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Registered Charity
ABN 42 006 173 379
Level 7, 461 Bourke Street
Melbourne VIC 3000
Telephone 03 9670 1000
StrokeLine 1800 STROKE (1800 787 653)
strokefoundation.org.au

Dr Lance Lawler
President, RANZCR
Level 9, 51 Druitt Street
Sydney NSW 2000

Sent via email: interventional@ranzcr.com

Dear Dr Lawler

Re: RANZCR Framework for the Recognition of Training in Percutaneous Stroke Intervention (PSI)

Australian stroke patients need and deserve to receive care from medical practitioners with the necessary training and experience to deliver safe and effective stroke treatment.

Stroke Foundation appreciates the opportunity to provide comment on the 'RANZCR Framework for the Recognition of Training in Percutaneous Stroke Intervention (PSI)' which in most international circles is referred to as endovascular thrombectomy (EVT). I provide this response as Chair of the Stroke Foundation Clinical Council.

General comments

1. Regional and rural Australians are 19 percent more likely to suffer a stroke than those in metropolitan areas, and are more likely to die or be left with significant disability as a result of stroke, due to limited access to best-practice stroke treatment and care. Stroke Foundation believes where you live should not impact your access to best-practice stroke treatment and care.

   It is clear that one of the key objectives of this Framework is to improve access to endovascular thrombectomy in geographical regions identified as areas of need. While the Stroke Foundation is strongly supportive of initiatives that reduce regional inequality of access to acute stroke treatment, we believe the complementary pathway outlined in this Framework may not achieve its intended goal.

   Training additional medical practitioners, particularly those already established in major cities, may not necessarily address the issue of regional and rural access to endovascular thrombectomy. This has been the case for interventional cardiology services, with few interventionalists moving to geographical areas of need, resulting in an excess of practitioners in metropolitan areas.

   We know procedural volume is strongly linked to procedural success. As such, there is a concern this complementary pathway has the potential to reduce the quality of care, by diluting the experience of practitioners.

   A more targeted approach is needed to address the regional inequality of access to endovascular thrombectomy in Australia. The CCINR, a body that has successfully developed guidelines for training and registration of interventional neuroradiology

practitioners, is well placed to fulfil this requirement for recognition of training. The Stroke Foundation would be supportive of the CCINR working with the RANZCR, and other relevant professional bodies that are party to the CCINR (NSA and ANZAN), to establish a subcommittee focused on improving access to endovascular thrombectomy in geographical areas of need. Where practitioners are committed to working in these areas, an individual pathway for training and recognition could be developed and approved by the CCINR on a case-by-case basis.

2. Importantly, we note this pathway is limited to Radiologists, and endorsing it could lead to the development of similar pathways for training and recognition by other professional colleges. We believe this type of duplication amongst craft groups should be avoided.

Specific comments

1. We note that this Framework may be administered by the CCINR, which in conjunction with the RANZCR, NSA and ANZAN, already has stipulated training requirements for Interventional Neuroradiologists. Of note, this Framework states under section 2.3.2, 'During training a minimum of 20 PSI cases must be performed and recorded in the logbook', while in section 4.3(k) of the CCINR Guidelines it states a minimum of 40 cases of endovascular treatment for acute ischaemic stroke should be performed. Importantly, this Framework provides no justification for the lower level of experience required in the proposed complementary pathway compared with the CCINR pathway.

   In addition, CCINR-trained practitioners are specifically required to demonstrate competency in managing other neurovascular conditions. As a consequence, these practitioners are better placed to manage these conditions, which can occur incidentally or as complications of endovascular thrombectomy, than practitioners who may or may not have come across them whilst completing their 20 case logbook as part of the complementary pathway.

In summary, we support measures to improve quality of care for all Australian patients, but believe the proposed pathway is unlikely to improve access to expert endovascular thrombectomy, either in metropolitan or regional and rural areas.

Thank you for the opportunity to feedback on this Framework.

Yours sincerely,

Bruce C.V. Campbell

Associate Professor Bruce Campbell
Chair, Stroke Foundation Clinical Council