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IRs shift to clinical approach will alter diagnostic practice

Upsides for all include more diagnostic exams and greater clout with hospital administration

The rapidly occurring changes in interventional radiology practice and the impetus behind this new clinical practice model have been chronicled.[1,2] Striking changes in admitting practices, establishment of IR clinics, and the use of physician extenders such as nurse practitioners and physician assistants have been documented.

Among the 100-plus training programs that lead to a certificate of added qualifications for IR, 78% admit patients; 45% admit 50 or more patients per year.3 According to 1990 data,4 only 33% of IR training programs admitted patients, and only 5% of those had more than 50 admissions in 1986, while only 8% admitted more than 50 patients in 1989.

The momentum behind these changes originated in part with the loss of a significant number of renal and peripheral angioplasty procedures to cardiology and vascular surgery and the development of three new IR procedures: uterine fibroid embolization, vertebroplasty, and varicose vein ablation.

The purpose of our commentary is neither to lament our losses nor to praise our procedural gains. Instead, we wish to comment on the strategic plan for IR2 developed by the leadership of the Society of Interventional Radiology and to discuss real and potential barriers that diagnostic radiologists in both academic and private practice might unknowingly impose on its implementation. Only with frank and open discussions between diagnostic and interventional radiologists will we reach consensus and overcome the fears of our colleagues in diagnostic radiology as well as any hesitancy among our colleagues in IR about adopting the plan.

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The strategic plan can be summarized by the following goals for interventionalists:

- Become recognized as leaders of image-guided therapy by patients, the medical profession, industry, and policy-makers, including insurance companies;
- Recognize competition and compete effectively;
- Establish an effective medical office;
- Become a source of patient referrals for other physicians; and
- Increase FTE practitioners by approximately 40% by 2006.

Barriers to rapid implementation exist, but issues concerning private practice versus academ-

Most IR training programs today admit patients.

Yale IR team (left to right): Dr. R.I. White Jr., Dr. J.S. Pollak, Dr. J. Aruny, Dr. N. Denbow, and Dr. M. Wysoki.

ic practice should not be an obstacle, as most IR practices are private. Only a relatively small number of the 4000 SIR members are university-based. If rapid implementation of the strategic plan is to occur, it must be accepted first and foremost by private practitioners of interventional and diagnostic radiology.

UPSIDES OF STRATEGIC PLAN

Among the advantages that diagnostic radiologists will accrue from acceptance of the strategic plan are an increase in the number of exams as a result of the growth of their partners' IR clinical practice, and greater clout with hospital administration.

- More diagnostic exams. At the Yale Vascular Malformation Center (www. hhtavm.org), as well as in our general IR section (www.yaleir.org), substantial growth has occurred in unenhanced spiral chest CT to document involution of malformations and growth of new ones. Similarly, there has been a substantial increase in the number of pelvic MRI examination for evaluation of uterine fibroid patients before and after embolization. Further growth in MR angiography for evaluation of peripheral vascular disease and aneurysmal disease has occurred in many practices and will continue.

The cynical among us might claim that these high-end exams would grow regardless of whether cardiology, vascular surgery, or interventional radiology was the source of these new patients. We would counter that the growth of diagnostic exams as a result of patient referrals from IR to diagnostic radiology is a more secure source of new exams. This precedent has already been established in cardiology, where the invasive cardiologist refers patients to the noninvasive cardiologist, and vice versa.

Although the "finger of self referral" may finally be pointed at diagnostic radiologists as it has been pointed at other specialists for years, self-referral between diagnostic and interventional radiologists will probably not become a major issue. Quality assurance and mortality and morbidity conferences are common, and referral of normal patients with minimal disease is discouraged. The justification for high-end exams and precertification approval required by third-party payers will also safeguard against improper tests.

- Greater clout with hospital administration. This issue is difficult to document, but we have seen favorable changes in the years that we have been admitting patients at Yale.

Hospital administrators have authorized a member of the admitting office to help guide patients and referring doctors through the maze of precertification for short-stay admissions for our IR practice. While 100 patient admissions per year is not unusual for one IR doctor, admissions multiply rapidly when other members of the IR group begin this type of practice. Hospital administrators will recognize that the radiology group is not just a recipient at the end of the imaging food chain, but a source of new patients and revenues for the hospital. Cardiology labs provide a good example of favorable resources attained by a specialty based on its large admitting services. We recognize, however, that this is a local and very political issue.

PERCEIVED DOWNSIDES

Both IRs and their diagnostic radiologist partners have expressed concerns about possible downsides to the IR strategic plan. Many interventional radiologists envisioned a career with a 50:50 mix of diagnostic and interventional radiology, and their partners want them to do a certain amount of diagnostic radiology. Many IR fellows over 45 would frown on any tampering with their way of life, and would assert that they did not enter radiology with the expectation of admitting patients and providing pre- and post-procedural clinic visits for patients following an intervention.

It is neither necessary nor desirable to begin this type of practice under duress. It would be simplistic to expect that all SIR members would begin in earnest to implement the plan in their practices following its

acceptance in April. Many options will be available for groups with two or more IRs. Some IRs should be able to enhance their imaging skills in CT angiography or MRA and acquire vascular imaging as a strong component of their practice. Others may gravitate to general imaging, where there are gaps in coverage. And new recruits to an IR practice will most likely embrace the initiatives and direction of the SIR strategic plan.

'The most significant issues involve establishing clinics, providing the IR with at least a half-day per week in the clinic, and hiring physician extenders.'

It is important that IR physicians already in practice support the needs of their new IR partners. This includes discussion in their partner meetings when allocation of resources, coverage issues, and other pertinent issues are debated.

Because most of the partners in large private practices are diagnostic rather than interventional radiologists, debate and resistance to parts of the plan will continue. Remember the debate about the CAQ exams in 1992-94: The potential disenfranchising of diagnostic radiologists performing IR if they were not fellowship-trained and did not take the exam within the five-year grace period was argued intensively. But we haven't heard much about that matter since enactment of the IR CAQ eight years ago. This is likely to be the case with the SIR strategic plan as well.

The most significant issues that will be debated involve establishing clinics, providing the IR with at least a half-day per week in the clinic, and hiring physician extenders—all changes that affect the bottom line. The chiefs of large practice groups may prefer to mount a delaying action, as consensus on bottom-line issues will be difficult to resolve.

Clinics are easy to initiate by sharing space in a preexisting facility or simply developing space for seeing patients in an office, neither of which is costly. The notion of allowing the IR physician a half-day off the schedule each week for an IR clinic is the issue most likely to substantially delay implementation of the plan. In large practices with four to six full-time IRs, this may equal one to three half-day clinics per week that prevent IR FTEs from performing IR or reading imaging studies. The clinic is critical to building a successful practice in IR, however, and many publications have demonstrated the benefits of such a clinic.[5,6]

The second issue that will be contested is hiring a physician extender, either a nurse practitioner (www.aanp.org) or physician assistant (www.aapa.org). The radiology group may argue that the hospital should contribute to this person's salary because it benefits from increased admissions. This is a favorite delaying principle. Hospitals have routinely refused to contribute to the salary and benefits of physician extenders for IR.

IRs are already too busy, and they need physician extenders now. These individuals have advanced degrees and can practice and bill under a physician's supervision. They are essential to the growth and success of the IR practice. This will be the most expensive part of the implementation of the SIR strategic plan, costing about $80,000, including benefits. But the addition of only 50 IR procedures yearly will provide the professional fees to pay for the physician extender. It is fairly simple to grow a practice with a physician extender, and radiology partnerships need to bite the bullet and hire one immediately if they want to move forward with the SIR strategic plan.

In addition to several IR meetings, symposia on building practices are held every year around the country (http://www.sirweb.org). They can help IRs already in practice flesh out issues related to their own groups Dedicating time and space for an IR clinic and hiring a physician extender are discussed at length in these symposia, meetings, and related publications.

PHYSICIAN SHORTAGE

The SIR leadership's goal of 40% more IR practitioners by 2006 is ambitious, and leaders of CAQ training programs have their work cut out for them. The effort has to begin with IR practitioners in departments affiliated with medical schools. A well-thought-out plan must be implemented to appeal to first- and second-year medical students who are as yet undifferentiated and desire a high-tech practice with lots of patient contact. With the American Board of Radiology's help, SIR must implement an IR pathway through diagnostic radiology that allows more clinical and research training for prospective interventional radiologists.[1] We believe this is likely to happen soon.

It is in our best interests to adopt these changes rapidly. Our futures depend on it. Residents choosing IR will not be disappointed, and their partners in diagnostic radiology will accrue direct and indirect benefits from a strong IR presence in their practices. ■

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