Editorial

What is the role of the WFITN with regards to the worldwide clinical practice of Interventional and Therapeutic NeuroRadiology, its world meeting and scientific challenges (research)?

To be a **worldwide organization** tends to be based on the international representation of its members but at the same time it represents a duty, a challenge and an opportunity. Its mission will also include elements of philosophy, and ethics in combination with practical applications. Seventeen years after its foundation in Val d'Isère 17th of January 1990, several questions, can be raised in assessing the functionality and possible impact of the WFITN.

Is the WFITN providing an opportunity to enrich from the differences among our membership or does it represent an obstacle to communicate?

Are the conclusions that we issue an expression of a marketing orientated thinking process or an attempt to consider clinical core issues or challenges; in other words is the world a source of inspiration or a potential area of diffusion and expansion?

Is our evidenced based certitude or knowledge applicable worldwide at a given moment or at term?

Is the value of our meeting resulting from the issues we identify to be common (questions or answers) among the countries represented in the WFITN or the differences that we bring to share, creating a forum for an independent review?

Is the worldwide diffusion of the information regarding our practices sufficient to built a consensus on questions and answers pertaining our practice?

Are the technical answers to medical ques-

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tions dangerously postulating the identical nature of these questions and their worldwide pertinence?

Why is it that technical solutions continue to be promoted when the clinical outcomes have already provided conclusive answers to the contrary: clinical significance of aneurysms neck remnants, the morbidity associated with the natural history of AVMs, the morbidity of the natural history of unruptured aneurysms, the VGAM outcome, ...

Can an answer be internationally supported if the question it answers is dissimilar in different areas of the world? Even if the questions are applicable world wide should there not be

vigilance and doubt to allow for world wide corrections.

Focalizing the issues of treatment challenges to techniques, to obtain “power” in statements can be deleterious when it commits practice to a passed knowledge, when it hides the reality of the medical progress and understanding: the pyloric ulcer being a bacterial disease or the cancer of the cervix the result of a viral infection allowing for a preventive vaccination versus debating treatment of the lumen of a partially thrombosed aneurysm to prevent hemorrhage, when experience has shown that bleeding originates from the adventitial areas?

In order to share answers and to make sure that we are addressing the same questions, is it not the primary step to secure or establish a common language that would make our exchange a true dialogue? Are not clinical and anatomical languages the simplest common ones to be used prior to evaluate and interpret practical managements?

The WFITN is a privileged body which expresses **3 faces and interrelationships**:

One is professional. The WFITN is not a union. Although we are concerned with the future of our profession, our place and role with respect to our sister specialties highly depend on the vacuum we may create through perceived lack of cohesiveness and quality. Our best tool is our experience and competence. That is the reason why *standards of training* to provide the most flexible necessary background and *standards of practice* to guaranty safety, are so important. *Standards for training of skills* are the next necessary step. Yet we are left with the evaluation of these skills, the *standards in diseases management*, the regional application of the standards of education, the variability of diseases profile around a world (different from epidemiology). “Fertilization” of the neuroscience field, is necessary to gain recognition by raising the appropriate questions to research: “Clinical experience is the luck of research.” (S. Aymé)

The second interface is with the industry. The necessary partnership with companies and potential conflicts of interests imposes an organization of these relationships, as attempted by several others specialties, administrative bodies and the companies themselves.

The third one is with the public. The WFITN, has a duty with regard to patients and public.

Both patients and public should understand that they could trust the independence of the expert opinions issued by the members of that Federation.

A world meeting allows for the opportunity to practice a common language. A language that facilitates people coming from far away geographically, to communicate with each other. The desire to share common interest, common concerns is dominant. Can such meeting give and provide common benefits? The primary objective for that is certainly to share issues that satisfy expectations among the participants. Amongst the issues that we share, techniques and technologies are the most likely to create segregations and frustrations between those members that can afford and those that cannot.

Knowledge in science and progress depends on several principles combining experience over time accumulated through intuition, assessment, postulates and techniques to modelise and stabilize them. Simply consuming a given product even with skill, does not necessarily creates a mature experience; gathering such type of experts does not guarantee realexpert opinions or teaching faculty. There are fundamental differences between sharing knowledge, diffusing advances and teaching even if the topic in question is the same. A master serves his pupils better when he shares with his results part of the thinking process, what took him years to treasure and mature, rather than communicate with them via the technical steps alone. It is simply wrong to believe that students know best what they should learn; which does not exclude student participation in the pedagogic dimension of a learning process and for a master to adjust to the generational evolution of the education process.

To try to be “perfect”, as was being featured in Beijing, is not being elitist or being in competition with others, but just a duty for being a good doctor; perfection is within the ethical field not in the moral one. It deals with the perfection needed to deserve to enter the privacy of a given patient, through imaging or with catheters, in areas where we interrogate the body but not the individual himself. This the reason why “Excellence and perfection is not a mark of elitism but compassion” (T. Naidich)

The perfection, cannot simply be satisfied with good intentions, perfection in results is al-

so to be expected. The results are to be expressed, focusing on "patient satisfaction" rather than doctor satisfaction. The goal should be to communicate effectively with the patient by explaining the clinical and anatomical considerations to them and not just the imaging tools and the skills used for storage of information or "pictures of treatment" alone. The latter tools are meant for eloquence and power in statements, but likely will be of temporary significance.

These coming years should be used

- to identify, enhance and recognize the differences that exist between patients and diseases around the world;

- to collect and share training methods, pedagogic techniques, curriculum contents, evaluation of knowledge and skills, and maintenance of competence from around the world;

- to preserve independence in treatment management through transparent debates and relationships with market driven structures.

All are needed to contribute to these works ahead of us, and in addition, I am convinced that all will be willing to be part of these challenging questions and issues for the best of the patients.

Pierre Lasjaunias
President of WFITN

Dear Friends,

We are pleased to announce a new electronic submission and peer review system that will be implemented for *Interventional Neuroradiology* starting in January 2008. The new system should improve and facilitate cooperation with our authors. It is a web-based system with full online submission, review and status update capabilities allowing you to upload files directly from your computer. We strongly encourage authors to use the system at the following URL:

<http://www.editorialmanager.com/in>,
<http://in.edmgr.com>

Prior to submitting your paper, please follow the instructions for authors published in the journal. Please note that you must have an e-mail address to use the online submission system.

In addition, all articles published in *Interventional Neuroradiology* will be available on the journal's website

<http://www.centauro.it>

and can be downloaded a year after publication in the hard copy edition.

Authors are encouraged to submit their papers via the website but manuscripts can be sent by e-mail or post if electronic submission is not possible.

We believe that these technical improvements will boost access to *Interventional Neuroradiology* further developing the journal's activity.

Thank you for your kind attention, with our best wishes for the new year.

Pierre Lasjaunias & Marco Leonardi