ASITN
American Society of Interventional & Therapeutic Neuroradiology

The Embolus

Summer 2002

Inside *this issue*

President's Message 2
ASNR 2002 2
Past President's Farewell 3
Editor's Column 4
ASITN Hires Director of Professional Affairs 4
ACR Update 5
ASITN and SIR Forge New Collaboration 5
ASITN Member Speaks at STOP Stroke Luncheon on Capitol Hill 7
ASITN Photo Highlights from ASNR Annual Meeting 8
ASITN Unveils Strategic Plan and Newest Member Benefit 10
ASITN Announces Creation of Corporate Advisory Council 10
New Executive Committee Takes Office 11
Practice Issues that Impact You 12
Welcome New ASITN Members! 15
Calendar of Events 16

ASITN Leadership Holds Intensive Strategic Planning Retreat

The ASITN Executive Committee met for an intensive planning session at the SIR office March 16-17. "We celebrate reaching our first decade milestone, and we recognize the crucial need to rapidly develop a strategic plan," said Randall Higashida, MD, ASITN President. During a facilitated planning session, the Society's leaders created the plan that will guide the organization's future direction, prioritize its goals, and ensure its continued growth. The Executive Committee developed the following envisioned future and goals:

ASITN Envisioned Future

By 2008, ASITN

- Is indispensable to practitioners in the Interventional Neuroradiology field
- Defines the quality of care in the Interventional Neuroradiology field
- Is the primary source of training in Interventional Neuroradiology techniques
- Has 400 active and 400 associate members from all appropriate disciplines
- Is represented in the ACR Council

Goals:

1. Pursue health care policy to achieve fair reimbursement
2. Improve understanding of the field
3. Protect patients through standards of care
4. Increase practitioners' skills through education and training
5. Obtain the financial, human, and capital resources to achieve the ASITN strategic plan
6. Involve practitioners in the accomplishment of ASITN's strategic plan

ASITN: A Ten-Year Historical Perspective

Jacques Dion, MD

As we celebrate our tenth anniversary, we cannot help but notice that there are very interesting parallels between our growth and that of SCVIR (now Society of Interventional Radiology – SIR). We were both formed early on as a small, elite group of mostly university physicians. The only difference is that they have led us by a good ten years – nonetheless, the parallels are remarkable.

We began with really shaky finances – in 1995, our assets were only $94,000 – and we had serious problems with indebtedness because of our national meeting. By 2001, we had more than three-quarters of a million dollars in the bank. Membership growth showed a similar curve. In 1994, we had only 70 active members (87 total members) and today, we have over 400 total members.

The major change that affected us occurred in the 1990s – the change in reimbursement in billings. We are still struggling with that change today, and though we have made significant strides in some areas, especially getting the hospital code for aneurysms to be changed, our fees lag well behind our neurosurgical colleagues for our common procedures.

continued on page 14

President's Message

Randy Higashida, MD

Hello and welcome to the newly designed *Embolus* newsletter – one of the enhanced member benefits you will be receiving from ASITN in the upcoming year!

It is indeed an honor to have been elected to serve you as President. I'm planning to build on the foundation that Jacques Dion laid down during his term as President. We all owe Jacques a debt of gratitude for all of his hard work over the past year.

I would like to extend a big thank you to the outgoing Executive Committee members. Andrew DeNardo, Van Halbach, Charles Strother, and Gary Nesbit contributed countless hours toward bettering your society and deserve recognition and our thanks!

It has been a busy year for ASITN – we held two successful scientific meetings, developed a Corporate Advisory Council, held a strategic planning session with a professional facilitator, hired a full-time Director of Professional Affairs, and published a guide to build an interventional neuroradiology practice – and the year is only half over! As you can see, ASITN has refocused and re-energized our activities. It's an exciting time to be a member!

Thank you for your continued support of ASITN! We look forward to another great year!

Randall T. Higashida MD

ASITN
American Society of Interventional & Therapeutic Neuroradiology

New Logo for ASITN

ASITN is pleased to unveil our new look! After many votes, the Executive Committee has decided on the following logo to take ASITN into the future! Logo guidelines and electronic copies of the logo for your use will be available to members in the next few months.

ASNR 2002

Chuck Kerber, MD

Randy Higashida organized an excellent interventional morning. Probably the most important talk given that morning was by Clay Johnston, a neurologist at UC San Francisco. Talk about a provocative title: "A Direct Comparison of Surgical and Endovascular Treatment (of cerebral berry aneurysms)". The first study he described was his, and was done at UCSF. Both surgeons and radiologists were blinded to outcome. He first divided the patients into a) those who should be clipped, b) those who should be coiled, and c) those who could have either therapy. For those who could have either, n=130; these became the study group. Two questions were asked of other reviewers: "would you treat this case?" and "what is the risk of treatment?" It was a surprise to find that the surgeons believed that the coiled cases were more risky (p=0.024), and the radiologists believed that the clipped cases were more risky (p=0.028). One important facet of the study was that the follow-up was long – five years. He made three conclusions: first, in the population of unruptured aneurysms that could have received either therapy, coil embolization was associated with significantly less risk. There were fewer short-term complications and fewer complaints at long-term follow-up. Second, neurosurgeons could not claim that they were treating the higher risk cases. Third, coiling was cheaper. He quoted a second study too – the University Health Systems Consortium, with data from 80 University medical centers. For the surgical group (n=2357) adverse outcomes were 18.5% with 2.3% in-hospital deaths whereas for the coiling group (n=255) adverse outcomes were 10.6% with 0.4% in-hospital deaths. Length of stay for the endovascular group was half as long, and the charges were one-third less. It gets better. A third study (which he called the California Study) done at 167 hospitals included 1699 treated surgically, and 370 treated with coils. In that group,

continued on page 3

So Long, Farewell, Auf Weidersehen, Goodbye!

Jacques Dion, MD

My term as President of ASITN ended recently at the 2002 ASNR meeting in Vancouver, where I handed over the controls to Randy Higashida, your new President. First, I would like to thank all of you who have entrusted me to serve the Society; it was a pleasure and an honor. The year was a busy, exciting and exhilarating one, as you can see from the contents of this newsletter. Tom Tomsick's shoes were very big and challenging to fill…He truly rejuvenated the ASITN and gave it a breath of pure oxygen. Your Executive Committee tried its best to carry Tom's mission. He has continued his involvement by creating the Corporate Advisory Council, which will strengthen our bonds with Industry.

The Society is definitely on the move: we are better organized and more dynamic than ever. Strategic alliances with SIR, JSCVS and ASA were formalized. This spring we had a very productive retreat that resulted in formulation of a real five-year strategic plan. We recently began conference calls with the newly created ASITN/JSCVS Coalition. We now have a full-time Director of Professional Affairs, Marie Williams, whose office is located in the SIR administration in Fairfax, Virginia. She is charged with keeping all of us in line and on schedule! I believe you will see significant improvement in our communication with the membership and our general efficacy in the coming year. The Society is keeping abreast of important issues such as the ACR's position on Clinical Practice in Interventional Radiology, the Kennedy Stroke Bill, Blue Cross of California billing for angioplasty policy, to mention only a few. By now, you have received your *Practice Building Guide* and I hope you are putting it to good use.

I look forward to the next two years of my involvement as Immediate Past President and Second Past President. I am thrilled to be part of our Society's transformation and maturation. Thank you for the privilege of having served you as President.

ASNR 2002 **continued from page 2**

adverse surgical outcomes were 25%, whereas endovascular adverse outcomes were 10%. In-hospital deaths for the surgical group were 3.5%, with only 0.5% percent in the endovascular group. So there…

And it gets even better…Andy Molyneux came from England to report that the ISAT (International Subarachnoid Aneurysm Trial) – a prospective randomized trial comparing endovascular to surgical results – had been closed for ethical reasons – there was too significant an outcome difference between the two arms. The endovascular treatment was simply better. The study began in 1997, with a goal of enrolling 2500 patients (44 centers), and a primary objective of showing a 25% difference in clinical outcome between the endovascular and surgical group. It was stopped for ethical reasons after 2143 patients had been enrolled (1491 with a one year follow-up) and a 24.3% reduction of relative risk ($p<0.001$) was demonstrated in favor of the endovascular group. Funding is in place for another 5 years to evaluate long-term rebleeding outcomes and there are plans to extend this surveillance period to 10 years. Dr. Molyneux promised an accelerated publication, probably in the Lancet.

Perhaps the new millennium has really arrived.

ASITN Hires Director of Professional Affairs

ASITN is pleased to announce the hiring of our first, full-time staff person! Marie Williams joined the ASITN staff on April 1. She is located at the SIR (formerly SCVIR) offices in Fairfax, Virginia and looks forward to meeting all of the ASITN members soon.

Marie brings with her 7 years of progressive association experience. Her most recent job was with the International Society for Clinical Densitometry where she served as Deputy Executive Director.

Feel free to contact Marie at **marie@asitn.org** or by phone at **703-691-2272**.

A Culture of Safety

One of the most dangerous places in the entire world is the deck of an operational aircraft carrier. There are few in America who have not seen the opening scenes from the movie 'Top Gun', which shows these dangers in graphic slow motion. The overall level of noise makes it essentially impossible to hear, goggles and helmets make it difficult to see, the deck is slippery with jet fuel and hydraulic oil, and the personnel are at risk to either get sucked into a jet engine, blown overboard by one, or walking into a whirling propeller. And yet, mishaps are so rare as to be nearly unheard of. What do they know that we do not? Maybe, more importantly, what do they do that we do not?

This question is especially important now because we are being severely criticized for the high level of iatrogenic illness. A recent article in the Wall Street Journal indicates that between 40,000 and 100,000 patients per year die because of our mistakes. I don't believe that the level of criticism has been appropriate, but on the other hand, we physicians have resisted changing the way we analyze and minimize risk.

Has the time come for us to learn from our military brethren? They certainly seem to have mastered the use of systems analysis and risk reduction.

Compare what a Marine pilot must do before flight to the way we prepare for a case. First, a weather briefing must be obtained and analyzed for the entire route of flight. Next, the pilot makes a careful and complete flight plan, calculates fuel burn, times, and routes – then creates a backup plan should the weather change or some mechanical problem occur. There must always be an alternate airport and enough fuel to get to it. Next, the pilot or pilots (there is usually more than one person flying any military flight) discuss each section of the plan. Then, they write down the five steps of operational risk management and see how each applies to their flight. Do we prepare ourselves and our team this well?

Here are the five steps of operational risk management:

- IDENTIFY HAZARDS: In our case, before an intervention, that might be a) discovering the patients has AIDS; b) identifying a clotting disorder in the patient; c) recognizing that the aneurysm that has recently bled has a wide neck, and so on.
- ASSESS THE HAZARDS FOR SEVERITY AND PROBABILITY: I recommend a scale of 1 to 5 with 5 being the most hazardous. We're required to fill in a table like this:

Hazard	Factor	Action to Reduce	Δ
AIDS	3		
Clotting Disorder	4		
Wide Neck Aneurysm	4		

- MAKE RISK DECISIONS: This is the point to consider each hazard and decide whether it is worthwhile to proceed. Do the benefits really outweigh the risks?
- IMPLEMENT CONTROLS: Decide how you will prevent yourself and your crew from being infected by the virus; decide that patients needs fresh frozen plasma to correct her clotting disorder, decide that you will use balloon remodeling technique to protect the neck of the aneurysm, and so on. You get the idea.
Now the table looks like this:

Hazard	Factor	Action to Reduce	Δ
AIDS	3	warn crew, caps, masks, eye cover	2
Clotting Disorder	4	fresh plasma	1
Wide Neck Aneurysm	4	balloon remodel	2

- SUPERVISE THE PROCESS: As the case progresses, control all actions to ensure that our and our crew's normal resistance to change does not defeat the process.

continued on page 15

ACR Update: Key Resolutions Focus on Supporting INR

Two resolutions of importance to ASITN members will be voted upon during the upcoming American College of Radiology (ACR) Annual Meeting September 28 – October 2 in Miami, FL.

The following resolution, if passed, will achieve one of the significant goals in the ASITN strategic plan developed in March 2002 and will represent a milestone for the Society, marking the positive membership growth that has enabled us to qualify for a voice in the ACR:

> BE IT RESOLVED, the American Society of Interventional and Therapeutic Neuroradiology be granted one representative on the Council of the American College of Radiology, effective at the 2002 ACR Annual Meeting.

The second key resolution impacts the evolution of neurointerventional and interventional radiology. This resolution is the direct result of a landmark meeting held March 17 – 19, 2002, "Interventional Radiology: A Multi-Organizational Forum." The Forum represented the first time that all major radiology organizations convened to consider issues central to the future of interventional radiology. Drs. Jacques Dion and Buddy Connors were at the table to represent ASITN and neurointerventional radiology during the meeting. This Forum was mandated by a resolution submitted by the Society of Interventional Radiology (SIR), "Recognition and Retention of Interventional Radiology within Radiology," and passed by the ACR Council in September 2001. Specifically,

> "be it further resolved, that the ACR take the lead in working with other organizations to establish a committee which will provide a comprehensive report to the Council in 2002 to include the current state of interventional radiology along with complete and specific recommendations for sustaining and enhancing interventional radiology."

Overall, the Forum was successful and resulted in a consensus that greater emphasis should be provided to the interventional radiology training pathway, that a new, more clinically oriented pathway should be considered, and enhancements to the RRC essentials for interventional radiology should be made to promote a more clinically oriented training environment as well as the working environment.

Major findings and actions included the following:

- Enhancements to the current IR pathway, including renaming it as an interventional radiology residency.
- A proposal for a more clinically oriented residency pathway that would be attractive to those with relevant clinical training. A proposal will be developed and submitted to the ABR for their Fall meeting.
- SIR's proposal for a new five-year residency pathway and primary certificate was presented. However, it was agreed that this proposal was realistic only in the long-term.
- Development of language for the Radiology RRC of the ACGME for interventional radiology essentials for fellowships that would define the necessary clinical environment for training.
- Development of ACR standards for clinical practice to be based on the 1999 resolution "Support of Clinical Patient Management by Vascular and Interventional Radiologists." A resolution will be presented at the 2002 ACR Annual Meeting (September) advocating development of such a standard, and the actual standards will be drafted and submitted for the 2003 ACR Annual Meeting (March).
- Other actions to facilitate a more optimal clinical practice environment included:
  - ACR will undertake an economic analysis on the use of physician assistants and nurse practitioners and submit this to the Board of Chancellors by June 2002.
  - ACR will support and elevate the importance of the vascular lab and the economic advantage of incorporating the lab into IR practice.
  - SIR will review current ACR positions on exclusive contracts.
  - ACR will promote in the ACR Bulletin the benefits of practice models outside exclusive contracts. ACR will educate groups on the pros and cons of exclusive contracts.

As a direct result of the Forum, the following resolution will be presented for vote during the September 2002 ACR Annual Meeting:

> BE IT RESOLVED, that the ACR develop standards for consideration by the ACR Council in 2003 to address the establishment of IR clinical services within the practice of radiology groups including the following:
>
> - Establishment of an adequate clinical team;
> - Dedication of adequate space for clinical visits;
> - Inpatient admitting service;
> - Dedicated time for seeing inpatients and patients in a clinic;
> - Noninvasive vascular laboratory;
> - Clerical services for scheduling, insurance authorization and billing of procedures and evaluation/management services; and
> - Support for time and materials for promotional and educational efforts.

ASITN fully supports the resolution and believes this is an important step for interventional medicine. Please encourage your state representatives to the ACR to support these important resolutions in September.

The field of interventional radiology is undergoing a rapid and dramatic evolution as it seeks to position itself as a clinical specialty.

ASITN and SIR Forge New Collaboration

The American Society of Therapeutic and Interventional Neuroradiology (ASITN), American Society of Neuroradiology (ASNR), and the Society of Interventional Radiology (SIR) have collaborated closely over the years on a variety of projects and activities of common interest, including training, radiation safety, legislative priorities, and reimbursement. The collaboration has been positive and fruitful.

Recently, ASITN leaders engaged SIR to assist them in hiring their first full time staff member to serve as their director of professional affairs. Members of the ASITN Search Committee held interviews at the SIR office in March and selected Marie Williams, who is now located in the Fairfax offices.

Leaders of SIR and ASITN were enthusiastic about the new relationship. "The field of interventional radiology is undergoing a rapid and dramatic evolution as it seeks to position itself as a clinical specialty. This new collaborative arrangement should only serve to strengthen and broaden all of our efforts to ensure a bright future for interventional and neurointerventional radiologists and the patients we treat," said Michael Darcy, SIR president. ASITN past-president, Jacques Dion, MD emphasized that his organization is at an important and crucial crossroad in its development and the hiring of full time staff represents the significant achievement of a major strategic goal.

(l-r) Paul Pomerantz, SIR executive director, and Jacques Dion, MD, ASITN past president finalized the new ASITN and SIR collaboration.

Intersociety collaboration will continue to be a focus for SIR and ASITN. "Today it is more important than ever to work actively and strategically together to advance our field and our common interests. Only through strong collaboration with ASNR, SIR, and other organizations will we evolve the specialty and ensure that life-saving, life-enhancing interventional procedures continue to thrive and develop," said Buddy Connors, MD, ASITN president-elect. Michael Brunner, MD, SIR president-elect echoed this sentiment stating, "We are far stronger if we work together to face the mounting challenges in areas such as reimbursement, credentialing, standards, training, and patient safety."

ASITN Member Speaks at STOP Stroke Luncheon on Capitol Hill

ASITN member, Kieran Murphy, MD, FRCPC, recently spoke at a luncheon briefing sponsored by the STOP Stroke Coalition, of which ASITN is a member. Dr. Murphy was wearing three hats that day, representing ASITN, SIR, and ASNR. He spoke on Stroke Treatment and was on a panel of experts including John Marler, MD, NINDS, who spoke on Stroke Research, Darwin LaBarthe, MD, Centers for Disease Control and Prevention, who spoke on Stroke Prevention, and Laura Lennihan, MD, Chief of Neurology and Director of Stroke Rehabilitation at Helen Hayes Hospital, who spoke on Stroke Recovery.

We were pleased when Lois Capps (D-CA), Co-Chair of the Congressional Heart & Stroke Coalition, stopped by to extend her support for the STOP Stroke Act. Roger Wicker (R-MS) and Chip Pickering (R-MS) also took a few minutes to talk to the group.

The well-attended briefing included the above-listed members of Congress, Congressional staffers, members of industry, and members of the STOP Stroke coalition.

Dr. Murphy… representing ASITN, SIR, and ASNR.

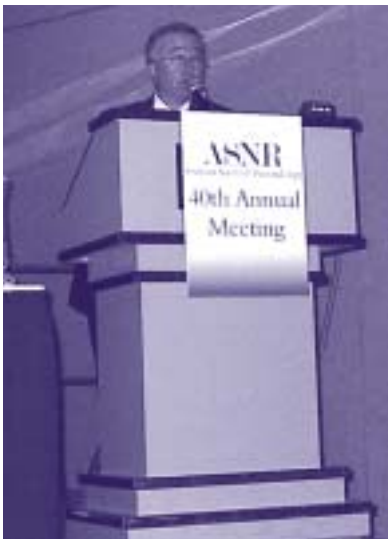
Dr. Kieran Murphy

Congressman Roger Wicker (R-MS)

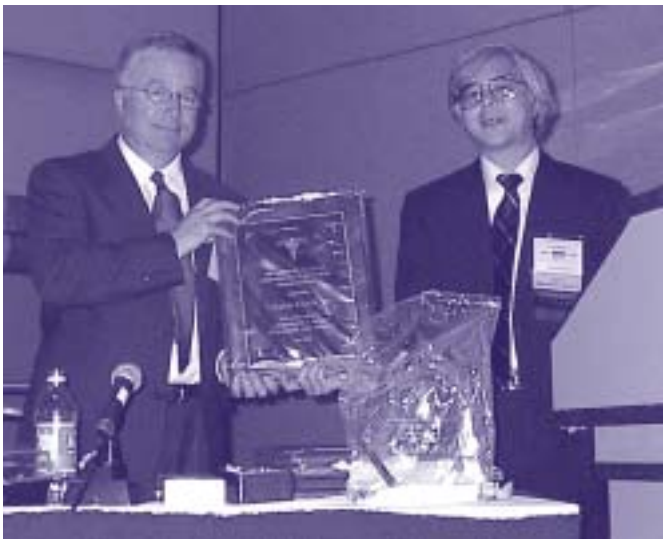
Congresswoman Lois Capps (D-CA)

Congressman Chip Pickering (R-MS)

ASITN Heads to Vancouver for the



Jacques Dion, ASITN President, addresses the members of ASITN at the Annual Business Meeting



Randy Higashida, ASITN President-Elect, presents a token of appreciation to outgoing President Jacques Dion

Randy Higashida presents Tom Tomsick with a plaque acknowledging his achievements in fundraising

Randy Higashida presents Buddy Connors with a plaque acknowledging his leadership in health policy and reimbursement

ASNR Annual Meeting

It's Standing Room Only for the session on Acute Ischemic Stroke!

Randy Higashida presents ASNR staff member Ken Cammarata with a plaque acknowledging his support for ASITN over the past few years

Randy Higashida presents John Barr with a plaque acknowledging his accomplishments in practice guidelines and standards

28th International Stroke Conference

Call for Abstracts

The 28th International Stroke Conference is a two and one-half day educational program, February 13-15, 2003 in Phoenix, Arizona, covering all aspects of stroke research and treatment. **The deadline for abstracts is July 31, 2002**. You may now access the online abstract submitter at **www.strokeconference.org** (and technical support is available during business hours). Abstracts selected for presentation will be published in the January 2003 issue of *Stroke, Journal of the American Heart Association*.

ASITN Unveils Strategic Plan and Newest Member Benefit!

ASITN members held a business dinner at the ASNR meeting in Vancouver where Jacques Dion outlined the new strategic plan and presented the newest member benefit – a practice building guide. ASITN, with the generous financial assistance of Target Therpeutics and the marketing savvy of Karen Zupko, has published the "Building Your Interventional Neuroradiology Practice" guide. This will be a valuable marketing tool for all ASITN members and we are thrilled to provide one copy to each Active Member free of charge!

The dinner was generously sponsored by Target Therapeutics and Philips Medical Systems. Target was presented with a small token of appreciation by the ASITN Executive Committee for their continued support of our mission.

Jim Feenstra, President, Target Therapeutics (far left) and Joe Fitzgerald, Target Therapeutics Vice President of Marketing (far right) are presented tokens of appreciation by Randy Higashida, ASITN President (middle left) and Jacques Dion, ASITN past president (middle right).

Jacques Dion, ASITN past president, presents ASITN's strategic plan

The guides were mailed out the week of June 24. If you have not received your copy yet, please send an e-mail to Marie Williams at **marie@asitn.org** and she will ensure that you receive one promptly!

If you are not an Active Member of ASITN, and are interested in purchasing a guide, contact Marie at **703-691-2272** or at the e-mail address listed above. Guides are $95 for members of ASITN and $195 for non-members.

ASITN hopes to be able to publish more guides in the future as we enhance your member benefits!

ASITN Announces Creation of Corporate Advisory Council

At their meeting in Vancouver, the Executive Committee voted to form a Corporate Advisory Council to strengthen the relationship between ASITN and industry. We are pleased to announce that **SIEMENS MEDICAL SOLUTIONS** is the first company to join the Council. If you work with any companies who would benefit from an enhanced relationship with ASITN, please send their contact information to Marie Williams at **marie@asitn.org**.

New Executive Committee Takes Office in Vancouver

The 2002-2003 Executive Committee took office at the Annual Business Meeting in Vancouver, British Columbia. Listed below, please find your new Executive Committee. Feel free to contact any of them with questions or suggestions for ASITN.

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Executive Committee Work

Chuck Kerber, MD

It was impressive to see the Executive Committee working until midnight while the rest of us were out having fun at the Joint Meeting. And, they got up for a 0630 hours meeting the next morning with the neurosurgeons. Theirs is generally an unsung, under-appreciated job and we would hope that you would give them a little bit of encouragement and thanks for the unheralded work done on our behalf.

The actual minutes of these meetings are available either from Lee Jensen or Marie Williams, our new Director of Professional Affairs. Most of the work had to do with CPT coding and the Kennedy stroke bill.

The Executive Committee also held two strategic planning retreats: one last summer and a second one this spring. It was decided to find and hire a full-time administrator to be housed in the SIR office. Changes in and additions were made to the AJNR editorial board and Nick Hopkins proposed a closer working relationship between our two groups, especially on the NATURE trial (ruptured aneurysms, unruptured aneurysms, and registry). We will tell you more about this trial as it develops. There was plenty of other discussion – too voluminous to include here, but as other projects mature, we will include those developments in the newsletter.

Practice Issues that Impact You

Buddy Connors, MD, ASITN President-Elect

A useful forum for member communication has been established on the ASITN web site at www.asitn.org. I urge everyone to utilize the Discussion Forum…

There are many issues of great interest to a large portion of ASITN members that might impact your daily practice. This brief article will serve as a short summary and update on several important practice areas that are often confusing, to me and everyone else. Before I begin, I would like to assure you that your leadership is committed to keeping you informed and to addressing your practice and professional issues and concerns. I encourage all members to communicate frequently with each other as well as with the elected leadership in order to more fully understand ongoing situations and to help steer the direction in which we go.

A useful forum for member communication has been established on the ASITN web site at www.asitn.org. I urge everyone to utilize the Discussion Forum in the "members only" section of the web site to make suggestions, ask questions, and offer tips on any subject thought to be of interest. We want to hear from you! We also need help with many of the issues that are discussed here.

Credentialing

Questions and concerns regarding credentialing are frequently brought to our attention. Members have expressed concerns that other specialists are requesting "credentials" in their hospitals to perform diagnostic and catheter-based interventional neuroradiology procedures, and they look to the ASITN as a credentialing authority to prevent this. Despite our fervent wishes, ASITN has no control over credentialing.

Credentials are determined at the hospital level, and while a hospital may rely on outside sources for recommendations, they are not bound by any of these sources. The more reputable the source the more likely the hospital will choose to abide by the recommendation. ASITN has not yet established the reputation to have a strong influence on hospitals, nor do we have the numbers necessary to influence these many hospitals. Larger organizations such as the American Heart Association (AHA) who have multi-specialty representation tend to be viewed by hospitals as more authoritative and more credible in their recommendations, and are considered less self-serving Therefore the ASITN is likely to be unable to satisfy the wishes of the membership to have hospitals adopt credentialing criteria that are approved and promulgated by the ASITN. However, given ASITN's expertise in INR procedures, it is appropriate for the Society to contribute to recommendations for credentialing standards and quality standards of practice for "outcomes" of procedures. To the extent that these recommendations can be supported by studies in the literature, they are more likely to be accepted by clinical practice committeesand hospitals. We will continue to make these efforts a priority.

CAQs

In 1994, the American Board of Medical Specialties authorized the American Board of Radiology (ABR) to examine and certify in the subspecialty disciplines of vascular and interventional radiology, neuroradiology, and pediatric radiology. Since then, the ABR has awarded these subspecialty certificates – originally, but no longer termed "Certificates of Added Qualification (CAQs)"– to Diagnostic Radiology diplomates who qualify for and successfully complete the examination in their field of training.

The ACGME, through its Residency Review Committees (RRCs) and member organizations, which comprise every medical specialty, establishes national standards for graduate medical education by which it approves and continually assesses educational programs under its aegis. The ACGME's accreditation processes for the various specialty and subspecialty training programs are developed and implemented in cooperation with the specialty Boards, since the Boards bear the ultimate authority and responsibility for certifying individuals who have completed accredited training programs. It is this participation and endorsement by all the member specialties that gives this agency its authority.

Long and intensive efforts went into achieving approval of the ABR's application for radiology subspecialty CAQs involving

working with the member organizations and societies of the ACGME. What does this mean for radiologists? Many of you may look to a CAQ as a means of protection for our procedures and a means to enhance our ability to receive reimbursement for our services. These, however, are not protections that a CAQ will provide. There are in fact many physicians without CAQs in neuroradiology who read and bill for CT and MRI exams. There are also physicians of many specialties who perform carotid stenting but do not hold a CAQ in any specific specialty. Then what is the benefit of a CAQ, you may ask? The benefit is to the patients. Patients care whether you have a CAQ. In the new practice arena, you must compete with all of the specialties that perform or are soon to begin performing INR procedures. Those who provide the highest quality service and outcomes and who focus on building a clinical practice will see the patients.

Accreditation

If you are beginning to feel discouraged, there is something concrete that we can do to further our cause. So far there are "0" (zero) neurointerventional radiology fellowship programs that have achieved accreditation from the ACGME. We currently have over 25 fellowship programs listed in the ASITN Directory of INR Fellowship Programs. If we wish to achieve recognition as a "mature" subspecialty, we need to have a substantial number of our programs officially "accredited". I encourage each and every program director to proceed full speed ahead with completing the application for accreditation. If you are totally overwhelmed at the prospect, contact the ASITN, and we will put you in touch with programs that are currently filling out their forms. Just do it!

Exclusive Contracts

As many of you are aware, radiology groups have exclusive contracts in many locations. Members often look to an exclusive contract to protect the procedures they perform. Historically, this has not proved to be a useful approach. While exclusive contracts can prevent other radiologists from performing procedures in your hospital, they have no effect on other specialists who wish to start performing interventional procedures. Furthermore, there are other problems with exclusive contracts in general.

Several recent legal practice articles in the SIR Newsletter that specifically address these issues may be a helpful resource for you (www.sirweb.org). In addition, as a result of the "Interventional Radiology Multi-Organizational Forum" (see page 5 of this newsletter for more details), the ACR has agreed to promote in the ACR Bulletin the benefits of practice models outside exclusive contracts and to educate groups on the pros and cons of exclusive contracts. Moreover, SIR plans to review current ACR positions on exclusive contracts and is in close communication with ASITN.

Training Issues: Recently Approved Residencies

The ACGME has recently approved a new subspecialty in vascular neurology, which is in essence a "stroke neurology" fellowship. The requirements and components of this training require them to be familiar with all aspects of stroke, CT, MRI, and endovascular therapy of stroke. These requirements can be found on the ACGME web site (www.acgme.org). As a next step, neurology is working to obtain a pathway to ACGME-approved interventional neuroradiology training, including aneurysm, AVM and epistaxis therapy. Prior to approval, the ASITN leadership provided comments to the ACGME clearly indicating that we did not support the vascular neurology pathway to INR subspecialization.

Given the fact that neurologists might eventually receive training to treat AVMs, epistaxix, and other INR procedures, it is even more important for ASITN to have well supported training standards and outcomes standards so that patients can continue to receive the highest quality of care regardless of which specialist provides that care.

We will attempt to keep everyone informed as best we can, but unfortunately, there are many things that happen that are not only out of our control, but also that we don't even know about. The discussion forum on our web site is vital to our remaining in contact with each other. We can also just call to chat with each other. Please do.

We're Hungry for News...

About You!

One of the most valuable services that ASITN performs is to provide various forums to help members keep up with industry trends, swap war stories, and share good news. To do that, ASITN has to hear from YOU!

How can you keep us informed? It's easy. Add us to your mailing list for all press releases, newsletters, and other publications. Call us or drop a note to let us know about new personnel, procedures, or studies. Send us copies of newspaper, magazine, or journal articles in which you are featured.

Send your materials to **info@asitn.org**, via fax at **703-691-1855**, or by mail at 10201 Lee Highway, Suite 500, Fairfax, VA 22030.

The Joint Meeting

Chuck Kerber, MD

The Cerebrovascular section of the AANS and ASITN meeting has become a highly successful meeting. There were more than 650 attendees, about half of them from industry. All of the major manufacturers had a presence – and thus donated to our cause. This gave us the opportunity to see their new devices and some also that have not yet received FDA approval.

The science was good, as were the social interactions. In order to strengthen and formalize our relationship with the JSCVS, a Joint Coalition was formed; it is composed of four members of the JSCVS (Robert Harbaugh, Hunt Batjer, Phil Steig, Warren Selman) and four of our members (Gary Duckwiler, Buddy Connors, Randy Higashida, Jacques Dion). Its purpose will be to explore mutually beneficial areas of cooperation; quarterly conference calls are planned, as well as a face-to-face meeting at the Annual JSCVS/ASITN Meeting.

ASITN: A Ten-Year Historical Perspective **continued from page 1**

Since SIR began 20 years before us, and since there are so many parallels in our growth and development, I believe it is worthwhile to look at their analysis of their history.

1973 to 1978 were considered their formative years. From 1979 through 1984, years of challenge and opportunity; from 1985 through 1989, years of expansion and maturing; and after 1990, the years of achievement.

In those early years, the formative years, membership varied from the mid 50s to almost 200. There was still a small group of academic angiographers who had essentially invented the field. In the second phase, challenge and opportunity, growing membership was the primary focus. They evolved into a society to enhance educational opportunities, and significantly introduced the democratic process while widening the membership base. In their third phase, their expansion years, they became a recognized authority with better organization. Opening up the organization allowed the membership to increase dramatically, and what also increased dramatically were the dues – to $250 per year, after members realized their society was actually providing them valuable services. They also began a journal affiliation with Radiology. In their fourth phase – achievement – they reorganized their bylaws, created a foundation, began to edit their own high quality journal, entered the computer age, got a seat in the ACR House of Delegates, and began to flex their political muscle. They designed and carried out their own Certificate of Added Qualification and became generally recognized throughout the American political scene and American medicine. Their membership has exceeded 4,000 at this point. In fact, SIR's 4000th member was Dr. Joshua Hirsch, an ASITN member!

A quick look at our evolution confirms the parallels. We have recently gotten corporate support, including long-term commitment from Target Therapeutics/Boston Scientific and Cordis Endovascular, and most recently have hired a full-time director of professional affairs who is based at the SIR office. We began a political program, interfacing with SIR and the Kennedy Stroke Legislation. We have recently obtained fellowships, published Standards of Practice documents, and begun an effective program to improve our billing and coding systems.

I believe that we are at an important and crucial crossroad in our development. Two questions present themselves: first, does our name truly reflect what we do and where we wish to go, and second, how do we control the growth of our market and our practice.

I would like to suggest that the most critical goals for our future are the following:

1. We should vigorously pursue a public recognition and perception campaign. This means, quite simply, good PR.
2. We need to develop public spokespersons.
3. We should strengthen our strategic alliances with the Joint Section, the Society of Interventional Radiology, and the American Society of Neuroradiology.
4. We must have enhanced communication with our membership.
5. We must ensure that we are serving the needs of our members.
6. We need to intensify our efforts on coding, reimbursement and standards of practice.

Your input into how this will be accomplished is essential. If you would like to get involved in a leadership role with the Society, please send an e-mail to Marie Williams, marie@asitn.org.

Editor's Column continued from page 4

By the way, it is important to define "hazard". The hazard is something that could potentially lead to mishap, accident, or bad outcome. It's the thinking in advance that makes the difference.

To summarize, here are the three principles of Operational Risk Management:

1. Accept risk only when benefits outweigh the cost
2. Accept no unnecessary risks
3. Anticipate and manage the risk through appropriate planning and execution

If you want more information, try contacting faherty.denis@hq.navy.mil, and see also the article by Paul Uhlig, the Cardiovascular surgeon at Dartmouth (Improving Patient Care by the Application of Theory and Practice from the Aviation Safety Community).

John Trotti, in his book *Phantom over Vietnam* speaks of a "culture of safety", explaining why military flying is so much safer than anyone has any right to expect. I wonder if it is time to re-examine our culture. What you think? If you wish, we can explore this further in the next issue.

A Final Thought

Reading through the contents of the newsletter, being told about all the iatrogenic illness we cause, and then being hit with our painfully dismal reimbursements might make anyone a little discouraged. But to put it all in perspective, most of us still awaken in the morning before the alarm clock goes off, and though we're way too busy clinically and with the paperwork burdens, most of us would go to work even if we didn't get paid. We love our jobs, we live in the best country in the world, and we live during the best of times in mankind's history. It puts one in mind of Samuel Johnson's quote: "I had intended to be a philosopher, but happiness kept breaking out".

Respectfully submitted,
Charles W. Kerber, MD

Welcome New ASITN Members!

The following new members were approved at the ASITN Business Meeting in Vancouver. Please help us extend a warm welcome to them!

Active Members

Albert E. Alexander
Baton Rouge Radiology
Baton Rouge, LA

Turgut Berkman
University of Miami, Jackson Memorial Hospital
Miami, FL

Matthew H. Berlet
St. Joseph's Hospital
Tampa, FL

Michael W. Budler
Bryan LGH Health System
Lincoln, NE

Brian W. Chong
Inland Imaging
Spokane, WA

Joel K. Cure
University of Alabama at Birmingham
Birmingham, AL

Timothy D. Duncan
Naval Medical Center, San Diego
San Diego, CA

Kai U. Frerichs
Brigham & Women's Hospital
Boston, MA

Charles A. Guidot
Saginaw Valley Neurosurgery
Saginaw, MI

David T. Jeck
Mallinckrodt Institute of Radiology
St. Louis, MO

Ramin S. Pakbaz
University of California, San Diego
San Diego, CA

David M. Pelz
London Health Sciences Centre
London, Ontario, Canada

Ian B. Ross
University of Mississippi Medical Center
Jackson, MS

Daniel Roy
University of Montreal, CHUM Notre Dame
Montreal, Quebec, Canada

Peter E. Schloesser
University of California, San Diego
San Diego, CA

Soma Sinha Roy
University of Virginia Health System
Charlottesville, VA

Sten Y. Solander
University of North Carolina
Chapel Hill, NC

Neil A. Troffkin
University of Miami/Jackson Memorial Hospital
Miami, FL

Timothy L. Tytle
University of Oklahoma Health Sciences Center
Oklahoma City, OK

John B. Weigele
University of Iowa Hospitals and Clinics
Iowa City, IA

Alain Weill
CHUM Hospital Notre Dame
Montreal, Quebec, Canada

Henry H. Woo
NYU Medical Center
New York, NY

Associate Members

Davender Bhardwaj
Temple University Hospital
Philadelphia, PA

Harry Haitak Chen
Phoenixville Hospital of the UPHS
Phoenixville, PA

Gary S. Cohen
Temple University Health System
Philadelphia, PA

Douglas F. DeOrchis
The Miriam Hospital
Providence, RI

Paul S. Jackson
Endovasix, Inc.
Belmont, CA

Paul B. Segebarth
University of Kentucky College of Medicine
Lexington, KY

Ali Shaibani
Northwestern University Medical School
Chicago, IL

David J. Shelley
Diversified Radiology of Colorado, PC
Lakewood, CO

M. Christopher Wallace
Toronto Western Hospital
Toronto, Ontario, Canada

Howard Y. Young
Connecticut Vascular Institute
Hartford, CT

Junior Members

Sultan Al-Qahtani
Montreal General Hospital/ McGill University
Montreal, Quebec, Canada

Anthony J.G. Alastra
NYU Medical Center
New York, NY

Joshua Bemporad
University of Iowa Hospital & Clinics
Iowa City, IA

Stephen M. Russell
NYU/Bellevue Hospital
New York, NY

Christopher L. Taylor
UT Southwestern
Dallas, TX

Calendar of Events

American College of Radiology Annual Meeting
September 28-October 2, 2002
Loews Miami Beach Hotel
Miami, Florida
Contact: Pam Mechler, 703-716-7545

American Academy of Family Physicians Annual Scientific Assembly
October 16-20, 2002
San Diego Convention Center
San Diego, California
Contact: AAFP, 913-906-6000

SIR/ASITN Neuro-Carotid/Stroke Therapy Course
October 18-19, 2002
Marriott City Center
Portland, Oregon
Contact: SIR, 703-691-1805

American Heart Association Scientific Sessions 2002
November 17-20, 2002
McCormick Place
Chicago, Illinois
Contact: AHA, 214-706-1543

Radiological Society of North America Scientific Assembly and Annual Meeting
December 1-6, 2002
McCormick Place
Chicago, Illinois
Contact: RSNA, 630-571-7850

American Stroke Association Stroke Conference
February 13-15, 2003
Phoenix, Arizona
Contact: ASA, 214-706-1575

ASITN/JSCVS Annual Meeting
February 16-19, 2003
Crowne Plaza
Phoenix, Arizona
Contact: ASITN, 703-691-2272

Society of Interventional Radiology
March 27-April 1, 2003
Salt Palace Convention Center
Salt Lake City, Utah
Contact: SIR, 703-691-1805
Abstract Deadline: October 4, 2002

The Embolus

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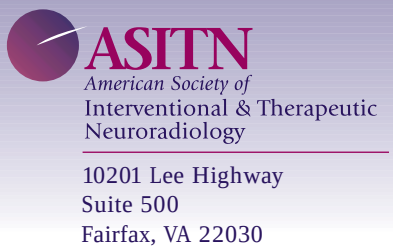

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