

# Endovascular Accreditation

This politically charged issue is far from resolved.

BY THE ENDOVASCULAR TODAY STAFF

**T**he turf wars of approving credentials and granting privileges for endovascular specialists have provoked nearly 2 decades of profound debate and scathing slingshots at the motives and competence of colleagues. At the core of the struggle is the question of professional expertise and a battle for economic survival while trying to focus on providing the highest standards of patient care.

## THE STANDARDS

Credential and privilege standards for endovascular therapies have their roots in the guidelines first established in 1988 for coronary angioplasty by the ACC and AHA.<sup>1</sup> As peripheral vascular procedures evolved, so did specific, often divergent, guidelines for this emerging field. The Society of Interventional Radiology (SIR), The American College of Cardiology (ACC), the American Heart Association (AHA), the Society for Cardiac Angiography and Interventions (SCAI), and the Society for Vascular Surgery (SVS) all set different standards for study, training, experience, and continued education to allow their members to present themselves to hospitals (and patients) as qualified to perform percutaneous peripheral vascular therapy.

The details and numbers vary among the societies, but the credentialing standards all consider the following components: (1) minimum number of diagnostic angiograms; (2) minimum number of peripheral interventions; (3) minimum number of diagnostic angiograms and interventions as primary operator; (4) minimum number of arterial lysis procedures; (5) minimum number of diagnostic angiograms and peripheral intervention performed per year; (6) proctoring requirements; and (7) annual CME requirements.

The major differences and cause for conflict in the approaches to credentialing standards are the minimum numbers of diagnostic and interventional procedures that a physician must achieve in a clinical training environment. Table 1 illustrates these differ-

ences and indicates how some societies revised their requirements.<sup>2,3</sup>

Although it is not the purpose of this article to analyze the merits and claims of the various standards, it is important to note and briefly indicate where the disagreements are still deep and passionately argued.

The standards of the AHA were formed by a multidisciplinary committee of surgeons, cardiologists, and radiologists, and are consistent with the ACC standards and are now endorsed by SIR (David Sacks, MD, personal communication, March 2004). The consensus reached in the AHA guidelines provides common ground for department chiefs and hospital committees trying to maintain their own fair and safe credentialing standards. Ideally, everyone wants the quality of patient care to be the first and foremost consideration in setting credentialing standards, but each physician and each discipline has ingrained biases and self-interests regarding the merits and motivations of their standards versus those of another.

The practical ramifications of the divergent credentialing guidelines from competing specialties leads, at times, to uncivil wars, more often to precarious but sustained truces, and in some ideal cases, unions that allow for progressive care.

**TABLE 1. REQUIRED CLINICAL EXPERIENCE GUIDELINES FOR CREDENTIALING OF PHYSICIANS TO PERFORM PERCUTANEOUS PERIPHERAL VASCULAR INTERVENTIONS**

Board	NUMBER OF PROCEDURES		
	Dx Angiography	PTA	Arterial Lysis
IR	200	25	0
ABR	100 (50)	50 (25)	10
AHA	100 (50)	50 (25)	10
ACC	100 (50)	50 (25)	10
SCAI (1990)	100 (50)	50 (25)	15
SCAI (1999)	0	3	0
SVS (1993)	50	10-15	0
SVS (1999)	100 (50)	38 (17)	0

*(numbers in parenthesis are procedures as primary operator)*

## CIVIL WAR

The most unfortunate outcome of conflicting standards for accreditation is when colleagues, practicing under the shared auspices of a prestigious hospital, feel forced to engage in open warfare. Rather than finding opportunities to work together in a way that might improve overall patient care and actually increase the size of the proverbial pie, they fight over shares of a pie that they envision getting smaller.

In one instance, a vascular surgeon at a major hospital (anonymous, personal communication, February 2004) described his experience with the internecine battle among competing interventionalists working under one roof. At this hospital, one department lobbied unsuccessfully to prevent another from performing any endovascular procedures. Attempts to establish a governing hospital-wide credentialing committee were also defeated by chiefs anxious to maintain control over their own departments.

In hospitals where each department has its own accreditation procedures, the department heads usually review new accreditation recommendations and forward them to that department's credentialing committee, which has final authority to grant privileges. The accreditation decisions stay within the various departments, guided—but not bound by—the guidelines of their respective societies. As a result, there may be two or three sets of accreditation standards (some more stringent than others) for the same endovascular procedure at the same hospital.

## ARMISTICE

By contrast, a similarly large and complex institution, Stanford University Medical Center, has been able to quell the passions and strike a tenuous balance by having an effective hospital-wide credentialing committee. Thoracic surgeon Walter Cannon, MD, is the long-term chair of the Credentialing and Privilege Committee at Stanford University Medical Center. He saw the precursor to the endovascular turf wars in the development of liposuction procedures when every surgeon associated with the relevant anatomical care wanted a piece of the action of the latest breakthrough (personal communication, March 2004). The credentialing committee dispelled this controversy by realizing and asserting that this procedure required special skills, knowledge, and judgment. First, they denied privileges for liposuction procedures to general surgeons who had not pursued cosmetic studies. They further tightened the privileging strictures by carefully looking at the training and experience of each subspecialty to ensure that they had the necessary array of cognitive and clinical skills to safely and effectively provide patients the highest standard of care.

Today, with endovascular procedures, Dr. Cannon and his committee have a constant struggle to hold the line against

underpracticed, undertrained physicians who aggressively pursue entry into this growing field to the potential detriment of their patients' health and welfare (and the financial/legal liability of the hospital).

At Stanford, the hospital-wide credentialing committee is in a constant dialogue and investigation with interventional radiologists, interventional cardiologists, and vascular surgeons about what their standards are and whom they allow in their practice. There is a constant effort to balance the claims and interests of all departments, not just in credentialing physicians but also in the assigning of limited resources of technical personnel, equipment, and space. If the credential committee believes that a physician is underqualified, they have the power to prevent that doctor from performing these procedures—in their hospital, at least.

Some of Dr. Cannon's anxieties about credentialing situations include the many outlying hospitals that will allow significantly lower standards of competence for doctors rejected by Stanford. Another concern is the inherent conflict of interest if a patient's cardiologist is the one performing the intervention (ie, the patient should have objective and thorough guidance from a cardiologist who doesn't stand to benefit from the course of treatment).

The credentialing committee at Stanford strains to maintain high standards as well as an interdepartmental fairness in credentialing and allotting resources as the cross-fertilization of techniques changes the defined limits of what each specialty can do. It is never easy, but through constant dialogue and review of procedural outcomes and staff training, some informed and objective consensus can be formed. A strong, hospital-wide credentialing committee can be an assertive and effective referee in the constantly increasing efforts of physicians to get in on the action.

## UTOPIA

Susan Heck, Director at Corazon, a Pittsburgh-based national consulting firm for heart and vascular programs, (personal communication, March 2004) has seen the turf wars fought in a wide variety of battlefields: big city, small town, major teaching centers, and rural community hospitals. In her experience, competition among departments and/or physicians of small hospitals can be just as intense and contentious as those at the largest university medical centers. From her involvement in creating Heart and Vascular Centers of Excellence, she points to programs such as Seattle's Swedish Heart Hospital and Miami Heart and Vascular Institute as examples of successful collaboration that can be achieved at hospitals of all sizes and locations. Warring sides can become allies with a shared mission, clearly defined values, high standards of care, and strong visionary leadership. Management, physicians, staff, and patients

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all can reap the rewards of a consolidated, multidisciplinary center for the treatment of vascular disease.

The synergy provided through a comprehensive approach to vascular treatment at a "Center of Excellence" can result in the following benefits: cohesive protocols for all stages of care (such as postprocedural nursing instructions); a framework for quality review to assure positive clinical outcomes; economized inventory centers; and a new identity for marketing—becoming a "brand name" for patients and their primary care physicians looking for specialized care for vascular disease. With a growing and underdiagnosed population of patients with peripheral vascular disease, a branded and aggressively promoted Vascular Center of Excellence can lead the campaign for awareness throughout a community and its wider region. This initiative can become a magnet for patients who might otherwise go untreated. The challenges of establishing such a center are considerable, not the least of which is having the visionary leaders to conceive, build, and sustain such an effort. Ms. Heck states, "Programs that can negotiate these turf wars and other challenges in vascular service development can demonstrate that the 'diamond in the rough' vascular service is a valuable addition to a hospital service profile and to the community at large."

In a less radical but equally positive circumstance, David Sacks, MD, (personal communication, March 2004) recounts that at Reading Hospital and Medical Center, an initially difficult environment with mutually suspicious departments was overcome in the early stage by the various disciplines sitting down, establishing the various protocols and definitions of complications, procedure requirements, and outcomes with a continued, regular case review and conference discussions. The departments all maintain their independence but with hospital-wide uniform credentialing requirements, mutually agreed upon standards, and a much more pleasant environment.

## SUMMARY

These are just a few examples of how credentialing is handled for endovascular therapies. Some of the divergent guidelines reflect the suspicions of competency and financial interests that can exist between specialties. More optimistically, there are increasing examples of interdepartmental conversation and cooperation, which seem to have the dual effect of raising the overall standard of care and creating a thriving, mutually beneficial practice. ■

1. Levin DC, Becker GJ, Dorros G, et al. Training standards for physicians performing peripheral angioplasty and other percutaneous peripheral vascular interventions. *Circulation*. 1992;86:1348-1350. Reprinted in *J Vasc Intervent Radiol*. 2003;14:S359-S361.
2. Woratyla SP, et al. Review of standards for competence in catheter based endovascular procedures: a resource and strategy for the interventional vascular surgeon. *J Vasc Endovasc Surg*. 2003;37:39-46.
3. Sacks D, Becker GJ, Matalon TAS. Credentials for peripheral angioplasty: comments on society of cardiac angiography and intervention revisions. *J Vasc Intervent Radiol*. 2003;14:S363-S367.