

August 25, 2015

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Dear Dr. Segall:
Dear Dr. Jackson:

We thank you for providing us the opportunity to comment on the joint ABR-ABNM statement that proposes to replace the current 5 years residency training program in nuclear medicine with a hybrid DR/NM subspecialty and to abolish the ABNM.

As you know, the Canadian Association of Nuclear Medicine (CANM) is the Canadian professional organization that represents the vast majority of the physicians practicing nuclear medicine across Canada. Most of these physicians practicing in Canada are certified in nuclear medicine by the Royal College of Physicians and Surgeons of Canada (RCPSC) and many have also obtained ABNM certification.

Except for the province of Quebec, where physicians can only submit medical professional billing in 1 single specialty, the nuclear medicine specialty in the rest of Canada is facing the same type of economic and market pressure as in the USA. There is little doubt that the evolution of multimodality imaging systems such as SPECT/CT, PET/CT and PET/MR that combine functional, molecular and anatomical information has established a new disruptive paradigm in the management of patients and added to these market pressures.

As steward of the quality of Nuclear Medicine delivered to the Canadian population and in order to maintain the core values of the specialty such as integrity, commitment, advocacy, respect and excellence, the RCPSC decided, in 2009, to improve the training of its graduates by revising and updating the general standards of accreditation, the objectives of training and the specialty training requirements in Nuclear Medicine.

As detailed in attachment A, physicians in Canada who desire to specialize and obtain certification in nuclear medicine can follow two routes: an unique 5 years Nuclear Medicine training with entry from PGY1 or a Nuclear Medicine training in association with Diagnostic Radiology training for a minimum of 6 years. The straight nuclear medicine route mandates a minimum of 6 months and ideally 12 months of cross-sectional imaging in Diagnostic Radiology as part of the core training. Physicians practicing nuclear medicine on a full time basis serve as examiners for the RCPSC for both pathways leading to the Nuclear Medicine certification.

The CANM strongly believe that in order to fulfill their mandate to patients, Nuclear Medicine practitioners have adequate and appropriate training and competency to offer the very best consulting advice, opinion and service to patients and their colleague physicians managing these patients.

Practically, the joint task force proposal of American Board of Radiology and the American Board of Nuclear Medicine aims at uniting Nuclear Radiologists and Nuclear Medicine physicians under the umbrella of the American Board of Radiology. With that proposal, new trainees would be required to follow a new, unique training pathway with a transitional year of clinical training, three years of Diagnostic Radiology core curriculum and two years of Nuclear Medicine. This approach represents a middle ground between the current independent mandatory 5 years training programs for Diagnostic Radiology and for Nuclear Medicine.

Besides leaving many questions unanswered, this proposal, for those of us who have been practicing Nuclear Medicine for a few decades, falls short of the core values of the specialty such as integrity, commitment, advocacy, respect and excellence that patients and health care insurance and governments agencies have the right to expect and demand from Nuclear Medicine practitioners and professionals.

The proposal leaves many unanswered questions including the type of procedures that future diplomat will be able and authorized to perform, the impact on current Nuclear Radiologists that can practice Nuclear Medicine after 4 months only of training in Nuclear Medicine, effect on current Nuclear Medicine physicians who are ABNM certified and on the Radiology and impacts Nuclear Medicine technologists.

Another major concern is the real qualification and proficiency of the Nuclear Medicine practitioners who will be required to master in two years the extremely complex regulatory framework for the use of diagnostic and therapeutic medical isotopes, the understanding and use of sophisticated equipment, nuclear physics, radio-pharmacy, an in depth understanding of physiology and pathophysiological processes, and molecular medicine in a constantly evolving and more than challenging socio-economic environment.

The creation of a hybrid, “middle of the road”, sub specialty training program that is folded under the umbrella of radiology under economic and market pressure could clearly fail patients and health care systems. The CANM strongly believe that patients across North America and for that matter across the world, would be better served by nuclear practitioners that have the current, well established, full fledged state-of-the-art training in Nuclear Medicine with additional, dedicated and specialized training in CT, MR and Molecular Medicine.

In the USA, Radiation Oncology is the best historical example for this approach. A subspecialty of Radiology, Radiation Oncology emancipated, creating a separate training and certification process and in 1976 the specialty of Radiation Oncology took its place as a unique and separate entity in the House of Medicine. Since then, Radiation Oncology has evolved into an independent, full blown medical specialty that has successfully incorporated hybrid medical imaging equipment into the complex world of radiobiology, three-dimensional conformal radiation therapy, intensity-modulated radiation therapy, image-guided radiation therapy, stereotactic radiosurgery, stereotactic body radiotherapy, concurrent chemo-radiotherapy, intraoperative radiation therapy, radio-immunotherapy, unsealed sources, total body irradiation therapy as used in stem-cell transplantation, total skin radiation therapy, high- and low-dose rate brachytherapy, and particle therapy.

More recently, in 2014, Interventional Radiology, which was also a sub-specialty of Radiology, was recognized as a separate specialty by the American Board of Medical Specialty. This resulted from the culmination of 7 years of focused work that revealed that the practice of Interventional Radiology required specific and dedicated training and emphasis on the importance of non-procedural patient care.

Since its inception in the late 40’s and because of its unique ability to characterize and quantitate the physiology and pathophysiology of tissue and organs, Nuclear Medicine physicians have always served as consultants in the continuum of patient care. In the 21st century, and at a time when complex diagnostic and therapeutic technology is paramount to manage patients, the clinical and non-procedural role of the Nuclear Medicine physicians in multidisciplinary teams is more critical than ever.

In the era of personalized medicine, abolishing the ABNM and folding Nuclear Medicine into a subspecialty of Diagnostic Radiology with limited Nuclear Medicine training is contrary to the reality of modern, integrated, multidisciplinary medicine and the needs and expectations of millions of patients that benefit from specialized diagnostic and therapeutic Nuclear Medicine procedures every year. It purely and simply ignores and scavenges the phenomenal contributions and development that researchers, scientists, clinicians, the radiopharmaceutical industry and the equipment manufacturers have made to the field over the past 60 years. It also relinquishes the quintessential role that Nuclear Medicine physicians play in the management of millions of patients to a simple subpar

imager figure that has limited knowledge and training in the specialty. Such a move would set up an irreparable precedent and would be extremely detrimental to the quality of patient care that the Academy of Medicine, the medical insurance companies, medical societies and associations and the federal health care authorities have tried to promote over the past two decades. Not only would patients be getting subpar Nuclear Medicine services, they might also be harmed by professionals who do not have sufficient knowledge to use safely and appropriately the vast range of diagnostic and therapeutic medical isotopes.

In Canada, we are blessed by the forth sight and wisdom of the Royal College to reaffirm, maintain and strengthen the requirement to practice and render Nuclear Medicine services to the Canadian population. This was reaffirmed two years ago with the recertification as a specialty.

Given the lack of a detailed proposal, the absence of an open discussion with the ABNM stakeholders and diplomats and the absence of a clear focus on quality and excellence for nuclear medicine services, the CANM cannot support the current proposal.

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