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NUCLEAR REGULATORY COMMISSION

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ADVISORY COMMITTEE ON THE MEDICAL USES OF ISOTOPES

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MEETING

+ + + + +

OPEN SESSION

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MONDAY,

APRIL 16, 2012

The meeting was convened in Room T2-B3 of Two White Flint North, 11545 Rockville Pike, Rockville, Maryland, at 10:45 a.m., Bruce Thomadsen, Ph.D., ACMUI Vice Chairman, presiding.

MEMBERS PRESENT:

BRUCE THOMADSEN, Ph.D., Acting Chair

DARICE BAILEY, Agreement State Representative

MILTON GUIBERTEAU, M.D., Diagnostic Radiologist

SUSAN LANGHORST, Ph.D., Radiation Safety Officer

STEVE MATTMULLER, Nuclear Pharmacist

CHRISTOPHER PALESTRO, M.D., Nuclear Medicine Physician

JOHN SUH, M.D., Radiation Oncologist

ORHAN SULEIMAN, Ph.D., FDA Representative

MEMBERS PRESENT (Continued):

WILLIAM VAN DECKER, M.D., Nuclear Cardiologist

LAURA M. WEIL, Patients' Rights Advocate

JAMES WELSH, M.D., Radiation Oncologist

PAT ZANZONICO, Ph.D., Nuclear Medicine Physicist

NRC STAFF PRESENT:

PAMELA HENDERSON, Acting Deputy Director, Division of Materials Safety and State Agreements

CHRIS EINBERG, Designated Federal Officer

ASHLEY COCKERHAM, Alternate Designated Federal Officer

MICHAEL FULLER, Alternate Designated Federal Officer

SOPHIE HOLIDAY, Alternate ACMUI Coordinator

REGINALD AUGUSTUS, FSME/DWMEP/DURLD/SP

NEELAM BHALLA, FSME/DILR/RB-B

SUSAN CHIDAKEL, OGC/GCLR/RMR

JACKIE COOK (via telephone), RIV/DNMS/NMSB-B

SAID DAIBES, Ph.D., FSME/DMSSA/LISD/RMSB

SANDRA GABRIEL, RI/DNMS/MB

LATISCHA HANSON (via telephone), RIV/DNMS/NMSB-A

DONNA-BETH HOWE, Ph.D, FSME/DMSSA/LISD/RMSB

HARRIET KARAGIANNIS, RES/DE/RGDB

ED LOHR, FSME/DILR/RB-B

NRC STAFF PRESENT (Continued):

AARON McCRAW (via webcast), RIII/DNMS/MIB

PATRICIA PELKE (via webcast), RIII/DNMS/MLB

GRETCHEN RIVERA-CAPELLA, FSME/DMSSA/LISD/RMSB

SHIRLEY XU, FSME/DMSSA/LB

MEMBERS OF THE PUBLIC PRESENT:

DARRELL BROWN, Fox Chase Cancer Center

KEITH BROWN, University of Pennsylvania

PETER CRANE (via telephone), *No Affiliation*

ROBERT DANSEREAU, NYS Dept. of Health

MOHAN DOSS, Fox Chase Cancer Center

BRYAN EDWARDS, Fox Chase Cancer Center

LYNNE FAIROBENT, AAPM

TRACI HOLLINGSHEAD, Avera McKennan

DEEPIKA JALOTA, Bayer HealthCare Pharm.

RALPH LIETO, St. Joseph Mercy Hospital

GARY LUNGER (via webcast)

ANDREW McKINLEY, ASNC

JANETTE MERRILL, SNM

MARY E. MOORE, Philadelphia VA Medical Ctr.

DONNA MOSLEY, Fox Chase Cancer Center

MICHAEL PETERS, ACR

SOBHA PHILLIPS, Fox Chase Cancer Center

KATHRYN PRYOR, Health Physics Society

MEMBERS OF THE PUBLIC PRESENT (CONTINUED) :

JOE RODGERS, Theragenics

GLORIA ROMANELLI, ACR

KAREN SHEEHAN, Fox Chase Cancer Center

MICHAEL SHEETZ, University of Pittsburgh

MICHAEL N. STEPHENS, Florida Dept. of Health

CINDY TOMLINSON, ASTRO

RICHARD VETTER, Health Physics Society

GARY E. WILLIAMS, VA NHPP

DAVID WILLIAMSON, University of Pennsylvania

TABLE OF CONTENTS

P-R-O-C-E-E-D-I-N-G-S

(10:50 a.m.)

ACTING CHAIR THOMADSEN: Welcome to the spring ACMUI meeting. I want to thank you all for joining us. Dr. Malmud cannot be with us for medical reasons, and we send him all of our best for a speedy recovery.

And to open the program, Mr. Einberg.

MR. EINBERG: Okay. Thank you, Dr. Thomadsen. I'm not sure if we can turn up the microphone for Dr. Thomadsen, or if you could speak up, but we are getting indications from the back that you need to talk a little louder.

Good morning. I'm going to open the meeting. I'm the Designated Federal Officer for this meeting. I am pleased to welcome you to this public meeting of the Advisory Committee on the Medical Uses of Isotopes.

My name is Chris Einberg. I am the Chief of the Radioactive Materials Safety Branch, and I have been designated as the Federal Officer of the Advisory Committee in accordance with 10 CFR Part 7.11.

Present today as the Alternate Designated Federal Officers are Mike Fuller, who is the team leader for the Medical Radiation Safety Team, and

Ashley Cockerham, who is the coordinator for this meeting.

This is an announced meeting of the Committee. It is being held in accordance with the rules and regulations of the Federal Advisory Committee Act and the Nuclear Regulatory Commission. The meeting was announced in the March 13, 2012, edition of the Federal Register, Volume 77, page 14837.

The function of the Committee is to advise the staff on the issues and questions that arise in the medical use of byproduct material. The Committee provides counsel to the staff but does not determine or direct the actual decisions of the staff or the Commission.

The NRC solicits the views of the Committee and values their opinions. I request that, whenever possible, we try to reach a consensus on the procedural issues that we will discuss today. But I also recognize there may be minority or dissenting opinions. If you have such opinions, please allow them to be read into the record.

At this point, I would like to perform a roll call of the ACMUI members who are participating today. As Dr. Thomadsen mentioned, Dr. Leon Malmud,

who is the Chairman of this Committee, is not in attendance. And I will go through the roll call right now. Dr. Bruce Thomadsen, who is the Acting Chairman for this meeting today.

ACTING CHAIR THOMADSEN: Present.

MR. EINBERG: Ms. Darice Bailey, state government representative.

MEMBER BAILEY: Present.

MR. EINBERG: Dr. Mickey Guiberteau, diagnostic radiologist.

MEMBER GUIBERTEAU: Present.

MR. EINBERG: Dr. Sue Langhorst, radiation safety officer.

MEMBER LANGHORST: Present.

MR. EINBERG: Mr. Steve Mattmuller, nuclear pharmacist.

MEMBER MATTMULLER: Present.

MR. EINBERG: Dr. Christopher Palestro, nuclear medicine physician.

MEMBER PALESTRO: Present.

MR. EINBERG: Dr. John Suh, radiation oncologist.

(No response.)

He is here today. I note that he is here. He stepped out of the room.

Dr. Orhan Suleiman, FDA representative.

MEMBER SULEIMAN: Present.

MR. EINBERG: Dr. William Van Decker, nuclear cardiologist.

MEMBER VAN DECKER: Present.

MR. EINBERG: Ms. Laura Weil, patients rights advocate.

MEMBER WEIL: Present.

MR. EINBERG: Dr. James Welsh, radiation oncologist.

MEMBER WELSH: Present.

MR. EINBERG: Dr. Pat Zanzonico, nuclear medicine physicist.

MEMBER ZANZONICO: Present.

MR. EINBERG: Okay. With that, we do have a quorum. And so we have at least seven members, and we can go ahead and participate -- proceed.

I now ask that the NRC staff members who are present identify themselves. I will start with the individuals in the room.

MS. HENDERSON: Pam Henderson, Acting Deputy Director.

MR. EINBERG: Thank you.

MR. FULLER: Mike Fuller, team leader, Medical Radiation Safety Team.

MR. EINBERG: Okay. I see that Dr. Sandy Gabriel is in the audience also from Region I.

MS. RIVERA-CAPELLA: Gretchen Rivera-Capella from the Medical Radiation Safety Team, NRC.

MR. EINBERG: Thank you.

MS. HOLIDAY: Sophie Holiday, also with the Medical Radiation Safety Team, NRC.

MS. COCKERHAM: Ashley Cockerham with the Medical Radiation Safety Team, NRC.

MR. EINBERG: Okay. Thank you. Are there anybody from the regions on the phone?

MS. COOK: Jackie Cook, Region IV.

MR. EINBERG: Thank you.

MS. HANSON: Latischa Hanson, Region IV, DNMS.

MR. EINBERG: Thank you. Anybody else from the regions?

(No response.)

Anybody I missed on the phone or --

(No response.)

Okay. I would also like to add that this meeting is being webcast, so other individuals may be watching online.

We have a bridge line that is available, and that phone number is 888-566-9152. The passcode to

access the bridge line is 23793-pound. Once again, the number is 888-566-9152. The passcode is 23793-pound.

Following a discussion of each agenda item, the Acting Chairman, Dr. Bruce Thomadsen, at his option, may entertain comments or questions from members of the public who are participating with us today.

At this point, I would like to turn the meeting over to Ms. Pam Henderson, who has some opening remarks she would like to make. And Ms. Henderson is the Acting Deputy Division Director for the Division of Materials Safety and State Agreements.

MS. HENDERSON: Good morning, and welcome to the spring ACMUI meeting. Brian McDermott, the Director, is representing NRC at the Organization of Agreement States Board of Directors meeting in Wisconsin, and, therefore, he is unable to be here.

In Dr. Malmud's absence, the current ACMUI Vice Chairman, Dr. Thomadsen, will act as the Chair. Thank you, Dr. Thomadsen, for acting in this capacity.

We would like to extend a warm welcome to Ms. Darice Bailey. She was appointed as the new ACMUI Agreement States representative on March 26, 2012. Ms. Bailey has been interacting with the ACMUI members and staff over email and phone for the past several

weeks, and we look forward to working with her over the course of the next four years.

We are happy to announce that Mr. Steve Mattmuller has been reappointed to serve a second term on the ACMUI. We appreciate Mr. Mattmuller's willingness to serve and for his valuable contributions to the Committee over the past four years.

On April 3rd, the Organization of Agreement States and the Conference of Radiation Control Program Directors met with the Commission to discuss medical event definitions for permanent implant brachytherapy, the expanded, increased control requirements for 10 CFR Part 37, and various other topics that impact our co-regulators in the states.

On April 24th -- next week -- NRC staff and ACMUI members and various medical stakeholders will be meeting with the Commission to discuss medical event definitions for permanent implant brachytherapy. The meeting will provide an opportunity for the Commission to receive important feedback from all interested parties before voting on the paper that is before them at this time. Dr. Welsh and Ms. Weil will be representing the ACMUI at that meeting.

On March 16th, the Commission approved the

Part 37 final rule with minor changes. Publication is expected this summer. The effective date of this new regulation will be one year after the publication date, and that is when NRC licensees will need to meet the new Part 37 requirements.

Agreement States will have three years from the date of publication to adopt compatible regulations.

During the meeting today and tomorrow, we will be covering a range of topics, including electronic signatures, patient advocacy, patient release, radium-223 chloride, medical event definitions for permanent implant brachytherapy, strontium/rubidium generators. We look forward to hearing the Committee's views on these important issues.

And with that, I will hand it back to Dr. Thomadsen.

ACTING CHAIR THOMADSEN: Thank you very much. And are there any questions from the Committee?

(No response.)

In that case, we will move on to the next presentation by Ms. Cockerham on Old Business. And that is under Tab Number 3 in your book.

MS. COCKERHAM: Good morning. For Tab

Number 3, I have new, updated handouts for you. So I'm going to pass these around. So you can pull out everything that is in your binder behind Tab 3.

And while those are going around, I will just start by saying I know a lot of these recommendations are from 2007 and '08. They seem very old and they seem to still be lingering around, but the good news is that almost all of them are included in either the permanent implant brachytherapy, the medical event definition, rulemaking that is currently undergoing, and also there is a Part 35 expanded rulemaking that is ongoing. So we are taking action on many of these items.

So for these old lists, I am actually going to go through them very quickly. I am not going to read the recommendations in detail. I can tell you for Items 2, 3, 6, 7, 8, 10, 25, all of those items are currently included in the Part 35 expanded rulemaking.

And then, when we get to Item 30, this is a recommendation for something that is in 10 CFR 35.1000. So the things that are 1000 uses, I believe the Elekta Perfexion, there is also a few items on here, if you look at Items 34 and 35, that deal with ophthalmic treatments, NeoVista, all of these things

that are Part 1000 uses are not being moved into the regulations at this time. That's why they say "open" and "delayed."

So for -- we stopped at Item 30, so for 31 I said -- 31 and 32 are both included in the Part 35 expanded rulemaking. And then for Items 34 and 35, that deals with the ophthalmic devices, and I mentioned that those will be considered for a future rulemaking, but not with the current expanded Part 35 or the current medical event definitions for permanent implant brachytherapy rulemakings.

For Items 36, 37, and that's it for that chart, those are both also included in the Part 35 expanded rulemaking.

So if we move on to 2008, Item 2 is also included in the Part 35 expanded rulemaking. And Number 5 is, as I said before, it's about Elekta Perfexion. It is not included in the current rulemakings, but it will be considered for a future rulemaking.

For Item Number 9, this deals with the abnormal occurrence criteria. And this -- the abnormal occurrence criteria was discussed during the ACMUI teleconference on December 15, 2011. The ACMUI reaffirmed this recommendation with the addition of

the letter S to physicians, and this recommendation -- NRC provided it to Research staff to propose to the Commission.

For Item 19, the Permanent Implant Brachytherapy Subcommittee report, this is currently in the permanent implant brachytherapy -- the medical event definitions for permanent implant brachytherapy rulemaking.

For Item 22, this is regarding yttrium-90 microspheres. Again, this is a 10 CFR 35.1000 use, and it will be considered to be moved to rulemaking at a future time. Right now it is still in guidance phase. So this is the same as the Elekta Perfexion and the NeoVista ophthalmic device.

For Items 26 and 27, these are regarding permanent implant brachytherapy, and they are included in that rulemaking. And the last three items -- 28, 29, and 30 -- are all in the Part 35 expanded rulemaking.

For 2009, Item Numbers 2 and 10 are included in the Part 35 expanded rulemaking. And for Item 9, that is just adding Dr. Welsh and Dr. Langhorst and Mr. Mattmuller to the Medical Events Subcommittee. And Dr. Suh was subsequently added in 2011, but we will get to that.

Any questions on any of these old recommendations? We are kind of seeing a trend here. It is either part of a current rulemaking, so the recommendation is under consideration, or it is a Part 1000 use, which we will consider at a future date.

Okay. So for 2010, the ACMUI will provide a list of action items for NRC staff based on the recommendations provided in the Patient Release Subcommittee report. This was still just lingering as an open item, but I know at the last meeting Dr. Langhorst stated that the Subcommittee felt it had addressed all issues in its report and that this item could be closed. And so I am just documenting that this item is now closed.

For 2011, I am actually going to start with Item Number 6. ACMUI created an action item to reevaluate its satisfaction with the reporting structure annually, and this recommendation was made in January of 2011.

So sometime this year we will need the Committee to -- I guess we can put that as an agenda item for the next meeting, to evaluate its satisfaction with the reporting structure. And this deals with reporting to NRC staff at the division

level where it currently does, or reporting directly to the Commission or some sort of other option.

For Item 7, Dr. Malmud will serve as the reviewer to screen I-131 cases for the ACMUI Medical Events Subcommittee. That is just an ongoing thing. The Medical Events Subcommittee will report to us later today.

For Item 9, ACMUI recommended a three-month notice for future public stakeholder workshop meetings. I went ahead and closed this item out. The workshops are over. But I think the NRC understands that ample notice is requested for public meetings.

For Item 10, this is regarding the public stakeholder workshops. The Committee requested that we have one of those workshops in August, which was a couple of months later than I think what we had proposed. And we did in fact have it in August in Houston.

For Item 11, this deals with permanent implant brachytherapy. And the ACMUI's Permanent Implant Brachytherapy Subcommittee report was finalized on February 7, 2012. It included recommendations for post-implant dosimetry but did not separate prostate implant brachytherapy from other types of permanent implant brachytherapy.

So I guess the point here is that this recommendation is kind of superseded by your subcommittee report. So I can actually -- I had put "partially accepted," and what I will do is go ahead and close this recommendation out, since your Subcommittee report is the final statement on this.

Any questions or comments on that?

(No response.)

Okay. Item Number 12 says that we would have the next meeting. This was for last fall, so I would just close this item out so it is not lingering open. You recommended we have a September meeting, and we had a September meeting.

For Items 13, 14, and 15, all of these items deal with attestation. And the last item deals with -- oh, they're all dealing with attestation, and they are all included in the Part 35 expanded rulemaking.

Then, we'll jump to Item 19, and Mr. Mattmuller asked the NRC staff to add ACMUI to the organizational chart on the FSME website. We are still working on this. I have identified two websites that I think the ACMUI can be added to. We just need to work through the process of going through our contractors and getting ACMUI added to that.

I did look at the NRC website as a whole, like the public website. And there is a very high level organizational chart. It does not include organizations like the Advisory Committee on Reactor Safe -- or Advisory Committee on Reactor Safeguards. I believe I've got that right. And, really, it only goes down to about the office level, and ACMUI -- there is an office level, and then there is the division level, and that's where the ACMUI reports to the division level.

So I don't think that ACMUI would be included on maybe the chart -- is that the chart that you had envisioned? I'm not sure -- or would it be more on the Office of Federal and State Programs and Environmental -- Office of Federal and State Materials and Environmental Management Programs website?

MEMBER MATTMULLER: I'm sorry. I can't keep up with your shorthand. I think the intent was greater visibility for the Committee.

MS. COCKERHAM: Okay.

MEMBER MATTMULLER: And so I will let you decide where best that can occur --

MS. COCKERHAM: Okay.

MEMBER MATTMULLER: -- or work in --

MS. COCKERHAM: I guess I just wanted the

Committee to know that I did look on the big picture, front page website. The NRC organizational chart, which starts with the Commissioners at the top, and then it has the Executive Director, but that chart only goes down to our Office Director.

And if this Committee reports at a division level, the Committee would not be on that page, but there are many other places -- and I have identified two other websites where I think we could get this included. So we will be working on that.

For Item 20, Dr. Langhorst requested that NRC staff place historical documents and past ACMUI membership information on the ACMUI website. This is something we are still working on, but it is noted and it's open.

For Item 21, this is the Electronic Signature Subcommittee, and that Subcommittee will be reporting to us during that -- during today's meeting.

Item 22, I just closed out this item. This is the abnormal occurrence criteria. This is the teleconference that the Committee had on December 15th, so I closed out that this discussion was tabled.

Item 23 is where Dr. Malmud added Dr. Suh to the Permanent Implant Brachytherapy Subcommittee.

Item 24, the Permanent Implant Brachytherapy Subcommittee will revise the Subcommittee report and provide it to the full Committee. And they did do this, so I have closed out this item. That October report was actually followed up by a February report, so we have moved on even since this point.

Item 26, NRC staff will provide an advance copy of the Permanent Implant Brachytherapy Subcommittee report to the Agreement States. This is because we did not have an Agreement States representative currently on the Committee. And Ms. Bailey participated in the teleconference as a member of the public on behalf of the Agreement States. So I have gone ahead and closed out this item.

Item 27, ACMUI planned to hold a spring meeting today and tomorrow. I closed this out because we're here.

This would be Item 28. I don't see a number, but it is Item 28 here. 28, 29, 30, and 31, all of these items here that I have marked closed, they are all modifications to the October Permanent Implant Brachytherapy Subcommittee report. All of these changes were incorporated into the report, and the report was finalized on October 18th and posted to

the public website. So this is just noting all of those changes that were made, so I have closed out all of those items.

And I believe this would be Item 32. ACMUI reaffirms the 2008 abnormal occurrence criteria as stated in the handout with the amendment that "S" be added to the end of "physician," which I discussed -- I think I mentioned this from a previous -- the bottom line is, the recommendations that you have made for abnormal occurrence criteria, the latest information has been provided to the Office of Research, and they are providing that to the Commission.

For the last chart -- this is 2012 -- ACMUI recommended two changes to the Permanent Implant Brachytherapy Subcommittee report. Those two changes were made to the report and included in the final revised report that is dated February 7, 2012. And these ACMUI recommendations in that February 7th report were transmitted to the Commission in a SECY paper or a Commission paper, and that paper is SECY-12-0053.

Are there any questions on any of these recommendations or their status?

ACTING CHAIR THOMADSEN: Yes. Dr. Van Decker.

MEMBER VAN DECKER: Yes, if I could. You know, I noticed on the agenda actually that there is not a little topic point for discussion of an update on the expanded Part 35 rulemaking, as far as what has gone on since the public meetings of last summer and our last meeting in September. Since a lot of these items are on that, can you just give us some concept of timeline of what has gone on in the last six months and where we see that playing out?

MS. COCKERHAM: Sure. Actually, Mike has a presentation on the agenda, and I believe -- I don't know if it states that it's a rulemaking update, but it is on permanent implant brachytherapy. I don't have an agenda in front of me. Is Mike on there?

MEMBER VAN DECKER: He is on for permanent implant brachytherapy, but not for Part 35 expanded.

MS. COCKERHAM: Mike, I can ask, are you going to cover that information for the Part 35 expanded rulemaking?

MR. FULLER: This is Mike Fuller. No, it is -- we probably won't cover that this time. The decision was made not to add the expanded Part 35 rulemaking to this particular agenda because, really, nothing has changed much since the last meeting that we had in September. In other words, we continue to

work through -- the working -- team is working. They are developing the preliminary rule text.

In other words, since the last meeting we haven't really tasked any milestones. So there really wasn't anything to update. We did ask that folks from our Rulemaking Division, you know, be here to answer questions throughout the course of the next day or so.

ACTING CHAIR THOMADSEN: Dr. Van Decker.

MEMBER VAN DECKER: So for an old man's memory, then, can you just remind me what your timeline for publication of a draft rule is?

MR. FULLER: These are estimates, of course, because we don't have that specified just yet in the form of, you know, formal direction from the Commission. But we are still anticipating a publication -- the publication of a draft -- I mean, of a proposed rule sometime either late this calendar year, anywhere until spring of next -- of 2013.

MEMBER VAN DECKER: Thank you, sir.

ACTING CHAIR THOMADSEN: Any other questions for Ms. Cockerham?

(No response.)

Seeing none, thank you very much for the update.

Our next presentation by Ms. Weil on

Fundamental Concepts in Patient Advocacy.

MEMBER WEIL: Thank you very much. I would like to talk about patient advocacy in general, health advocacy writ large, if you will, and to discuss for a moment my role on the ACMUI as a patient advocate. I am a non-technical non-scientific member of a technical committee, and my perspective, therefore, is unfettered by professional loyalties in the clinical realm.

And I am able perhaps to make use of my limited scientific knowledge to focus more clearly on the very zoomed-out public health issues of patient advocacy as well as the very zoomed-in patient perspective. So defining patient advocacy or health advocacy, which is the broader perspective, is often very difficult.

But one could say that a primary role is supporting individual patient choice, enabling autonomous decision-making, promoting patient and public safety, and increasing access to health services and the quality of those health services.

There are two sets of underpinnings for this particular perspective, and I would like to borrow from the tradition of the protections of human subjects in clinical research, specifically the

Belmont report, which was isolated -- which was drafted by the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research in 1979, because it -- in response to the Tuskegee syphilis study and the public outcry over the way people were treated in that particular study well into the 1970s, these three ethical principles were identified, which can be used much more broadly to define concepts of patient advocacy in the larger world of any medical encounter.

So the first principle is beneficence, which is a fairly straightforward idea of maximizing benefit and minimizing risk to patients.

The second principle of respect for persons identifies patients as autonomous beings with rights, preferences, and person-specific values, and the third principle of justice discusses equality in terms of sharing of the burdens and benefits of research in the Belmont perspective. But in the broader patient advocacy perspective, one could interpret this to talk about the justice and equality of access to health care services in general.

The second underpinning, the concept of rights, is a more legalistic form when we start to think as rights-only in the statutory sense. Statutory

rights are rights that are either legislated or codified and are enforceable by courts and law enforcement agencies.

There is a very strong tradition of grievance and redress, which supports these rights in a way that everyone understands. In the normative tradition, it is a much more flexible kind of rights. The rights represent the prevailing values in a society and are not necessarily enforceable. These are rights that are often characterized as what ought to be or what should be.

If we look at statutory rights again, an example would be the Emergency Medical Treatment and Active Labor Act, which was -- which prevents hospitals from dumping patients who have no ability to pay for emergency care. It relates only to emergency care, but it promises that every patient has the right to present to an emergency room and receive a medical evaluation and receive emergency care if needed, without any respect to the patient's ability to pay.

This was in response to a number of incidents where patients were refused admission to emergency departments and sent down the road to the local municipal or county hospital, or to the hospital where their insurer would pay for care. And there were

some deaths associated with that, including deaths to kids.

So in the normative tradition, we could look at this as an example of Rowe v. Wade. This is a statutory law that is being somewhat modified in the normative tradition by prevailing values of society. Rowe clearly stated that a woman has a right to terminate a pregnancy.

In the current discussions, this law is now being shifted a bit by local legislative and political activities to try to change that standing to match more clearly the values of local communities, states, and perhaps even of the federal law.

This third category, which I have called the Professional Codes of Ethics category, is really a category about implied rights. And I would like to cite as an example a professional Code of Ethics, the American Medical Association's Code of Medical Ethics, which puts out norms of behavior for clinicians and the implied rights that patients have based on those norms of professional behavior.

To be specific, I would like to talk about the AMA's code about -- that talks about medical errors. And I would like to quote, "Patients have a right to know when a medical error or unexpected

adverse event has occurred, whether or not the patient has actually been harmed."

So while patients have no statutory right to know of a medical error that has not caused substantial injury, clearly the AMA's Code of Ethics implies that because physicians have an ethical obligation to disclose, patients, therefore, have a right to know. And there are other examples of these kinds of professional norms that imply rights to patients, but they are not enforceable in any court.

If we go back to Belmont for a moment, the Belmont report identifies respect for persons as the underlying ethical principle behind patient autonomy. And there are enablers and there are barriers to autonomy, of course, and I would like to just give a few examples.

Some of the enablers of autonomy are full information from clinicians about treatment options, transparency about how those treatment options have been arrived at and chosen, and access to care. Barriers to autonomy would be geography and payment issues, and both of those play into that access sphere.

In rural areas, patients have very limited access to choice of provider or to perhaps centers of

excellence, because there are more limited numbers of health care providers in some areas.

Insurance issues certainly play into access. Decisions about treatment options are often made based on insurance coverage rather than patient choice.

And this last category as an example, provider bias, is something that isn't often cited as a barrier to autonomy, but it is clear that health care providers have biases about treatment. They have choices that they prefer; they have reasons for recommending certain things that sometimes aren't based in clinical decision, but, rather, based on personal bias.

And some of those bias issues involve gender and racial considerations. There has been enough in the literature that describes decision-making by clinicians that is based in gender or racial considerations rather than clinical considerations that it does have an impact on patient autonomy.

So there are issues before the ACMUI that have patient advocacy issues fairly firmly embedded in them. The first would be the permanent implant brachytherapy discussion about medical event definition.

Now, if we look at the American Medical Association's clear description of physician responsibility regarding disclosure of departures from the expected plan of care, then our medical event definition might leave patients not able to know that there has been a departure if the departure does not reach the level of medical event definition, whereas the AMA's Code of Ethics would suggest that perhaps the patient should have been told when there was a departure from what was the anticipated plan.

It is often stated that patients don't want to know, that they would prefer not to be told about what a clinician might consider a fairly insignificant departure. But there is good evidence among surveys of patients that patients do want to know, they do wish to be told, and it does affect their future medical decision-making.

So I would like to cite just a couple of surveys that have been done of patients. One is Witman in Archives of Internal Medicine who states -- and I am going to quote -- "Virtually all patients -- 98 percent -- desired some acknowledgement of even minor errors. Patients were significantly more likely to consider litigation if the physician did not disclose the error."

Witman goes on to describe the discrepancy in litigation as being 12 percent of patients who had a discussion about the medical error with their physician were likely to take their suit to court versus 20 percent who found out about the treatment error or the adverse event on their own.

Another study, Hobgood in Academic Emergency Medicine, said that a majority of respondents wish to be informed immediately of any medical error. And they talk about this being 76 percent. And of those 76 percent, 88 percent wanted to have full disclosure of the error's extent.

Now, med mal insurers know this well, and run training programs to assist physicians in learning how to disclose medical errors and adverse events effectively, honestly, and with some degree of apology, because they know that this is protective of the physician as opposed to being an unwelcome exposure.

And I would like to pose that physician reluctance is more likely driven by a misplaced fear of litigation and a lack of models in having these discussions, because it is certainly not something that is generally taught in medical school, or it may be self-deceptions about patients' actual preferences.

Another issue that is relevant in the field of patient advocacy that has come before the ACMUI is the release of patients following 131-iodine treatment. And the concern here is patient release instructions and whether or not patients understand them.

And while I would be the last person to suggest that patients are incapable of understanding instructions, the timing of those instructions is problematic in this situation, the degree of preparation that patients have, the confusing and often contradictory instructions that patients get from even within the same facility, the problems of non-English speakers or limited English speakers, all really conspire to give me a degree of concern about whether or not the current situation is allowing patients to follow these instructions in a way that protects the public and their families.

If we were to extrapolate from the situation with Emergency Department patients, who are equally stressed and anxious when they are discharged from the Emergency Department, we know from a study by Engel in Annals of Emergency Medicine that 78 percent of English-speaking patients -- and this doesn't even attempt to address the problem with non-English

speakers -- 78 percent of patients do not understand their discharge instructions.

So it is reasonable I think to assume that iodine-131 patients are equally challenged due to stress and complications, and all of those other things, to be able to follow those instructions adequately.

The CardioGen strontium/rubidium generator issue that we are going to discuss later I believe also raises an issue about disclosure. If the patients exposed do not reach the threshold for medical event, it is questionable whether they will be told that they have been exposed to a potentially damaging isotope inadvertently.

So these are the kinds of issues that are within the realm of patient advocacy that have become -- come before this Committee. And this is a list of references that I have cited.

Thank you very much for your attention.

ACTING CHAIR THOMADSEN: Thank you very much for your presentation. Questions or comments from the Committee?

MEMBER ZANZONICO: I have a question. It is sort of a general question. There is often issues in terms of communicating with patients where there is

controversy, if not out and out disagreement among themselves, regarding the level of hazard, if any. And this is certainly the case with respect to radiation controversy, like the linear non-threshold hypothesis, et cetera, et cetera.

How does one deal with that? In other words, how does one kind of candidly convey hazard or lack of hazard in the face of uncertainty or controversy among specialists in the field?

MEMBER WEIL: That's an interesting question, and you could zoom out a bit and look at regional variations of practice. Also, in that different recommendations will be made to patients depending on where they seek care, there are regional preferences, there are regional sets of beliefs, one could look at this as medicine in the normative tradition.

I don't know the answer to your question specifically. One says that medicine is an art rather than a science, and I suspect that there is some truth to that about radiation exposure as well, the way one interprets the modeling and the numbers. I really can't answer you, but it is a very interesting issue.

ACTING CHAIR THOMADSEN: Thank you. Any other questions? Dr. Welsh.

MEMBER WELSH: A couple of comments and questions. One, I am not sure I would agree with one of your statements, and correct me if I misunderstood what you said. But as far as disclosures and transparencies on your second-to-the-last slide, you mentioned that much of this is certainly not taught in medical school.

I'm not sure where that statement comes from, because as far as I know almost all medical school curricula in the United States do incorporate a good deal of ethical training in the curriculum now. And examples would be the courses called Patients, Ethics, and Society, and a variety of other names. But I would take issue with that particular statement.

MEMBER WEIL: Yes. And I probably wasn't clear about what I meant. What I was talking about was very few residents have an opportunity to witness an attending physician have a disclosure discussion with a patient in the hospital.

It is -- they just don't get the chance to witness it done well, and mostly that is because those discussions, if they happen, happen in a very private way with the physician and the patient, and rarely are residents invited into that process. At least that is my experience in my hospital career.

MEMBER WELSH: I would reply that that has not been my experience. And most of the time the residents are asked to witness these types of discussions, which may happen once or twice, fortunately, during a four-year residency training program, for example. But that has not been my personal observation.

That leads me to another question, which is, in order for a physician to demonstrate competence or capability in taking care of patients in his or her chosen specialty, they must go through required training and educational experience, residency program, medical school, et cetera, and then go on to take a rigorous board of -- board examination to become board-certified.

How does one become an adequate patient advocate? And the question comes up because I wonder how a patient advocate can truly assure that he or she represents and advocates on behalf of the patients and truly reflects those desires and opinions of the patients.

And in the patient release controversy that is before the ACMUI, we are hearing statements that patients want this, patients want that, but it becomes confusing as to how we can know that the

statements that I am reading about what patients want are truly correct. Can you enlighten us on this?

MEMBER WEIL: Well, the first rule of Advocacy in -- with a capital A, I mean, not just patient advocacy but advocacy -- when you are representing someone, you have to take yourself as much as possible out of the equation and attempt to represent what you hear from the -- your client or from the community that you are advocating for, and to try to actuate those desires separate from any personal bias that you might have.

Now, one only does that imperfectly, of course. But one has to attempt to do that in an impartial way.

I am not sure particularly which statements you are referring to, but I can tell you that when I talk about the iodine-131 patients I spent a long time talking to patients at the Thyroid Cancer Survivors Association's meeting in December, talking about their experience with patient release.

I have no personal experience there, so I am not talking about my own experiences. I am talking about what patients have told me.

And the best that I could answer that question is to say that I am simply a recipient of

information from patients and try to represent them in this Committee. Does that get to what you are at or --

MEMBER WELSH: It does. But it raises the larger question of how reliable a patient advocate's voice can truly represent the patient's opinions at large. And to go back to the controversy at hand with the I-131 patient release issue, we hear a lot of opinions, and we hear a lot of comments that these particular assertions that are made by one person or another reflect the thyroid patients at large.

And I am left scratching my head about whether or not I can really believe that, because to my knowledge, unlike what we are trying to do in medicine, which is move towards evidence-based medicine, scientific medicine, medicine that is based on sound scientific improvement principles, I am not sure that the same is done presently in patient advocacy.

And, therefore, when I hear that most patients would like to be kept in the hospital for their I-131 treatment, I wonder if what I am hearing is truly reflecting the majority opinion of patients, or if it might be the opinion of one or two advocates that may be advocates, maybe they're not correct advocates. It leaves me questioning the whole process.

I'm not sure how to solve this situation.

MEMBER WEIL: I don't think any patient advocate can presume to speak for all patients. Our job is simply to raise questions. And you're right, it's not a scientific process. It probably needs some testing in some kind of fact-gathering survey to determine what Patients -- with a capital P -- want. But I don't think that that would really solve anything.

I think one could safely say that patients want to safeguard the public from -- in this iodine-131 scenario from exposure to radiation. Whether that means they should be isolated in hospitals, whether they want to be isolated in hospitals, whether they simply want better instruction on how to protect people around them, these are all open questions.

And this advocate's role is to raise questions, not to prescribe for -- or to presume to speak for all patients. Patients are very able to speak for themselves.

ACTING CHAIR THOMADSEN: Thank you. Any other comments?

(No response.)

Thank you, Ms. Weil.

We are running a bit ahead of schedule.

Point of order, can we take up the next item, or do we break early for lunch?

MR. EINBERG: I would suggest we break for lunch early and take up the item after lunch, in case people -- members of the public want to listen in on these agenda items.

ACTING CHAIR THOMADSEN: Fine. So we stand adjourned until 1:30.

(Whereupon, at 11:43 a.m., the proceedings in the foregoing matter recessed for lunch.)

A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

(1:30 p.m.)

ACTING CHAIR THOMADSEN: I would like to call the Committee back to order after lunch.

The first item of business is the report of the Electronic Signatures Subcommittee, which I chaired. You have at Tab 5 the report.

The Subcommittee was charged to look into electronic signatures, and we found that there is already a federal policy on this, which you have in the report. And the government has had standards for electronic signatures since 1999. The policy follows international protocols and was written by NIST, and it approves the use of electronic signatures for documents using passwords or PINs or the types of digitized signatures, as you might find in the supermarket checkouts.

So we find that the Subcommittee was not really necessary, that there is a policy in the government for that, and that we just recommend that the NRC recognize electronic signatures as per the government policy.

I think at this point I would ask if there was a motion by the Committee to accept and endorse the Subcommittee's report.

MEMBER WELSH: So moved.

ACTING CHAIR THOMADSEN: We have -- Dr. Welsh has moved -- has made the motion. Do we have a --

MEMBER ZANZONICO: Second it.

ACTING CHAIR THOMADSEN: We have a second by Dr. Zanzonico. Discussion?

MR. EINBERG: Yes.

ACTING CHAIR THOMADSEN: Mr. Einberg.

MR. EINBERG: I'd like to thank the Subcommittee for looking at this issue, and this is something that, you know, we have been kind of struggling with for a while to make sure that when we do implement an electronic signature policy here at the agency that it doesn't have any kind of deleterious effect with licensees and it -- or licensees are already using electronic signatures.

So from that standpoint, did the Subcommittee find or look at whether this law would have any kind of negative impact on licensees, or what impact would this have if we were to adopt this kind of recommendation?

ACTING CHAIR THOMADSEN: In looking at this, it seemed there would be no deleterious effects, in that you don't have -- all this would be doing

would be saying that the NRC could accept from any user in any record an the electronic signature as were it a written signature.

MR. EINBERG: Okay. And then, because there are electronic signature systems out there. And just so I'm clear that, you know -- you know, that this -- they are already complying with this law.

ACTING CHAIR THOMADSEN: The policy -- the federal policy recognizes all of these softwares as being valid. But they go farther than that to acknowledge essentially any form of electronic signature over which the signer has control.

MR. EINBERG: I see. Okay.

ACTING CHAIR THOMADSEN: That's where the supermarket-type signatures apply, or if you have any other way of indicating your approval uniquely.

MR. EINBERG: Okay. So some of the things that we touched upon when the Subcommittee was formed were issues such as authentication, repudiation, data integrity, records retention and inspection. And so this law would address all of these various aspects.

ACTING CHAIR THOMADSEN: Yes.

MR. EINBERG: Okay.

ACTING CHAIR THOMADSEN: It does not address record retention. That does not seem to be --

MR. EINBERG: I guess we were looking at records inspection. We have a requirement to inspect hard copy records or be -- not necessarily hard copy, but to have records inspectable. And so from that standpoint we wanted to ensure that, you know, whatever we adopt is inspectable as well.

ACTING CHAIR THOMADSEN: Right. The electronic signatures would have to be maintained --

MR. EINBERG: Okay.

ACTING CHAIR THOMADSEN: -- as far as being able to pull them up if you were being inspected.

MR. EINBERG: Okay. May I turn to the staff and see if they have any questions?

ACTING CHAIR THOMADSEN: Please.

MR. EINBERG: From the medical team, are there any questions or --

(No response.)

There are no questions at this time.

ACTING CHAIR THOMADSEN: Fine. Dr. Welsh.

MEMBER WELSH: So since electronic signatures have been used regularly for several years in medical practice, they have to be compliant with certain rules, restrictions, regulations, JCAHO perhaps.

Wouldn't it be reasonable to propose that

if it is used and approved by JCAHO that it could be reviewed by NRC and, if deemed acceptable, adopted rather than have NRC try to create something new and independent that would, therefore, have to be reviewed to be assured that it is JCAHO-compliant as well? Wouldn't it be easier to go the other way around?

ACTING CHAIR THOMADSEN: Do you have any reason to think there is a discrepancy with the Joint Commission policy? I would guess that they are following NIST, which is the policy that we, as a Subcommittee, have -- are endorsing.

MEMBER WELSH: I think you're right.

ACTING CHAIR THOMADSEN: Dr. Langhorst.

MEMBER LANGHORST: I have a question for NRC. If -- when adopting this, is there a chance that NRC will accept electronic submissions for amendments and license renewals? Is that coming anytime soon?

ACTING CHAIR THOMADSEN: Mr. Einberg?

MR. EINBERG: I am not prepared to answer that right now, so --

MEMBER LANGHORST: That's okay. Just know I have the question --

MR. EINBERG: Okay.

MEMBER LANGHORST: -- as does --

MR. EINBERG: It has been discussed, but

there are no -- I am not prepared to give you a definitive answer on that.

ACTING CHAIR THOMADSEN: Any other questions or comments?

(No response.)

In that case, I will call the vote. All those in favor say aye.

(Chorus of ayes.)

Opposed, no.

(No response.)

And abstentions.

(No response.)

It is passed unanimously. Thank you very much.

Dr. Welsh, you're back up with the Medical Events Subcommittee Report.

MEMBER WELSH: Thank you, Mr. Chairman. Thanks for the opportunity to present the fiscal year 2010-2011 medical events summary.

Beginning with the 35.200 series, the diagnostic medical events, we see that there were a total of four found in the NMED database. One case was an I-123 treatment that was contaminated with I-131. An oral I-123 capsule was given, but imaging revealed peaks for both I-131 and I-123, and it was discovered

that the cap was contaminated with I-131.

A total of 380 rad to the thyroid of a child was estimated.

Another case was what is described as a technical medical event, because it was a very low dose, but it did exceed what was called for by more than 20 percent. It was actually just about 21 percent, and the discrepancy was on the order of 20 microcuries. Nonetheless, it meets the definition.

Another case was I-123 being intended. However, I-131 was administered. Five millicuries of I-131 was given instead of the I-123.

In another case, a more concerning case, an indium-111 octeotride scan was ordered, but strontium-89 was given. And this is a bit concerning, perplexing. Apparently, it is due to human error in which the strontium-90 vial, syringe was picked up and used instead of the octeotride scan. And a dose of 63 rem to the bone marrow was given.

Moving on to the 300 series, there are a total of nine medical events, but the asterisk there indicates that a couple of cases are in the gray zone because no written directive was prepared, because the intention was diagnostic. But therapeutic isotopes or doses were administered.

There were four I-131 medical events in this category, two samarium-153 EDTMP medical events. One case was due to use of a lead syringe, which is a bit ironic in that the lead syringe has been proposed to solve one problem but may have inadvertently caused a new problem.

I can tell you that it is difficult to use the lead syringes when administering this type of treatment because you can't really see as clearly as you might need to. All of these cases were perhaps due to human error.

How an I-131 administration could be given in the absence of written directive is unclear, but this did happen.

Moving on to the 400 series, manual brachytherapy. The good news is that there haven't been any manual afterloader medical events for quite some time now. The last ones were back in 2010.

Similarly, there were no strontium-90 eye application -- eye applicator brachytherapy medical events.

And the last vascular brachytherapy event was back in 2010, but very few of these are being performed nowadays.

Unfortunately, the same pattern is not

true for permanent implant brachytherapy. I don't know if we set any records this past year, but it is pretty close. Certainly, there is no difference -- major difference or major improvement in this particular area. There were 30 medical events involving 94 patients recorded -- reported during this particular period.

Importantly, 81 patients in 17 medical events were reported during this period but actually occurred more than six months prior to the period in question. And some of them were as far back as 2003, and this corroborates an assertion made by the ACMUI a while back. This was a pattern that was predictable.

As far as the specifics, isotope data was not available for all the patients, but at least 18 had used palladium-103. Thirty-four at least had I-125, and at least one patient involved cesium-131.

As expected, the most common cause of medical events during this timeframe was underdosing -- for example, D-90 less than 80 percent. And there were at least 39 cases in this category.

The second most frequent cause, as expected, was overdose based on D-90. There were at least 18 identified, meaning that at least 60 percent, and perhaps more, of the medical events in this

category were attributed to this dubious criterion of the use of D-90.

There was one I-125 normal tissue overdose due to an incorrect seed placement. There was one medical event using palladium that was -- that involved the wrong set of seeds. Two sets of seeds were ordered. The older set was implanted, even though it was for May 12, 2011, and the correct set should have been put in on June 10th.

Because this was more than a half-life difference, there was a slight -- a significant underdosing because of the 17-day half-life. This probably would have been more significant if it was cesium-131, and maybe less so if it was I-25. But, nonetheless, wrong seeds qualifies as a medical event of course.

Another medical event was reported involving an aborted procedure. And this one probably should not be a medical event, because upon my review of the situation the authorized user did absolutely the right thing.

The authorized user aborted the procedure after eight seeds were implanted, and the authorized user realized that the anatomy was going to preclude adequate placement of the lateral two columns of

seeds, and, therefore, called off the procedure, because of patient's anatomy. Nonetheless, it was described as an underdose-based medical event.

There was a case involving cesium-131. That was an overdose due to administration of a full treatment of 114 gray when the prescription called for a partial treatment of 85 gray. There was another case in which the wrong activity was administered. The seeds were ordered in air karma -- air kerma but delivered in millicuries. And another overdose was due to the wrong activity entered into the software. Millicuries were entered instead of air kerma.

These are examples of the -- what we call this morning standard or expected medical event definitions. And there are a few patients that fall into this category every so often. But it might be an opportunity for getting rid of this particular subtype of error once and for all.

ACMUI has previously recommended standardization of activity, and I think air kerma was recommended. I don't know if it would be possible to enforce that. It was just a recommendation by the ACMUI. Societies can recommend it, but suppose if a statement came from NRC. Practitioners would listen, and everybody would use the recommended units and this

type of error would go away.

There was an example of an underdose attributed to seeds that supposedly moved out of place. A procedure was done in October, but the medical event was identified almost six months later, March of the next year when the patient returned for a post-implant CT scan.

When we have intervals of this long, which are not advocated, these things can happen. And the question will always remain unanswered about whether or not the seeds truly moved or the patient's anatomy changed. Unfortunately, for this particular authorized user and medical facility, it is described as a medical event. But I personally am skeptical that seeds can truly move, but it underscores the concept of having scans done at the appropriate time for post-implant dosimetry.

Several licensees had medical events that involved more than one patient, and one stands out very obviously. Thirty-five patients, all from the same facility, were involved in medical events. Fourteen of these had no written directive, 20 of these had no post-implant dose recorded, and of these patients 17 didn't even have post-implant CT.

The authorized user was removed from the

license, the program was permanently suspended, and perhaps this was appropriate.

But at another facility there were two medical events that were identified during a review of 12 cases done in 2008. These were both underdoses using the D-90 criteria. And, not surprisingly, to quote the NMED report, "The NRC is reviewing this event and has not yet determined that it is a reportable medical event."

Nevertheless, in December of 2008, this facility permanently terminated its program, and the last procedure was done in December of 2008. One wonders, in contrast to the previous facility that shut down, which was appropriate, whether this was perhaps unnecessary.

Perhaps the most interesting thing that came from our annual review this year were retractions. Here is an example of a retracted overdose in which the facility conducted a comprehensive review of 44 procedures done since 2003.

This particular overdose involved a D-90 that was more than 20 percent of the prescription. But the overdose was retracted -- the medical event was retracted when a new post-implant dosimetry study, a post plan was generated which determined that the D-90

value no longer met the reportable criteria.

And this slide title should probably say "Underdoses," but it illustrates the same concept. Two medical events involving four patients that were based on calculated underdoses to the prostate that was believed to be due to prostate swelling. And these medical events were subsequently retracted after the team concluded that the pre-dose to the prostate was in fact within 20 percent of the prescription.

Here are some of the details, which I won't go into, from the NMED database, that led them to state that this was due to prostate swelling. Same thing with the other event -- due to prostate swelling. And this corroborates our point that we have been making for many years -- that there can be instances in which a calculated dose to the prostate would meet the definition of "medical event" and perhaps be a perfectly good implant in reality.

Up to this point, it has been largely hypothetical. So I think these particular events are important because they document for the first time what we have been saying for several years now. You can't have a definition that works on Monday but doesn't work on Tuesday. That is exactly what is going on here.

These so-called medical events were retracted upon repeat imaging, at a more appropriate time perhaps. Importantly, the D-90s in these cases were initially 44 percent. And that indicates to me that even our previous threshold of a D-90 of 60 percent might not really represent a true underdose if that D-90 is calculated during the adenomatous period.

And, therefore, my assertion that the use of D-90 in any form or fashion is perhaps not appropriate for regulation, and I feel stronger than ever about that assertion because of this data.

As far as Gamma Knife, there were two events, and this is where the NMED database becomes a little bit cumbersome. The Perfexion unit is Gamma Knife treatment. I include it here in the 600 series, although maybe it belongs in 1000.

A dose of 1,600 centigray was prescribed to multiple lesions, but there was erroneous labeling of one of the tumor sites resulting in delivery less than -- much less than what was prescribed. And the hospital suggested that Elekta make improvements to site identification. So this is an example involving the Perfexion unit.

There was another Gamma Knife medical event involving Model C malfunction. It was reported a

few months later. The patient was prescribed 2,000 centigray per lesion to 10 separate lesions. Following treatment of the third lesion, the couch failed. The physicist and the neurosurgeon entered the room and manually pulled the couch out of the unit. The physicist's badge read a dose of one millirem peak dose and two millirem superficial dose equivalent.

This one I am going to save for next year, because -- I apologize -- it is from the next year's reporting period. So at least we know we will have something to talk about next year.

Moving on to other events in the 600 series, appreciate Dr. Thomadsen for putting together this table. But you can see that it looks like 12 versus eight, but when you go down to the Gamma Knife we didn't include Gamma Knife in this particular table, because some Gamma Knife is in 1000, some is in 600. There were two events there, so the difference is really 12 versus eight, not very significant.

There were no frequently encountered problems. Two involved lung treatments. Both had problems with the dwell position identification. One patient -- one event involving two patients, involved the wrong length, one was the wrong transfer tube; two breast applicator problems; a lobe puncture and a SAVI

catheter split; and one case in which a treatment planning problem was encountered.

There was one event in the 600 LDR remote afterloading scenario -- a biliary treatment where the catheter shifted during treatment occurred. The patient only received 124 centigray of the intended prescription of 2000 centigray. And this was, again, a low dose rate remote afterloader procedure.

Moving on to the Part 1000, there are 11 in this category. Maybe one more for the Perfexion, three SIR-spheres, eight with the glass microspheres or TheraSpheres. Not very different from 2010, although there was a slight increase in the number of microsphere events in Part 1000 this time around.

In fact, in this table where we have LDR remote afterloader, there probably should be one there, which I included in the 600 section. And, similarly, one in the Perfexion, which I included with the Gamma Knife, which underscores some of the difficulties we have when using this NMED database because it is kind of cumbersome. We are used to reporting things in terms of the CFR, but that is not the way the NMED database is organized at present.

Three of the TheraSphere cases are described here. One was a misread prescription,

clearly human error; another involved the wrong artery, interventional team intentionally tried a different route; in another patient, there was stasis during the first fraction and pain during the second fraction, which caused the team to discontinue.

And since this is a patient-related phenomenon, one might argue that the authorized user and the team did the right thing by discontinuing the procedure. But it was deemed as a medical event.

Eight of the microsphere cases in this reporting period involved the glass microspheres. One was the wrong site due to duodenal shunting. Another was a wrong dose due to an error in ordering. Five were low doses due to technical problems, such as clumping, leaking, needle insertion into the vial, catheter problems. And one was another clear human error in which the wrong site was treated.

And I guess that is pretty much it. There might -- is that a gorilla? This is an 800-pound gorilla in the room that represents the strontium/rubidium generator situation. And rather than try to do it just here, we have a special session -- special set of sessions tomorrow which will address this particular topic.

So I will stop at this point.

ACTING CHAIR THOMADSEN: Thank you very much, Dr. Welsh. Do we have questions? Yes, Dr. Zanzonico.

MEMBER ZANZONICO: I am just a little confused. If you have -- on the slide with the permanent implant prostate brachytherapies, it says 30 medical events involving 94 patients. And then, 17 medical events, 81 patients.

MEMBER WELSH: Yes.

MEMBER ZANZONICO: What I'm misunderstanding apparently is it's like more patients than medical events.

MEMBER WELSH: Yes.

MEMBER ZANZONICO: So what exactly happened? I mean, I would have thought there would have been like a one-to-one correspond --

MEMBER WELSH: No. This is not uncommon. When an institution reports a medical event, that medical event could include multiple patients within that same event. It has got something to do with the reporting scheme or the definition.

MEMBER ZANZONICO: Okay.

MEMBER WELSH: And this is not at all uncommon.

MEMBER ZANZONICO: Okay. So that's --

ACTING CHAIR THOMADSEN: This is systemic.

MEMBER ZANZONICO: Okay. Okay. So it's not necessarily a patient by --

MEMBER WELSH: It is not. In some ways, it would be better if the number of medical events meant the number of patients, but this is the way it is right now.

MEMBER ZANZONICO: And so just another question. So with the proposed change in the definition of "medical event" from your Subcommittee, I gather that probably over half of those would not be medical events?

MEMBER WELSH: Perhaps more than 60 percent --

MEMBER ZANZONICO: Yeah.

MEMBER WELSH: -- because at least 60 percent of the events --

MEMBER ZANZONICO: Were based on the D-90.

MEMBER WELSH: -- were based on D-90. Now, that doesn't mean that if we used the more appropriate modern definition that there wouldn't be medical events in that subset, but the use of D-90 is probably capturing -- inappropriately capturing event -- cases that are not truly medical events.

MEMBER ZANZONICO: And one other question

if I may.

ACTING CHAIR THOMADSEN: Certainly.

MEMBER ZANZONICO: What was the logic of the agency in characterizing stopping the treatment in the case of the TheraSpheres when stasis occurred? I mean, that sounds like the exactly right thing that should have been done.

MEMBER WELSH: Yes. It would seem that in that particular case, because of stasis, you can stop the procedure or -- because of medical concerns, such as pain. The decision should be with the authorized user and the team to discontinue the procedure.

But I think Dr. Thomadsen might be more familiar with the specifics in this case, so I will ask --

ACTING CHAIR THOMADSEN: In the NMED database where I got the information, it didn't say anything more than the users said it should be withdrawn, but the agency said no. That's all I can tell you. There is no justification.

MEMBER ZANZONICO: It doesn't seem to make sense.

ACTING CHAIR THOMADSEN: Yes. Dr. Langhorst.

MEMBER LANGHORST: Yes. And was that NRC

regulated state or an Agreement State, or do you remember?

ACTING CHAIR THOMADSEN: It was an Agreement State.

MEMBER WELSH: I would agree that from the limited description that we have it probably shouldn't have been labeled as a medical event.

ACTING CHAIR THOMADSEN: Dr. Langhorst.

MEMBER LANGHORST: A question I have -- and I don't know that it is tracked in the NMED database, and I'm still trying to learn that system -- and it may be one that we might want to consider going forward on the microsphere medical events. It might be interesting to know if the authorized users are interventional radiologists or radiation oncologists.

I just -- that was a question that I had as far as, if we have any more, is it -- is there any correlation there. So I just raise the question; not expecting anyone to be able to answer that, but for --

MEMBER WELSH: I think that is a very good question that is presently not answered with the data that is in the NMED database as far as I can tell. But I think that question is important for the Y-90 microspheres as well as the I-131 thyroid treatments.

I would like to know how many events per

year might be due to radiation oncologists, nuclear medicine physicians versus endocrinologists, who, as I have stated in the past, in my opinion might not have the -- well, they do not have the same degree of training in the use of ionizing radiation as the other two professionals.

It would be very difficult to answer the overall question of appropriateness of non-radiation oncologist/non-nuclear medicine physician being appropriate for being authorized user from this database, because we don't always have the denominators.

But if we could have denominators and we could see trends over years, we could answer the question of whether or not an inordinate number of medical events can be attributed to those who have less training than those who have the detailed residency-focused training.

ACTING CHAIR THOMADSEN: I do think that it is an excellent question, and it is an issue that needs exploring. I can tell you that in the microsphere cases that there are none of those that would have anything to do with who the authorized user was.

Any other comments or questions? Mr.

Einberg.

MR. EINBERG: Dr. Howe pointed out that we do not have a requirement to report who the authorized user is, and, as such, that's why it is not tracked in the NMED database.

ACTING CHAIR THOMADSEN: Thank you. Any other comments? Yes, Dr. Van Decker.

MEMBER VAN DECKER: Just since Dr. W is our denominator person, you know, obviously, there is a lot of prostate brachytherapy programs that seem to have closed here, do you have any sense, from volume of denominator, what is going on with the denominator in that category right now? And then, as an adjunct, the denominator in the sphere therapy category, is that going up, one going down, as far as denominators go?

MEMBER WELSH: It's a good question. Unfortunately, I don't have the answer for you this year. We did have the denominators last year. It is not a trivial process to obtain them. It is fairly expensive, and we have elected to collect those denominators for a more comprehensive report every other year or every two years rather than annually.

But I can tell you that my distinct impression -- in the absence of proof, I must admit --

is that prostate brachytherapy continues to decrease sharply.

MEMBER ZANZONICO: Can I just follow up?

ACTING CHAIR THOMADSEN: Dr. Zanzonico.

MEMBER ZANZONICO: Is that a decrease in permanent implant brachy or to all sort of invasive or aggressive forms of treatment of prostate cancer?

MEMBER WELSH: It is probably more specific to prostate -- permanent prostate implant brachytherapy. There is an increase in the use of intensity-modulated radiation therapy. There are more proton therapy facilities available.

But I am not sure that prostatectomy has taken the same hit as permanent implant brachytherapy has. It may have; I just don't have the information. But I know that in the world of prostatectomy the use of robotic surgery has perhaps kept that process going strong, whereas a number of factors, perhaps in no small part the negative publicity of medical events, has caused a noticeable decline in the use of permanent implant brachytherapy for prostate cancer.

MEMBER ZANZONICO: So it is not related necessarily to this -- you know, this high profile controversy about the value of PSA and just aggressively treating prostate cancer as opposed to

watchful waiting and this kind of thing that is --

MEMBER WELSH: Not for this particular reporting period. In years to come --

MEMBER ZANZONICO: Right, it may.

MEMBER WELSH: -- there could be a sharp decrease overall, but I don't think for the periods that we are talking about presently.

ACTING CHAIR THOMADSEN: Dr. Suleiman.

MEMBER SULEIMAN: Yes. I think I will add to Dr. Zanzonico's question or answer. I think you are going to see dynamic changes, both with different alternative modalities for treatment, some of it being driven by evidence-based outcomes, some of it being driven by reimbursement rates, and a whole bunch of other factors.

So I think it is interesting to -- I mean, safety is one of them. So if the medical event criteria could be trusted to be consistent across all modalities, it would be a real good metric to see that, you know, this modality is safer than some other modality. But I think it is good, but I don't know why -- I think you are probably right about the IMRT displacing some of this.

ACTING CHAIR THOMADSEN: Thank you.

MEMBER WELSH: There is no doubt that there

are financial motivations for choosing one treatment over another or directing patients in one direction or another. But I think a fact that is supported by the literature that remains -- the fact remains that permanent implant brachytherapy is effective and, if done properly, is very safe and effective.

ACTING CHAIR THOMADSEN: Thank you, Dr. Welsh.

Now we have Mr. Fuller. Are you concerned that we are too far ahead of schedule? I see you looking at your watch.

MR. FULLER: Excuse me, Mr. Chair.

ACTING CHAIR THOMADSEN: Mr. Fuller will be talking about permanent implant brachytherapy.

MR. FULLER: Well, to answer your question, I was looking at my watch, and we are quite ahead -- a bit ahead of schedule. My only concern is is that sometimes people look at the agenda and they plan to join in at a particular time. And so if we get halfway through it, and so forth, I do concern myself with that. But --

ACTING CHAIR THOMADSEN: Would you prefer for us to take a break right now?

MR. FULLER: I will leave it entirely up to the Committee. It is just a sensitivity that we have,

but it --

ACTING CHAIR THOMADSEN: Right.

MR. FULLER: -- is your meeting.

ACTING CHAIR THOMADSEN: We understand. Is there a sense of the Committee? Shall we try to stay on schedule for those who may be calling into this? Is there an objection to taking a break now and resuming at 3:00, when we are supposed to take up this topic?

(No response.)

Hearing none, we stand adjourned until 3:00.

(Whereupon, the proceedings in the foregoing matter went off the record at 2:12 p.m. and went back on the record at 2:58 p.m.)

ACTING CHAIR THOMADSEN: Welcome back. And we will pick up with Mr. Fuller's presentation on the update on proposed changes related to permanent implant brachytherapy.

MR. FULLER: Thank you, Dr. Thomadsen. It is a pleasure to be here today to provide the ACMUI with an update on the proposed changes to 10 CFR Part 35 related to permanent implant brachytherapy.

The purpose of my presentation this afternoon is to provide the ACMUI with an update on the more recent developments related to staff's

proposed changes to the medical event definition for permanent implant brachytherapy.

I know that most of you are very familiar with the history associated with this issue but for some of you a brief history may be helpful. And for all of us, I think a bit of background should add some context to my presentation.

In 2005, the Commission directed the staff to develop a proposed rule to modify both the written directive requirements and the medical event reporting requirements to be activity-based instead of dose-based, as had been recommended by this committee.

In 2008, the Commission approved publication of a proposed rule to amend pertinent Part 35 sections involving permanent implant brachytherapy. However, during late summer and early fall of 2008, a substantial number of medical events involving permanent implant brachytherapy were reported to the NRC. Based on its evaluation of that information at the time, the staff believed that a number of these medical events would not have been categorized as medical events under the proposed rule. So in 2009, the Commission sought further advice from this committee and directed the staff to work with the ACMUI to provide recommendations to the commission on

regulatory changes for permanent implant brachytherapy programs.

In 2010, the Commission disapproved publishing a revised proposed rule and directed the staff again to work closely with the ACMUI and others from the broader medical and stakeholder community to develop revised medical event definitions that protect the interest of patients, allow physicians the flexibility to take actions that they deem medically necessary, while continuing to enable the Agency to detect failures in process, procedure and training, as well as any misapplication of byproduct material by authorized users.

Additionally, the Commission directed staff to hold a series of stakeholder workshops to discuss issues associated with the medical event definition, which was done last summer. I would note that these workshops that the NRC staff learned a great deal from the medical community about their needs related to the medical event definition.

On Tuesday February 7, 2012, the committee, the ACMUI, held a public teleconference and endorsed the ACMUI Permanent Implant Subcommittee report and provided NRC staff with recommendations for changes to the medical event definition for permanent

implant brachytherapy.

On April 5, 2012, NRC staff provided the Commission with the staff's recommendations for changes to the medical event definition. Those recommendations were in the form of a SECY paper, specifically SECY-12-0053. The paper was made public on April 10th, which was last Tuesday, and we provided to you the entire ACMUI on that same day. This presentation will focus on the recommendations that the ACMUI provided to the staff and whether staff differed from those recommendations in our paper to the Commission.

I should make it clear that my presentation is not intended to detail the staff's recommendations but rather to go over those recommendations that we received from the ACMUI. As I indicated in the previous slide, we only -- Our paper was only made public last Tuesday. And so in preparation for this presentation, there really wasn't enough time to even develop a presentation on the SECY paper itself. Next week, Dr. Ron Zelac will be making that specific presentation to the Commission. And it is probably appropriate that that presentation be made to the Commission as opposed to going over a great deal of detail at this point in time. And again, at

the time that we were putting together this presentation, while we were very hopeful that we would have the staff's paper public at this time, we had no guarantee and I would like to thank those who helped us make that happen. There were special accommodations made on the part of the Commission last week to get this paper out and make it public right away.

So again, I will be talking about primarily what we heard from the ACMUI and how we may have differed. But then since the paper is public now, when we get to the end of the presentation and the questions and answers, I will be happy to address any questions that folks have about the staff's paper.

So, the ACMUI recommendations for the target if greater than 20 percent of the sources fall outside the treatment site and as long as that is not resulting from patient-related causes such as edema or source migration after placement, the ACMUI recommended that this situation be defined as a medical event.

For normal tissue, there are two criteria. For neighboring structures such as the bladder or rectum and in prostate implants as an example, the dose to at least five contiguous cubic centimeters exceeds 150 percent of the dose prescribed to the

clinical target volume or the planing target volume or for intra-target structures. And again using the prostate as an example, the urethra in this case, the dose to at least five contiguous centimeters exceeds 150 percent of that structure's expected dose based upon the approved pre-implant dose distribution.

Other ACMUI recommendations for what would constitute a medical event involve using the wrong radionuclide, using the wrong activity or source strength as specified in the written directive, delivered to the wrong patient, delivered directly to the wrong site or body part with the exceptions of seed migration, edema and other patient-related factors or source displacement following placement, as long as the first criteria, a few slides back, is not violated. In other words, if less than 20 percent of the seeds are implanted outside the treatment site but at some distance from the treatment site, then a medical event has occurred.

I recall the discussion on this point when we were in Houston and I remember that there was quite a bit of consensus amongst the panelists that this situation should be considered an ME, a medical event, that is. However, I want to let folks know that I believe that the staff will have to be very careful to

ensure that the rule language is crafted in a manner that makes the requirement clear, concise, and unambiguous. And I say that because in the current rule when we think in terms of wrong treatment site, which is what I think we are really getting to here, there is a dose-based criteria associated with that. So I just want to let folks know that I see this as not insurmountable because we did include it in our recommendations, but it is going to take some care on the part of the staff as we develop rule language.

Another ACMUI recommended criteria for what would constitute a medical event is delivering, using the wrong modality and finally, I mean or using the leaking sources.

Another ACMUI recommendation was that the authorized user should provide a statement attesting that the implanted sources have been placed in accordance with the final plan distribution.

So, NRC staff recommendations. What did we do? The staff incorporated all of the ACMUI recommendations in the staff recommendations to the Commission with one exception and I will talk briefly about that exception.

One recommendation from the ACMUI's revised final report but not incorporated in staff's

recommended medical event criteria involves possible bunching of implanted radioactive seeds in the treatment site, instead of being distributed as the authorized user had planned before the start of the procedure. We recommended that NRC staff require that the authorized user affirm in writing on the written directive after the implant is completed that the distribution of the sources within the treatment site was as intended per the pre-implant written directive.

The staff contends that appropriate regulation for patient protection from undeclared or unrecognized bunching exists through two existing requirements and the authorizing user affirmation is unnecessary.

One of the existing requirements is the present 10 CFR 35.40 entitled "Written Directives" section that requires completion of the written directive after the implantation. This affords the authorized user an opportunity to acknowledge any seed bunching that may have been done intentionally or that may have been unavoidable.

The second existing requirement is in the present 10 CFR 35.41 "Procedures for Administrations Requiring a Written Directive." This section requires licensees to develop, implement, and maintain written

procedures that provide high confidence that, among other things, each administration is in accordance with the written directive and, if applicable, with the treatment plan. To accomplish this objective, these written procedures have to include conducting post-implant assessment of each implant procedure. Bunching that is not declared and explained in the preceding written directive would become apparent through this assessment and follow-up medical remediation could be considered.

Moreover, this paper includes a recommended medical event criteria involving observed dose to normal tissue structures. In order to evaluate the doses to normal tissues and structures, or at least to assess whether variances from expected results are significant, imaging to determine the positions and locations of the implanted sources is essential. Here also, bunching that is not declared and explained in the written directive would become apparent and follow-up medical remediation could be considered.

Okay, so what are the next steps? There are actually a couple that are missing on this slide. My apologies.

Okay, as I mentioned before, next week we

have a Commission meeting on April 24th where staff, NRC staff as well as two members of the ACMUI and other stakeholders will be addressing the Commission on this issue and discussing the staff's recommendations. After that meeting, and one of the main purposes of that meeting is to help the Commission prepare as they get ready to vote on staff's recommendation. So after that and hopefully fairly soon, we will be receiving the Commission votes. And then typically the way that works, is once they have all voted, then based upon what they say, we get what is called a Staff's Requirement Memorandum, or an SRM. And it is in that SRM that we will be given the direction on what to do next in the form of rulemaking.

Two more points I would like to -- two more things in the process that I somehow inadvertently left off of the slides that you see but are on my slides is shortly after we get the SRM we can begin developing what is called a regulatory basis. A regulatory basis is what our rulemakers need, the folks that are specialists when it comes to developing rules and new regulations. That regulatory basis will be developed by the NRC staff or staff from the medical team and then provided and once accepted

by the folks who do the rulemaking, then we can incorporate this into the expanded Part 35 rulemaking effort which is currently underway.

So then after that, we will have hopefully in a reasonable amount of time, a proposed rule. So again, our plan is and our hopes are that this will be incorporated by the end of the summer into the expanded, the ongoing expanded Part 35 rulemaking. I know we have discussed that a number of times in the past and that proposed rule should be out and again, we don't have a hard and fast date right now but our hopes are to have that late, at the very earliest, would be the very end of 2012. More likely, it would be sometime next spring, springtime of 2013.

That concludes my presentation. I am happy to answer any questions. As I indicated before, when we put this together with had great hopes that the permanent implant brachytherapy, that the staff's recommendations to the permanent implant brachytherapy program would be public and I have had people say that they are. But that was just last Tuesday.

ACTING CHAIR THOMADSEN: Any questions for Mr. Fuller? Yes, Ms. Weil?

MEMBER WEIL: Can you help me understand the imaging requirement, which isn't really a

requirement, I gather, but it is somehow implied in your slide number 11.

MR. FULLER: Yes, and let me go to our actual paper on this because I want to make sure that I get this just right.

One of the things that we did here, loud and clear from the workshops last summer, was a strong consensus that post-implant imaging should be a requirement. And so we have incorporated that. Let me see if I can find it exactly but we have incorporated that in our recommended changes to the Commission. So in fact if the Commission agrees that that should be a requirement, then that will be a new requirement.

MEMBER WEIL: And what is the nature of that imaging requirement timing-wise?

MR. FULLER: Well the timing is in our recommendations to the Commission would be within 60 days. So our understanding from what we heard during the workshops and from what we heard from this committee is that 30 days is, for the majority of cases, for I guess standard, if you will, for post-implant imaging and dosimetry. But we have also heard that there are exceptions and there are cases in which folks really can't get back exactly when they need to and so forth and so on.

So for our recommendations in the paper, we suggested a time frame of 60 days, which should give people ample time. And again, there are certainly situations where someone might not be able to get back at all and there should be or there are provisions in our recommendations as well for that.

But to get to your point and to answer your question directly, we believe that the requirement to have policies and procedures in place that provide high confidence that the procedure is conducted in accordance with the authorized user's written directive or intention, coupled with this new recommendation for post-implant imaging would provide the licensee with ample information and data to be able to make an assessment on this bunching issue.

ACTING CHAIR THOMADSEN: Dr. Zanzonico.

MEMBER ZANZONICO: So I have a question that is about the ME based on seeds implanted directly into the wrong site of the body. Now I think as you said on the slide, that would be first to sort of remote sites from the target site. So for neighboring sites or intratarget normal structures, that is accounted for by the dose-based criteria.

MR. FULLER: Right and we followed the ACMUI recommendation. In fact, both of these are ACMUI

recommendations.

MEMBER ZANZONICO: Right. So this, I guess it is 4D in one of your write-ups, this refers to seeds being implanted more remote than neighboring sites.

MR. FULLER: Yes.

MEMBER ZANZONICO: And it says, this again is a little picayune but it says seeds, plural. I mean, is there some regulatory specification of number of seeds or just any seed or seeds that wind up remote from the intended target?

MR. FULLER: Right, and when we were discussing this again, I think it was discussed briefly, very briefly in New York but it was actually a topic that got quite a bit of discussion in Houston where folks discussed the fact that any number of seeds. So I could have said seed or seeds that are implanted clearly as a mistake that that ought to constitute a medical event.

There was very, very strong agreement it seems, which actually surprised me a little bit. And when I went back over it again the next day and summarized everything, no one disagreed with me when I said this is what I thought I heard.

And so the way that we think of this and

the language that has been in and around the rule for a long, long time, although not in the current rule specifically like this, we refer to these instances or these cases as wrong treatment site, which is different than normal tissue normal structure, which is in close proximity. So, I really believe that we will be able to deal with that effectively but I just wanted to remind folks that in the past, wrong treatment site has a dose-based criterion associated with it and this recommendation did not. And again, not that we can't deal with that but I think what types of questions that I expect to receive as we work on this language is that how far is far. How far away is far away? How far away is distant? Those are the things that we are going to have to wrangle with. And again, I think we can be successful but I also think that we are going to have to be careful, that we do not write proposed rule language that ends up putting us in a situation where we now have an interpretation that was something that, you know, in other words, unintended consequences for things like this or things that I am concerned about and I think all of the medical team is a little concerned about at this point.

MEMBER ZANZONICO: Can I just follow-up?

Can I just ask a question for some of the brachy specialists on the committee?

And this is completely my own ignorance but what I picture in terms of seed implantation is a seed gun or some dispenser that is inserted into tissue. Is it always, is the tip of the gun, for lack of a better term, always inserted directly into the target tissue or do you sometimes have to traverse normal structures to get the intended point of deposition into the target structure or is the target structure always exposed?

ACTING CHAIR THOMADSEN: Dr. Welsh.

MEMBER WELSH: I'll take a stab at answering that question.

You would almost always traverse some normal tissue in order to get to your target in clinical practice. The only way around that would be with an intra-operative approach and intra-operative brachytherapy is a very different situation from what we are generally talking about here.

What we are generally talking about here alludes to primarily prostate brachytherapy. But the reason why this bullet point D is so critically important is because we have generalized beyond prostate brachytherapy. And I think the majority of us

feel that if your aim is to treat the left breast and you put a seed in the right breast, even if it is one seed, you have committed an error. And if your intention is to implant the prostate and you start implanting the lung, there is a major error, whether it is one seed or how many. So in that context, wrong site is a medical event irrespective of how many seeds have placed.

MEMBER ZANZONICO: I guess what I am trying to get at is, you know envisioning simple mindedly this insertion method. Is it possible someone could be too quick on the trigger, so to speak and inadvertently deposit or insert a seed along the path of the needle near but not in the intended site and should that not or not be an ME?

MEMBER WELSH: I think I can reply to that.

ACTING CHAIR THOMADSEN: Dr. Welsh.

MEMBER WELSH: That scenario that you are describing does not uncommonly occur. With prostate brachytherapy, for example, when we withdraw the MIC applicator, the seeds can be vacuumed back out of the area that they were originally correctly implanted into and, therefore, you can have this migration effect. But I think that is very different from being quick to jump the gun when you are in completely the

wrong organ. And if you are in the wrong organ, the wrong body site, there is no excuse for that. And that is why I think wrong site belongs here. But we do have to be careful when we are talking about seeds that have migrated into the perineum or into the bladder or have migrated through and wound up embolized in the lung, which does happen with prostate brachytherapy as an example. But those seeds were not directly placed in the wrong site.

MEMBER ZANZONICO: Okay. That was my concern.

ACTING CHAIR THOMADSEN: Dr. Langhorst.

MEMBER LANGHORST: The question that I have is on the attestation. And your point is that the current regulations allow the authorized user in that final completion of the written directive clarification on what actually was able to be implanted. Is that correct?

MR. FULLER: Again, that is a piece of it. I think what we tried to describe in our paper was that there are three things that in combination makes the need, in staff's estimation, the need for a written attestation unnecessary.

So it is not just the fact that there is an opportunity for the post-implant -- completion of

the written directive after implantation but before completion of the procedure, which we also have tried to clarify in the staff's recommendations.

But that coupled with the requirement that you have policies and procedures that provide high confidence and coupled with what we are recommending as a new requirement for post-implant imaging, that those three things together make the need for a written attestation to be unnecessary.

MEMBER LANGHORST: Okay, my question is on the completion of the written directive. If a physician authorized user cannot implant all the seeds that were planned as we had talked about in one of the medical events, is that still a medical event if the physician documents that they changed their mind or were unable to do that? Are you recognizing that that may not be a medical event? Is that -- I'm trying to get is that what you are allowing for here or am I stretching it too much?

MR. FULLER: I certainly don't want to try to get out ahead of where we might be directed. But the current recommendations from the staff really don't change any aspect of it very much. The only thing we did was clarify what was the completion of the procedure. I think you will still need to compare,

in general terms, what was intended and what did you achieve. And it is really that now.

And this is really where we get ourselves in a bit of a pickle, I guess, and it is always imperfect because you are going to have some situations where you simply did not successfully complete the procedure. There are going to be other cases -- and I mean for whatever reason it was unavoidable.

You are going to have other situations where mistakes were made. And so we have to have a rule that sort of accounts for that as well. So while our direction from the Commission was that we needed provide the medical or the authorized user or the medical professionals the flexibility that they need to be able to react to things that unforeseen. We have to provide -- We have to be accommodating to that situation.

What we want to avoid and what we will be working on when we actually develop the real language is that situation where someone simply didn't do what they really wanted to do, they recognize that they haven't and then they have changed the written directive to document what they did and not what they intended to do. And that is still something that we

are struggling with and we are hoping to get more clarification.

ACTING CHAIR THOMADSEN: Dr. Suleiman.

MEMBER SULEIMAN: I have two or three questions but one of them sort of tails with yours because I am still confused.

You go in, you have got 50 seeds, arbitrary number. You wind up implanting 40 of them. You think you have put them in very randomly, very uniformly, I mean and so I think this is an enough. I would like to stop there and recalculate the dose and figure maybe you need to go back and do a second procedure. Would that be a reportable event? Or they go in and they deviate and then they say we deviated from the written directive and this is why. Would that be a reportable medical event?

MR. FULLER: No, it shouldn't --

MEMBER SULEIMAN: Okay.

MR. FULLER: -- because again, the objective is to make sure that the dose that was delivered was what was intended, recognizing, especially in these types of manual procedures, that the medical practitioner has to have the flexibility to react to things that happen or that they find or they discover while they are in the middle of a

procedure.

MEMBER SULEIMAN: Okay now my other two much more black and white questions. Wrong site. Now there is a difference between left or right, wrong patient, and unintended migration from an adjacent site. One is, I think, within that gray area of uncertainty associated with the practice of medicine and the inherent precision or lack thereof. Another one is just a flat out mistake.

And the second question, which is kind of related to that, I think I know the answer which is why I am asking it. If somebody writes the written directive wrong, puts a decimal point, is off by a factor of ten but they go ahead and administer the written dose appropriately but they are off by a factor of ten, that is not a medical event. Correct?

MR. FULLER: That is always -- Yes, the way the rule is currently written is that if you make a mistake when you write the written directive and then you carry out the procedure in accordance with that written directive, it is not a medical event. That is true.

MEMBER SULEIMAN: That runs counter to the intent of all of this. I mean, if people make an honest mistake, they need to be able to fess up to it.

A patient's health may be --

MR. FULLER: Agreed. I think -- Well I don't want to speculate. Go ahead.

MEMBER LANGHORST: I'll speculate. Sue Langhorst. It is not correct but is that where NRC can regulate? I mean, that is, again, that is the practice of medicine and maybe that is how the physician wanted to make that written directive and it may be wrong in every other circle but NRC can't regulate everything medically.

And you are right, it is not the correct thing to do for the patient and it should be looked at in another round, but does it have to be in the NRC space? You have to define it in some way.

MEMBER SULEIMAN: Well, I don't care if the NRC doesn't regulate it as such. I would hope that somebody could assure me that that is covered by his professional practice or the hospital or something. But I would think, if nobody else is picking it up, then the NRC should pick it up.

I mean, writing a mistake that gives you -- and it is easy to do with our base ten system, you can be off by a factor of ten. And that does happen. That does get picked up periodically.

MR. FULLER: Yes, I mean I will say this

about that. We do, as a matter of policy, which all of these rules have to be in compliance with -- you know, our Commission has issued a statement on the medical use of radioactive material. And it is clear that when it comes to therapy that it is okay, if you will, or appropriate in accordance with the Commission to regulate the use of this. But we are limited in that our regulations should be such that they are to ensure that what the authorized user has written in their written directive is what the other folks that they work with comply with.

In other words, licensees have to have policies and procedures in place to ensure that what the written directive says is what is ultimately carried out. And so that is the way it is currently as a matter of policy.

So I don't know if that is entirely satisfactory but -- And again, this whole thing about the post-implant written directive completion and so forth and so on, you know again that is one of those situations which we have struggled with for many years because of the fact that we really need to be very -- We are treading a thin line there as far as getting over into regulating the practice of medicine and we have to be very careful.

ACTING CHAIR THOMADSEN: Any other questions? Dr. Welsh.

MEMBER WELSH: I don't want to belabor this point unnecessarily but I would just say that I think I disagree with Dr. Langhorst's assertion that this should not be NRC territory. Because when we are talking about written directives and deviations from the written directives, I can't think of anything else that would cover such controversies.

And in my opinion, like I said I don't want to get too far off the main point, if there is something wrong with the written directive, irrespective of whether the treatment was done in exact accordance with the mistake in the written directive or done differently, something is wrong and I would think that that should be of interest to NRC and perhaps qualifying as a medical event. But I don't think that that is the main gist of the topic here and I don't want to stray too far.

ACTING CHAIR THOMADSEN: Dr. Langhorst.

MEMBER LANGHORST: My point is that NRC cannot, I mean, it is not how the NRC regulations are written right now. So if it is in accordance with what the written directive said, that that is where NRC space is. If the written directive is wrong, NRC does

not have authority under its current regulations.

Now, granted it needs to be looked at because patient safety, correct medical procedures and so on. That still goes on in looking at what went wrong. And as an RSO, I look at those things because I consider it a near-miss and I would like to know what went wrong here and how we can make sure it is unlikely to happen again?

So my only point was NRC doesn't have that regulatory authority at this point in time. That is not to say that you should not look at the event and correct what went wrong.

ACTING CHAIR THOMADSEN: Dr. Welsh.

MEMBER WELSH: A quick response would be that I understand and I recognize the controversy and the problem but as we saw from our medical event report this morning there were occasions where the intention was to give partial treatment and full treatment is administered for prostate brachytherapy as the example and they were flagged as medical events.

So there is precedent for treatment that is delivered that is not what was intended being a medical event. And so logically it would make sense if what is written down is not what was intended,

particularly if it was followed, should be a medical event. It would seem illogical that if my intention was to give a partial treatment to the prostate because they are going to get external beam and I give a full treatment, it is a medical event, unless I have written that I -- If I have made two mistakes, it goes away but if I made one mistake it is labeled a medical event.

So there seems to be something inconsistent there that might be subject for a future discussion and examination.

ACTING CHAIR THOMADSEN: Thank you, Dr. Welsh. Any other comments? Yes, Dr. Suleiman.

MEMBER SULEIMAN: Yes, this is directed to Dr. Langhorst. So if the NRC doesn't look into it, who would catch that factor of ten error? Okay? If NRC can't get involved, who, which agency, which professional group, which institution will hold that individual responsible for making a factor of ten mistake?

I mean if that exists, then this is a moot argument but I want to know where is the assurance that the patient is going to get the right dose or if a mistake has occurred they uncover it? I mean, if you can answer that, then I will back off.

MEMBER LANGHORST: Well, I mean I can't tell you a federal agency who would be looking at that but in looking at review of patient charts and this looks like an error, then in my institution they would look at what went wrong in having a factor of ten mistake. And it may be that we find so that a medical physicist would know to question that perhaps in the future if it was greatly outside the norm. But I can't tell you a federal agency that would be looking at that or a regulatory agency that would be looking at that. It is how you look at errors in any medical practice.

ACTING CHAIR THOMADSEN: Dr. Guiberteau.

MEMBER GUIBERTEAU: I agree with Sue. I mean, I think there is no guarantee that even if you made this a regulation that it would be caught because physicians in practice are able to use drugs off-label at their discretion. They are able to use their judgment to apply, even if that is faulty judgment, the doses of drugs or radioactivity that they feel is appropriate. If they are in error, there are procedures in most institutions, well in fact all institutions that are accredited, in terms of peer review committees, departmental peer review committees. And almost every accredited organization

requires, you know, institution requires peer review which includes chart reviews. And there are also state medical boards that cover these issues if there are breaches that come up that cannot be cured at the local level.

You know, I think it is a difficult problem. And I do understand the concern. On the other hand, I don't think that the NRC's purview or intent is to tie the hands of those of us practicing medicine. And I would strongly agree with Sue that this is not an area that we need to get into.

I think that if there is overwhelming evidence about this, that it can be addressed through various professional societies and state organizations, if you feel it isn't strenuous enough. But I don't think we need to tie the hands of honest folks practicing medicine. A mistake is a mistake, not matter where it occurs. But on the other hand, it isn't a mistake, I think, in terms of the regulations. If it is not a mistake in terms of the regulations, I don't think that we should be involved.

ACTING CHAIR THOMADSEN: Dr. Welsh.

MEMBER WELSH: I didn't want to belabor this point but it seems like the subject is going on. I would have to strongly disagree with the statements

I have just heard. And the reason is that if we are talking about written directives, this is an NRC term. And I can tell from, maybe it is just my personal experience but when I talked about written directives to hospital administrators or even other physicians who are outside the specialties represented at this table, they are clueless. And therefore, I am not confident that when there is some discrepancy within the written directive, that anybody other than the NRC or the states would be able to step up and address this particular concern.

I am not as confident that other professional organizations or other entities within hospitals or advocacy groups are going to want to tackle questions relating to an NRC definition, which is the written directive. And outside of the NRC environment, written directive is a foreign concept to many medical practitioners and administrators.

MEMBER GUIBERTEAU: Dr. Guiberteau. As much as I understand that concern, I don't think it is grounds for the NRC to invade the practice of medicine and that is exactly what you are asking the NRC to do.

ACTING CHAIR THOMADSEN: Dr. Welsh.

MEMBER WELSH: Well I strongly disagree with that assertion because if a mistake is made, and

that is we are talking about, errors in the written directive, irrespective of whether the procedure is carried out in accordance to that erroneous written directive or not, a mistake has been made. And therefore, I don't think that it is NRC encroaching on medical practice if they say a mistake has been made using, in respect to our term, the written directive, and we are going to investigate. So I am not sure that this is really encroaching on the practice of medicine but I feel that this conversation is going, encroaching on territory that might not be relevant to Mr. Fuller's initial discussion.

ACTING CHAIR THOMADSEN: Dr. Suleiman.

MEMBER SULEIMAN: Yes, my intent here was just to calibrate. I thought that somebody who is off by a factor of ten was more dangerous than being off by misplacing the treatment field a little bit adjacent. And so I just want to be assured that somebody, people if they are going to be off by a factor of ten and there is no ramifications for that, then they may continue to not worry about it. So I think there has to be something to constrain such really wrong behavior.

Whereas, I think sometimes the imaging and the slight migration in my opinion may be over

regulation; whereas, I think in this case it is almost ignoring where it is very safety related. I think I just want to hear that there are other methods that are picked up that force the user to make sure that when they write something they are doing it correctly.

I mean, that is what the whole medical physics community is around, making sure you are documenting.

MEMBER GUIBERTEAU: Again, that is what peer review is for and that is what peer review is all about. For instance, if I review a chart that Dr. Welsh has treated a patient and I look at his written directive and say my goodness, I would have treated with one and a half times this dose, is that then a mistake? You know, if he did what he wrote on the written directive, then that is what he intended to do and what he did. Whether it agrees with my assessment of what he should have done is entirely different.

MEMBER SULEIMAN: Well I'm not saying difference of opinion. I am saying simple mathematical mistake, where somebody wrote down the wrong number.

MEMBER GUIBERTEAU: Well what if the same occurs on -- What if I write you a prescription for digitalis and I triple the dose by mistake? Who is responsible for that? It is a peer review issue if

there are issues with the patient's treatment.

ACTING CHAIR THOMADSEN: Dr. Welsh?

MEMBER WELSH: I will just quickly counter that. There is a fundamental difference between a prescription which we have in prostate brachytherapy as the example and the prescription for digitalis, as you were talking about, versus the written directive, which is an NRC term, and NRC-specific issues that only the Nuclear Regulatory Commission tells us what does and does not need a written directive. And therefore, I still feel that if there is a mistake in the written directive, it remains in NRC territory and it wouldn't be outside of their purview to address this question.

The prescription would be a different issue, however.

ACTING CHAIR THOMADSEN: There is also the problem that, to the best of my knowledge, I don't think there is 100 percent compliance with peer review for all cases.

Any other comments? Hearing none -- Oh, Dr. Van Decker.

MEMBER VAN DECKER: Well I have a tangential topic so I want to stop -- I think Dr. Guiberteau is trying to tell me his length in medicine

by picking digitalis as a medicine, the foxglove plant.

Before you leave and I know I touched this point this morning and I know that this is -- and I'm not looking for exact -- There is a lot of different things going on at the same time. And can I just talk timeline for a bit? Because I am starting to see how far this is going so we all have a sense of this.

So timeline-wise, stop me at any point in time that I am incorrect because I am from North Jersey.

You are essentially telling us that we are going to go into ten months of kind of quiet here. And during that ten months we are going to see an SRM clearly on the brachytherapy piece. And I assume you are intimating that we are going to see an SRM on the expanded Part 35 because they are coming back together to be looked at together down the line. And so therefore, that kind of has to happen before a draft proposed rule comes out next spring.

MR. FULLER: Yes, let me explain that. We have already sent the paper up over a year ago to the Commission and explained that our intention, we called it the Integrated Plan Paper and made a presentation here on that, where our intention was to include the

expanded Part 35 rulemaking is underway. A lot of preliminary rule techs has already been drafted and so forth. A lot of that, there has been a lot of work done on that. The intention is to fold this into that rulemaking and then they will work together from that point. We won't need two Staff Requirements Memoranda to make that happen.

We will get an SRM after this paper is discussed and so forth. We will develop a regulatory basis and part of that regulatory basis will be to, in accordance with what we have already described in the paper to the Commission to include in that expanded Part 35. So as long as our Division of Intergovernmental Liaison and Rulemaking accept that, then that is exactly what will happen. And we can't delay the rulemaking schedule from what we described a year or so ago.

MEMBER VAN DECKER: So then from ACMUI's perspective in October we will still kind of be in this silent building period and there may be some general discussion about the SRM but not much as far as final definitive stuff but some update.

MR. FULLER: Right.

MEMBER VAN DECKER: Then in the spring of 2013, which I will ask you to define for me as prior

to ACMUI or after ACMUI, there will be a -- I know.

MR. FULLER: I can tell you what our hopes are.

MEMBER VAN DECKER: Okay.

There will be a draft proposed rule which I guess most of us would be pushing to before ACMUI so that we are in the open commentary period and we have got open commentary period here with the public at that time. So that would probably be a good time for us. And then we will be in an official 90-day commentary period? Remind me again.

MR. FULLER: Well, I'm not exactly sure how long the comment period will be for, probably longer than 90 days. I will say this, is that ACMUI is in accordance with your internal procedures, you will see a draft proposed rule and have 90 days to provide staff your comments before it is published. And so there will be a published, again, the hopes, the objectives are that it be published early to mid-spring of 2013. It might be late spring. I mean, really can't hold me down on that because there is just a ton of work that is involved and a lot of coordination with various parties.

But one of those parties that according to procedure, because this is a rulemaking-related major

medical policy issue, you will get 90 days before it published to provide the staff with your comments.

MEMBER VAN DECKER: Okay.

MR. FULLER: And then once it goes into public comment period, once it is published it is public comment, probably 120 days.

MEMBER VAN DECKER: Okay. And so then the next step would be you would see final rule in fall of '13 before/after ACMUI at that point in time?

MR. FULLER: No. Our hopes are to have a final rule by the end of 2014.

MEMBER VAN DECKER: By the end of 2014. Okay and throughout this period of time OAS will be part of the discussion for Compatibility B pieces? Because here is the reminder of where we are trying to come to closure here. If you see December 2014 as final rule and then you have three years of OAS compatibility, you are talking about a final rule in December of 2017 for any of the stuff we are talking about right now, whatever minor decisions you want to make.

You know, so then my question becomes -- Here comes the crux of my question. So when you look at these medical events between 2014 and 2017, will we get a mixture of medical events on states that have

not yet transitioned using old medical event issues and NRC states using new medical event issues? And how will you track the percentage of states changing over that three-year period of time? And because I am getting older these days and I have teenagers, I wonder whether I will live to 2017 or whether they will live to 2017. It is even money right now.

(Laughter.)

MEMBER VAN DECKER: And not to be difficult, I am just trying to get a sense for where we are because you know, some of these issues over five years here or six years is going to be a lot of mixtures here and how we play into where the commentary periods they are between when they meet and what moves that along and what OAS does for three years. Because if you look at the state turnover when Revise 35 itself went through, it was not -- as a matter of fact, it 11th hour for the majority of states.

MEMBER BAILEY: That is probably more the norm than not.

MEMBER VAN DECKER: So if 38 states aren't going to go until 2017, then we at least have got a line on what we have as a mixture in-between and that was my only point.

MR. FULLER: Point well taken. It is not something that we have not thought about and considered and deal with all the time in rulemaking.

MS. FAIROBENT: Mr. Chairman, may I ask a question?

ACTING CHAIR THOMADSEN: Yes, a member of the public, please.

MS. FAIROBENT: Lynne Fairobent with American Association of Physicists in Medicine. Mike, just to clarify to follow-up on Dr. Van Decker's timeline, when you had said you anticipate a proposed rule at the end of this calendar year to sometime in the spring of 2013, is that a public proposed rule or is that the proposed rule for the 90-day review period for ACMUI and OAS?

MR. FULLER: According to our integrated plan, which we published back I guess about a year, year and a half ago, we hope to have a proposed rule published by initially we were saying the end of 2012 but in all reality we recognize now that we are probably talking a year or so from now.

MS. FAIROBENT: Okay. So in actuality what you are really saying is you hope to have a pre-decisional proposed rule for the Advisory Committee and the Agreement States to review at the end of this

calendar year, which would give them their 90 days until the spring, which could actually slip, depending on the extent of the comments received from the Advisory Committee and OAS.

So in actuality we could see a proposed rule not until the summer of 2013. So that even throws your timeline, Dr. Van Decker, out potentially longer.

I know it is all speculative.

MR. FULLER: It is very speculative at this point. I do know that there is a lot of pressure on the staff to move this along. And I don't know what else I can tell you.

MS. FAIROBENT: Okay.

MR. FULLER: There is a great deal of pressure on the staff to move this along as quickly as possible but we have lots and lots of different procedural requirements that we have as we go through the rulemaking process.

I wish I were a rulemaking expert and then I could maybe give you a little bit more. But it is a very deliberative process that we must follow.

MS. FAIROBENT: I just wanted to be sure because I don't think that there was a sense of the fact that the 90-day period for the pre-decisional review by the advisory committee in OAS would not

occur much before the end of this calendar year, if that. That is your earliest time frame, based on what you said this morning.

MR. FULLER: Yes, I mean like I said, we are going to get direction from the Commission and then we are going to ride the reg basis and once it is accepted by the Division of Intergovernmental Liaison and Rulemaking, then we can start drafting the rule language.

And so you just add that all up and you are into the fall. I mean --

MS. FAIROBENT: Okay, thanks.

MR. FULLER: Sure.

ACTING CHAIR THOMADSEN: And Dr. Welsh.

MEMBER WELSH: I might just say in closing here that I appreciate how much stress and pressure the staff has been under and I know that this has been a topic of conversation and heated debate since I was sitting over on that side of the room. And you can see from my position at this point that it is time for me to retire. But I can see that at this stage, staff has listened to recommendations from ACMUI from the stakeholders, from the conversations during workshop discussions, and there has been a tremendous amount of work that is clearly evident in this latest SECY paper

and that, from your presentation, the topic has been debated and considered since 2005 and may go on until 2017 or longer. But I applaud the staff for all the efforts that have been made and for the cooperation that I have encountered during these long periods of time since I have rotated to this present position. Thank you.

ACTING CHAIR THOMADSEN: Thank you very much. Any other comments? Hearing none, thank you very much Mr. Fuller.

MR. FULLER: Thank you.

ACTING CHAIR THOMADSEN: We now have Dr. Daibes talking on the status of the Commission paper on patient release.

DR. DAIBES: Hi. It is a pleasure to present here today to ACMUI the status of Commission paper on patient release. My name is Said Daibes.

Our purpose here today is to provide ACMUI with a status of completion of tasks provided to staff and the SRM-COMGBJ-11-0003, data collection regarding patient release.

I am going to provide you some background so you are familiar with some of the information that has been happening now for the last year or so.

The Commission back in 2011 summer

provided to the staff an SRM directing the staff to multiple tasks. The first one was to evaluate whether there are gaps in the available data on doses received by members of the public from release of patients treated with medical isotopes; and how the agency could go about collection additional data if needed, and that is, if indeed there were gaps identified; and a recommendation, as an alternative option, on the feasibility of revisiting the dose assessments used to support the 1997 patient release rulemaking. Those were three tasks identified from that SRM. And the SRM also asked for staff's recommended approach on the use of expert elicitation.

Based on the provided SRM and on the provided task, the staff went out and searched available technical published data and indeed gaps were identified in the available empirical data that was collected and the staff concluded the following.

Since the staff has concluded that there are gaps in the available empirical data regarding doses being received by members of the public as a result of release of patients treated with medical isotopes, these gaps in the available empirical data relate to the following. Internal doses to the members of the public from close physical contact with

patients or radioactive contamination from bodily fluids.

Number two, internal and external doses to members of the public from patients released to locations other than their primary residences. For example, houses, apartments, et cetera.

By identifying those gaps, staff concluded the following. They said in developing this recommendation regarding both the feasibility of collecting data for the identified gaps and whether the calculations and assumptions involved in determining whether a patient may be released should be reevaluated, the staff considered the following four options. And this was provided in a notation in both papers early this year to the Commission.

And the options are the following. And again, those options were based directly from the identified gaps in the data.

Option 1: Do not pursue any further research or data collection and do not revisit calculations and methods described in the NUREGs.

Option 2: Perform research or empirical data collection to fill identified gaps in the available data.

Option 3: As an alternative to collecting

empirical data, revisit calculations and methods described in the NUREGs' guidance for patient release.

And Option 4: Perform analytical and limited empirical research/data collection and revisit calculations and methods described in the NUREGs' guidance for patient release.

Upon the submission of that paper, we recently were informed by the Commission that votes were in and that an SRM was generated on April 9th directing staff to pursue Option 4, which is this option here on the screen. And it says the following in that SRM.

The Commission has approved Option 4, which would include revisiting calculations and methods described in Agency Guidance, as well as limited amount of analytical and empirical data collected from field measurements. As noted in Option 4, the staff should include informal discussions with experts in the field, as well as ACMUI as appropriate.

At this moment, that SRM is still in evaluation and staff is putting together a plan to pursue that data collection. At this moment that is where we are on the status of this paper. Is there any questions?

ACTING CHAIR THOMADSEN: Any questions from

the committee? Dr. Langhorst.

MEMBER LANGHORST: Is the data collection anticipated to be done only by NRC staff or would NRC request proposals for others to also do data collection?

DR. DAIBES: That is under evaluation right now.

MEMBER LANGHORST: Okay.

DR. DAIBES: So that will be something that we will need to get back to the committee with that information.

ACTING CHAIR THOMADSEN: Other questions or comments? Dr. Zanzonico.

MEMBER ZANZONICO: It is not so much a question as a comment. I think given the sentiments that this whole issue has raised, I mean it would be my recommendation, and I am speaking just for myself, not for the ACMUI, that this reevaluation with data collection would best be done through an external peer-reviewed vehicle such as a grant as opposed to an internal NRC effort.

I think the more transparent the effort is, the more satisfactory it would be to everyone concerned. And most likely, the more scientifically credible it would be as well. That is just a comment.

DR. DAIBES: Thank you.

ACTING CHAIR THOMADSEN: And can I ask a question to the NRC staff? And that is, is there a possibility that such a project could be funded for external evaluation?

MR. EINBERG: Currently, -- This is Chris Einberg. Currently the SRM directs us to gather a plan for collecting a set of data. In our internal budgeting process here we have provided the staff resources or we are planning on the staff resources and contract support for this. The Office of Research is responsible for putting this plan together. And so they are in the process of developing the plan for collection of the data.

So we will inform them of our conversations here today and the concerns and comments that we have received.

ACTING CHAIR THOMADSEN: Very fine. Thank you.

Other questions?

MR. EINBERG: Dr. Thomadsen, there was a member of the public who maybe on the line, may wish to make a public statement. But if not, that member of the public wanted his statement put into the record. So, I would request that with your permission that we

enter his written statement into the record and it will be part of the transcript that goes out.

ACTING CHAIR THOMADSEN: Please do so. And I know the members of the committee have received this, at least from discussions I have had, we have read it and are considering it.

MR. CRANE: I am the person who -- My name is Peter Crane. I am the person who filed that statement and I would appreciate the opportunity to deliver it orally.

ACTING CHAIR THOMADSEN: This has been read and is in the record. If you can, we can have just a few minutes, about three or four minutes, if you could highlight some points from that.

MR. CRANE: Very well. I guess I began by asking whether anyone was on the committee who would be comfortable with the idea of their own daughter without her knowledge cleaning the room and bathroom of a patient who had just received an outpatient dose of 200 millicuries of I-131. Is there anyone who would be content to have their daughter doing such work?

ACTING CHAIR THOMADSEN: I don't think that the committee is going to be dealing with the hypothetical question right now. Please hit the points.

MR. CRANE: Very well, I will continue. We know as a matter -- My concern about the paper was that it reflected that changes had been made at the instigation of the ACMUI, including deletion of the staff's intent to tell the commission that it did not have confidence that members of the public were not receiving more than five millisieverts of radiation. I think it is troubling that that was taken out.

It seems to me that there is a profound medical and moral issue that patients are being sent to hotels while radioactive, that these rooms are being cleaned by housekeepers who have no awareness that they are dealing with a contamination situation. I compared it to a situation in which I know that I have got a toxic and carcinogenic mess in my basement and instead of hiring people with hazmat suits I called the local maid service and have somebody come out because it is cheaper that way. And I don't see how that is distinguishable from the provider who sends a patient off to a hotel except that I get to see the person I am harming and the provider who sends a patient to a hotel doesn't have to.

The staff wanted to tell the Commission that I-131 can be transmitted by kissing and breastfeeding, which is perfectly true and everybody

knows it. And yet the ACMUI somehow told the, persuaded the staff that it was obligated not to say this because of the terms of the SRM, which I think makes no sense.

The AMCUI has talked about doses to hotel workers but it based it on an estimation of the amount that could be absorbed from bed sheets soaked with sweat, whereas we know that saliva is a thousand times hotter, radiologically speaking, than sweat. I think that this is a gaping hole. We know from *The ASCO Post* article that patients are being sent to hotels. We know from the staff's testimony that they have in fact, that there are doctors justifying sending patients to hotels, saying it is better to do that than have them drive home with a loved one.

But the basic principle is informed consent. If you drive home with your spouse and you are the patient, the spouse is getting some benefit and is given informed consent. But there is no informed consent for the hotel worker and informed consent is just basic to the way we operate, at least in this society.

The staff wanted to speak of -- Well I'm sorry, the point is sometimes made that the patient who gets under 30 millicuries and has an intact

thyroid, is getting this for hyperthyroidism, may be more of a radioactive hazard than somebody getting more than 30 millicuries but who is athyreotic. And that is true but what that calls for is for a thorough reexamination of the whole rule.

There are some valuable data points in the literature right now. Some of them to be found in the journal thyroid at the ATA, including an article by Beasley on release instructions for hyperthyroid patients who warn that small children may well receive exposure to radiation levels in excess of the limit of five milisieverts and he cites a study in which a three-year-old received 7.2 milisieverts. And bear in mind that our starting point on all of this is that our American standards, our NRC standards allow five milisieverts, whereas, the rest of the world thinks that one millisievert is the right limit.

And as you may know, in 2008 the staff rejected the idea of the one millisievert limit in a paper that never even made its way to the Commission.

So it seems to me that -- and in addition, if you look at the regulations of one state after another, it tells them based on --

ACTING CHAIR THOMADSEN: Can you wrap this up in another minute, please?

MR. CRANE: Yes. It tells us that they should look to a pamphlet put out by the Society of Nuclear Medicine in 1987. Well, that was the days of the 30 millicurie rule. Now that we have got people being sent home with 400 millicuries, it is simply not good enough to say well look at this old guidance and change the numbers particularly.

Appropriately, I mean Dr. Zanzonico did great work in NCRP 155 in developing new guidelines. But those ought to be the basis of guidelines that are sent out to the whole world. As it is, patients and licensees are getting guidance that is all over the map, very irregular. And if you read Dr. Kloos' article, it is not clear that this guidance is even being transmitted.

I'm sorry that this is somewhat less articulate than it would have been if I had been allowed to read my statement, but I think I have made the major points I want to and I am happy to respond to any questions anybody might have.

ACTING CHAIR THOMADSEN: Thank you very much. Comments from the committee? Dr. Zanzonico.

MEMBER ZANZONICO: Pat Zanzonico. Thank you, Mr. Crane, for your comments. Just several points of clarification.

The analysis on the dosimetry to hotel workers that was published in the ACMUI report actually was not limited to exposure from perspiration. In fact, it included conservative assumptions about the amount of activity excreted in urine into bed sheets, really unrealistically conservative assumptions. And with those, the projected doses to hotel workers, specifically housekeepers taking care of those rooms was well, well under 100 millirem.

The issue you raise about informed consent is well taken but it puts them under scenario that should people moving to Denver be given informed consent that they will receive annual doses of 100 millirem greater than individuals in the rest of the country. I think it is a matter of quantitation. Yes, the doses to hotel workers will be non-zero but they will be well under the projected doses, I should say the projected doses will be well under doses to other cohorts in the country from natural and other sources that probably do not receive informed consent. And again, I am thinking of individuals living in Denver and other parts of the country where there is higher cosmic radiation background, higher naturally occurring radioactivity in soil and so forth and so

on. So it really is a matter of scale.

One could, of course, go to one extreme and say anyone who gets any dose beyond a population average should be informed consent but it becomes really impractical. All one can and should do, I think is make the best technical judgment as to what projected doses are and even do it conservatively so. And then make a judgment whether those projected doses warrant or do not warrant informed consent. And I think that is what has been done up to this point in the case of radionuclide therapy patients who are released from hospitals.

ACTING CHAIR THOMADSEN: Thank you, very much Dr. Zanzonico.

MR. CRANE: If I could respond to that Dr. Zanzonico. First, BEIR VII says that the argument about Denver and background radiation is irrelevant and gives an explanation for that.

But as far as the bed sheets, it seems to me that the amount of urine that is going to be deposited in the bed sheet is trifling compared to the amount of urine that is going to be put into a toilet. And if you grant that urine is taken into account, why not count the toilet and why not count the sink? We know about saliva. We know also that a lot of common

household products cause radio iodine to volatilize, so people can be inhaling.

What is the reason for not taking into consideration toilets?

ACTING CHAIR THOMADSEN: Thank you very much, Mr. Crane but we are not going to have a debate on this right now.

MR. CRANE: And just one last point. Okay, suppose it is under 100 millirem --

ACTING CHAIR THOMADSEN: Mr. Crane?

MR. CRANE: -- for the hotel worker who does it once.

ACTING CHAIR THOMADSEN: Mr. Crane?

MR. CRANE: But suppose he does it ten times.

ACTING CHAIR THOMADSEN: Thank you very much for your comments, Mr. Crane. We are not having a debate on this issue right now. We are talking about getting more information in order to look into issues about this.

Other questions to Dr. Said Daibes about the proposals?

(No audible response.)

ACTING CHAIR THOMADSEN: Hearing none, thank you very much.

DR. DAIBES: Thank you.

ACTING CHAIR THOMADSEN: And Dr. Welsh, we are up to you again.

MEMBER WELSH: Thank you, Mr. Chairman. Thanks again for the opportunity to discuss matters before you today.

This will be a far less heavy subject than the one we just reviewed and is strictly for informational purposes. It is an interesting subject and I will keep it strictly at a qualitative level for this presentation today.

I have to thank my scientific colleagues who have worked with me on this particular presentation and subject and introduced me to this fascinating possible scientific observation.

We know that radioactivity supposedly decays with a very predictable exponential function. And from an educational website dealing with radioactivity, it specifically says that no operation, physical or chemical, has ever been shown to change the rate at which radionuclide decays and this statement in some form or fashion can be found in this book, *Radiations from Radioactive Substances* by these very well-known and respected authors, Rutherford, Chadwick, and Ellis.

But we do know that there are some exceptions. And the exceptions that come to mind immediately are those involving electron capture, where the chemistry can affect the half-life and the affect is relatively small on the order of 0.2 to maybe 0.8 percent in most cases. But to pick a more extreme example, beryllium-7 in hydrated form compared to beryllium oxide where it is covalently bonded to highly electronegative element that is going to be pulling its electrons away and therefore making the electron less accessible for electron capture, the difference in half-life is on the order of 1.5 percent.

Interestingly, isomeric transitions, including technetium-99m are another category of isotopes in which half-life changes can occur due to chemical environment. And in fact technetium-99m was the first metastable isotope that ever demonstrated observable half-life change due to the chemical environment. It is about 0.3 percent different in sodium or potassium protactinate in physiological saline versus technetium sulfide as an example.

But these are due to electron capture and isomeric transmissions where conversion electrons may be less available or covalently bonds and make

electron capture less possible.

But in contrast to those two examples of decay via electron capture and gamma versus internal conversion, there might be another exception to this general law. And recent studies have suggested decays of some isotopes might follow anomalous or demonstrate various variations that are unexpected. And these observations now raise the question of whether such variations could have clinical relevance that has previously been unrecognized in temporary brachytherapy, teletherapy and gamma knife radiosurgery.

So where did all this come from? It actually stems from my flight back from an ACMUI meeting in which I picked up a *Popular Science* magazine read it on the flight and it said that while looking for sources of random numbers, researchers found disagreement in measured decay rates, which is odd for something that is supposed to be a physical constant. Well, apparently they looked further into a collective data and came across further surprises, including long-term observations of decays of certain isotopes demonstrating small seasonal variations so that the decay was slower and slightly faster in the winter than in the summer. So radioactivity is

stronger in the winter.

So I thought this was scientifically fascinating but I was fully prepared to dump it until I came across some further information about a coronal mass ejection, which was basically a large solar flare in February of 2011 that meant more than just an attractive aurora borealis. It meant that certain radioisotopes will show a decrease in radioactive decay. I thought that truly is scientifically interesting from the perspective of someone involved in nuclear physics and nuclear medicine.

So I read on further and found another article that discussed the scientists at Purdue noticing the decay rate of an isotope that dropped during the solar flare and dropped actually before the solar flare did.

So it could be useful in an early warning of an impending solar storm. That could be relevant to astronaut health. But then I thought well that is very interesting because I am a health practitioner and this is interesting nuclear physics but the phrase medical isotope caught my attention. So I decided I must read a little bit more.

And the bottom line here where it says when doctors determine the proper dose of

radioactivity to treat a cancer patient, is what really hooked me. And when these popular scientific magazines mentioned this aspect, I decided it is time to go ahead and read the papers in greater detail.

So upon a more detailed examination, I learned that scientists evaluated databases that were required in a number of institutions and they found significant discrepancies in the measured decay rates. So rather than go into the details, I will just mention that there are a number of papers that show quite large discrepancies that were difficult to dismiss simply on the basis of errors in measurement. In fact, I think in this particular paper the bottom line in this abstract says that the seasonal differences of approximately 0.5 percent can be present between winter and summer months. So it is quite fascinating.

Then the team from Purdue went ahead and evaluated things in further depth and observed similar phenomena. The published literature provides support of this hypothesis and some of these graphs can be quite striking in terms of demonstrating a seasonable variability. This is demonstrating a periodicity with a timescale and thousands of days. And here is the paper that talked about that particular December 2006

solar flare.

A further study by these teams, indicated that the swings seemed to be in sync with the earth's elliptical orbit so that the decay rates oscillated as a function of distance from the sun. And looking at further data, they found an interesting recurring pattern over 33 days, which was surprising to them because the sun rotates with a period of 28 days and this was a little bit longer than that. But they astutely pointed out that the core spins at slightly different rate than the surface does. So this raises the possibility of neutrinos, solar neutrinos being to blame.

Well, that is hard to believe, given the cross-section of neutrinos as they interact with matter of any sort but it is amenable to investigation. A sphere should have a greater internal flux of neutrinos if radioactive, a radioactive sphere, than a radioactive foil sample. So the investigators decided to see if the half-life of a radionuclide depends on its shape. And this, if true, would be of great interest to medical physicists and radiation oncologists because the geometry of our sources, sealed sources varies widely.

Some members of the same team who proposed

this phenomenon, went on to test this particular hypothesis and they found that when comparing a sphere of gold 198 with a thin foil of gold-198 that despite the differences in neutrino flux, that there was really no significant difference in decay rate.

But this did not solve the problem because an inherent challenge with this particular experiment is that the neutrinos that were proposed to cause the phenomenon in the first place were solar neutrinos and they were different from the electron antineutrinos in the gold-198. We know that solar neutrinos which supposedly exhibit a flavor and mass state oscillation that accounts for the solar neutrino deficit might have a slightly different effect on radioactivity than electron antineutrinos. So that was a possible way around it.

But there are other more serious challenges to this hypothesis. One is where the observed variations in decay rate simply caused by changes in response of the experimental apparatus between summer and winter versus the isotope decaying themselves. So this was examined. And in this particular paper, the team evaluated this question in greater depth and concluded that it was quite unlikely that the observed differences could be attributed to

temperature or humidity changes or any other environmental changes in the detection systems.

Another criticism or challenge to the team came from radioisotope thermoelectric generator data. Radium-226 decays by alpha emission but it demonstrates an annual periodicity. So, does this phenomenon apply to alpha as well as beta? If true, Cooper should have been able to demonstrate a fluctuation in the power of output of the NASA Cassini satellite because that satellite which was launched in 1997 reached Saturn in 2004, approached as close as Venus and as far from the sun as Saturn, yet the plutonium-238, an alpha emitter with a half-life of 88 years did not show any seasonal variation for variability with proximity to the sun.

So the response to this was that plutonium-238 and radium-226 are both alpha emitters but radium-226 that was studied was in secular equilibrium. In about 200 years, a sample of radium-226 will have about 42 percent of its photon emission due to beta decaying daughter products and the ionization chamber is not going to discriminate where those photons are coming from. So, while radium 226 decays by alpha decay, the daughters which contribute significantly to what was being measured do decay by a

beta mechanism and these were perhaps demonstrating the annual cycle. But in contrast, the plutonium in the RTG was not in secular equilibrium and, therefore, no non-alpha emitting daughters were contributing to any meaningful degree and, therefore, the variation was not observed.

Well, another challenge was put forth and an experiment conducted by Norman and colleagues that calculated ratio between two different types of decay, beta and alpha, for example, and that would be expected to cancel out any changes in equipment between summer and winter. And it was assumed that if there was an annual variation, it would affect different decay processes differently and, therefore, the ratios would change but when looking at these particular sets of isotopes, there was no change annually.

The reply to this is that while americium-241 as an example decays primarily by alpha, it is possible that like the radium-226 example, its decay products which decay via beta mechanisms would be subject to the annual influence but a more important and legitimate point may be that different radionuclides are inherently different.

And in beta decay, some may show this

variability, others may not. And if one looks further into this subject, you will see that although electron capture half-lives, isotopes which decay via electron capture in some cases showed variability as a function of chemical state but others do not. Beryllium-7 as I mentioned in the early slides demonstrates such a change in half-life, if it is electrons are bonded, whereas potassium-40 seems less susceptible to this particular type of phenomenon. So it is reasonable to assume that the same thing would be true for beta decay susceptible to this particular type of variability.

So in summary here, anomalous variations have been characterized by strong annual periodicities, as well as short duration deviations. And it is the short duration deviations from the apparent decay rate that persists for hours or days that could be of significant concern to radiation oncology.

The annual periodicity has been observed in 14 radionuclides thus far, including this set of isotopes that are used in radiation oncology. But the annual oscillation amplitude varies from nuclide to nuclide and is typically less than 0.5 percent and would never be of clinical relevance. On the other

hand, the short duration deviations which have been observed only in a small number of radionuclides thus far but including cobalt-60, strontium/yttrium-90 and radium-226 could have more important clinical ramifications. Preliminary analysis of these short duration deviations suggests changes in apparent half-life that can persist for up to two days at a time. And therefore, this could affect HDR or Gamma Knife efficacy if delivered during this window.

It remains unknown whether such short duration decay rate variations exist in other commonly used medical isotopes like the ones listed here. And it also remains uncertain whether short duration variability if it does exist in these isotopes results in any clinically relevant dosimetric changes. But preliminary investigations show flat regions in the decay curve. Flat regions are called short duration deviations that can be as significant as 600 percent in terms of a change in apparent half-life and that can last as long as two decades.

So if the treatment happened to be given during a period where the half-life differed by as much as 600 percent, one could anticipate that the dosimetry could indeed be affected.

And of interest, some of the raw data that

was used in coming to these conclusions was acquired during calibration sequences and precision measurements or in establishing references. These are procedures that are quite commonly done by medical physicists and very familiar to medical physicists. Therefore, additional investigations could include not just analysis of archived data but careful evaluation of existing calibration data from gamma knife units, from HDR units, from active clinics that are sampling at frequencies that might be sufficient to detect any such rate variations.

So at this point, I will stop the discussion, aside from showing some of these slides from some of the papers that have been published. You can see that the variability here, which is kind of odd, is plotted out in other studies and analyses and in some cases, it can be very striking. And here is the data from that 2006 solar flare. You can see the count rate dropping right before the flare, which opens up the subject of this so-called helioradiology, where you could use this type of information to determine if a solar flare which could be of health significance to astronauts is on its way.

And here you can see differences in the calculated half-lives during these flat periods where

in one situation the calculated half-life might be estimated at several-fold the calculations in other areas of the curve.

So I will stop it at this point.

ACTING CHAIR THOMADSEN: Thank you very much, Dr. Welsh. Comments or questions for Dr. Welsh? Dr. Zanzonico.

MEMBER ZANZONICO: Well Dr. Welsh, you elevated the nerdiness of this committee.

(Laughter.)

MEMBER ZANZONICO: And the question I have, you would think if this is related to a solar flare phenomena there would be a geographic effect as well. In other words, the magnitude of these effects would differ in different parts of the earth. Is there any evidence of that? In other words, closer to the North or South -- North Pole in particular, a more pronounced effect than near the equator?

MEMBER WELSH: Thus far, no. And it is being investigated but if it were neutrino-based, you might not expect to see such a variation. These neutrinos can go through the entire planet quite readily. But if it is neutrino-based it is hard to understand how it possibly could make sense because the cross-sections are just so minuscule.

It is subject of investigation and thus far there is no clear answer to your question but there have been proposed new particles, things called nutellas, I think, that I will refrain from discussing in any depth here. But there is no shortage of interesting proposed mechanisms but more data is required.

ACTING CHAIR THOMADSEN: Any other questions or comments? Yes, Dr. Weil?

MEMBER WEIL: No.

ACTING CHAIR THOMADSEN: In that case, any last words from the staff for today?

MR. EINBERG: Yes, thank you Dr. Welsh for the presentation.

I would ask the committee to be sure to check their calendars for upcoming meetings and go to Tab 14. Tomorrow we will be discussing the next ACMUI meeting. So be prepared to look at your calendars and see if you have any conflicts. So let's just serve it as a reminder.

And I thank the committee for all the interesting presentations and discussion today. And we will reconvene tomorrow morning at eight o'clock.

ACTING CHAIR THOMADSEN: We stand adjourned.

(Whereupon, at 4:46 p.m., the foregoing meeting was adjourned to reconvene on Tuesday, April 17, 2012 at 8:00 a.m.)

Peter Crane / 6545 27th Avenue NW / Seattle, WA 98117 / 206-783-8485 / kinderhook46@yahoo.com

STATEMENT OF PETER CRANE
NRC Counsel for Special Projects (retired)
Submitted to the
ADVISORY COMMITTEE ON THE MEDICAL USES OF ISOTOPES
Meeting of April 16-17, 2012
Submission filed April 9, 2012

I appreciate the opportunity to submit a statement to the Committee. I am including in it a memorandum that I submitted to the Commissioners on March 21, 2012. I wish here to emphasize just a few points.

1. Hotel workers

First, I would ask the Committee members whether any of them would be agreeable to the idea that a daughter or granddaughter of theirs, working as a housekeeper in a hotel near a cancer center, was unwittingly cleaning the rooms and bathrooms of persons who had just received doses of 200 millicuries of I-131 as outpatients. Suppose she was pregnant or nursing. Is there anyone among the Committee who would be comfortable with that prospect?

Unless I hear a chorus of yeses, I will conclude that there is no one on the Committee who would be comfortable with that – and rightly so. You would be horrified, of course. And yet we know that this is happening every day, to hotel workers who have no clue that they are being exposed, have given no informed consent, have no way to protect themselves, can't decide to quit rather than accept such risks to themselves or their child, and so on. The doctor who tells the NRC staff without embarrassment that he sends five percent of his I-131 patients to hotels, the *ASCO Post* article in which doctors defend the practice – this is reality, not fiction.

Can anyone deny that this is a moral issue as well as a medical one? To deem one class of workers essentially expendable, for the sole reason that to reveal the hazard, and protect against it properly, would be economically disadvantageous to medical providers and insurance companies?

In my memo to the Commissioners, I said that if I had a toxic and carcinogenic contamination in

my basement, and instead of having the job done at high cost by professionals in hazmat suits, I called a maid service, and had some young woman clean it up, without telling her about the presence of toxic substances, you would call me heartless and immoral, and you would be absolutely right. How is this different, except that I would see the face of the person I was harming, and the doctor who sends a highly radioactive patient to a hotel never has to?

The principle of informed consent is basic. It is not optional. It cannot be dispensed with or applied selectively in the interest of some perceived greater good.

I realize that the subcommittee, in 2010, calculated the dose to hotel workers from contact with the sheets of an I-131 patient and found that it was below 100 millirems, or one millisievert. There are two problems with that, one of which the staff pointed out: that we have no idea how many such rooms a hotel housekeeper may clean in a year, if the hotel is associated with or near a big cancer center. The second is that saliva and urine are far more radioactive than sweat – saliva, in fact, is 1000 times hotter than sweat – so the real test is not the contamination dose received from the used sheets, but from the sinks where patients brush their teeth and the toilets where they urinate.

2. Informing the Commission

The staff wanted to tell the Commission, in this staff paper, that "it is not known whether members of the public are, in fact, receiving doses that are less than 5 mSv from the released patients." This statement was removed from the paper at the insistence of the Committee, which argued, speciously in my view, that the Commission's SRM prohibited it from saying this. Note that the Committee wasn't saying that this statement was inaccurate; rather, it was arguing that the staff was not permitted to say this to the Commission.

Likewise, the staff wanted to tell the Commission that I-131 can be transmitted by kissing and breastfeeding. Of course it can. Everyone in the field knows this. The International Commission on Radiation Protection issued a long report on this subject in 2004, ICRP 94. The NRC issued a Regulatory Issue Summary four years ago for the sole purpose of telling medical licensees about ICRP 94 and warning them of the danger to small children from radioactive patients, especially from kissing. So this is not a secret from the medical community or the patient community. Should the Commissioners be the only ones left in the dark? Yet the Committee claimed that the SRM barred the staff from revealing this to the Commission, and regrettably, the staff gave in and deleted the sentence in question.

I do not agree that the SRM was a gag order prohibiting the staff from informing the Commission about risks to the public from NRC-licensed activities. I respectfully suggest that the reason for the ACMUI's existence is to make sure that the Commission receives important information relevant to its regulatory responsibilities over medical isotopes. Here, unfortunately, it seems that the Committee's concern was to **prevent** such information from reaching the Commission.

3. Turning the clock back on internal dose

The staff paper says that the staff has determined that it "may be beneficial to re-examine one of the assumptions in NUREGs-1492 and 1556 guidance which underlies current release practices, specifically that internal dose to members of the public is negligible compared with external dose." This remarkable statement plainly implies that this assumption about internal dose is still operative and valid. It isn't, and it hasn't been since 2008. In that year, the NRC issued a Regulatory Issue Summary making clear that the current rule reflects an erroneous underestimation of the danger of internal dose to small children. It is too late for the agency to turn the clock back and retreat from that position. The Committee owes it to the staff and to the Commission to say loud and clear that with respect to small children, internal dose from contamination is not a negligible danger, but a clear and present one.

"The significance of a patient as an external source of radiation exposure is illustrated by the fact that if patients … had been 'packages,' seeking transport as air cargo, most of them would have been refused passage even though consigned to the cargo compartment. Yet as 'passengers' any of them could have sat next to other persons in the passenger section. … The quantity of radioiodine discharged in body wastes treated at a major medical center can substantially exceed that released from a large commercial nuclear power plant. … A person who is treated on an outpatient basis can become an avenue of transport for radionuclides through contamination within the home and through person-to-person contact."

That's not me talking. That is the late Dr. Dade Moeller, who for more than 20 years was a member of the Advisory Committee on Reactor Safeguards and the Advisory Committee on Nuclear Waste. He was writing in 1978, in the American Journal of Public Health (AJPH). He was also Chairman of the Department of Environmental Health Sciences at the Harvard School of Public Health. His co-author, Dr. Jacob Shapiro, was a radiation protection officer at Harvard University. What is more, they were writing in the days of the 30 millicurie rule, before the radical deregulation of 1997. They were responding in part to a study by Jacobson, Plato, and Toeroek, published in the same March 1978 issue of the AJPH, which found significant internal doses to young children of thyroid patients given I-131: 612 millirems in a three-year-old, 1330

millirems to a child of four months.

I would draw the Committee's attention to a number of useful articles that have appeared in recent issues of *Thyroid*, the journal of the American Thyroid Association. These include an article by Rémy et al., "Thyroid Cancer Patients Treated with 131I: Radiation Dose to Relatives After Discharge from the Hospital" (January 2012), and "Release Instructions for Hyperthyroid Patients Treated with I-131" (October 2011), by Beasley, et al. The latter article, responding to the American Thyroid Association study of Sisson et al. (2011), warns that "small children may well receive exposure to radiation levels in excess of the limit of 5 mSv." He cites a study in which a one-year-old was found to have received 3.3 mSv, and a three-year-old received 7.2 mSv.

Is that point clear? It is not just adults who may be receiving more than the dose limit of 5 mSv, it is small children.

4. Conclusion

The 5 mSv (500 millirem) standard found in the NRC's rule is itself an anachronism, rejected by the world community. I know of no country in the world, other than the United States, where today, children can legally get radiation doses of 5 mSv, a level five times the limit recommended by the International Commission on Radiation Protection and the National Commission on Radiation Protection. Surely that alone should be a firebell in the night to the Commission, alerting it to the grave inadequacy of its regulations.

Sadly, if this Committee had its way, the child of a patient who received one I-131 dose in March and another in October could legally get 10 mSv in that year, since limits would be on a per-release, rather than a per-year basis. (I offer that example because it is drawn from real life: 22 years ago, when I had two 150-millicurie treatments with I-131, my children were 4 and 6.) Fortunately, the NRC staff has not bought this ill-advised proposal.

The argument is sometimes made that a return to the 30-millicurie rule – as I initially proposed in my petition for rulemaking in 2005 – would fail to take account of the fact that a hyperthyroid patient given 15 millicuries may, because of the longer retention of I-131 in an intact thyroid, be more of a radiation hazard than the athyreotic (that is, lacking a thyroid) cancer patient given many times as much I-131. I concede that. But that is hardly a valid basis for maintaining the status quo; rather, it argues for revising the rules in such a way that family members and the public are protected from both the cancer patient **and** the hyperthyroid patient treated with I-131.

Dr. Pat Zanzonico of this Committee did yeoman work in NCRP 155 in coming up with separate sets of instructions for hyperthyroid patients and cancer patients. (Using them, incidentally, would make it impossible to send patients to hotels, since the instructions include the separate laundering of patients' linens.) Why isn't that the basis of NRC guidance, to be made available to every licensee, for transmission to every patient? Today there is a patchwork of overlapping and conflicting guidance. Patients today are confused, because there is no central source of guidance, and what they are told is all over the map, as is obvious to anyone who follows the websites on which they communicate. And what are licensees told? If you look, for example, at the regulations of the state of Wisconsin, you see that they tell licensees to use guidance that was prepared in 1987 by the late (and greatly lamented) Dr. David V. Becker. Excellent in its time, that guidance was developed in the era of the 30 millicurie rule, and it is obsolete today, when patients are often given 200 millicuries or more as outpatients. To tell licensees that they should use this dated guidance, and just adapt it to present conditions by changing the relevant numbers, is very little help.

The Commission needs to face up to the fact that its rules badly need revision, in part owing to circumstances that were not foreseen when the rules were changed in 1997. This Committee, rather than trying to screen the Commission from the facts, should be helping it to learn, understand, and come to grips with them.

Thank you.

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March 21, 2012

MEMORANDUM FOR: Chairman Jaczko
Commissioner Svinicki
Commissioner Apostolakis
Commissioner Magwood
Commissioner Ostendorff

FROM: Peter Crane
Counsel for Special Projects (retired)

SUBJECT: SECY-12-0011, "Data Collection Regarding Patient Release"

Since this memorandum from the staff to the Commission has been posted on the NRC website and is a public document, I am offering some comments on it. I would have done so sooner, but I only recently became aware of its existence.

The first thing to say about it is that it represents a creditable effort on the part of the staff to come to grips with a difficult, contentious, and neglected issue: namely, radiation doses to the public and family members from thyroid patients treated with radioactive iodine 131 and then released with high doses of the isotope in their systems. The staff rightly acknowledges that there are gaps in its knowledge about (a) the internal doses to others from released patients generally, and (b) the internal and external doses to others from patients who go to locations other than their homes, such as hotels. It therefore proposes ways of obtaining such information.

The paper is not without shortcomings, however. Some result from revisions made at the urging of the Advisory Committee on the Medical Uses of Isotopes. Almost without exception, those changes are in the wrong direction: rather than clarifying the present situation, they tend to obscure and confuse it. This is hardly surprising, given that the ACMUI's position, as stated in its October 2010 report to the Commission, is that the status quo on patient release is perfectly satisfactory as is and should be left unchanged.

Specific comments follow.

1. Disregard for Internal Dose

The paper says, at page 3-4:

> The staff determined it may be beneficial to re-examine one of the assumptions in NUREGs-1492 and 1556 guidance which underlies current release practices, specifically that internal dose to members of the public is negligible compared with external dose. This re-examination may be warranted because current release practices permit patients to be released with much higher activity than was the case when this assumption was made in promulgating the patient release rule. Accounting for internal dose is particularly important in the case of children and women.

The statement that "current release practices permit patients to be released with much higher activity, etc." is certainly accurate: patients **are** released with vastly more I-131 in their systems

than was possible before the current rule was put in place in 1997. But that does not mean, as the sentence might be taken to mean, that the risk of internal exposure is entirely new information, unavailable in 1997. On the contrary, the assumption in 1997 that internal dose could be ignored was an aberration, a radical deviation from long-standing NRC (and AEC) policy.[1] Only 11 years earlier, in 1986, the NRC had concluded a major rulemaking on the medical uses of isotopes, codifying decades of practice[2], in which it declared that released I-131 patients posed a danger **both from internal and external dose**, and provided elaborate restrictions to protect hospital staff and members of the public from being harmed by these patients. 51 FR 36932 (Oct. 16, 1986).

It is therefore troubling to read, in the first sentence quoted above, that it "may be beneficial to reexamine" the assumption that internal dose to members of the public is negligible compared with external dose. In fact, the NRC made that reexamination almost four years ago, seemingly once and for all. It was May 2008 when the NRC, citing ICRP Publication 94, "Release of patients after therapy with unsealed radionuclides" (2004), issued a Regulatory Issue Summary (RIS-2008-11) warning of the danger to infants and young children from I-131 contamination from patients. The accompanying NRC press release (No. 08-097, May 16, 2008) stated clearly that the RIS told physicians to "consider hospitalizing patients whose living conditions may result in the contamination of infants and young children." (Contamination, in this context, translates to internal dose.) The press release continued:

> These regulations were based on the assumption that internal doses to family members or others from a patient released following iodine therapy would be small compared to external doses received from being near the patient. However, concern has increased in recent years that contamination of infants and young children with saliva from a patient in the first few days following treatment may result in significant doses to the child's thyroid.

What could be clearer than that the NRC was acknowledging that the assumption underlying the

[1]There was no shortage of commenters in the rulemaking, including state health departments, to tell the NRC that it was going down the wrong path, and that internal dose remained a danger. But NRC was relying on one chosen medical consultant, of decidedly non-mainstream views. For instance, he wrote to the EDO in 1998 that I-131 is not carcinogenic, and several years ago, in a journal article, claimed that if a nuclear accident occurred, any health effects on the public would be beneficial. The National Academies of Science discussed and rejected his views in BEIR VII.

[2]Previous to the enactment of general rules in 1986, these restrictions were included as conditions in individual licenses.

1997 rule was erroneous, and resulted in understating the danger to children from contamination? But SECY-12-0011 does not even mention that 2008 RIS, much less the press release. It is as though the clock had been turned back to a time when the RIS did not exist, and the significance of internal dose was still an open question in the staff's mind. I hope that this was just an oversight in the drafting process, and not a signal that the staff has retreated from the 2008 RIS. For the assumption that internal dose is insignificant (certainly as to children) was dead and buried four years ago, and no good purpose would be served by trying to resuscitate it now.

Once the Commission recognized (in 2008) the defect in the 1997 rule, the most responsible course of action would have been to take steps to change it, either by reverting to the 1986 rule or – better yet – by developing a new rule drawing on experience and studies in the intervening years. Instead, the NRC left it in place, while issuing an RIS calling on licensees for voluntary action to deal with internal dose to children. Given that such voluntary action is contrary to many or most licensees' financial self-interest, the key question is whether the RIS actually changed the percentage of patients hospitalized because of children at home. I don't have data on this point, and I doubt anyone else does, either. This is a knowledge gap that badly needs filling.

2. Radioactive Patients in Hotels

The most salient fact about the issue of radioactive patients in hotels is that no one foresaw this when the 1997 rule was promulgated. Everyone, myself included, was thinking at that time in binary terms: patients would either be approved to go home or they would stay in the hospital. The hotel issue emerged only later, in two separate contexts: (1) the patient who is far from home; and (2) the patient who goes to a hotel either because the licensee realizes that the criteria for home release cannot be met, owing to excessive dose to family members, or because the patient or the doctor is concerned about exposing household members.

The Commission's SRM told the staff to assume that Commission guidance on patients, including the recent guidance on patients in hotels, was being followed. Unfortunately, the Commission was misinformed in this regard: we have hard evidence that the rule is being flouted. The staff, the ACMUI, and many others know this perfectly well.

If you are the ACMUI and the staff, what do you do in such a situation? Do you inform the Commissioners that unfortunately, their assumption is inconsistent with the facts, and tell them what the actual situation is? Or, in the name of complying with the letter of the Commission directive, do you engage in a game of make-believe, and withhold information about what is

really going on? The staff paper indicates that the ACMUI argued for the latter approach, and that the staff acceded to it. This is regrettable, because it means denying the Commission information that it needs to know.

The fact that radioactive patients are going to hotels, without objection from doctors, is hardly a secret. In a memo to the ACMUI in September 2011, I attached a March 2011 article from *ASCO Post*, an online journal for endocrinologists, in which a thyroidologist at Sloan-Kettering Memorial Cancer Center in New York explained that his facility gives outpatient doses of up to 200 millicuries of I-131 to thyroid patients, notwithstanding that the doctors know that they will be going to hotels. Some have no choice, he said, since they fly in from all over. With a card saying that they have been treated with I-131 at Sloan-Kettering, he explained, they can go to an airport in New York, and if they set off the radiation alarms, the authorities will understand. The problem for these patients is to get off at the other end, where restrictions are likely to be much tighter, and a card from Sloan-Kettering will cut no ice. (In Germany, for example, you must be hospitalized if you have 8 or more millicuries of I-131 in your system.) And so the patients are advised to cool off, radiologically speaking, in a hotel, before heading home.

Thus it is not a matter of conjecture, but of cold hard fact, that the Commission's guidance on patients in hotels is being disregarded. (The much tougher language of the New York City Department of Health, in a 2009 directive, is also being ignored.)

In addition, at the October 2011 conference of the Thyroid Cancer Survivors' Association, Jim Luehman of the NRC staff described, in the presence of Commissioner Apostolakis, how a nuclear medicine doctor told him that he sent about five percent of his patients to hotels, and saw nothing wrong with it. Indeed, this doctor thought that under some circumstances it was preferable, from a health and safety point of view, for a patient to go to a hotel than to ride home in a car in close proximity to his or her spouse. The necessary implication is that the radiation dose to the spouse matters, and is worth minimizing, whereas the dose to the unsuspecting hotel housekeeper does not matter – an appalling proposition, that should shock the conscience.[4] For there is no informed consent on the part of the housekeeper, in contrast to the spouse.

One issue that the staff identified in the October 2010 Commission meeting is that patients at big

[4]If you are the spouse of a patient receiving I-131 treatment, you are indirectly a beneficiary of the treatment, and you also know how to minimize exposure to yourself. If you are a housekeeper unknowingly cleaning a contaminated room, you get no benefit, and have no way to reduce exposure to yourself. There is no one there to warn you, for example, not to put your hands anywhere near your mouth.

cancer centers, attracting many out-of-towners (think Sloan-Kettering, the Mayo Clinic, Massachusetts General, M. D. Anderson, Cleveland Clinic, and some others), are likely to be going to the same nearby hotels, which means that one hotel housekeeper may clean multiple radioactively contaminated rooms in a year.

The ACMUI subcommittee steadfastly declined to deal with that point. Instead, it offered an analysis showing that the hotel worker who handled contaminated sheets was likely to receive a dose of under 100 millirems, as though that solved the problem.

What's wrong with that? A great deal, and not only the fact that the housekeeper who does this 10 or 20 times in a year may receive a dose far in excess of safe limits. It is also that the ACMUI subcommittee has focused only on bed linens, contaminated with patients' **sweat**. But sweat is far less radioactive than any of the other bodily fluids of concern. Consider ICRP 94, at p. 26: "Thus, the risk from iodine-131 contamination in sweat is small. ... Nishizawa et al. (1980) measured iodine excretion from a number of hyperthyroid patients, with some interesting findings. In patients who received 25 mCi, activity per ml was highest in saliva....It was 20-fold lower in blood ... and 1000-fold lower in sweat."

If you really wanted to know the radiation exposure to hotel housekeepers, you would consider not just the consequences of handling contaminated linens, but also the dose to the person who cleans a sink in which a patient has brushed his or her teeth, and the toilet in which he or she has urinated.[5] The problem, of course, is to replicate the effect on a housekeeper who has no suspicion that radioactivity is present. You cannot, for purposes of experimentation, ethically send an unknowing person to clean a contaminated room and bathroom, but once you give warning of the radioactive contamination, you alter the person's behavior.

In my September 2011 memo to the ACMUI, I offered a practical suggestion for developing information about the effects of radioactive patients in hotels: namely, to ask permission of certain hotels to place radiation monitors at the registration desks. (Some major hospitals have arrangements for preferential rates at nearby hotels.) Then when a radioactive patient arrived to pick up his or her key, the monitors would signal his or her presence. At that point, instead of sending some innocent housekeeper, possibly pregnant or nursing, to clean the patient's room the

[5] I don't know whether this is standard practice, but when I was an I-131 patient at the National Institutes of Health around 20 years ago, for five inpatient treatments in a three-year period, much of the sink and toilet would be covered with duct tape, to protect surfaces from saliva and urine. The tape would be removed and disposed of as a first step in decontaminating the room after use.

next day, arrangements could be made for a properly protected radiation safety professional to visit the room, clean it, and take appropriate measurements.

Would hotel managers take kindly to the idea that their rooms were being contaminated, and their employees and guests exposed to radiation, without their knowledge? Probably not. The present system is based on the fact that the hotel and its workers will be kept ignorant, and that if harm results in the future, no one will be able to trace it to its source.

Suppose for a moment that I knew that my basement was contaminated with some highly toxic and carcinogenic substance, and instead of paying suitably trained and equipped professionals to do the cleanup, I decided, in the interest of saving money, to call a local maid service agency and have a low-paid immigrant woman come to my house and scrub my basement, telling her nothing about any contamination. If I did that, you would call me heartless and immoral, and you would be right. You would probably also be asking whether there wasn't some criminal law under which I could be prosecuted. How is that different from the medical professional who directs or allows a patient go to a hotel with 200 millicuries of I-131 in his or her system, knowing that an unsuspecting chambermaid, who may be pregnant or nursing, will be cleaning that person's contaminated sink and toilet?

The ACMUI subcommittee surely knows the score on this, since one of its members was also one of the principal authors of NCRP 155, *Management of Radionuclide Therapy Patients* (2006). Appendix B, at pp. 166-174, includes instruction sheets, "Radiation Safety Precautions for Radiopharmaceutical Therapy Patients," drawn from a journal article of which the same subcommittee member was the lead author. Example 1 is for a thyroid cancer patient given 175 millicuries of I-131; Example 2 is a hyperthyroid patient given 10 millicuries of I-131. Patients in both categories are told that for the first day after treatment, they should observe the following precautions (quoted here in full, so that there can be no question of selective quotation):

> • To the extent that is *reasonable*, generally try to remain as far away from individuals around you as possible.
> • After using the toilet, flush twice and, as usual, wash your hands. If possible, use paper towels to dry your hands and dispose [*sic*] the paper toweling in the trash.
> • You *should* otherwise observe good personal hygiene and may shower, bathe, shave, etc. as you normally would, rinsing the shower stall, tub or sink thoroughly after use.
> • Wipe up any spills of urine, saliva and/or mucus with tissues or a small amount of disposable (*i.e.,* flushable) paper toweling, and dispose of the tissue or toweling down the toilet.

- Use nondisposable plates, bowls, spoons, knives, forks and cups. If possible, you *should* wash plates, bowls, spoons, knives, forks and cups which you use, using a separate sponge or wash cloth from that used by the rest of your household. Rinse the sink thoroughly after use, wipe the fixtures with paper towels, and dispose of the paper toweling in the trash.
- If you use a dishwasher, wash your plates, bowls, spoons, knives, forks and cups separately from those of the rest of your household.
- Use the same set of plates, bowls, spoons, knives and forks for 1 day after your radionuclide therapy.
- Store and launder your soiled/used clothing and bed linens separately from those of the rest of your household, running the rinse cycle two times at the completion of machine laundering.
- Do not share food or drinks with anyone.
- After using the telephone, wipe the receiver (especially the mouth piece) with paper towels, and dispose [*sic*] the paper toweling in the trash.

These are all sensible measures, but they are plainly designed for the patient who is at home, with access to flushable paper towels, a washing machine, a dishwasher or sponges, dish soap, etc., and above all, with the knowledge that a radioactive hazard is present. How many of these precautions are applicable to the hotel context? Are the patient's bed linens going to be washed separately from those of other guests, with two rinse cycles at the conclusion? Of course not.[6] If the patient gets food from room service, will his or her dishes and cutlery be washed separately? The answer is obvious.

If family members are worth protecting from radiological contamination, and they certainly are, then hotel housekeepers deserve to be protected equally – no more and no less. One of the things that sets American society apart from the totalitarian regimes of recent history is that we do not condone sacrificing the health and well-being of working men and women to serve some perceived higher goal.[7]

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[6]We know from the Braidwood Motel incident several years ago that a worker at the La Salle nuclear power station set off radiation alarms at the plant because he had slept on sheets that had been laundered together with those of a motel guest who was an I-131 patient. That was in addition to the worker at the Braidwood plant who had to be decontaminated after having spent the night in the room just vacated by the patient. That room had to be kept out of service for months.

[7]In this connection, the same ASCO Post article I mentioned earlier also included a striking quotation from the CEO of the American Thyroid Association, who said that staying in a hotel "can be done safely and reasonably" by radioactive patients, but suggested that patients pre-register, so as to minimize their time in the lobby. He thus showed himself concerned to reduce the dose that will be received by others in the few minutes they spend in the registration line in the lobby, but he had not a word to say about the vastly greater radiation dose that hotel

It was more than six years ago that I wrote to the NRC that the problem of radioactive patients in hotels, and the dose to housekeepers, was a "medical and moral issue that the NRC cannot in conscience ignore." It still is, and it won't go away. The only viable solution in the long run is a binding rule that reflects the Commission's original intent in 1997: that if the provider cannot find that the patient is suitable for release to his or her home (or a friend's or relative's home), that patient *must* be hospitalized.

Is there ever a valid excuse for allowing radioactive patients to go to hotels and irradiate unsuspecting housekeepers? The Sloan-Kettering doctor quoted earlier offered one when he suggested that some patients "have no choice," since they cannot immediately fly home to countries where standards on patient release are so much more stringent. No choice? Surely a patient who can afford to fly to New York from abroad for medical care, and pay for an expensive treatment at Sloan-Kettering, can also afford a couple of nights in the hospital.

3. Miscellaneous Other Points

A. Annual vs. Per-release limits

The ACMUI comments, Enclosure 4, p. 4, ask the staff to include a reference to the final rule on patient release, making clear that the 5 millisievert (500 millirem) dose limit applies on a per-release, rather than an annual basis. The problem is that you cannot point to anything in the final rule that says what the ACMUI claims it says. The staff believes, rightly, that the intent was that the limit be annual, which accords with international practice. The staff was correct to reject this ACMUI proposal, which in any case has little or no relevance to the task at hand in this paper.

As far as the merits of the issue, the ACMUI seems to think that it would be a crushing burden on licensees to make them responsible for factoring in the dose of I-131 that patients had received elsewhere within the past year. There are many things wrong with this argument. First, patients do not commonly flit from one I-131 provider to another between treatments. Second, they also do not walk in off the street and demand a dose of I-131, like someone going into a bar and asking for a beer. Patients come to nuclear medicine providers by referral, bringing charts which document the diagnoses and treatments they have received.

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housekeepers will receive as they scrub the patient's contaminated sink and toilet.

To offer an example from my own experience, there was one year, when my children were little, when I had a 150 millicurie dose of I-131 in the spring and another of the same amount in the fall. At the time, all doses in excess of 30 millicuries required hospitalization, but suppose that happened today. Why is it not reasonable, in calculating dose to family members from a treatment in October, to take account of the estimated dose they received in March?

B. Removing Alleged Conservatisms

The Office of Nuclear Regulatory Research, in Enclosure 3, at p. 2, suggests that licensees' calculations of probable dose, and of compliance with NRC's 5 millisievert (500 millirem) standard, are "likely to be less conservative than the guidance provided by NRC because it is likely to be site specific, whereas NRC's guidance, not being based on any specific situation, serves as a generic screening tool, and hence must be conservative by its nature." This language is not easy to parse out, but to the extent I can, it seems to misunderstand what the NRC did in NUREG-1556. That was to offer mathematical formulas which licensees could use, plugging in site-specific conditions that reflect the patient's actual living situation, in order to come up with a figure for the probable dose to household members.

As far as whether NRC standards are unduly conservative, it should be remembered that the NRC staff, in rejecting my petition for rulemaking in 2008, embraced the 5 millisievert or 500 millirem standard for all members of the public, including children, pregnant women, and strangers. This was (for children, pregnant women, and members of the public) five times the 1 millisievert or 100 millirem standard advocated by the ICRP and NCRP. Patients in the U.S. are sometimes sent home to their families with 400 millicuries or more of I-131 in their systems. In Europe, Japan, the Philippines, etc., no patient with 15 millicuries is allowed out of the hospital, and in many European countries the standard is even stricter than that. Thus the Commission should be disabused of the notion that its standards are conservative. They are anything but.

C. ACMUI vs. NRC Staff

The NRC staff wanted to say to the Commission in this paper, "it is not known whether members of the public are, in fact, receiving doses that are less than 5 mSv from the released patients." This is simple and undeniable fact. But the staff deleted this sentence – not because it was untrue, but in response to the ACMUI's specious claim that it was obligated to do so by the terms of the Commission's SRM. (See Enclosure 5, p. 6.) In fact, the Commission did not instruct the staff to tell it that everything was working like a charm; the Commission wanted to know where it needed more information, and of what kind, in order to judge **whether** the current system is

working as it should.

Similarly, the staff wanted to tell the Commission that radioactive material can be transmitted by kissing and breastfeeding. That is hardly news; the NRC said this in the 2008 RIS, which drew on ICRP 94, issued in 2004. But the ACMUI objected that the staff was forbidden to make such comments by the terms of the SRM. (See Enclosure 5, page 6: "The Subcommittee believes that ... any recommendations involving questions about the instructions given to patients or how the patients follow the instructions runs contrary to the SRM.") Remarkably, the staff gave in to this demand. It should have stuck to its guns, for it was plainly in the right.

The 2008 RIS was intended to publicize the fact that there is a danger that I-131 contamination will be transmitted to children by kissing. Yet here we have the ACMUI subcommittee instructing the staff that it is barred from discussing in this paper whether patients ever hear this instruction, and if so, whether they follow it. Surely this is information that would be of value to the Commission. The ACMUI is paid to furnish useful information **to** the Commission, not to keep useful information **from** the Commission.

D. Questionable Assertions

In Enclosure 1, the "Summary of Staff Gap Analysis," the paper states, at p. 2: "Existing data supports that radiation doses to other individuals can be safely controlled by current patient release regulations," citing Reference 20. We do not in fact know that. If the staff does not know whether members of the public are receiving doses less than 5 millisieverts from released patients (see the discussion above), how can it say that the current patient release regulations can safely control radiation doses to others? By the same token, I see no basis for the statement, further down on the same page, that the staff agrees with the ACMUI subcommittee "that the current NRC release criteria appropriately balance public safety with patient access to medical treatment." If we knew that to be the case, there would be no need to be asking questions about the adequacy of our information base.

4. Conclusion

When most Americans think about radiation safety, they think of nuclear power plants, although the dose to the public from the plants is minimal. At the same time, however, we know from NCRP 160 that the average American's annual dose of radiation has doubled in the past 30 years, not because of nuclear power, but almost entirely because of medical procedures (not all of which, of course, are subject to NRC regulation). Average annual doses of medical radiation

increased sevenfold in that time, NCRP 160 reported. In that same period, the rate of thyroid cancer in this country has approximately quadrupled; whether there is a connection between the two increases is unproven, but it is certainly suggestive, since the only known environmental cause of thyroid cancer is radiation. The Commission needs much more information in the medical area, and this staff paper, notwithstanding the shortcomings I have described, is a useful step in that direction.

Finally, if Commissioners want truly reliable information about what is happening in the real world of I-131 treatment, they should come to the annual conference of the Thyroid Cancer Survivors' Association (ThyCa), whose Executive Director, Gary Bloom, addressed the Commission in October 2010. Commissioner Apostolakis attended the 2011 conference in Los Angeles, along with the new Patients' Rights Advocate, Laura Weil, Steve Baggett of his personal staff, and Jim Luehman of the NRC staff. At the Commissioner's request, special early morning sessions were set up so that he could meet informally with small groups of patients, hear their stories, and ask them questions. Doctors were also there, and contributed useful information about their own practices. Not only was the presence and interest of the NRC delegation greatly appreciated by the patients, it meant that Dr. Apostolakis could gather primary data from the source, not filtered, interpreted, or spun by anyone else. I hope other Commissioners will follow his example.

Respectfully submitted,

/s/

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