

2000 ASNR Presidential Address

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Dear friends and colleagues, it has been an honor and a privilege to serve as your president. My years on the Executive Committee have been a tremendous learning experience, and clearly, the highlight of my career.

First, I would like to acknowledge publicly a few of the people who have been instrumental in my reaching this day. Harold G. Jacobson, the chair of radiology at Montefiore Hospital in New York City, gave me the opportunity to become a radiologist and set an extraordinary example through his dedication to teaching and excellence. Thanks to Norman Leeds and Robert D. Zimmerman, whose infectious enthusiasm for neuroradiology clearly influenced my own career choice during residency. Thanks also to many others with whom I have trained or worked: Irv Kricheff, Tom Bergeron, Norm Chase, Ajax George, Richard Pinto, Alex Berenstein, and Thomas Naidich. Finally, thanks to Michael Huckman, who provided my first “real” job as a neuroradiologist and made me feel welcome in Chicago back in 1980. Most importantly, my deepest thanks and appreciation to my wife Sandi and my children Abby and Meredith for their love and understanding, without which my work for the society these past 5 years would not have been possible.

As president, I have been blessed with a remarkable Executive Committee and central office staff led by James Gantenberg. I am confident that very strong leadership remains in place to continue our efforts to move forward with our strategic goals as the new century unfolds. Bill Ball, our new president, is a tireless worker, a clear thinker, and a no-nonsense guy, whom I have grown to admire and respect. With the help of the ASNR meeting staff led by Tim Moses and Lora Tannehill, and the specialty program chairs from the American Society of Interventional and Therapeutic Neuroradiology (ASITN), the American Society of Spine Radiology (ASSR), the American Society of Pediatric Neuroradiology, and the American Society of Head and Neck Radiology, Bill put together this spectacular program in record time, while working also on countless other ASNR projects. Bill Dillon, your vice-president, has already outlined a terrific 2001 meeting in Boston—we are in great hands.

We have made significant progress in fulfilling our mission and strategic plan this year. Our membership has for the first time surpassed 3000, we are financially strong, and our central office is sta-

ble and dedicated. All of you who serve the society through committee service should take pride in what we have accomplished. I take this opportunity to review the activities of the past year, and also to look toward the future.

Last year in San Diego we moved to solidify our relationships with our related subspecialty societies through renewed attention to committee composition and restructuring of the ASNR annual meeting. This year, we have also worked to broaden our interactions with other organizations outside of neuroradiology, reasoning that true influence requires a broad consensus. We cannot afford to be isolated from our colleagues in related radiologic or neuroscience disciplines; in fact, we need to build stronger bridges. Our society has grown from a few founders with a clear vision in 1962 to an organization of more than 3000 members, and yet we need to expand to further broaden our scope.

The constitutional amendment we adopted last year was designed to encourage all those who practice neuroimaging and neurointervention, and our friends in basic imaging science and neuroscience, to join us as ASNR members. I am pleased to tell you that we have successfully recruited an initial group of basic science colleagues, several of whom participated in this year’s meeting. The superb physiologic imaging symposium organized by Bill Ball showed the value of cooperation and scientific interchange across disciplinary boundaries. One of our key goals in the next year is to expand this effort. We all have much to gain by encouraging such collaboration.

The Clinical Practice Committee (CPC), formed in 1995 in an effort to more fully address issues of importance to community-based neuroradiologists, has expanded in scope and effectiveness this year. Socioeconomic advocacy has become increasingly important to all of our members, as decreasing reimbursement for our services forces community-based and academic neuroradiologists alike to become more productive. Since the day in 1995 that Arliss Pollock agreed to take on the chairmanship of the CPC, following a bit of arm-twisting by then ASNR President Bob Lukin, his deep-seated dedication to the mission of the CPC has become increasingly clear. Working in this sphere requires a long-term commitment; Arliss’s leadership skills and the hard work of ASNR staff member Paula Berchos, CPC Coordinator, have led us through a daunting socioeconomic playing field. We can now

wield our influence when and where it is most effective, and can better influence health care policy and develop training and practice guidelines that protect our patients and benefit us all. Thank you, Arliss and Paula. We are all in your debt.

Importantly, we are no longer dependent on other organizations to look after our interests. This year the Coding and Reimbursement Subcommittee, chaired by Blake Johnson, participated in the development of many new billing codes, secured supervision and interpretation codes for spinal injection procedures against strong opposition, and is now collecting data to provide input into practice expense valuation for many of these new codes to support appropriate reimbursement. For this excellent work on our behalf, Blake received the Burgess-Gordon Award from the American Medical Association (AMA) Current Procedural Terminology (CPT) Advisory Committee. Also, working cooperatively with the ASITN, the ASSR, the Society of Cardiovascular and Interventional Radiology (SCVIR), the American College of Radiology (ACR), and the North American Spine Society, we developed a new CPT code for percutaneous vertebroplasty, which was recently approved by the AMA CPT Advisory Committee. This will directly help patients across the country gain access to this procedure, which has much promise for reducing the chronic debilitating consequences of osteoporotic and other types of spinal fracture. In addition, our Government Relations Subcommittee has worked to place our members in contact with local Medicare Carrier Advisory Committees to ensure our input on key reimbursement issues, and the Utilization and Appropriateness Subcommittee is working on an internet database to link the Internal Classification of Diseases (ICD)-9 clinical indications with CPT codes.

Our Standards Subcommittee, in cooperation with the ASITN and SCVIR, successfully completed the newly approved ACR Standard for Cervicocerebral Angiography. This document sets evidence-based thresholds for the performance and interpretation of neuroangiography. Our members can now use this guideline to promote quality improvement programs at their own institutions to hold all who would perform neuroangiography and related procedures to a high standard. Other guidelines are currently in process, including one exploring the developing technique of carotid angioplasty and stenting, also a cooperative effort among societies. Our efforts to work with the ACR on these issues were recognized by repeated references to ASNR-ACR projects in the keynote address given by retiring ACR President Ron Evans at their annual meeting in Washington, DC this past fall.

Several months ago we held an organizational meeting between the leaders of the ASNR, ASITN, and SCVIR, which yielded improved understanding and should solidify what I consider to be a key working relationship that we need to continue to build upon. We have broad areas of mutual interest,

as we can see from the projects I have already discussed. Committees with overlapping objectives have begun to exchange members, and closer staff contacts have been secured to insure efficiency in our approach to practice guidelines, socioeconomic initiatives, public relations, and research. Planning has begun for a cooperative targeted stroke educational program, which will take place in October in Washington DC. This is designed to provide attendees with the latest information related to acute stroke diagnosis and intervention. Also, these three societies participated in a working consensus conference in Memphis, Tennessee on the use of newer thrombolytic and antiplatelet agents in acute stroke intervention. Led by a member of the ASNR Stroke Task Force, Buddy Connors, it will yield a registry to track thrombolysis outcomes, a critically important project meant to identify optimal therapeutic regimens for our patients in the wake of the Federal Drug Administration decision not to approve pro-urokinase for intraarterial thrombolysis.

Although these successes are encouraging, it is not nearly enough. We need to move beyond our usual relationships, and promote the best practices and high-quality patient care on as broad a stage as possible. In an era when some seek to perform procedures without adequate training or experience, we cannot and will not relinquish our high standards for expedience, and we must work even harder to make sure that we are positioned to bring our expertise to any forum at which policy related to these issues may be set. We are uniquely qualified to bring together the technical aspects of imaging science and our clinical perspective as physicians to set these high standards. Toward this end, we have secured ASNR representation on the Executive Committee of the Cardiovascular Radiology Council and, with the recent appointment of Tom Tomsick, we are also represented on the Stroke Council of the American Heart Association (AHA). This important step will enable us to consistently bring our expertise to this multidisciplinary patient-oriented organization, and begin to develop consensus documents on several topics that relate to our specialty. Through the work of Randy Higashida, chair of the new AHA Cardiovascular Radiology Council Committee on Cerebrovascular Diseases, we have gained approval for three new working groups. These groups include representation from the fields of neurosurgery, neurology, and other disciplines in order to develop consensus statements for physiologic imaging in stroke, intracranial MR angiography, and endovascular treatment of intracranial aneurysms. We have the means to bring our perspective to this stage, and we must lead these efforts in support of optimal patient care.

This brings us to another key issue we have worked on this year, our educational mission. We have spent much time working on training guidelines. In cooperation with our colleagues in the ASITN and American Association of Neurological Surgeons, we have approved a guideline for neu-

rointerventional training. I believe that the future of neurointerventional practice lies in our setting high training standards. We will work with the Residency Review Committee to bring this to the American Council of Graduate Medical Education for approval, to ensure that well-trained practitioners are available for all who need these services, without compromising our training programs in diagnostic neuroradiology.

Let us briefly focus on our diagnostic training program. In 1988, in his presidential address in Chicago, Michael Huckman expressed hope that subspecialty certification in neuroradiology might finally become a reality; his hope was based on a supportive speech given in San Francisco the week before by the American Board of Radiology (ABR) President Lee Rogers. Subspecialty certification actually took a bit longer to achieve, but it helped define the quality of our training and the strengths we bring to patient care. This has since served us well, but we now need to reexamine our programs. In the same address, Dr. Huckman chose to speculate on the form that neuroradiologic training would take in the year 2000. He noted that we were in danger of becoming, in the words of Lewis Thomas, the "ultimate purveyors of halfway technology," an approach to disease beyond the point of its origin, when expensive measures are often taken too late for a significant positive impact on outcome. He observed that if we were to remain viable, we must use "high technology," and work to make sure that our trainees have the opportunity to learn the basics of neuroscience in order to approach disease from a fundamental point of view. We have made progress over the years, but still struggle with this today. The imaging tools are now available to explore neurophysiology *in vivo*, and I believe that we must grasp the ring, or risk all that we have gained as a specialty. Those of you who attended the physiologic imaging symposium clearly understand this, and also appreciate the synergy that we must nurture with our basic science colleagues.

It is the opinion of your Executive Committee that our current training programs must be further expanded in order to educate our members and trainees fully in modern neuroimaging and intervention. We face a critical challenge, one as great as any we have ever faced, and yet many of us still do not perceive the threat. Physiologic neuroimaging is a powerful research tool and is taking on an expanded clinical role, and yet too few of us are involved in this research or the incorporation of it into our own clinical practices. As a society dedicated to education, we must lead the effort to provide educational resources in physiologic neuroimaging for our trainees and members, and we must do this now.

To support this effort, we are in the process of creating a new internet-based educational structure within the ASNR to support the expanded training curriculum, which will be more physiologically ori-

ented and based more deeply in basic imaging science. The outline developed by the Task Force on Education in the 21st Century, which was ably led by James Barkovich at our February retreat, is in place. With your help, we will integrate the modern curriculum into a new cyclical annual meeting structure, which will feed the renewal of this internet-based educational resource year after year. This past March, each member of the society received a letter from me and a description of our plan. To gain experience in the design and layout of such programs, the ASNR will place on our website several "How-To" sessions from this year's annual meeting. We are also ready to begin developing additional content to be placed on an ASNR Foundation Continuing Medical Education (CME) site. Bill Ball, as our new president, will help guide us through this development stage, along with our Education Committee chaired by Jay Wippold, your officers, the Executive Committee, and staff.

The fulfillment of this vision also requires that we identify a physician educator, and we are now conducting a search led by Vice-President Bill Dillon. We need to refine our initial plan and bring together our improved central office infrastructure and the efforts of volunteers to reach our goal. This aggressive effort, which is essential for us to remain competitive, will also require additional staffing at ASNR headquarters. The ASNR Foundation will support this major effort, but we all need to take responsibility for its success. I hope that you sense the urgency with which I ask you to say yes when you are asked to volunteer time, and when you are asked to provide financial support through your dues and donations to the ASNR Foundation. The Foundation will now support not only research, by funding young investigators and scientific projects as it has in the past, but it will also underwrite this educational effort. It is with a sense of excitement and anticipation that your Executive Committee, the leadership of the Foundation, and the entire ASNR staff embrace this exciting new agenda to provide better education for fellows in training and practitioners.

The ASNR has long required a 2-year fellowship for senior membership status; we believe this produces more competitive practitioners and academicians. Because of the pressures of economics, and the *de facto* certification afforded by the Certificate of Added Qualifications examination that only requires a 1-year fellowship for entry, fewer trainees now complete 2 years. With the need to expand physiologic subject matter in the new curriculum further, and our desire to provide more clinical and research training to remain competitive, providing for a 2-year specialty program is now even more important. Toward this end, we are exploring with the ABR an alternative pathway to provide this dedicated time. The model is based on the Holman research pathway recently approved by the ABR, and a similar 72-month pathway through residency and fellowship training recently devel-

oped for vascular/interventional radiology training. This can provide a full 2 years of training in neuroradiology, and is within the current guidelines set by the ABR. This program requires full cooperation between residency and fellowship directors at the host institution, but may provide the time we seek.

The ASNR needs to develop further an overall strategy in regard to the internet. We have become a more effective organization through expanded use of this medium. Broadcast email capabilities have improved our ability to communicate with our members, and I encourage all of you to keep the central office apprised of changes in your email address by writing to executive@asnr.org. This permits staff to contact you quickly when action is required on short notice, and will not be abused. With the recruitment of Caroline Shelby as our new webmaster, we will more rapidly develop the ASNR website to improve member services and communications, including the internet-based Foundation CME site I referred to earlier.

This year we also will translate the *AJNR* into an electronic publication. After a competitive analysis by the Publications Committee, led by Chair

David Norman and Director of Communications Angelo Artemakis, the Executive Committee has approved initial funding for the development of the *AJNR* on-line. The objective is to provide members and subscribers with easy access to cutting-edge research and the use of powerful search capabilities for all journal content, from any location. Although an initial investment will be required, it will pay dividends to our members and permit the journal to compete in an increasingly competitive information marketplace.

As I close, let me say that we believe that scientific research is the foundation upon which the clinical practice of neuroradiology is built. With the strong leadership of Vince Mathews, chair of the ASNR Research Committee, we are pleased to support the ASNR Foundation's efforts to promote research in neuroradiology through donations to support young investigators. We need your help to broaden the scope of this effort and, by doing so, we can secure our own future. Thank you all for your support, and thank you for the opportunity to work for our specialty that has given so much to me.