Dear Colleagues,

This is my last letter to you as ACNM president, as there will be a changing of the hands in January. As we get closer to the end of our ACNM 40th anniversary year, I am encouraged by the continued increase in our membership. This is one of the areas that was focused on during my presidency in an effort to stabilize the college financially and also to increase the ACNM presence, improve our image and be a stronger voice for nuclear medicine in general. Another accomplishment was completion of updating and refreshing our ACNM website.

Take a look if you have not already at www.acnmonline.org. A great big thanks to Dr. Erin Grady in overseeing this!

I also began a round of strategic planning with these three general categories in mind: (1) residents/young professionals, (2) education/CME opportunities, and (3) ACNM presence/advocacy. I can tell you that we are working on many items related to this, some of which have just come to fruition and several that your board is working on diligently. There are too many items to list separately in this letter, but you will be hearing of them in various announcements and through our newsletters and meetings in the future.

Saying that, I would like to delineate some of the many items/accomplishments that have already been achieved this year:

1. Thanks to the contribution of Dr. Punnet Chandak, the first of the new annual Clinical and Best Personal Mentor Awards was established and presented at the ACNM Awards Banquet at the Mid-Winter Meeting in 2014. The first awardees were Abass Alavi, MD, FACNM, and S. James Aldelstein, MD, PhD.

2. ACNM Lifetime Achievement Award was presented to Dr. Dadparvar.

3. An amendment was made to the ACNM bylaws to open up full membership to international members and to include nuclear pharmacists.

(Continued on page 2. See President.)

NMRO UPDATE

Alexander Antoniou, MD, MA
NMRO President

We have started our resident membership drive both domestically and internationally. I’m happy to report that thus far we have increased our resident membership by 20% from last year.

We continue to encourage more residents to join and become active members of the society, as well as invite recently graduated members to become full participating members.

One of the main priorities for NMRO this year is resident education. We are working closely with the ACNM board of directors and the ACNM President, Dr. Bartel, to bring high value and peer-reviewed educational content to our members. This process will be gradual over the next several months. We will be preparing board review material, building our case review files, updating other online resident resources and continuing to provide the very popular virtual journal club and educational webinars. The hope is to become an integral and active component in nuclear medicine education—all of which will be free for our resident members.

If you are a faculty member or senior resident and would like to contribute to this educational endeavor either via PowerPoint, lecture webinar, interesting case review or board prep material, please contact acnm@acnmonline.org. The online webinars and other educational material can be used during an institution’s morning or noon conference. Again, the content is free and is intended to supplement a program’s curriculum.

Letter from the President

Twyla Bartel, DO, MBA, FACNM

Alexander Antoniou, MD, MA

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4. ACNM had a voice in the recent Kinevac shortage.
5. ACNM had a voice regarding the DTPA/MAA hike.
6. ACNM wrote an inquiry/statement to TJC on the new CT interpretation requirements with a request for nuclear medicine representation.
7. ACNM had representation and a voice on the SNMMI-ACNM Government Relations Committee, IAC, ABSNM, AMA (delegate, alternate delegate, Young Professionals Section, Women Physicians Section) and ARR.
8. The college established a separate Education Committee to strengthen what is already provided for both ACNM and NMRO members and development of new items. Dr. Amol Takalkar and I will head this up.
9. The college established a separate Government Relations/Advocacy Committee to strengthen our involvement with and support the SNMMI GR Committee and to also tie in all other representation ACNM has for the field of nuclear medicine. Dr. Erica Cohen will be the chair of this committee.
10. We began a new webinar series. Keep an eye out for CME related to these in the future.
11. We created Spotlights, our new electronic newsletter.
   Many thanks to Dr. Dadparvar for starting and overseeing this.
   Your ACNM board and I are listening to you and trying to incorporate the requests/suggestions you have given us. This includes fundraising for our NMRO/young professionals to enable us to strengthen and support their activities, as they are a vital group of future leaders in nuclear medicine.
   We hope to see you at the annual Mid-Winter Meeting in San Antonio, Texas, which takes place in January 2015. Don’t forget: If you are planning on submitting an abstract for this meeting, the submission deadline is December 4, 2014. There will be ample opportunity to receive an award for your presentation. The awards will be presented at the ACNM Awards Banquet, so don’t forget to sign up for that, also.
   I would like to thank all of the ACNM board and various committee members for their dedication and service. I would also like to thank Virginia Pappas, Nicki Wenzel-Lamb, Anne Hiller, Joanna Spahr, Rachel Woodson, Vincent Pistilli, Sue Bunning, Paul Hamel, Matt Dickens and any other support staff I have failed to mention for their many hours of contributing to ACNM’s success.
   Last of all, I request that each of you strongly support our next president, Dr. Rathan Subramaniam, in the upcoming year as he continues with this great momentum!

Best to all of you!
Twyla B Bartel, DO, MBA, FACNM
ACNM President

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**Do You Know about ACNM’s Awards?**

**Erin Grady, MD, CCD**

Awards season is upon us. And, no, we’re not talking Hollywood or red carpets; we’re talking the ACNM awards. If you don’t know about them, you should. ACNM gives a number of awards:

1) **ACNM Fellowship Award**

The ACNM Fellowship is an honor bestowed upon board-certified nuclear medicine physicians who have made outstanding contributions to the field of nuclear medicine and/or the American College of Nuclear Medicine (or American College of Nuclear Physicians). Per the ACNM bylaws, “Fellows shall be those persons who have shown evidence to their peers superior competence, integrity and maturity in the application of their nuclear medicine knowledge and skill and who have been elected to this honor by the board of directors.” The candidates can be nominated by an ACNM fellow or can be self-nominated. This year’s **deadline is December 12, 2014**. For more information, visit the overview by Bennett S. Greenspan, MD, FACNM, FACR, on our website [here](#) or the nomination form [here](#).

2) **ACNM Best Mentor Awards**

The ACNM has a tradition of celebrating and acknowledging the most effective mentors in nuclear medicine. This award category and the selection criteria were revised to include the best “clinical” mentor and the best “personal” mentor. The revised award was spearheaded by the generous initial philanthropic contribution of Dr. Punnet Chandak (in memory of Dr. Robert Lull) and through the administrative help of the Education and Research Foundation in 2014. The best clinical mentor is one who has been a dedicated teacher of nuclear medicine (including clinical and scientific training or other colleagues in the field at large). The best personal mentor is one who has selflessly devoted her or his time with an amicable demeanor and has been dedicated to mentoring nuclear medicine professionals for leading a productive personal and professional life. We do expect the awardee to be present in person to receive the award at the ACNM Awards Banquet to be held in January 2015 in San Antonio, Texas, at the Conjoint ACNM Annual Meeting/SNMMI Mid-Winter Meeting. This year’s deadline is also **December 12, 2014**. For more information on the mentorship awards, [click here](#). Nominations are accepted from ACNM members. To nominate an individual, please the person’s name and a one-page (or less) description of why you believe the individual you are nominating should receive the award to Anne Hiller at [acnm@acnmonline.org](mailto:acnm@acnmonline.org) with a subject line “ACNM Best Mentor Award.”

3) **ACNM Lifetime Achievement Award**

The discussion of awards would not be complete without discussion of the most prestigious award, the ACNM Lifetime Achievement Award. The candidates are selected by the ACNM Board of Directors and Fellows of the ACNM; there are no self-nominations. You may have already seen a call for nominations on our e-update Spotlights, on Facebook and on Twitter. This award is presented to an individual who has demonstrated an outstanding level of dedication to the ACNM and the field of nuclear medicine. For a full list of criteria, [click here](#).
ACNM Advocacy & Government Relations Corner

It is my pleasure to introduce the newly developed ACNM Advocacy and Government Relations Committee. This committee will function as a formal liaison to the already-established joint SNMMI-ACNM Government Relations Committee. In addition, it will integrate ACNM’s delegates to various other medical organizations, including the American Medical Association, Intersocietal Accreditation Commission, Academy of Radiology Research, and American Board of Science in Nuclear Medicine, as well as advocate for nuclear medicine interests to government and third-party organizations.

On September 30, representatives from ACNM and SNMMI and patients whose lives have been affected by nuclear medicine attended Patient Advocacy Day on Capitol Hill. Participants visited the offices of 24 members of Congress to educate staffers about nuclear medicine and lobby for continued funding of nuclear medicine research and to ensure the availability of a reliable domestic supply of Mo-99.

- For nearly 60 years, the Department of Energy has funded essential, basic nuclear medicine research, as high as $34 million dollars in 2006. This has been progressively cut each year, and for fiscal year 2015 appropriations, nuclear medicine research was not included in either the House or Senate bills.
- The American Medical Isotopes Production Act of 2011 (S.99) mandated that industry convert its technology from highly enriched uranium (HEU) to non-HEU. While the United States uses half of the world’s supply of Mo-99, we still do not have a domestic source, and the Canadian facility will be phased out of commercial isotope production beginning in 2016. In the fiscal year 2015 budget, funding for the NNSA’s Global Threat Reduction Initiative was decreased by ~25% based on the development of a non-HEU domestic source, but there is doubt that production will be achieved within this critical timeframe.

The Advocacy/GR Committee encourages EVERYONE to reach out to their local government representatives regarding these and other important issues by taking part in our “Advocacy in Action” campaign. Send us a photo and description of your advocacy in action, and you will receive a special feature in ACNM’s online newsletter, Spotlights. More information is available on our website under Publications and Spotlights E-Newsletter.

Challenge Case

Erin Grady, MD, CCD

The patient is a 20-year-old male evaluated because of left heel pain following trauma.

What is your diagnosis?

(Continued on page 6. See Challenge Case.)
How the AMA Is Integral to Your Livelihood and That of the Medical Profession

Current procedural terminology (CPT) codes are required to report medical services and procedures and are part of the process in determining how physicians get paid. First developed and published by the American Medical Association (AMA) in 1966, CPT is the preferred system for universally describing health care services and procedures, measuring performance, and tracking new and emerging technologies.

The Centers for Medicare and Medicaid Services (CMS) pays physicians according to a schedule that multiplies relative values (relative value units—RVUs) for work and practice expenses—the resource-based relative value scale (RBRVS)—by a monetary conversion factor. Payments are then made on a per-visit or per-procedure basis as defined by the CPT codes. Most private payers take their cue from CMS but apply their own conversion factors.

Annual updates to the physician work relative values are based on recommendations from a committee involving the AMA and national medical specialty societies. The AMA formed the AMA/Specialty Society Relative Value Scale Update Committee (RUC) in 1990 to act as an expert panel in developing relative value recommendations to CMS. CMS is mandated to make appropriate adjustments to the new RBRVS in response to the Omnibus Budget Reconciliation Act of 1989 to account for changes in medical practice coding and new data and procedures. The purpose of the RUC process is to provide recommendations to CMS for use in annual updates to the new Medicare RVS. Values are assigned to new CPT codes and re-evaluated for existing codes by the RUC to make recommendations about the values of physician services to CMS.

The RUC is a unique committee that involves the AMA and specialty societies and gives physicians a voice in shaping Medicare relative values. The AMA is responsible for staffing the RUC and providing logistical support for the RUC meetings.

The RUC represents the entire medical profession (nuclear medicine is represented by radiology), with 21 of its 31 members appointed by major national medical specialty societies including those recognized by the American Board of Medical Specialties, those with a large percentage of physicians in patient care, and those that account for high percentages of Medicare expenditures. Four seats rotate on a two-year basis, with two reserved for an internal medicine subspecialty, one for a primary care representative, and one for any other specialty. The AMA Board of Trustees selects the RUC chair and the AMA representative to the RUC. The individual RUC members are nominated by the specialty societies and are approved by the AMA.

RUC Committee:
- Chair, RUC
- American Medical Association representative
- Chair, CPT Editorial Panel
- American Osteopathic Association representative
- Co-chair, RUC Health Care Professionals Advisory Committee

Review Board
- Chair, Practice Expense Review Committee

- 25 specialty society representatives: anesthesiology, cardiology, dermatology, emergency medicine, family medicine, general surgery, geriatric medicine, infectious disease*, internal medicine, neurology, neurosurgery, obstetrics/gynecology, oncology/hematology*, ophthalmology, orthopaedic surgery, otolaryngology, pathology, pediatrics, pediatric surgery*, plastic surgery, primary care*, psychiatry, radiology, thoracic surgery, urology (* indicates rotating seat)
- Over the last 20 years, the RUC has been responsible for valuing all new procedures and determining what physicians get paid. It takes many years for a service to move from clinical trials, to approval for use, to payment. The CPT and RUC processes take developing treatments in medicine and eventually translate them into a language that allows insurers to pay for the service.
- For 2015, the AMA has proposed to CMS that they will expedite the review processes for new, revised and potentially misvalued services, revising their meeting agendas and workflow to allow timely publication of the Proposed Rule in the Federal Register, which would eliminate the need for temporary G codes. The American College of Radiology supports this proposal.
- Policies in the 2015 Medicare Physician Fee Schedule (MPFS) Proposed Rule would result in significant radiology and radiation oncology reimbursement cuts. Nuclear medicine reimbursement is generally within +/- 3% of 2014 levels.
- For 2015 Hospital Outpatient Payment System (HOPPS), the only proposed pass-through radiopharmaceutical for Ambulatory Payment Classification (APC) offset is Healthcare Common Procedure Coding System (HCPCS) Code A9520, 99mTc-tilmanocept (LymphoSeek) up to 0.5 mCi, proposed 2015 APC = 1463.
- We spend a great deal of our clinical time providing secondary interpretation, generating a full diagnostic report, of images performed elsewhere that are utilized for comparison to images performed at our institution. In general, Medicare does not pay for second interpretations, although these are often more time consuming, due to different formatting and display programs not compatible with or integrated into our system, and are clinically relevant and integral to patient care. For 2015, CMS is soliciting comment for under which conditions a secondary interpretation should be reimbursed as a professional service.
- The ACNM is represented in the AMA, an organization integral to our livelihood, by Drs. Hadyn Williams and Erica Cohen, as Delegate and Alternate Delegate, who are available to integrate your input into our representation.
- Hidayn T. Williams, MD, FACNM, FCR
  Georgia Regents University
  Medical College of Georgia
  hawilliams@gru.edu
- Erica J. Cohen, DO, CCD MPH
  Edward Hines VA/Loyola University Medical Center
  ericajill@gmail.com
The Academy of Radiology Research

Bennett Greenspan, MD, MS, FACNM, FACR

I have been the ACNM representative on the board of directors of the Academy of Radiology Research (ARR) for the last several years. The ARR was established in 1995 as an advocate for research supported by the National Institutes of Health (NIH). It is the role of the ARR to illustrate to policymakers (Congress and regulatory agencies) the importance of imaging research. The ARR emphasizes the important message that imaging science is providing better health and increasing hope for patients and that a strong and sustainable investment in medical research must continue to be a national priority. The ARR is an alliance of multiple professional imaging societies, currently 28. The academy now also includes 44 academic research departments. These academic departments together with the professional societies represent the scientific community in advocating for medical imaging research.

The ARR also is the umbrella organization for the Coalition for Imaging and Bioengineering Research (CIBR). CIBR was established to foster collaboration among other important stakeholders in the imaging research community: patient advocates and industry. By representing a unified voice in support of imaging research, ARR and CIBR represent the three main constituents of medical research: academia, Industry and patient advocates. These stakeholders work together as a unified voice to help ensure that the federal government continues to invest in research at the National Institute of Biomedical Imaging and Bioengineering (NIBIB) and other agencies (NIH and elsewhere) that support imaging research. Among its achievements, the ARR was highly instrumental in the creation of the NIBIB within the NIH.

The ARR conducts several advocacy activities that promote support for research funding. The organization’s headline event, the Medical Technology Showcase, was held in the Kennedy Caucus Room of the Russell Senate Office Building this past year. The goal of this activity is to highlight the impact of imaging research in front of congressional members, staff and agency leaders. The ARR also conducts briefings to directors of several of the NIH Institutes with the goal of keeping imaging science at the forefront of these Institutes’ scientific agendas.

They also conduct tours of the NIBIB labs for congressional staff and tours for Senators and Congressmen of academic departments in their districts—with the goal of gaining champions for imaging science in particular. In addition, the academy regularly meets with key members of the administration to provide data and describe how these data may help guide federal science budgets. Recently, the current ARR president, Jonathan Lewin, MD, Chair of Radiology at Johns Hopkins, was invited to testify before Congress regarding findings of the ARR (published in the June 2014 issue of Nature Biotechnology) that showed funding for imaging research has produced increased levels of innovation and economic impact.

The ARR’s number one policy priority, the Medical Imaging Research Initiative (MIRI), was also just included in both the House and Senate appropriations bills and has received positive feedback from the White House Office of Science and Technology Policy (OSTP). MIRI will establish a standing Imaging Research Committee within the White House OSTP and will be charged with creating a federal roadmap to accelerate this important area of science and technology. The ACNM will be asked, with a number of other societies and subspecialties in imaging, to help craft this roadmap, which will eventually be transmitted back to Congress for enactment (including accelerating appropriate budgets for imaging research programs).
**Answer and Discussion:**

Dynamic perfusion images acquired immediately following injection of the radiopharmaceutical demonstrate prominent bilateral increased blood flow to the bilateral heels. Soft tissue phase images likewise demonstrate prominent bilateral increased calcaneal activity. Additional focus of increased soft tissue activity is identified at the lateral aspect of the right extremity, proximal to the foot, in the expected location of the lateral malleolus.

Additional delayed phase images demonstrate marked bilateral increased uptake in the bilateral calcanei. An additional punctate focus of increased uptake is identified in the right lateral malleolus. These findings suggest acute fracture given the abnormalities that are present on all three phases, compatible with the patient's history of recent injury.

Given these findings, we should query the mechanism of injury and possible additional injuries such as thoracolumbar fracture or forearm fractures (or get more pictures while the patient is in the department). The reasoning behind getting additional history is this: this constellation of findings is most compatible with bilateral calcaneal fractures that have been described as a triad of fractures known as the “Lover’s Fractures” or “Don Juan Fractures.” Fractures of the calcanei, wrist(s)/forearm(s) and spine have been seen in the setting of a jump from a height. They received the names in quotes as this has been seen in the setting of someone jumping out of a bedroom window to escape discovery. Of course, we are not sure of this patient's history, but the images suggest a fall from a height, landing on the feet. Approximately 10% of the time, these fractures are bilateral, as in this case.

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**Focus on the Fellow:**

Hazem H. Chehabi, MD, FACNM

Simin Dadparvar, MD, FACNM, FACR

I have the pleasure of introducing to you my fellow nuclear medicine colleague Dr. Hazem Chehabi, whom I have known for more than a decade. Dr. Chehabi had previously served as ACNM president and is currently president of the Education and Research Foundation for Nuclear Medicine and Molecular Imaging (ERF). He has a unique outpatient imaging center, which is a great model for those who are interested in pursuing private practice.

Hazem H. Chehabi, MD, FACNM, was born in Allepo, Syria. He received his medical degree from University of Damascus in Syria. He spent his internship and training as post-doctoral fellow in University of Texas Health Science Medical Center in Dallas, Texas. Then, he completed his nuclear medicine residency and a cardiac imaging fellowship in University of California, in San Francisco, CA. He is a member of several professional societies and published many papers.

Dr. Chehabi is the founder and president of Newport Diagnostic Center in Newport Beach, California. He has held several leadership positions in the State of California as well as at the national level. He is an associate clinical professor at UC Irvine and chair of the department of radiology at Loma Linda Medical Center in Murrieta, California.

We also discussed the following questions:

**SD: What got you interested in nuclear medicine?**

HC: While in medical school, I spent a month during a summer rotation in Nuclear Cardiology at CCU in Parkland Hospital in Dallas, Texas. A portable gamma camera, one nuclear medicine technologist and one cardiology fellow marked the beginning of a lifelong commitment to nuclear medicine.

**SD: What was the best advice you received when you were just starting out as an attending physician?**

HC: Remember, you were there not too long ago. Be the first one in and the last one out. Be kind.

**SD: What gives you the most career satisfaction?**

HC: My interactions with my patients and their families.

**SD: Is there a book that you would recommend that has helped you in your professional career?**

(Continued on page 8. See Focus on the Fellow.)

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**Let us know your opinion!**

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, the ACNM Scanner Newsletter editor, at egrady@christianacare.org. We will do our best to be a valuable resource for you.
Summary: Imaging specialists have a greater than 50% chance of being sued during the course of their careers, and most of these claims involve allegations of “failure to diagnose.” This paper will provide you with a checklist of good practices intended to reduce the risk of committing malpractice, as well as the risk of being sued, even when you haven’t committed malpractice.

I. What Is Medical Negligence?
Medical malpractice law is generally governed by the law of each of the various states, rather than federal law. In virtually every case, in order to prevail on a claim of medical negligence, a claimant must show that the physician had a duty, that the physician breached that duty, and that the breach was a cause of injury to the patient.

Assuming the existence of a physician-patient relationship, the source of a physician’s “duty” might be the common law of the state in which the physician practices, or a duty created by statute or regulation, state or federal. Broadly speaking, however, in order to prevail on a claim of medical negligence, a claimant must demonstrate that: (1) the physician breached the standard of care by failing to act as a reasonable, prudent physician, practicing in the same locale and specialty, would have acted under the same or similar circumstances; and that (2) the breach in the standard of care was a cause of injury to the patient. It is important to remember this two-prong requirement—many acts that constitute a breach in the standard of care do not result in an injury, e.g., a nurse who gives two aspirin when the medication order calls for only one has breached the standard of care, but very infrequently will this result in injury to the patient.

II. The Problem: Why Do Imaging Specialists Get Sued?
As noted above, misdiagnosis is the most frequently alleged complaint against imaging specialists. And two of the variables that often reduce the risk of committing or being sued for malpractice are not usually applicable to imaging specialties.

Physicians get sued, because the patient had what the patient believes is a bad outcome and because the patient believes that the physician is at least partially responsible. There is no one cause of medical negligence. A pediatrician who follows a child from birth is much less likely, however, to be the target of a medical negligence action than a physician whose practice consists of a single encounter with a patient. The reasons for this are simple: (1) the more often a physician sees a patient, the more informed the decisions made by the physician; and (2) a close relationship with a patient reduces the likelihood that the patient will sue. The imaging specialist rarely enjoys the benefits of either of these. Moreover, insofar as radiology is not often a clinical practice, the extent to which a radiologist will have access to a patient’s history and physical, as well as lab studies, varies from case to case. This absence of clinical findings and laboratory results often results in a longer list of differentials.

III. Avoiding Malpractice and Avoiding Getting Sued
One of the objectives of the ACNM is “to foster the highest standards in Nuclear Medicine consultation and service to referring physicians, hospitals, and the public.” Practice consistency, informed analysis, clear and effective communication with the referring physician and inclusion of all reasonable potential diagnoses furthers that goal and reduces the risk of a medical malpractice claim.

Practice consistency: Practice consistency comes from developing a written routine in reviewing images and following that routine. Even the most experienced pilot utilizes a checklist before every flight; so, too, should the imaging specialist. Each read by an imaging specialist should involve a routine that is in keeping with the current good-practice recommendations of reputable professional associations, e.g., the American College of Nuclear Medicine, the American College of Radiology, and the Society of Nuclear Medicine and Molecular Imaging. Practice consistency also means spending as much time as necessary to reasonably perform the task at hand—i.e., never allow external demands to cause you to spend less time that you are comfortable spending on any given task. Skilled physicians almost never commit malpractice if they take the time necessary to fully perform the task at hand. This doesn’t mean that you will always be correct in your diagnosis—but an error in a medical judgment that is supported by a thoughtful analysis is not medical malpractice.

Informed analysis: Practice consistency in keeping with currently accepted practices, and sensitive to trends, comes from a regular (at least monthly) review of new practice guidelines (parameters) and peer-reviewed publications. Each will keep the imaging specialist attuned to trends. In addition to lowering the risk of error in the reading and interpretation of films, a physician who maintains an understanding of developing trends and can testify to his or her regular continuing medical education is simply a better and more credible witness.

Clear and effective communication/differential diagnosis: Diagnostic imaging may or may not provide a definitive diagnosis in any given case. In circumstances where it does not, the best the imaging specialist can do is provide a list of the most likely, ordered by likelihood or severity of the risk. The balance to be struck is often not an easy one, i.e., should you err on the side of over-inclusion or under-inclusion?

As an attorney who has had multiple cases involving medical negligence by an imaging specialist, I can tell you without hesitation that under-inclusion is never the right course. Instead, if a potential diagnosis involves a risk of serious sequelae or death, it should be included on the list of possible diagnoses. It is fine to state that the diagnosis is less likely than another one, but it should be listed and might include, where appropriate, a recommendation for further evaluation by the referring physician.

IV. Conclusion
In order to reduce the risk of committing medical malpractice, and of being sued even when you haven’t committed malpractice:

• establish (or adopt) and follow a written protocol to follow in the handling and administration of all tracers and the reading of every image;

(Continued on page 8. See Malpractice Issues.)
HC: The best book I read when I was a resident was John Walker and Donald Margouleff’s A Clinical Manual of Nuclear Medicine. I loved its portability and practicality.

SD: Why did you choose private practice?
HC: I thought I would be an academician for the rest of my life. After completing my training, I wanted to stay at UCSF, but the University had a hiring freeze at the time. Still wanting to stay in California, I joined a private hospital-based practice, staying for two years before starting my own practice. I am a strong believer in providing the highest-quality patient care and felt that going on my own would allow me to do that.

SD: What is the reason for your success?
HC: Over the last 23 years, my amazing staff has put quality first, taking care of our patients, their referring physicians and the community. Our shared values have made this practice a success.

SD: What helped you to excel?
HC: The simple answer is: have passion for what you do. Facing the inevitable challenges, you reinvent yourself and adapt. You continue to provide the highest-quality care possible, treating your patients with compassion, respect and dignity.

SD: In your experiences with ACNM, what was good or not so good?
HC: I enjoy the small intimate gatherings with colleagues, but the college is still struggling for relevancy in a complex medical scene.

SD: What do you think that ACNM should do to improve its value for its members?
HC: Become an effective advocate for the field.

SD: What was your role at ACNP?
HC: While president of the ACNP, I succeeded in combining the leadership of the ACNP and ACNM. With the support of dedicated colleagues, we created the new ACNM to bring a stronger voice to the nuclear medicine community.

SD: In creating the new college, what would you like to see at ACNM?
HC: I would like to see an increase in membership with more specialists, increased collaboration with other professional organizations and more action relevant to the ACNM members.

SD: How can the ACNM benefit from partnership with the ERF?
HC: The ERF promotes education and research in the field by supporting grants and awards given by the SNMMI to physicians, technologists and scientists in nuclear medicine and molecular imaging. As ERF president, I support working with the ACNM to raise funds in support of ACNM educational goals.

• subscribe to (and read each month) professional publications that contain peer-reviewed articles regarding trends in nuclear medicine; and
• take your time.

1. Stephen Malouf is a partner in the Dallas-based law firm of Malouf & Nockels, LLP. Stephen has been representing clients in medical malpractice (including imaging failure to diagnose) cases since 1984 and has what is believed to be the largest medical malpractice verdict in U.S. history—$268 million. His honors and awards include being selected as a Texas Monthly Magazine “Super Lawyer,” D-Magazine “Best Lawyers” in Dallas, and Who’s Who in American Law.

2. Pinto A, Brunese L., Spectrum of Diagnostic Errors in Radiology. World J Radiol 2010; 2:377–383. Most medical negligence claims involve allegations of failure to properly diagnose or failure to properly treat, i.e., claims that an error in medical judgment caused an injury. Outright failures, i.e., operating on the wrong leg, are a small subset of overall medical negligence claims. According to a recent study, “[e]ach year during the study period [1991–2005], 7.4% of all physicians had a malpractice claim, with 1.6% having a claim leading to a payment (i.e., 78% of all claims did not result in payments to claimants).” Anupam B. Jena, M.D., Ph.D.; Seth Seabury, Ph.D.; Darius Lakdawalla, Ph.D.; and Amitabh Chandra, Ph.D., Malpractice Risk According to Physician Specialty. N Engl J Med 2011; 365:629-636. August 18, 2011DOI: 10.1056/NEJMsa1012370

3. The National Conference of State Legislatures has compiled a survey of state laws governing medical negligence claims at http://www.ncsl.org/research/financial-services-and-commerce/medical-liability-medical-malpractice-laws.aspx. Another resource is published by the law firm of McCullough, Campbell & Luee LLP at http://www.mcandl.com/states.html. Since the laws of your state may have changed since these surveys were published, you should also conduct a simple Google search for “medical malpractice in the state of _________."

4. Dorland’s defines differential diagnosis as “the determination of which one of several diseases may be producing the symptoms” (Dorland’s Medical Dictionary for Health Consumers, Elsevier Inc., 2007). Lawyers, however, often use the term to mean all of the possible diagnoses for a given set of clinical, laboratory and diagnostic imaging results that may or may not be ordered by likelihood.
You Speak, We Listen: Results of the Connectivity Survey
Erin Grady, MD, CCD

We thought you might like to see how everyone answered for our recent survey. Below are the findings.

On question #6, 64% of the respondents currently read the Scanner newsletter; no topics were suggested. On question #7, only 2 people responded that they would like a podcast.

Thanks for giving us your opinions! If you have others you'd like to share feel free to email acnm@acnmonline.org, or message us on Facebook, LinkedIn or Twitter.
History of Nuclear Medicine

Test your knowledge of Nuclear Medicine history! For the people you may know in NM history, the answers will be last name only unless otherwise specified.

Across

3 In 1971, Nuclear Medicine was recognized as a specialty and in 1972, this board was formed (abbreviation)
6 He along with his colleagues at Brookhaven National Laboratories developed the Mo-99/Tc-99m generator
8 This individual with the help of Phelps and Hoffman have been credited with the development of PET at Washington University School of Medicine
10 This well known researcher kept a sample of radium from the Curies in his vest pocket
12 This individual along with Kaminski pioneered radioimmunotherapy (RIT)
13 This Italian physicist along with Glenn Seaborg isolated Tc-99m
14 Often referred to as the "father of Nuclear Medicine", he was the first to use P-32 to treat leukemia
17 This individual along with McAfee developed phosphates for bone imaging as well as several other radiopharmaceuticals
18 Edwards and this nuclear medicine physician/researcher developed SPECT in 1963
21 A daughter of a legend, she too made strides in radioactivity demonstrating artificially produced radionuclides (first name)
22 Known as "Tappy", his contributions to aerosol lung ventilation, thyroid, liver & renal imaging were key
24 This town in Tennessee along with its lab played in integral role in the discovery/development of radionuclides
26 This Scottish pathologist was the first to use radioiodine to treat thyroid goiter
27 The creator of the rectilinear scanner
28 This discoverer of thallium had a penchant for the paranormal; also developed a radiometer

Down

1 This German physicist coined the term isotones
2 She along with her husband isolated radium, thorium, polonium and coined the term "radioactivity"
3 This individual was a pioneer in nuclear endocrinology and developed I-131 mIBG and iodocholesterol
4 A calculation of the speed of light which was given to us by this famous man, allows us to have lines of response in PET imaging
5 This individual with the help of Nutt developed the PET/CT scanner
7 This is what electrons were called in the 1890s
9 This individual along with Strauss introduced non-invasive myocardial perfusion imaging in 1973
11 This British chemist coined the term isobars
14 This lady was one of the early pioneers in the use of radiotracers and one of the founding members of MIRD
15 This lady along with Marinelli developed calculations of radiation dose. She was also one of the founding members of the American Association of Physicists in Medicine
16 Also involved in the development of SPECT, he now has a phantom named after him
19 A man of many accomplishments and accolades including international outreach, he pioneered work in brain imaging and neuroreceptors
20 The first developer of the scintillation gamma camera; did you know his highest degree was a master's?
23 This nuclear medicine physician reports on the first human use of lung scanning and was instrumental in the development of the ABNM
25 This radiochemist coined the term "tracer principle" after tracing metabolic pathways in animals
Register for the American College of Nuclear Medicine (ACNM) Annual Meeting, held in conjunction with the Society of Nuclear Medicine and Molecular Imaging (SNMMI) Mid-Winter meeting, January 22-25, 2015 in San Antonio, TX.

Topics of interest include:

- Appropriate Use Criteria - Where are we now, Where are we going and Where do we fit in?
- The Year in Review - The Best NM & MI of 2014
- Appropriate Use of NM as Consultant and Colleague - How NM Practitioners can Give Clinicians the Best Information Every
- Appropriate Use of Radiation in Everyday Practice - Diagnostic and Therapeutic Considerations
- Challenging Cases in Pediatric NM – RWE
- Personal Branding - Turning Your Learning Portfolio into the Career You Want
- Appropriate Use of NM & MI in Cancer Screening and Diagnosis
- Using Evidence-based Medicine Appropriately in Imaging - Being Everyday Change Agents

Plus, don’t miss the two-day 100-CT Case and 20-MRI Case Reviews—providing you with the opportunity to obtain CME and case credit for meeting CT/MRI training and credentialing recommendations.

Early-bird registration deadline: Thursday December 4, 2014

www.snmmi.org/MWM15

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SCANNER IS PUBLISHED BY THE AMERICAN COLLEGE OF NUCLEAR MEDICINE

Editor-in-Chief: Erin Grady, MD, CCD
Managing Editor: Nikki Wenzel-Lamb, MBA
Graphic Designer: Laura Mahoney