Letter from the President

Warren R. Janowitz, MD, JD, FACNM

Following the merger of the ACNM and ACNP several years ago, the ACNM has moved forward with several positive developments. Clinical Nuclear Medicine has become the official journal of the College and has been well received by our membership; the Nuclear Medicine Residents Organization has grown stronger and is a positive voice for nuclear medicine residents; and the ACNM has been active in supporting the specialty of nuclear medicine with input to the AMA, SNM, ACR and ACGME. This summer Dr. Hossein Jadvar and I attended the Intersocietal Commission of the ACR meeting with close to 100 other leaders of radiology subspecialty societies. Our annual meeting in New Orleans, held jointly with the SNMMI Mid-Winter meeting, will be hosting representatives from the Chinese Society of Nuclear Medicine with young professionals from the United States and China presenting scientific abstracts at a joint session. The top two Chinese and American presenters will travel to the United States and China respectively for exchange visits.

All, however, is not rosy. The ACNM is entering a crucial phase in its existence. Like many other medical specialty societies, it is facing financial challenges that threaten its survival. A poor economy, decreasing reimbursement and a poor job market for both Nuclear Medicine physicians and Radiologists have put the College in a financially precarious position. The major expense incurred by the ACNM is the management fee paid to the SNMMI which we have limited flexibility to change. The cost of management has tripled from what we paid (Continued on page 2. See President.)

Register today!
ACNM Annual/SNMMI Midwinter Meeting in New Orleans

While you’re registering, don’t forget to sign up to go to the ACNM Awards Dinner and see the new fellows who will receive FACNM designation and the illustrious Mentor of the Year, among other awards!

Some exciting topics:
• Plenary lecture on healthcare reform and what it means for nuclear medicine
• A general NM update—reviewing our bread and butter and why it’s been getting better with age
• The role of PET/MRI
• CT and MRI case review workshops
• A review of the early experience with dopamine transporter imaging
• How to improve quantitative PET imaging in research and a discussion on quantitative PET and SPECT
• Thoughts on teaching the modern generation of NM trainees
• Emerging technologies in molecular medicine
• Coding and reimbursement updates

And the list goes on…

Don’t miss the 2nd Sino-American Conference on Nuclear Medicine

This friendly competition between young investigators in the United States and China is the second of its kind. This time, it’s conveniently scheduled with the ACNM/SNMMI joint meeting in New Orleans. Twelve young investigators from both countries will be chosen to present their research. Additional exciting discussions will follow regarding novel radionuclide therapies in oncology, guidelines for reporting PET/CT exams as well as a highly anticipated discussion of education/training and research in the United States and China. There will also be an address from the president of the Chinese Society of Nuclear Medicine.

For more about this conference, please visit www.snmmi.org/mwm2013.
previously. The Clinical Nuclear Medicine Journal is our next highest expense, but also is our most popular member benefit. Our current expenses are about $25,000 over revenue and our reserve funds may be exhausted within two years. The leadership of the College is looking at ways to decrease our expenses including changing our management company and looking at all our expenses on a line by line basis. Our preferred choice to maintain the ACNM as a viable organization is to increase our membership. An increase in membership of approximately 120 new members would balance our budget. This is not an unrealistic goal given that less than 10% of the full members of the SNMMI are currently members of the ACNM.

Prospective members often ask: Why should I belong to the ACNM when I am already a member of the SNMMI? This is certainly a valid question that we must be able to answer. The SNMMI is the major scientific and educational organization dedicated to our specialty, with over 15,000 members including physicians, scientists and technologists. Close to 100% of our members also belong to the SNMMI. This is similar to the situation in radiology, where the ACR and RSNA have a very large overlap in membership, with the ACR largely representing physician interests and the RSNA providing scientific and educational resources. The major difference is that most SNMMI physicians and scientists do not belong to ACNM. There are probably many reasons for this that I am not able to fully explain. One of the reasons may have been the existence for many years of two competing organizations, the ACNM and the ACNP; but this is no longer an issue. Another is that the differences between the two organizations may not be clear. I also felt that the SNM represented my interests as a nuclear medicine physician. It was only relatively recently when my experience as a member to the SNM Board of Directors and as Commissioner of the Health Policy Commission of the SNM made it clear to me that there is a need for nuclear medicine physicians (and scientists) to have their own organization that is better aligned to advocate for their interests.

The SNMMI Board of Directors (BOD) consists of physicians, scientists and technologists. Physicians may or may not constitute a majority of the BOD. Technologists have significant input into BOD decisions. This is appropriate given their importance to the field and the large number of technologist members. Physician and technologist interests are, however, not always aligned. This is not meant to say that one position is right and the other is wrong; both may be right from their respective viewpoints. For example, the ACR took a strong stance against physician self-referral over the past few years. In-office imaging adversely impacts imaging physicians by diverting work from hospitals and independent imaging centers to self-referred physician-owned centers. The SNM BOD voted against endorsing the ACR position to repeal the Stark exemption for in-office imaging mainly due to the fact that many technologist members worked in those offices, despite the fact that many physicians in the society were in favor of supporting the ACR position. This may have been the right position for the SNMMI and the technologists, but not one most nuclear medicine physicians would support. The ACNP BOD did in fact vote to oppose the Stark exemption.

It is important for nuclear medicine physicians to have a voice independent of the SNMMI to represent their interests. The ACNM allows us to have representation at the AMA, the ACR Inter Societal Commission, the RUC and other governmental organizations separate from the SNMMI. We are not going to ever have the resources to replace the SNMMI, and need to belong to both organizations, but we do need to keep the ACNM viable. This is even more important as we enter a time of significant change in health care delivery under the Affordable Care Act.

The major benefits of membership in the ACNM include a subscription to Clinical Nuclear Medicine (CNM, which costs $484 a year for individuals who are not members), the possibility of being recognized as a Fellow of the ACNM, leadership opportunities in a nuclear medicine organization, the opportunity to mentor nuclear medicine residents and networking in an organization not as overwhelming as the SNMMI. I would urge all members to talk to their colleagues about joining ACNM. If only half of us were successful in recruiting one new member, the college would be financially stable. At $225/year, membership costs less than half the price of a subscription to CNM. It’s easy to join online at www.acmnonline.org.

There are many things occurring in our field that need to be addressed by the college. Survival of nuclear medicine as an independent specialty is probably the most important. Changes in residency training in diagnostic radiology and in nuclear radiology are ongoing, and we need to be involved with the issues of the job market for nuclear medicine physicians, practice standards and appropriateness criteria development and interaction with governmental agencies. We can only do this by keeping the ACNM a viable organization.
How often have we heard this? If one were to listen to the candidates in the recently completed elections, one might think that they were here to help healthcare. In practice, it makes little difference who was elected president. While the president himself or herself may have little impact on direct healthcare, the Congress can have tremendous impact. There are significant differences between the Republican and Democratic viewpoints on how healthcare should go forward. We will take a little time below to outline these differences.

Republican views: the Republicans have not formally put forward its detailed views on healthcare. No direct plan is available for analysis; however, one can infer the Republican position from the statements made by Rep. Paul Ryan (R-WI) as part of his congressional career. In essence, Republicans favor a system that, while maintaining the basic structure of Medicare, would change it to a voucher system. In a voucher system the beneficiary is given a voucher worth a specific dollar amount. This voucher is used to purchase health insurance. It is presumed that the voucher could be used to purchase Medicare insurance or other commercial insurance.

The concerns with this approach are that the gap between the worth of the voucher and the cost of insurance may increase over time. Should this happen, especially with lower income folks, the ability to pay any copay will certainly diminish. If the gap between the voucher’s value and the cost of insurance is too large, the individual is likely to choose to forego insurance, increasing the numbers of “no pay” patients. Of course the mandate under Affordable Care Act (ACA) for compulsory insurance would come into play in this wetting. Subsidies might be required to purchase as yet unknown benefits packages.

Democratic views: the Democrats prefer sticking with the Affordable Care Act (ACA) and making modifications to that act as time goes on. Presumably, these modifications would correct some perceived errors in the ACA. However, as with anything Congress does, the devil is in the details. We have no idea what these modifications might be. The ACA increases the number of Medicaid patients significantly, meaning the states have more control. Traditionally states have underfunded Medicaid. States are concerned about the potential for Medicaid to increasingly gobble up their state budget after the Federal subsidized phase in. Republican governors by enlarge are not implementing the provisions of the ACA and only 27 states have indicated whether they will establish the required insurance exchanges.

The results of the recent election virtually guarantee the ACA (Obamacare) will not be repealed. Public opinion polls indicate that Americans do not like the act itself; however, when surveyed, the majority of the public are in favor of the provisions. This is a fascinating exercise in public opinion. It shows that Republican strategists have been successful in demonizing the ACA, and the American public is grossly unaware of what the provisions of Obamacare are.

If we look at some of the issues that affect medicine today, some need to be corrected relatively urgently and will require congressional action. The first of these issues relates to the sustainable growth rate (SGR). If uncorrected the SGR will result in physicians facing approximately a 27% reduction in payment of Medicare professional fees starting on January 1.
1, 2013. Obviously, this is unacceptable. While Congress has been looking at this issue for a while, it has kicked it down the road each year by only patching problems one year at a time. This year, the item will come up for consideration again with the lame-duck Congress. Considering the deadlock in this Congress, it is possible that no solution will be found. If any solution is found, it is likely to be a relatively short-term fix, perhaps another year. The only hope for any permanent solution is to have both houses of Congress controlled by the same party or a bipartisan agreement, something that has been sorely lacking in recent years.

The problem with the SGR fix is that money needs to be found somewhere to offset the cost of this correction. If Congress were controlled by a single party, then Republicans control would be demanding offsets to compensate for the additional expense. It is unclear what the Democrats will do about an SGR fix. This is perhaps the single most important issue to medicine overall in the short term. Since neither party has a majority in both houses and the problem of the SGR is linked with the “Fiscal Cliff,” an acceptable resolution of this item is problematic.

Our technologist community for the past 10 years has been attempting to pass the CARE Act. They have been unsuccessful, with both Republican and Democratic congresses, in bringing this act to completion. It is unlikely the new Congress will affect this process.

Another issue that particularly troubles the medical imaging community is the continued decrease in reimbursement for medical imaging procedures. Unfortunately, here we have a problem. We have too few friends in what is often referred to as the House of Medicine. What alienated others in the medical community is the relatively high salaries of imagers over recent years. Imagers often make three times the salary a primary care physician does. We need to repair our relations with other physicians so that we can support them in their quest for fair reimbursement while assuring that we continue to have adequate reimbursement. This is a political issue within the House of Medicine.

The issue of separate reimbursement for radiopharmaceuticals is another priority. The rules governing Medicare HOPPS as they currently exist require packaging of all components of an examination to create a single dollar reimbursement for any procedure. This includes all elements or costs that are related to the procedure. It would take congressional action to change this. There is no evidence that either political party is likely to champion this action.

The issue of turf is one that bedevils us. Other specialties have poached nuclear medicine procedures and the same thing is currently happening to radiology. This occurs because Medicare by law does not recognize medical specialties. As written, the law requires Medicare to pay any physician who performs a given procedure. This is best illustrated in emergency medicine, where if an emergency room physician reads a chest x-ray prior to the radiologist reading it, he can get paid for it, but the radiologist cannot then be paid for reading the same film. The only remedy for this would be to change the Medicare rules, and that would likely create chaos. Neither political party is likely to touch this issue.

Still another issue is fair reimbursement for imaging procedures. This is not an issue that political parties will delve into. This is again predominately an issue within the medical community. Relative value units (RVUs) are set within medicine and executed by Medicare. Unless the overall payment system is changed (an unlikely event), we need to fight this out with our colleagues. We should expect no help from political parties in this area. We need to recognize that Congress and Medicare have set the priority on training more primary care physicians. For the ACA to be successful, we need more primary care physicians. This puts stress on reimbursement for all other physicians. For the moment this is also unlikely to change based on political party.

The only other issue we need to look at is the likelihood of tax reform. In this area, Republicans want a tax cut for everybody. The Democrats on the other hand advocate increasing taxes for those who make greater than $250,000 a year. This could have a significant economic impact on physicians.

If we look at scenarios other than the tax area, it may not make a great difference who was elected. Both parties are going to find it difficult to make major changes in the healthcare area. Neither party is likely prepared to deal with detailed issues that we have. So what do we do? We need to develop data showing how we decrease the cost of care overall and how we benefit patients. The Fiscal cliff has dire implications for Medicine. The reductions in payments to all healthcare providers mandated in the law will cause financial problems for all medical practices and hospitals.

Medicare is not free to do what it wants and will most likely follow existing legislation. Since a Democrat was elected President, we are likely to see further movement in the direction already laid out by the ACA. Significant amounts of money have already been spent for the establishment of insurance exchanges. It is unclear in the long run what benefits and risks we will face from the reforms of the ACA and the settlement that will ultimately resolve the Fiscal Cliff issues. It is unlikely that we will benefit from these changes.

So, here we are. Neither party clearly has articulated physician issues. No matter what, we are likely to suffer further setbacks in the short term. More aggressive presentation of our issues is required as well as a smarter approach as to how we present ourselves is required in order to blunt the cuts that are coming.

**Scanner Feedback**

As part of the “new and improved” ACNM, we would like to make this newsletter a useful resource for you. We hope to keep you abreast of the news that matters to you. This includes things like upcoming events and items available for public comment that could affect the future of our specialty.

We welcome ideas for topics you would like to see in the newsletter. Likewise, if you have any clinical questions you would like us to forward to an expert or letters to the editor of the ACNM Scanner Newsletter, please send us your inquiries. Additionally, if you’re a member and have an exciting accomplishment to highlight or share with the rest of the nuclear medicine community, please send us your announcement.

Please send your inquiries or announcements to Erin Grady, MD, editor, at acnm@acnmonline.org. We will do our best to be a valuable resource for you.
In this issue we will highlight Munir Ghesani, MD, a recent past president of the ACNM, someone who is truly passionate about the field of nuclear medicine.

Just over a year ago I had the great pleasure of sharing a train ride with Dr. Ghesani on the way to the SNM 2020 Taskforce meeting in Washington, DC. On the train ride, my first high-speed one, we were able to discuss some things (in the quiet car).

He is a fascinating guy and has had a long history of working to forward nuclear medicine through research, government relations and numerous speaking engagements.

While talking in the quiet car, one of his experiences struck a chord with me—about his first ABNM exam. In those days, you had to travel to take the exam. His was scheduled in Detroit, his first visit to that city, and being the planner he is, he drove the route from the hotel to the testing location the night before. What he didn’t know is that the stretch of highway he was driving then would be under construction the following morning, in fact no signs indicated there would be construction when he drove the night before. In a time before GPS or iPhone maps (which may not have helped him anyway), he didn’t know of a different route. After stopping and getting incorrect directions a couple times, he finally found an honest soul who directed him to the site of his exam, but he was late. The proctor of the exam thankfully allowed him to sit for the exam—but more importantly, allowed him to get a big cup of coffee in the cafeteria, without which he would have been tough to take the exam. I have Dr. Ghesani to credit for getting to my ABNM exam around 45 minutes early.

Dr. Ghesani came to nuclear medicine providentially. Prior to coming to the United States, he was trained as a radiologist in India. After coming to the United States, he started an internal medicine residency on a path toward a cardiology fellowship and ended up being in charge of scheduling to the United States, he was trained as a radiologist in India. After coming to nuclear medicine providentially. Prior to coming to the United States, he was trained as a radiologist in India. After coming to the United States, he was trained as a radiologist in India.

Dr. Ghesani said, “It has to be patient care.” He then gave an example of a recent patient who had been labeled as having stage IV malignancy. Dr. Ghesani pulled all the patient’s prior exams dating back 8–9 years and found that the osseous lesions of concern had persisted without change. The patient went on to receive a biopsy that demonstrated a benign fibrotic process. This newfound information changed everything for the patient and his family.

Family is a big part of Dr. Ghesani’s life. He has three beautiful children and a beautiful wife. He strives to find balance for his family and professional lives. He said, “I try very hard not to compromise my time with them.”

The forefront of nuclear medicine and molecular imaging excites Dr. Ghesani, especially the movement toward personalized medicine. He looks forward to a day when imaging using the same basis for chemotherapeutic agents to predict response to therapy becomes a reality. The benefits to patients, cost savings from not using futile chemotherapy and benefits to the profession will be profound.

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During his interview he also gave a profound recommendation, “Be visible with your colleagues.” We must be at the tumor boards, hospital-wide events and the like to ensure that nuclear medicine is remembered and used appropriately to the benefit of our patients.

Despite all of his leadership roles, research and experiences, Dr. Ghesani remains a very approachable man, one whom I hope you’ll pull aside at the next meeting and thank for his efforts to support nuclear medicine.

Importance of Government Relations
Erin Grady, MD

More and more over the history of medicine in the United States we have seen involvement of the government in the practice of medicine. In truth, this dates back to 1798 when then President John Adams signed a bill into law to establish the U.S. Marine Hospital Service. Flash back to the 1880s and you’ll see the establishment of the National Institutes of Health; 1935 marked the beginning of Social Security and its subsequent associated grants to states for health purposes; the National Cancer Act of 1937 established the NCI. Numerous other health-related bills were made in to law, but perhaps the best-known legislation on healthcare is the Medicare Bill that then-President Lyndon B. Johnson signed into law on July 30, 1965.

After March 23, 2010, when now-President Barack Obama signed into law the Affordable Care Act (ACA), and on June 28, 2012, when the individual mandate was upheld, he succeeded in doing what many presidents before him did not (including Presidents Theodore Roosevelt, Jimmy Carter (Continued on page 6. See Government Relations.)
and Bill Clinton), getting greater governmental involvement in healthcare delivery.

As you may or may not know, the ACA has many layers of implementation, many of which have not occurred. The upcoming election may have a great impact on how much or in what way the portions of this act are implemented. If you want to know more about the expected timeline of implementation, visit: http://www.healthcare.gov/law/time-line. Interesting and potentially concerning items that have yet to be implemented include linking payments to quality outcomes (expected in late 2012), the expanded authority to bundle payments (expected in early 2013) and paying physicians based on value, not volume (expected in early 2015). Of course a number of wonderful things do come from the legislation like allowing people to be covered regardless of pre-existing conditions, ensuring coverage for those in clinical trials and eliminating annual limits on insurance coverage.

In addition to the ACA, there are a multitude of other factors that affect you and me as we practice and do research in nuclear medicine. There are many laws, guidelines and rules you follow from governmental agencies such as the NRC, FDA, CMS, DOE—and the list goes on.

At this time in medical history, it is imperative that we not only have the knowledge of what is considered for governmental oversight into healthcare but also are also willing to do something about it. The ACNM and SNMMI have a joint Government Relations Committee. This committee holds an annual Capitol Hill Day; the next one is scheduled for Monday, April 29, 2013. During this day, you will learn about some of the key issues facing nuclear medicine and have the opportunity to discuss them with your Congressional representatives. I encourage you to put this on your calendar, circle it, highlight it and make it a commitment.

In the accompanying picture, you see Dr. Simin Dadpar

A 48-year-old woman is referred for PET/CT evaluation of a 12 mm right upper lobe nodule identified on a CT exam. CT lung windows (A), mediastinal windows (B and D), and hybrid 18F-FDG PET/CT (C) are presented. What is the most likely diagnosis?

A. bronchioloalveolar carcinoma
B. carcinoid
C. granuloma
D. hamartoma

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Upcoming Nuclear Medicine Meetings:

January 2013
- 2013 Mid-Winter Meeting and 2nd Sino-American Conference

February 2013
- Northern California SNMMI Chapter 2013 Mid-Winter Meeting
  Pleasanton, California / February 28, 2013

March 2013
- Pacific Northwest SNMMI Chapter 2013 Spring Meeting
  Portland, Oregon / March 9–10, 2013

April 2013
- 42nd Annual Mid-Eastern Chapter SNMMI Meeting
  Ocean City, Maryland / April 11–13, 2013
- SNMMI Capitol Hill Day
  Washington, DC / April 29, 2013

May 2013
- 20th International Symposium on Radiopharmaceutical Sciences
  (ISRS2013)
  Seoguipo, Korea, Republic of / May 12–17, 2013

June 2013
- SNMMI 2013 Annual Meeting
  Vancouver, BC, Canada / June 8–12, 2013

Challenge Case:
Submitted by Patrick Colletti, MD

A. bronchioloalveolar carcinoma
B. carcinoid
C. granuloma
D. hamartoma

(Continued on page 8.  See Challenge case answer.)
The personal statement should preferably begin with a memorable line. Typically the personal statement will contain some interesting information about the candidate’s background and often experiences outside of school and residency. It is usually wise to limit the personal statement to a single page. In some institutions the curriculum vitae follows a standard format. Where a standard format is not required, it is important to follow the usual recommendations regarding content, but to also remember that what should be emphasized is what the candidate wants the prospective employer to know. Also remember that in some jobs, any additional schooling or experience in business, information technology, website design, etc. may be helpful in landing the job. (4, 5)

The interview is very important. The first step is for the candidate to research the job opportunity, people in the nuclear medicine section (including their research interests and where they trained), the hospital or clinic or company, the community, etc. Much of this can now easily be done on the Internet and by asking questions of one’s network. Those who do this will perform better on their interview, and the interviewer will appreciate the interest the candidate took. (4)

It is also helpful to practice for the interview with an associate. If the person has a habit such as saying “um” or “you know” a lot, twirling their hair, or shaking their knee up and down, that should be pointed out. (4, 5) Sometimes there may be something that is not positive in the candidate’s history, such as changing jobs quickly. Answers must be prepared in advance for likely questions on such subjects. The responses to interview questions should not be long winded. Of course, honesty is essential. Typically, far more important than the candidate’s words is the body language and attitude displayed. This includes much more than making eye contact and having a firm handshake. It includes showing enthusiasm, energy, friendliness and a zest for life, as well as enthusiasm for the field of nuclear medicine. It is unwise to spend a lot of time asking questions about money and time off during an initial meeting. There should be appropriate questions asked regarding numerous other aspects of the job, such as equipment, future directions of the practice, how rotations in nuclear medicine will be handled among the members of the group, rotations if any outside of nuclear medicine and productivity expectations. If the job is an academic position, there should be questions regarding research and teaching expectations and opportunities. If the nuclear medicine practice is within the department of radiology, there should be the opportunity to meet some of the radiologists who do not practice nuclear medicine. The candidate should also be alert to see how everyone interacts with each other, the morale of the nuclear medicine personnel and to look for clues as to the stability of the practice. The candidate should not say he or she will accept a job just to keep a job offer open while another opportunity is explored. On the other hand, if the applicant has any thought of accepting a job offer, it is important to show interest. At the conclusion of the interview, the candidate should summarize his or her qualifications and state why there is interest in the job. There should also be plans made for a follow-up in-person interview or phone call. (4)

The applicant should be very careful in all of his or her interactions with others during the interview day and prior phone calls. Being rude to a...
secretary, aside from being inexcusable in and of itself, may well get back to those doing the hiring and result in the candidate not getting the job. It is wise to avoid highly emotionally charged topics during the interview, such as politics. It is also important to be appropriately dressed and groomed and to show up on time. It is not acceptable to be late because of getting lost driving to the location. The applicant should know the way, even if it means making a dry run before the day of the interview. (4, 5)

Sometimes the spouse is invited to the city during the interview day. It is important that the spouse is enthusiastic about moving to the city. It is also important that the spouse and the candidate not argue in front of others during the interview day. (4)

Finally, after the interview, the applicant should send out thank-you notes to those who interviewed him or her. (4)

Conclusions: The job market for many nuclear medicine physicians is challenging. Some tips about getting a suitable position are presented, including the possibility of additional training in radiology, networking to find offers, asking only people who will give glowing letters to write the letters of recommendation, and having fine interviews.

References: