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ASNR Presidential Address, 1988

Michael S. Huckman[1]

One of our colleagues in general radiology recently called me from a small town in Pennsylvania. It seems that a local group of neurosurgeons and neurologists had purchased an inexpensive MR scanner and hired a "board certified" osteopathic neuroradiologist to read their scans. In case you did not know, osteopaths can be certified in neuroradiology. He said that his group of general radiologists had a better scanner and more experience but had lost a major volume of their neuroradiology cases because referring physicians claimed that the other group had a certified neuroradiologist reading the scans.

I had no advice for this gentleman, but I lamented to him that organized radiology has opposed the granting of added qualifications in neuroradiology. He replied, "We sure don't want that."

It has been 2½ years since Tom Bergeron stood on this platform and suggested that the "powers that be" in radiology had been stubborn in granting recognition for expertise in the various subspecialties of the field. The reply of our colleague in Pennsylvania shows that we still have a formidable task ahead of us.

Yet, a few concrete gains have been made. We have submitted an application to the Residency Review Committee of the American Board of Radiology (ABR) for approval of fellowships in neuroradiology, and after many rewrites and with the assistance of Drs. Ted Tristan and Jim Youker, this application has been forwarded by the Residency Review Committee to the Accreditation Council for Graduate Medical Education for the Council's approval. This promises to be a lengthy process, but the cow is out of the barn.

I recently read that the state of New York has proposed mandatory recertification of all physicians, a trend that may extend to other states. The intended law would allow for recertification by specialty boards. I would certainly hope that the subspecialty option for recertification would be available in radiology.

The momentum for added qualifications in neuroradiology must be kept alive. Until last week I thought now would be an appropriate time to take the idea that Tom put forth in 1986 and convene a meeting of representatives of radiology subspecialty societies in hopes that such a meeting could produce a unified, reasoned position statement supporting the idea of subspecialty certification.

However, on the basis of the Presidential Address delivered by Lee Rogers to the American Roentgen Ray Society (ARRS) last week in San Francisco, I and the Executive Committee have decided not to call that meeting at this time but rather to monitor immediate developments on this issue in the near future.

In Dr. Rogers's speech, he said, "The time has come for us to restate and reframe our standards." He went on to say that radiologic groups have recognized that each individual radiologist cannot do all things for all patients and that more than 50% of residents take 1 or more years of fellowship training. He concluded that "for these reasons some form of subspecialty recognition is not only desirable but likely inevitable and clearly in the best interest of our specialty."

I suspect the millenium has come when we hear that from someone who simultaneously wears the hats of president of the ARRS, chairman of the board of Chancellors of the American College of Radiology (ACR), and member of the ABR. This is indeed the most promising development that has occurred on this front in the last 2½ years. A grace period should be given to allow positive further action on this issue, but, should it not be forthcoming in a reasonable length of time, a meeting of radiology subspecialty societies remains a viable course of action.

What goes around comes around, and we now hear our own arguments from other corners. Today our colleagues in the Society of Cardiovascular and Interventional Radiology and many of our own members who limit their practices to interventional neuroradiology have developed their own agendas for recognition of their expertise. As a society, we can only sympathize with the Society of Cardiovascular and Interventional Radiology but we can be of service to the interventional neuroradiologists who are members of the ASNR.

First and foremost, we, as a society, must not be intransigent and must recognize the special skills of those involved in this field. It seems that neuroradiology is evolving along the path that general radiology followed in the 1960s; that is, toward two fields: diagnostic neuroradiology and interventional neuroradiology. This is an inevitable development, and the idea should be nurtured and accepted by this society. Just as many people in the 1960s practiced both radiation therapy and diagnostic radiology, I envision that for the next few years, many people in neuroradiology will practice both diagnostic and interventional neuroradiology. However, it will soon become clear that just as the general radiologist had to make the choice between being an expert diagnostic radiologist or an expert therapeutic radiologist, a similar choice will have to be made by neuroradiologists as the complexities and training requirements of diagnostic and interventional neuroradiology diverge from their common origins. The ASNR must commit itself to making the resources available to allow both groups to develop their own unique training criteria and have equal opportunities to express their ideas in the forums of the ASNR, which of course is where both disciplines were born. I personally am committed to this and think it is the

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proper response for a society that itself has made a similar request on its own behalf to the rest of organized radiology. But make no mistake. Call it surgical neuroangiography or interventional neuroradiology, it is still part of neuroradiology. Those who think that it should be a technique shared with and taught to nonneuroradiologists are naive to think that those who would covet their expertise would do so for altruistic reasons. Would the people so trained be neuroradiologists? Most would, under current guidelines, be ineligible for membership in ASNR or, for that matter, for the ABR examination. What will the neuroradiologist get in return for providing such training? Will the finished product be a better physician? Let us be certain we know what is being given away and what can be expected in return.

I would now like to briefly summarize some highlights of the past year. Dr. Osborn and Mr. Schuyler have drawn up a standard agreement between commercial interests and the ASNR indicating how contributions to the society will be handled and how they will be recognized. The agreement form is one with which the society and its commercial friends can feel comfortable. All the events on our social and scientific program are society-sponsored, although many are assisted by grants from commercial interests. Invitations and publicity for the events and recognition of corporate sponsors is to be done by the society in a tasteful manner.

Whereas I had requested a few changes in the constitution regarding succession to the presidency, Dr. Bryan and the Rules Committee, with the expert assistance of Mr. Hedland of our central office, have streamlined the document so that it now fits the needs of a society that has grown from 14 members to more than 1000 members in 26 years. Our constitution was at best clumsy to work with when I was secretary from 1980 to 1983 and ran the whole organization out of a three-drawer file cabinet that sat in the bathroom adjacent to my office. You can imagine how difficult it is to use that same document today when the scopes of our meeting and our membership have broadened so greatly. The proposed constitutional changes have undergone extensive review by the Executive Committee and several past-presidents before being submitted to the membership. The changes represent a great deal of work, and I believe their adoption is essential for proper functioning of our society if we wish to continue to enjoy the kinds of meetings, publications, and membership services we now have.

Our journal is an unqualified success. An article in the January 1988 issue of *Radiology* showed that *AJNR* ranked eighth among 30 radiology journals in the number of times it was cited in the articles of other radiology journals. Inasmuch as many of our early articles had the *AJR* as their citation source, the true ranking is probably higher. This listing also referred to an impact factor, a method of allowing comparisons of large and small journals. In this regard, *AJNR* ranked fourth out of the 30 journals reviewed. This is a tribute to the high standards maintained by our editorial staff.

At the start of my term, I reviewed our society's representation on the committees of the ACR. At the summit meeting in Colorado Springs last summer, I told Dr. Meaney that I thought we were inadequately represented. Since that time, Dr. Kieffer and I have had extensive correspondence with him, recommending individuals for membership on various college committees. I was most concerned about our participation in the establishment of relative value scales (RVS) for radiology. I felt strongly that our representation on the committees addressing that issue was inadequate. In response to our efforts, two of our members have recently been appointed to the RVS consensus panels.

This year Dr. Harwood-Nash, chairman of the Awards Committee, reports that we will award two ASNR fellowships thanks to grants from Berlex, Inc. He also reports that competition for the Dyke Award was stiff and produced several papers worthy of the prize.

Financially, we are in good shape. Our investments suffered only a minimal setback on Black Monday, and we have been blessed with excellent support by our exhibitors and commercial sponsors. Our first categorical course was a great success and should show a profit. The *AJNR* is also a continued source of revenue.

Inasmuch as we are only 12 years away from the millenium, I feel compelled to speculate on what the training of the neuroradiologist and the role of the ASNR should be in the year 2000 and how those goals might be reached. Today, for the most part, the training we provide is an extension of residency, with concentration in a limited area. We define a certain number of procedures that must be performed. The literature of our specialty is top-heavy with descriptions of the radiographic findings in a number of incurable diseases. We are in danger of becoming the ultimate purveyors of what Lewis Thomas calls "halfway technology," that is, the technology that comes into play when a disease is discovered after it has run half its course. It is the technology used in diagnosing and treating late-stage arteriosclerosis or metastases to the brain or grade IV glioblastoma. Dr. Thomas refers to this halfway technology as the most costly and, at the same time, the least effective technology in medicine, and he says it is usually based on little or no understanding of the disease process.

He refers to "high technology" as the most effective and least costly. It is based on a thorough understanding of the disease. An example of this is the vaccination: cheap, effective, well-understood.

If neuroradiology is to be a viable specialty, we must develop and use high technology in the neurosciences. Rather than just teaching pattern recognition and long lists of differential diagnoses, fellowship training in neuroradiology must include the biology of neurons and glial cells, cerebral metabolism and blood flow, a study of the blood-brain barrier, the reaction of neural tissue to injury and infection, immunology of the nervous system, and how all these factors relate to imaging. I am not implying that we do not do this now, but these areas require more emphasis.

In our current economy, only 33% of competitive NIH grants are funded. Those are pretty tough odds. Our NIH liaison committee has proposed a basic neuroscience course for trainees in neuroradiology. Last month I discussed this with Dr. Murray Goldstein, director of NINCDS, who thought it should be an essential part of the training we offer. "After all," he said, "do you want to be technicians for others, or do you guys want to be the principal investigators?"

I do not know what the rest of radiology will do, but we must lead the way into the 21st century by broadening the scope of our training as I have outlined. Our society needs to solidify its reputation among other medical societies, charitable organizations, and granting agencies—not only as a radiologic society but also as a bona fide neuroscience society. I have asked Dr. Leeds to rejuvenate the Intersociety Liaison Committee dialogue with other neurologic societies, not to discuss turf and the issues that divide us, but to discuss those things that we and they can do together to educate, lobby, carry out scientific investigation, and improve delivery of medical care. The last neuroradiologist to serve on the National Advisory Stroke and Communicative Disorders council of NIH was Dr. Taveras, whose term ended in 1984. I have recently nominated four individuals from our society whom I feel the Conjoint Committee for Radiology can nominate with confidence for this position.

In April, Dr. Schellinger, Dr. David Davis, and I attended the annual meeting of the National Coalition for Research in Neurologic Diseases (NCR) in Washington, DC. We lobbied congressmen and senators for increased NINCDS research funding and impressed the neurosciences establishment with our concern in this area. I recently have forwarded the name of one of our members to the NCR nominating committee to be considered for a position on its board of directors.

A steady increase in the size of our membership is important to us if we are to have a voice in the councils of organized radiology and medicine. Therefore, this year's constitutional revision proposes removal of the limits on how long one may be a junior member, allowing those who do not become senior members to remain in the society. They are important to us: they strengthen our voice, attend our meeting, and submit articles and subscribe to our journal. We must find a proper niche for them in our society if they do not become senior members. Where that niche may be is uncertain, but I know it is wrong to drop them as we are now required to do.

I hope that in the next few years, and I emphasize in the next few years, we may alter our membership criteria in several categories. I would propose that we have "members" and "fellows." Those who now qualify for junior membership and are board certified should be eligible to become members. Those who possess the current qualifications for senior membership would have the title Fellow of the American Society of Neuroradiology. The Membership Committee could, in addition, make recommendations to elevate various members to fellowship, based on a combination of additional training and achievements in teaching, publication, and investigation. All members and fellows should be eligible to vote and hold office. Under that scenario, the members might then vote to abolish the fellowship classification. I suspect they will not and will probably wish to keep it as a goal to which they might aspire.

George Bernard Shaw once wrote: "The reasonable man adapts himself to the world; the unreasonable one persists in trying to adapt the world to himself. Therefore, all progress depends on the unreasonable man." In some ways, that describes the position our society has assumed. If we are to bring radiology into the modern age, one in which the radiologist will have the expertise and respect needed to converse professionally with our highly subspecialized colleagues in other disciplines, then this society must not be afraid to sound "unreasonable," and it must continue to jab at the conscience of organized radiology.

Collectively and individually, we must set the example of innovation and excellence in clinical practice and investigation that has made our reputation and has continually attracted highly qualified people to our membership. We must broaden the scope of the training we offer fellows and establish the reputation of our society as both a radiologic and neurologic organization. We must continue to press for official recognition of excellence in neuroradiology and in other radiologic subspecialties. Finally, we must allow the ASNR a healthy growth so as not to become a mutual-admiration society. I think the plans I have outlined will allow us to do all these things without lowering our membership standards.

During the past week, the *Chicago Tribune* has run a most fascinating series about how scientists are unraveling the mysteries of the brain and the mind, which seem increasingly to be perceived as one. Reading about the advances in molecular biology of the brain and imaging of its most basic structure and functions was exciting but at the same time depressing, mainly because so little of the work was done by neuroradiologists. As long as radiology is taught and practiced the way most of us learned it, we will continue to purvey halfway technology. But I am optimistic. The history of this society tells me that we will again set the standards for the rest of radiology, that by the turn of the century we will have become an integral part of the true high technology of CNS imaging, and it does not require a crystal ball to see that the way we now practice neuroradiology is destined to become obsolete. The perseverance, adaptability, ingenuity, and intelligence to keep abreast of these new challenges are here in this room today. Let us all resolve to make that happen.