The Society for Computer Applications in Radiology

WE HAVE ALL HEARD the drum of the need for a usable standard beat many times in the last several years. The distressing aspect of the soon-to-be approved ACR-NEMA version 3 or DICOM Standard is, however, the continued attitude of the many members of the imaging community towards this topic. It is not uncommon for me to hear comments such as "Well, it's not a completed standard yet, we'll adhere to it fully when it's released," or such things as "we have every intention of being fully compliant with the standard, but until it is released, in its new version, we can not offer that availability," or even "don't you know that the standard has vague areas and areas where it is unclear and this has limited our implementation."

In reality, there is a kernel of truth in each of these comments, but all of them miss the main point. A common standard will be extremely good for the clinical imaging community. Notice my emphasis on clinical imaging. A standard that truly works will best allow the clinician to connect equipment from a variety of vendors into an integrated total system. This is obviously not always in the best interest of each individual imaging company, when viewed from the short range. However, it is clear to me that widespread use of DICOM will occur. The implementation of this standard equipment will be primarily customer driven rather than company driven. The installation of the systems and the connectivity is not without its problems, but with continuing refinements and definitions to the standard, the necessary point-to-point connections between vendors will become less and less problematic.

I have had the opportunity in the last few weeks to visit one of the many institutions around the world that has been totally digitized and is filmless. My immediate impression is that, for the volume of work done, there is a marked decrease in the number of personnel involved. Due to direct image capture by the use of storage plate technology, and the use of long-term archives, the need for file room personnel both in the active file room and the storage file room is drastically eliminated. The use of hard copy is also drastically reduced and limited mainly to patients leaving the institu-

tion, by the judicious placement of a distributed imaging network through the high volume areas of the hospital, such as the operating rooms, the emergency rooms and the intensive care units. Visiting such a site inspires confidence that we are headed in the right direction, and the future does indeed hold increased efficiency and productivity while maintaining an excellent quality of care in the digital environment.

My last observation is on the "convergence" of solutions within this technology. While there is still no one correct way of implementing a PACS, an increasing number of vendors seem to be converging towards similar approaches to the solution. Everyone seems to be settling on work stations, based viewing systems, modularity, and distributed archives. Multiple smaller networks, that are interconnected through gateways and backbones are becoming more standard. One observes more commonly now the inclusion of the capabilities for the workspace to be modified as desired for each physician. While there is some increasing uniformity on these items, there still remains a healthy diversity in the specific items and details of implementation of each manufacturer's system. In a way, it is encouraging that the field has a direction in which certain classes of solutions are seeming to make appropriate sense to larger and larger groups of individuals.

On a closing note, let me give you a status of our Society as of this fall. Membership remains just below 400, although we are beginning to see some slight increase from our membership initiatives. Planning is continuing to proceed for the S/CAR meeting in June at Bowman Gray. Again, I urge both your attendance and your submission of papers to what promises to be a memorable meeting. The paper submission deadline has been extended to January 15, 1994; send your abstracts to Dr John Boehme: S/CAR94, PO Box 8800, Harrisburg, PA, 17105-8800 or fax it to 717-561-5360.

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