDG for use at the local PET center and distribute FDG on a regional basis. The commercial partner generally provides the staffing and obtains regulatory approval for distribution (e.g., obtaining an FDA abbreviated new drug application). There are currently 12 regional distribution centers that are distributing FDG doses to the local PET center, to other PET centers and to nuclear medicine departments using SPECT imaging and coincidence camera imaging. Because of the regulations related to distributing FDG, most PET centers with a cyclotron do not distribute FDG without an agreement with a commercial partner.

To meet future needs for FDG for lung cancer staging and SPN evaluation, the 38 centers that are producing their own FDG will need to produce an additional 13 FDG doses each day. This will require major changes in production techniques and personnel. The distribution centers will need to produce daily the 13 doses used locally and the doses distributed regionally. Because of the 110-minute half-life of ^{18}F and the absence of proven methods for rapid distribution, the amount of FDG production necessary for distribution within 2 hours of the production facility is approximately 3 or 4 times that needed for local use. This demand will require more distribution centers, more efficient production of FDG and more efficient transportation methods.

Addressing the Challenges

These challenges of meeting the potential demands for clinical FDG-PET studies will be addressed by instrumentation manufacturers, nuclear medicine facilities and FDG suppliers. These new challenges facing the nuclear medicine community are better than the challenges of not having enough demand for clinical FDG-PET studies. Clinical PET is no longer on the brink of extinction; it is an important part of the present and future practice of nuclear medicine. PET centers that have so long struggled with how to address a low procedure volume will now have to contend with the problems of high procedure volume and increased clinical demands. Not only will PET centers need to change, but instrumentation manufacturers will need to provide dedicated imaging instrumentation that will produce excellent clinical studies in less than 1 hour, and FDG suppliers will need to provide the radiopharmaceutical in the amounts and at the times necessary to perform these clinical studies. The nuclear medicine community needs to prepare for the number of PET studies that will be needed. Rapid growth can result in problems that may be more challenging than those we faced before if it is not managed correctly. Are we ready?

REFERENCES

1. Coleman RE. Revealing biochemistry in a single image. *J Nucl Med* 1995; 36(9):32N-33N.
2. Kuhl DE, Wagner HN, Alavi A, et al. Positron emission tomography (PET): clinical status in the United States in 1987. *J Nucl Med* 1988;29:1136-1143.
3. Al-Aish M, Coleman RE, Larson SM, et al. Advances in clinical images using positron emission tomography. National Cancer Institute Workshop Statement. *Arch Int Med* 1990;150:735-739.
4. Gambhir SS, Hoh CK, Phelps ME, Madar I, Maddahi J. Decision tree sensitivity analysis for cost-effectiveness of FDG-PET in the staging and management of non-small-cell lung carcinoma. *J Nucl Med* 1996;37:1428-1436.
5. Valk PE, Pounds TR, Tesar RD, et al. Cost effectiveness of PET imaging in clinical oncology. *Nucl Med Biol* 1996;23:737-743.
6. *FDG positron emission tomography for non-CNS cancers.* Chicago: Blue Cross/Blue Shield TEC Assessment Program; 1997;12:5.
7. Martin WH, Delbeke D, Patton JA, et al. FDG-SPECT: correlation with FDG-PET. *J Nucl Med* 1995;36:985-995.
8. Coleman RE. Camera-based PET: the best is yet to come. *J Nucl Med* 1997;38:1796-1797.

—R. Edward Coleman, MD
Department of Radiology,
Duke University Medical Center, Durham, North Carolina

—Ruth D. Tesar, CNMT
P.E.T.Net™ Pharmaceutical Services,
Sacramento, California

For correspondence contact: R. Edward Coleman, MD, Box 3949, Duke University Medical Center, Durham, NC 27710.

Lines from the President

(Continued from page 21N)

demic institutions and private practices worldwide. Once gathered, the data will be expanded to include indications for studies. The final data set, not expected to be collected until some time in the future, will be the outcome for patients undergoing procedures.

Communications

While continuing to publish our well-regarded journals, the SNM Department of Communication Services is witnessing a revitalized book-publishing program and launching an innovative nuclear medicine self-assessment series.

In the past six months, the SNM Communication Services Department has released two important new books: *MIRD Cellular S Values* (a long-awaited and much-needed reference text by the SNM MIRD Committee) and *Radionuclides in Nephrourology* (published in partnership with the Group on Radionuclides in Nephrology and containing major consensus reports). Over the next nine months, two more notable books will be added to the SNM list—*Diagnostic Differentials*, by

(Continued on page 25N)

Lines from the President

(Continued from page 24N)

Edward Silberstein (a revised and updated version of the highly respected *Gamuts in Nuclear Medicine*), and *Nuclear Medicine Patient Management for the 21st Century*, by Naomi Alazraki and Andrew Taylor. (Sponsored by the SNM Education and Research Foundation, this book will replace the much-admired staple, *Fundamentals of Nuclear Medicine.*)

The Communication Services Department has also initiated two new self-assessment series in nuclear medicine cardiology and nuclear medicine oncology. Each series consists of eight topic modules, with a new module slated to appear every three to four months. The first topic booklets in each series—*Physical and Technical Aspects of Nuclear Cardiology*, from the nuclear medicine cardiology program, and *Overview of Nuclear Medicine Oncology* and *Conventional Tumor Imaging*, from the nuclear medicine oncology program—are now available.

Also available are ten new patient pamphlets, nine of which are subject-specific, as well as a Spanish-language version of "Guidelines for Patients Receiving Radioiodine Therapy."

Information Services

This vital headquarters department assists all areas of the Society. Particularly important is its responsibility for developing and maintaining the SNM web site (www.snm.org). If you haven't already visited your home page, please do so. You'll find a wealth of continually updated information on meetings and other key Society functions, as well as news on the field of nuclear medicine. For the first time this year, the SNM Department of Meeting Services will be accepting meeting abstract submissions via the site and providing registration and hotel reservations on-line.

Other Activities

This report would be incomplete without some mention of two important position searches. The search for a new *JNM* editor-in-chief is in its final phases. The Publications Committee will make the difficult choice among several superb candidates by the end of December. The search for a new SNM executive director is also under way and should be completed by January. While the search takes place, Virginia Pappas, SNM Associate Executive Director, is serving as chair of the Interim Management Committee. Pappas, working with our skilled, knowledgeable department directors, has maintained the organizational momentum that allows the Society to enhance the practice of nuclear medicine.

As 1997 draws to a close, I hope that each of you has found a portion of that personal satisfaction and professional challenge that the science and art of nuclear medicine provide. For the coming year, I hope that you will join me in a renewed effort to expand the role nuclear medicine plays in serving humanity.

– H. William Strauss

CHCPP News

(Continued from page 22N)

1997 delays the implementation of the resource-based practice expense system until January 1, 1999, and specifies the manner in which practice expense RVUs in 1998 are adjusted. Although nuclear medicine is exempted, the 1997 BBA enacted a provision that in 1998 would redistribute practice expense RVUs in the direction of resource-based RVUs. The 1998 practice expense RVUs for certain services are reduced to 110% of their work RVUs for the service, and the monies are used to raise the practice expense RVUs for office visit procedures.

HCFA intended to eliminate the separate 8.3% budget-neutrality adjustment to the work RVUs that resulted from changes made during the five-year review of work RVUs. Because of effects of the 1997 BBA, however, HCFA is postponing the elimination of the separate budget neutrality adjustment until 1999.

HCFA has adopted a proposal to increase the work RVUs associated with global surgical services to reflect the increased evaluation and management present in the preservice and postservice portions of these services. Because of these increases, HCFA has reduced all work payments by 0.7% to maintain budget neutrality.

HCFA has also set regulations for the new entity "Independent Diagnostic Testing Facility (IDTF)" to replace the "Independent Physiological Laboratory." The replacement will be phased in, with completion scheduled July 1, 1998. For more specific information on the IDTF requirements, see the October issue of "CHCPP News" (*J Nucl Med* 1997;38:35N,48N) or section II.D.3 of the October 31, 1997 *Federal Register*.

As a result of its review of submitted comments on the definition of "actual charges," HCFA did not issue a final rule and will study the issue further. (For related information, see the issue of "CHCPP News" noted above and the *Federal Register* section II.J.)

To obtain more information on these policies or the 1998 physician fee schedule of RVUs, contact the Superintendent of Documents at (202) 512-1800. Specify stock number 069-001-00101 (10/31/97 *Federal Register*). The cost per copy is $8. If you have specific questions concerning these policies, please contact Wendy Smith at (703) 708-9000, ext. 242, or by e-mail at wsmith@snm.org.

—Wendy Smith, MPH, is the SNM director of health care policy.