Frank J. Veith, MD

As Dr. Veith and the meeting that bears his name join forces with the Cleveland Clinic, he discusses the newly formed ISVS, board certification, and the evolution of vascular "surgery."

At the 2005 VEITHsymposium, in addition to a lecture schedule packed with excellent content and respected speakers, there was some big news regarding the future of the meeting and its new affiliation with the Cleveland Clinic Foundation. What can you tell us about this exciting change? What will the impact on the symposium be? The Cleveland Clinic is an outstanding medical institution, particularly in the area of vascular and cardiac disease. The Clinic has embraced the VEITHsymposium and recognized its quality and value, ultimately agreeing to support in a long-term fashion the development, evolution, and expansion of the meeting. As far as the potential impact on the meeting, most elements will remain in place; it will continue to be held in New York, and there will not be any major programmatic or philosophical changes, but some lecture content may spread into related areas.

We already have an excellent relationship with interventional radiology, thanks to Dr. Jacob Cynamon's AIM meeting, but it is our hope to further develop relationships in other areas as well. We would like to add a more extensive laparoscopic vascular surgery component, material on dialysis access, perhaps a wound-treatment component, and very importantly, an interventional cardiology component. Most elements of the meeting will remain the same, but we will have the option to grow and become even better.

Which talks and developments would you consider to be this year's highlights? Peter Bell's spirited debate with Ken Ouriel regarding the SAPPHIRE Trial results was stimulating, interesting, and clearly a highlight. The ongoing discussion of the impact and interpretation of the EVAR and DREAM trials was also of great interest, and I think our effort to present both sides of controversial issues such as these really sets our meeting apart. I thought the numerous talks on thoracic endografting illustrated the rapid development of the procedure. I was pleased that one theme many of the lecturers emphasized was that just because an intervention can be done, doesn't mean you should do it. Finally, the session on why we still need an independent board for vascular surgery was extremely enlightening and effective in getting the message across.

Can you elaborate further on your thoughts with respect to more conservative application of interventional therapy? It is important that we as interventionists reserve treatments for those patients who truly need it. With all of the new technologies available and the excitement over favorable outcomes, it's increasingly important that we understand which patients will truly benefit from immediate intervention and which patients should be observed for the time being. Not only is this in the individual patient's best interest, it's also best for society as a whole because as we increasingly use technologies and perform procedures, the cost of health care in turn goes up. If we start putting stents in lesions that do not need them, society will not have the funds to pay for the patients who do.

There is also a conflict of interest issue. In the US, physicians get paid for the procedures they perform, which is not necessarily a flawed system, but when there is a financial incentive to treat, there is a possibility it will impact the decision to treat. To add to this, in most cases, disease is also easier to treat in the patients whose need for therapy is borderline (or less); their results are often better than those who present with complex or calcified disease, or a larger aneurysm, etc. In light of these factors, we need to be sure we make every effort to remain objective and do what's best for the individual patient, which in some instances may mean applying therapy more conservatively.

You were one of the first surgeons to embrace endovascular therapy. What was it like trying to convince other surgeons of the potential benefits? I was fortunate to meet up with Juan Parodi during the early days of his initial work with endografts, and I thought

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this technology would be sure to transform the practice of vascular surgery. Not everyone shared this view—in fact, almost no one did at first. I had to pay for the first endografts I implanted with my own money.

At that time, I was very active in the SVS and regional societies, and I went around talking about our first cases and trying to enlighten other leaders. I was greeted with negativism, disdain, distrust, and people saying I wasn't telling the truth. Some said that if this procedure was going to work, it should be the radiologists who perform it, but I felt that if vascular surgeons didn't get involved, we would become extinct as a specialty. The title of my 1996 SVS presidential address was "Charles Darwin in Vascular Surgery." Some people were swayed by it, but most were not, and they resisted, especially the leaders at the time.

Then, as the years went by, they started to do the procedures themselves, and most of them saw that they were going to transform what we did. I was just lucky enough to be in a position where I saw the light early, and I attribute this to my connections with Barry Katzen and Julio Palmaz in radiology, and ultimately Juan Parodi in vascular surgery.

You have long been a strong advocate for separate board certification for vascular surgery. Which parties are standing in the way of this objective, and why? The principle group that stopped us from getting an independent board in vascular surgery was the American Board of Surgery, and they admit to this. They actively and aggressively opposed us in our struggle to get through the American Board of Medical Specialties process. At both our 2002 original hearing before the Liaison Committee for Specialty Boards (LCSB) and at the appeal, which didn't occur until 2005, the American Board of Surgery opposed us bitterly. I and others do not believe the American Board of Medical Specialties gave us a fair hearing. The outcome was known and was even told to us before the case was heard. So the American Board of Vascular Surgery is quite disturbed by the fact that the process was obviously unfair. There were conflicts of interests, individuals who were present at the original LCSB meeting were not present at the appeal, and no records or minutes were kept. Unfortunately, there is no oversight over the American Board of Medical Specialties.

Where does the battle for this recognition currently stand? We are not giving up. There is too much at stake—legal matters, ideal patient care—issues that simply cannot be ignored. There is unanimity among the board that we need to continue the struggle. The primary certificate of the American Board of Surgery is not a permanent answer to our issues. Vascular surgeons regard it as a stepping stone to an independent board, but the American Board of Surgery and the American Board of Medical Specialties regard the primary certificate as the end of the line for vascular surgery. We strongly believe that general surgeons have not and cannot represent the interests of vascular surgeons.

What are the objectives of the newly formed International Society for Vascular Surgery? First and foremost, it is an international society. The President is Sir Peter Bell, the Vice President is Bob Hobson, the Treasurer is Giorgio Biasi, and I am the Secretary. The purpose of the society is to promote recognition that vascular surgery is a separate, defined specialty throughout the world. In some countries, it is already recognized as such, but in some, such as the US, it is not. We are also trying to set up international standards of training and practice, and we are looking to set up international centers where individuals can go to receive updated vascular training at a location that is not close to home; it can sometimes be difficult to get this training near one's own practice because many people are not looking to train potential local competition. We will not be putting together an annual meeting with scientific sessions, but we will publish a journal for distribution to our members.

We also want to promote that although some elements of vascular surgery have changed, its definition has not. Surgery is defined as the treatment of injury and disease by manipulative means, so by this definition, every radiologist or cardiologist who performs noncardiac vascular work is also a "surgeon." And of course, although many people think of surgery as cutting and sewing, much of our work as vascular surgeons involves little, if any, of either. We administer medical therapy, interventional treatment, open surgery, and often, no treatment at all when this course of action is appropriate.

The International Society for Vascular Surgery is not restricted to surgeons in the sense of cutters and sewers—it's for people who treat vascular disease by manipulative and other means. There is no medical specialty treating vascular disease that has really dominated the field and pushed out the others. There are at least three interventional specialties: vascular surgery, interventional radiology, and interventional cardiology, and possibly others who are committed to treating vascular disease, and we are excited to get those people on board and involved in the society. ■