Bulletin... SUMMER 2010

The Pennsylvania Radiological Society

A Chapter of the American College of Radiology

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GO GREEN GO GREEN GO GREEN GO GREEN

Remember, the ***Bulletin*** is available on the Internet at the following home page: http://www.paradsoc.org/

PRESIDENT'S MESSAGE

Melvin Deutsch, MD, FACR
University of Pittsburgh
Pittsburgh, PA

In a few weeks, the PRS will have its annual meeting in Pittsburgh, Pennsylvania. Dr. Pyatt has put together an excellent program on the strategic issues confronting radiology practices. I have always found the Saturday sessions to be extremely interesting and timely, even though they are mainly about diagnostic radiology and I am a radiation oncologist. Dr. Joel Greenberger, who spoke to this group three years ago when the PRS met in Pittsburgh, will give an update on radiation terrorism. Dr. Greenberger is the recipient of a huge grant to study the effects of a radiation terrorist attack and the means to respond to it.

This year the honored radiologist will be William R. Poller, M.D., F.A.C.R., who has been a good friend and colleague for the past three decades. The honored lecturer will be Bernard Fisher, M.D., who, in my opinion, is the greatest surgical oncologist of the 20th century, and has been the most influential scientist in the development of the modern treatment of breast cancer.

This past year saw the passage of a major health care bill. We are all trying to decide how this will affect not only the practice of radiology and radiation oncology, but all of medicine over the next decade. The results of the 2010 congressional and gubernatorial elections will likely play a large role in determining how physicians and patients will be affected by the recently passed health care legislation. Again, I urge the membership to become involved politically. It is important not only to vote, but also to support candidates with money and time. Money buys influence.

I recently reviewed the list of senators and congressmen who received money from RADPAC and also from the ASTRO political action committee. I was dismayed to see people on the list who I would not even shake hands, much less support their candidacy. Sometimes I think organized medicine groups will support a candidate who seems supportive on one or two issues which might be beneficial to the medical community in the short-run, but the particular candidate may be a poor choice because of his or her views and intentions on so many other issues which affect this nation and its people. The views of a candidate on issues such as energy policy, foreign affairs, economic policies, taxes, government spending, tort reform, etc. are more important to the country and also to physicians than the candidate's position on insurance coverage for CT colonoscopy or proton beam radiotherapy. While it is important to support RADPAC, it is also important for us to support candidates we think will be best for the country.

Get involved and vote!!

EDITOR'S COLUMN

Anne P. Dunne, MD
Geisinger Medical Center
Danville PA

The annual meeting of the American College of Radiology in Washington, D.C. May 15-19, 2010 was interesting and stimulating. It was clearly focused on the current issues facing the country, health care and the radiologic community. There

was a large presence of residents and fellows in training which bodes well for the future of our specialty.

Pennsylvania was well represented on many levels. First, Congratulations to the Pennsylvanians who became Fellows of the American College of Radiology:

David Steele Buck, MD	Turtle Creek, PA
Richard P. Kennedy, MD	East Stroudsburg, PA
Elaine Renee Lewis, MD	Reading, PA
Mitchell D. Schnall, MD, PhD	Philadelphia, PA
Mark Gerard Trombetta, MD	Pittsburgh, PA

For the first time, there was a poster competition in the ACR Resident/Fellow Section. Over 40 posters were displayed with impressive representation from training programs in the Commonwealth.

The Moreton Lecture was given by Jeff Goldsmith, PhD, President, Health Futures Inc. It was entitled "Future of Radiology in the New Healthcare Paradigm". Among the examples he mentioned were the endeavors at Geisinger Health Systems in central Pennsylvania.

Congratulations to Robert S. Pyatt, Jr., MD, FACR. He has become the chair of the RADPEER Committee under the ACR Commission of Quality and Patient Safety.

Dr. Pyatt has assembled a stellar program for the fall meeting on October 9 in Pittsburgh. The speakers are leaders in our field and the topics presented are the subject of national meetings. All this plus 7.75 CME credits and the charms of Pittsburgh! See you there!

Please read Dr. Pyatt's submission in this issue of the Bulletin on reporting of missed diagnoses and disagreements. This is vital for all of our practices, especially those with teleradiology services, off-site readers and residents/fellows who give preliminary reports.

GO GREEN!!! In an effort to conserve resources and pare down expenses, we would like to send the PRS Bulletin to members electronically rather than by traditional mail. When you receive your dues notice, please indicate if you would like the Bulletin sent to your e-mail address. For all members, please give us your up to date e-mail address, mailing address and phone numbers.

CME Requirements for Unrestricted Medical License - Pennsylvania State Board of Medicine

Robert S. Pyatt, Jr., MD, FACR
Chair, Committee of Radiologic Education
Chambersburg Imaging Associates
Chambersburg, PA

STATE BOARD OF MEDICINE
CONTINUING MEDICAL EDUCATION
CME REQUIREMENTS FOR
(MD) UNRESTRICTED LICENSE
JANUARY 2010

In order to renew a license, completion of 100 credit hours of continuing medical education in the preceding biennial period, which runs from January 1 of the odd year through December 31 of the next even year, will be required for medical doctors.

- Twenty (20) of those credit hours must be completed in AMA PRA Category activities.
- At least 12 hours of the 100 must be completed in activities related to patient safety or risk management and may be completed in either Category 1 or 2.
- The remaining credit hours shall be completed in either Category 1 or Category 2 approved activities.

PRA/BOARD CERTIFICATION certificates are NOT proof of CME compliance by themselves. In addition to submitting a copy of their Board Certification or PRA certificates, the physician must supply copies of the certificates/documents submitted to earn the above. Please note: These certificates must include all of the required acceptable information.* All dates must fall within the two year time frame of the renewal cycle.

The following are guidelines established by the Board for CME

Category 1 activities are those that have been approved by an accredited provider. Your CME certificate will also state that the activity has been approved for Category 1 credit and name the
institution or organization that is awarding the credit. If you have participated in Category 1 activities, the provider should provide you with a certificate of completion.

*Acceptable certificates/documentation must include:

- Name of the licensee
- Name of the course
- Date of the course
- Number of credit hours earned
- Provider of the course
- Category type

Category 2 credit hours is self designated and claimed by individual physicians for participation in education activities not designated for AMA PRA Category 1 Credit that:

- comply with the AMA definition of CME; and
- a physician finds to be a worthwhile learning experience related to his/her practice.

Examples of learning activities that meet the requirements for AMA PRA Category 2 Credit include but are not limited to:

- participation in educational activities that have not been designated for AMA PRA Category 1 Credit.
- teaching physicians, residents, medical students or other health professionals
- unstructured online searching and learning

- reading authoritative medical literature
- consultation with peers and medical experts
- small group discussions
- self assessment activities
- medical writing
- preceptorship participation
- research

Category 2 Credit Documentation must include:

- activity title
- subject or content area
- date(s) of participation (Le., Month/day/year)
- number of credits claimed

A Category 2 Continuing Medical Education Reporting Form can be found on our web site at www.dos.state.pa.us/med.

Calculation of Category 2 Physicians should claim credit based on their participation time with sixty minutes of participation equal to one (1) AMA PRA Category 2 credit. Credit is claimed in 15 minute or 0.25 credit increments; physicians must round to the nearest quarter hour.

Approved activities in the area of patient safety and risk management may include the following topics:

- Improving medical records and record keeping
- Reducing medical errors
- Professional conduct and ethics
- Improving communications
- Preventative medicine
- Healthcare quality improvements

The following exemptions of the continuing medical education requirement may apply for certain physicians:

- A physician applying for licensure in this Commonwealth for the first time shall be exempt from the continuing medical education requirement for the biennial renewal period in which initial licensure is acquired.
- A physician holding a temporary training license within the renewal cycle shall be exempt from the continuing medical education requirement.
- A licensee who holds an **active/retired license,** who provides care only to immediate family members, shall be exempt for the continuing medical education requirement
- A physician who is on **inactive status** shall be exempt from the continuing medical education requirement.
- A physician who is seeking to reinstate an inactive or lapsed license shall show proof of compliance with the continuing education requirement for the preceding renewal period.

Waiver of the CME requirements may be permitted as follows:

- The board may grant a hardship waiver of all or a part of the continuing medical education requirement in cases of serious illness, military service or other good cause provided that the public's safety and welfare will not be jeopardized by the granting of the waiver
- A request for waiver must be made in writing, with appropriate documentation, and include a description of circumstances sufficient to show why compliance is impossible. All waiver request must be presented to the Board for review/approval prior to the renewal of the license.
- Waiver requests will be evaluated by the board on a case-by-case basis. The Board will send written notification of its approval or denial of a waiver request.
- **The waiver request is considered untimely if it is made after the license period during which the CME was to have been completed.**

For additional information regarding continuing education course providers, the following websites may be helpful:

Pennsylvania Medical Society www.pamedsoc.org

American Medical Association www.ama-assn.org/go/cme

Department of Insurance www.mcare.state.pa.us

Additional information about continuing education and a copy of the Board's law and regulations can be found on our website at www.dos.state.pa.us/med.

PLEASE NOTE: THE BOARD DOES NOT APPROVE NOR RECOMMEND ANY CME COURSES. IT IS THE LICENSEE'S RESPONSIBILITY TO MAINTAINITRACK THEIR PERSONAL CME CREDIT HOURS

Committee on Hospital and Physician Relations

Robert S. Pyatt, Jr., MD, FACR, Chair
Chambersburg Imaging Associates
Chambersburg, PA

There is significant discussion and activity occurring statewide between radiology groups and hospitals/health systems. The June 2010 issue of JACR has an excellent article for you to review. Our PRS Committee is ramping up knowledge and activity to assist radiologists in PA. We also hope to have the Chair of the ACR Committee, Cynthia Sherry, MD, FACR at next year's PRS Annual Meeting in 2011 in Philadelphia.

Abstract of the JACR article (go to www.JACR.org):

ACR Task Force Report: Relations Between Radiologists and Hospitals and Other Health Care Organizations

Cynthia S. Sherry, MD, Richard B. Gunderman, MD, PhD, William T. Herrington, MD, Leonard Berlin, MD, Paul A. Larson, MD, Lawrence R. Muroff, MD

The vast majority of US radiologists are affiliated with hospital-based group practices, making professional relationships between radiologists and hospitals one of the most crucial factors for a successful practice. However, tensions between radiology groups and hospitals have been increasing and have led to some well-publicized breakdowns. The ACR Task Force on Relationships Between Radiology Groups and Hospitals and Other Healthcare Organizations was charged to identify key factors affecting these relationships and to make recommendations and propose positive steps that could improve relationships and benefit radiologists, hospitals, and patients.

2010 PRS Annual Meeting Educational Program

Robert S. Pyatt, Jr., MD, FACR
Chair, Committee on Continuing Education
Chambersburg Imaging Associates
Chambersburg, PA

2010 PRS Annual Educational Meeting
October 9, 2010
Omni William Penn Hotel
Pittsburgh, PA
7.75 AMA PRA Category 1 Credits
Moderator: Robert S. Pyatt, Jr., MD, FACR

8:00 Welcoming Remarks, Melvin Deutsch, MD, FACR, President of PRS
Introductions, Robert S. Pyatt, Jr., MD, FACR, Program Chair
"National Issues Facing Radiologists and Radiation Oncologists",
James Thrall, MD, FACR, President, American College of Radiology

8:45 "Radiation Terrorism", Joel S. Greenberger, MD, Professor and Chair, Department of Radiation Oncology, UPMC

9:30 Coffee Break

9:45 "Nighthawks and Other Teleradiology Ventures – Good or Bad for Radiology?"
David C. Levin, MD, FACR, Professor and Chairman Emeritus,
Radiology Department, Thomas Jefferson University Hospital

10:30 "Utilization Management in Radiology: Controversies and Strategies"
Vijay M. Rao, MD, FACR, Professor and Chair,
Radiology Department, Thomas Jefferson University Hospital

11:15 Q & A

11:45 Annual PRS Business Meeting

12: 00 Lunch
"Teleradiology Partners: Three Important Points – The right setting, the right partner and asking the right questions that can help you find the wolves in sheep's clothing".
Timothy V. Myers, MD, Chief Medical Officer,
Nighthawk Radiology Services.

1:00 "Hot Topics/Issues Facing Radiology Residents and Fellows in Pennsylvania"
Eric Faerber, MD, FACR, Chair, Department of Radiology, St. Christopher's Hospital for Children

1:45 "Turf Battles in Radiology – Strategies and Tactics for Winning: Part I"
David C. Levin, MD, FACR and Vijay M. Rao, MD, FACR

2:30 Coffee Break

2:45 "Turf Battles in Radiology-Strategies and Tactics for Winning: Part II"
David C. Levin, MD, FACR and Vijay M. Rao, MD, FACR

3:30 "The Health Care Law – Dissected" (Prognostications from a Political Junkie)
Timothy Farrell, MD, FACR

4:15 Panel discussion and Q & A

4:45 Adjournment

6:00 Reception

7:00 "Historical Perspectives of Breast Cancer"
Lecture Honoring William R. Poller, MD, FACR
Honored Lecturer: Bernard Fisher, MD

7:30 President's Banquet

8:30 Award Presentations and Inaugural Address of New President of PRS, Eric Faerber, MD, FACR

QUALITY AND PATIENT SAFETY COMMITTEE REPORT

Robert S. Pyatt, Jr., MD, FACR, Chair
Chambersburg Imaging Associates
Chambersburg, PA

"Report on Missed Diagnoses, Disagreements, etc."

The Q & PS Committee wants PA radiologists to be aware that they **must** report any interpretation errors to the Pennsylvania Patient Safety Authority. This is a state legal mandate since Act 13. This legal requirement applies for all health system errors, such as drug mis-administrations, wrong site surgery, missed diagnoses, nursing errors, etc. Any disagreements with teleradiology reports, ED physician readings, or internal readings by group members or residents/fellows **must** be reported to the Patient Safety Authority. There is peer review legal liability protection for those who comply with these requirements. Report your missed diagnoses to your local hospital Patient Safety Committee, which is a required committee for every healthcare facility in PA, along with a Patient Safety Officer. This information will be valuable for re-credentialling, QM Office, etc. Attached is a very recent article available on the PA-Patient Safety Authority website. The main website is at: http://patientsafetyauthority.org/Pages/default.aspx

The specific article is entitled: Communication of Radiograph Discrepancies between Radiology and Emergency Departments. The link is:

http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Mar7(1)/Pages/18.aspx

Here is a partial report from the website, excluding references, etc. (See the site for all details).

Communication of Radiograph Discrepancies between Radiology and Emergency Departments

Pa Patient Saf Advis 2010 Mar;7(1):18-22.

ABSTRACT: A radiograph ordered in the emergency department (ED) may not be reviewed immediately by a radiologist for a number of reasons, including limited availability of radiology services after hours and the increasing demand on radiology services due to growing ED volume. In 2008, facilities submitted 195 reports to the Pennsylvania Patient Safety Authority identifying a discrepancy between an ED physician's preliminary radiograph finding and the results of a radiologist's final reading. Processes for communicating radiograph readings from the radiology department to the ED vary among facilities due to factors including the availability of radiology services during off hours and availability of technologic services such as picture archiving and communication systems. When discrepant interpretations occur between the preliminary reading by an ED physician and the final reading by a radiologist, communicating the radiologist's findings to the ED and patient for follow-up is essential to ensure that the patient has received appropriate care. This article examines risk reduction strategies, including standardization of systems for communicating and reconciling radiograph discrepancies between the radiology department and ED that will promote optimal patient care.

Clinical Literature

A review of the literature found that discordance between ED physician and radiologist interpretations of radiographs has been reported in a number of studies as ranging from 0.3% to 17%.[3-6] The majority of studies focus on rates of discrepancies; however, few studies evaluate the clinical impact of discrepancies on patient care. Not all discrepancies have the same degree of clinical significance. A 2003 study comparing ED physician and senior radiologist interpretations of 509 chest radiographs investigated the effects of misinterpretation of chest radiographs on discharge recommendations.[7] The study showed that, when classified by level of clinical significance (i.e., mild, moderate, high), the highest sensitivity of the ED physicians' interpretation (60%) was found in the group with highly significant clinical findings (e.g., consolidation, congestion, pleural effusion, mediastinal widening). While this study found that the missed findings were of a minor nature, another study found that follow up of ED radiographs detects clinically important abnormalities that may have been overlooked. During a six-month study period, 19,468 ED visits generated 11,749 radiographic examinations. Discrepancies were detected in 175 patients (1.5%). Of these 175 patients, 136 (78%) were subsequently shown to have been incorrectly interpreted in the ED (i.e., false negatives), with 40 patients (23%) undergoing a change in management as a result. In the remaining 39 discrepancies, the ED interpretation was evaluated to be correct, with 16 patients requiring additional investigations or visits to the ED to confirm the radiographic finding.[8]

While the literature is inconclusive about the impact of discrepancies on patient management, reports submitted to the Pennsylvania Patient Safety Authority show that discrepancies occur often and may have an impact on patient safety if not communicated by the radiology department to the ED.

Authority Reports

The Authority received 3,173 reports from June 2004 to December 2008 related to discrepancies between the ED physician interpretation of a radiograph and the final reading by a radiologist. The Authority received 2,699 of these reports over a two-year period from the same facility, possibly reflecting a targeted quality-improvement project. In 2008, facilities submitted 195 reports of this event type, which Authority analysts reviewed individually. None of these reports were submitted as a Serious Event. However, 68 (35%) of the reports indicated that the discrepancy involved a potentially significant clinical finding, as follows:

- Fracture: 50
- Pneumonia: 14
- Appendicitis: 4
- The information in the reports does not convey how or when the discrepancies in the radiology findings were communicated between the radiology department and ED, although 55 (28%) of the reports indicate that communication was a factor contributing to the event. Also, the reports do not indicate that an error occurred in every case in which a discrepancy occurred. The reports do reflect the potential for patient harm if a discrepancy is not communicated between the radiology department and ED in a timely manner.
- Examples of Authority reports related to such communication issues follow.
- **Communication of Radiology Discrepancies to the ED**
- A patient presented to the ED with the complaint of a seizure. The patient had a seizure and fell. A preliminary reading of a CT [computed tomography] scan was reported as negative, and the patient was discharged from the ED. A review of the radiographs the next day showed the patient had compression of the spine. The results were not conveyed to the ED physicians. The patient returned to the ED several days later and was admitted for neurosurgical intervention.
- [A radiology staff member left a voice-mail message] regarding x-ray discrepancy for ED support staff. The voice mail was listened to later the next day. The support staff discussed [the discrepancy] with the physician. The physician stated the patient must return to the ED. Voice mails should not be left on ED support staff phone. If [there is] no answer, [the caller] MUST [sic] notify charge nurse.

- **Communication of Radiology Reports to the ED**
- An x-ray was done and the report was signed 45 minutes later. The ED physician/department was not notified of a result of subdural hematoma.
- A patient was admitted from the ED. The physician reported several hours later that the patient had a dissecting aneurysm. A review of the chart showed patient had a CT done in the ED. The overnight radiology service report of CT showed dissection of aneurysm. [The aneurysm was] not documented in ED notes and was not treated.
- A patient was diagnosed with a sprain. The patient was discharged and instructed to follow up with orthopedics. The patient returned later that day with pain. Radiology report was reviewed and was negative. A quality review of radiology report two days later found a radiology report addendum from the previous day showing a dislocation that was not reported to ED.
- **Practice Guidelines**
- The Joint Commission National Patient Safety Goal for improving communication among caregivers addresses critical test results by requiring that facilities have a process in place for verbal and telephone communication of such results. The 2009 communication goal requires that facilities "measure, assess, and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values." Accredited facilities are expected to apply this goal not only to laboratory tests, but also to all diagnostic tests (e.g., imaging studies, arterial blood gas assessments, electrocardiograms).[9] The Joint Commission requires organizations to define an acceptable length of time between when critical tests are first ordered and when critical results are reported.[9]
- The American College of Radiology (ACR) guideline on communication maintains that the radiologist is to provide imaging services to patients seen in the ED, including interpretation and appropriate communication.[10] The guideline emphasizes that interpretation should be timely to facilitate decisions regarding treatment, although it does not specify a time frame in which radiology results should be communicated. The ACR guideline also addresses discrepancies in interpretation between a preliminary and final radiology interpretation. Changes between preliminary and final interpretation should be reported in a manner that reasonably ensures timely receipt by the referring or treating physician when such changes could impact patient care.
- The American College of Emergency Physicians (ACEP) endorses that the interpretation of diagnostic studies ordered for the immediate evaluation of and management of ED patients should be done contemporaneously with the ED visit.[11] If the ED physician believes that urgent consultation is needed for the interpretation of a diagnostic study, the radiologist must be immediately available. The interpretation of the diagnostic study, both preliminary and final, must be documented in writing and entered into the patient's medical record.

Risk Reduction Strategies

Although Joint Commission, ACR, and ACEP do not provide specific guidelines related to how a facility should communicate discrepancies, a number of methods for following up on ED/radiology discrepancies have been suggested. The process has been referred to as an "information chain," starting with image generation, proceeding with image interpretation, and ending with communication of the interpretation.[12] The goal of the entire process is to follow up on any clinically significant discrepancies with the patient. The way the process operates will depend on the availability of technology such as PACS, voice-recognition dictation systems, and EMRs. However, with any system, it is important to do the following:

- Develop a system for interpreting radiographs and communicating the interpretations that can be implemented regardless of the time of day or day of the week.[13, 14] A hospital may have separate processes for each shift for handling radiograph interpretation, depending on availability of radiology services. In the case of plain radiographs, a common scenario is interpretation of ED radiographs by the radiologist during normal business hours and interpretation by the ED physician during after-hours shifts, with a radiologist overreading the radiograph the next day. Although rates of discrepancies between ED physician and radiologist interpretations vary in the literature, standardizing the method of identifying discrepancies and the action plan for responding to them—for all shifts—will avoid confusion related to the use of multiple systems.[13]
- Implement a standardized method for informing the radiologist of the ED physician's interpretation.[13,14] If the hospital uses a paper-based system, the ED physician can document his or her interpretation for requisition by the radiologist.[15] Another paper-based approach involves the radiology department maintaining a log in the ED to document all radiographs. Radiology staff are responsible for logging the patient's name and views taken. The ED physician can make a notation of his/her reading in the log. The log can then be taken to the radiologist for review.[15] If PACS technology is available, methods for integrating notations into the system from the ED physician and the radiologist have been described in the literature.[16-18] For example, one facility successfully implemented a PACS that includes a preliminary note window. The window contains two text boxes—one for the ED physician's preliminary interpretation and the other for the radiologist's interpretation.[16]
- Implement a standardized system for communication of the radiologist's interpretation of the ED radiograph to the ED in a timely manner.[13,14] If a discrepancy

occurs between the ED physician's and radiologist's interpretations, it is important that the ED receives this information. A 2008 survey of current ED imaging practices showed that the most commonly used method of communicating urgent findings or a discrepancy is verbal communication between practitioners.[19] Documentation of any verbal communication in the patient's record is essential. Voice-recognition dictation systems can expedite the availability of a radiologist's final report, but they do not eliminate the need for a consistent method to transmit the report to the ED in a timely manner.[16-18]

- Develop a consistent method to reconcile the radiographic interpretation with the actual care provided.[13,14] A consistent system for identifying the clinical significance of the finding is essential. The ED physician may find that (1) the discrepancy has no clinical importance, (2) the patient has already been admitted and the subsequent treating physician needs to be notified of the finding, (3) the patient has been transferred to another facility and the subsequent treating physician needs to be notified of the finding, (4) the patient has received appropriate treatment in the ED and requires no follow-up, (5) the finding was missed and the patient requires a follow-up contact, or (6) follow-up studies are required for equivocal findings.[15]
- Develop a consistent method for timely communication of radiographic readings to the referring or subsequent treating physician and the patient as appropriate. One approach described in the literature for ensuring that radiologic findings are communicated in a timely manner is direct communication of the findings by the radiologist or radiology facility to the patient.[20]

Conclusion

- As Authority reports indicate, discrepancies may occur between the ED physician's interpretation of a radiograph and the final interpretation of the radiologist. A discrepancy may be clinically significant, and a system must be in place to communicate the discrepancy to the ED. Every ED needs a system to ensure that once a discrepancy is communicated to the ED, the discrepancy is correlated with the patient record to determine whether follow-up is necessary. Although systems may vary depending on factors such as availability of an electronic record, the system of communicating discrepancies should be simple and broadly applicable across all hours and days of the week. Finally, open communication among ED and radiology providers will help promote patient safety by ensuring that the patient will receive timely and appropriate follow-up care should a discrepancy occur.

If you have any questions, please contact me at: bob_pyatt@hotmail.com

Licensing of Medical Physicists

Anne P. Dunne, MD
Geisinger Medical Center
Danville, PA

There is a movement underway for states to license medical physicists. This has already gone into effect in New York, Texas, Florida and Hawaii. Bills are pending in state legislatures in Pennsylvania (HB 1835), Ohio, California, Missouri, Michigan and Massachusetts.

As diagnostic radiologists and radiation oncologists, we know the importance and value of these health professionals to patient care and safety. The American College of Radiology (ACR), the American Association of Physicists in Medicine (AAPM) and the American College of Medical Physics (ACMP) recommend that standards be established to allow only qualified individuals to practice Medical Physics and support licensure of qualified medical physicists.

Standards would include appropriate education and training and experience and certification by the American Board of Medical Physics, the American Board of Radiology, the American Board of Science in Nuclear Medicine or the American Board of Health Physics, depending on the area of expertise. This would cover Diagnostic Medical Physics, Medical Nuclear Physics, Therapeutic Radiological Physics and Medical Health Physics.

Lastly, as director of a radiology residency program, I am indebted to the physicists who teach imaging physics so well to our residents. The creation of the AAPM/RSNA physics tutorial modules with emphasis on clinically relevant physics is a great boon to the education of our residents.

To see House Bill 1835: "An Act regulating medical physicists; establishing the State Board of Medical Physicists; and providing for funds, for licensure, for disciplinary action, for remedies, for penalties and for preemption." Go to The Pennsylvania General Assembly website and type HB 1835 in the upper right hand corner. A white paper can be found on the AAPM Joint Medical Physics Licensure Subcommittee (JMPLSC) website.

Please support this endeavor of licensure of medical physicists in Pennsylvania and nationally.

Information for this column was provided by Joseph G. Och, MS, DABMP, System Director of Medical Health Physics, Geisinger Medical Center, Danville, PA and Eric L. Gingold, PhD, Assistant Professor, Director of Diagnostic Radiological Physics, Department of Radiology, Thomas Jefferson University Hospital, Philadelphia, PA.

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2009-2010

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