What Does It Mean to Be an Interventional Radiologist? SIR and the Private Practice Initiative

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Abstract

The new interventional radiology (IR) residency training pathways seek to graduate physicians who are not only experts at imaging and technically savvy but clinically oriented doctors capable of preprocedural workup and postprocedural care. The goal is for compassionate IRs who are holistic in their treatment of the patient and their disease, not just an expert at the procedure. However, much of this new envisioned approach for the modern IR is contradicted by the stark reality that most IRs in practice today (and most of the job market) are in private practice, where resources for clinical care in reality may not be prioritized as much in this idealistic scenario. The Society of Interventional Radiology (SIR) has recently made it a priority to represent the unique needs and frustrations of IRs in private practice and hopefully find a solution to the imminent reality that is facing most practicing IRs and future graduates.

Keywords

- interventional radiology
- private practice
- IR residency training pathway
- job market
- Society of Interventional Radiology

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What Does It Mean to Be an Interventional Radiologist?

This loaded question may portend a spectrum of responses depending on its context, ranging from banality and commonplace answers to tendentious and controversial retorts. While there is variation in every medical specialty, when someone tells you they are a cardiologist or neurosurgeon or dermatologist or family practice physician, you have a pretty good idea about their job (if not about the details of their life or daily routine). But the existentialist question about who or what an interventional radiology (IR) is runs deep and is multifaceted. It is arguably the most poorly understood field of medicine by the general public, and likely equally so by our medical colleagues.

If this question was asked to you casually by an old acquaintance at a high school reunion, after the quizzical look of telling them the job title, these may be some of the typical responses to explain one's self:

- "I perform minimally invasive image-guided procedures."
- "IRs use catheters, wires, and needles to perform treatments on patients."
- "You know how cardiologists perform catheterization for the heart to place stents? IRs do the same thing for the rest of the body."
- "I'm a minimally invasive surgeon."

If one were to hypothetically ask the same question to our physician brethren from surgery and medicine on how to describe IR, you may hear the full gamut of responses as well:

- "IRs are jack-of-all-trade docs who can do anything."
- "IRs are radiologists who also do biopsies, drains, and angios when I ask."
- "IRs use radiology techniques to stop bleeding or open closed vessels."
- "IRs are proceduralists who perform procedures on patients when I order a study but for whom I have to do the follow-up, admitting, and deal with complications myself."
- "IRs are constantly reinventing themselves as the future of medicine."

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And if we were to take it one step further and introspectively ask IRs to look inward and describe what it means to be an IR, the responses would probably get even more interesting:

- "IRs aren't experts in a specific organ system but rather draw on multidisciplinary experience to perform minimally invasive, image-guided procedures."
- "IRs are radiologists who use technical skills along with imaging for therapeutics in addition to diagnostics."
- "IRs are not radiologists, but rather clinicians who use image guidance to perform diagnostic and therapeutic treatments."
- "IRs perform complex interventions using creative techniques through small holes."
- "IRs are the people to call when nobody else can (or won't) intervene on a patient." [said with an impish grin].

But what does this all mean? The point of all this is that IR is a nascent field with an identity issue. IR has evolved along some interesting pathways during its first few decades, but now is faced with the reality of truly defining who we are as we continue the transition into our own medical specialty. At play is a dichotomy that has yet to be addressed or reconciled between what type of IR we are training for the future of our specialty, and where and how current IRs and future graduates will train.

Before we address this dichotomy, we must first circle back and explore some background. As previously alluded to, a debate still rages on what being an IR actually means. Is it necessary to have an IR clinic and an inpatient consult service to be a good IR? What if you are one IR who performs all the procedures for your group, or you are in a group and split your time providing diagnostic coverage? If you perform an embolization that was ordered rather than consulted, are you less of an IR? Does the person who performs biopsies and drainages and vascular access only not qualify as an IR? What if you practice IR only 10% of the time, with the rest focused on diagnostic radiology (DR)? What if an IR has a physician assistant or nurse practitioner perform all their clinical duties—are they still part of the new wave of clinical IR? Who gets the right to decide this anyway?

Over time the spectrum has become a little less foggy. On one side, there are the evolved IR clinicians. Mostly in academics, highly specialized mega-groups (either with DR or surgical partners), pure IR groups, or outpatient IR laboratories, these IRs mainly pride themselves on being on par clinically with their surgical and medical colleagues, spending a good portion of their time performing clinical duties apart from procedures—outpatient clinic, inpatient consult services, admitting patients, managing medical diseases, calling patients postprocedurally, dealing with complications, etc.

On the other side of the spectrum are IRs who identify more as radiologists who are technically savvy at doing procedures. They may spend time reading imaging in between performing procedures, or spend 3 days a week as an interchangeable part with their DR partners. As many of these IRs will be in larger DR groups, the will and desire of many of the non-IR partners will decide what type of clinical resources are available; many times, this can create a conflict. For others, there is no desire to be involved with "true patient care": to some, the joy of performing the procedure is what makes IR so professionally satisfying. Of course, there is so large a gray zone in between with some IRs on the academic side performing so much research, teaching, and administrative work that they become a victim of their own success. Meanwhile, the small town private practice IR may be performing the complex cases and is technically on par with the best, all while reading computed tomography and magnetic resonance images between cases.

IR seems to be entering its adolescence as it tries to strengthen that identity. Over the past few decades, IRs in academic centers have evolved to a more clinical model and often are largely independent of their diagnostic colleagues in almost every way. Private practice IRs, however, have evolved much more slowly, likely largely in part due to restrictions (be it perceived or real) placed on them by their own partners and facilities. Those practicing in a more traditional private practice setting with DR partners may face several complicating issues.

First, while many IRs also want to perform some diagnostic imaging, the question frequently is how much the radiology group wants or requires and how much it supports clinical work that it perceives as nonrevenue generating. Spending a large amount of time doing diagnostic work or interposing diagnostic reads with one's IR procedures may not lend itself to establishing a high-end clinical practice. Second, another challenge is whether the DR partners value and are willing to support IR becoming a clinical service. The transition necessitates the creation of an outpatient IR clinic with staff so that one can accept referrals for treatment, establishing an inpatient consult service so that inpatient procedures are requested rather than being ordered by other services, and following patients longitudinally.

Third, supporting those needs also likely means renting or building office space, hiring advanced practice providers, spending more time doing things not readily converted to a work relative value unit chart, seeing follow-ups on the floor and in the clinic (sometimes for minimal reimbursement), and spending a long time having conversations with patients telling them when a procedure is not indicated. Not every radiology group would willingly invest time and capital to build such a robust clinical IR service, particularly when it means that some of their interventional partners will be reading fewer imaging studies, with the implication that the diagnostic partners will then be doing the diagnostic work otherwise done by the IR.

Over the past few decades, the divide between these two approaches to IR has resulted in a true divergence in practice models *in private practice*. While years ago nearly all IRs were part of diagnostic groups, many IRs have split off from their radiology groups out of frustration, joined forces with other specialties, or found other innovative ways to follow their true passion. This wide array of practice styles makes defining an answer to the question, "what is a private practice IR" quite challenging.

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In the 50 years since Dr. Charles Dotter's ingenious but unwitting decision to create a new field of medicine in lieu of open surgery, IR has showcased its unique triad of imaging expertise, procedural acumen, and clinical patient-based care. Although those first two tenets have been a mainstay of IR since its inception, clinical patient care has taken its definitive form only relatively recently. Today, the importance of clinical patient-based care has become so recognized and embraced that it has changed the IR training paradigm.

Over the past decade, many of the leaders in IR (most of who are academic) realized that to truly flourish all trainees in IR would have to have the proper training in the nuances of clinical medicine in addition to the technical acumen and imaging expertise, *whether they choose to use them in practice or not*. Therefore, IR was transformed from a 1-year fellowship to a complete separate residency program over 4 to 5 years (complete with multiple iterations and entry points) to help with continuity and to truly push a global understanding of the disease state and patient-centered care as opposed to simply learning catheter skills (figuring all the rest out later on their own was the challenge to newly graduated IRs).

Therein lies the inherent paradox. IR as a field has now changed its training paradigm to graduate clinicians ready to take care of the entire disease state and have the patient call them "*their doctor*," However, as this influx of trainees enters the workplace, will there be a job matching what they were trained to do? Will private practice IR jobs, which likely represent at least 60 to 70% of all IR jobs in the United States, mandate or even allow clinically practicing IRs? How can this dissonance ultimately be reconciled?

In 2016, to help define and address the perceived frustrations of many private practice IRs, the Society of Interventional Radiology (SIR) Executive Council formed the Private Practice Task Force, now known as the Private Practice Advisory Committee. The group was charged with defining "private practice" and assessing the need for dedicated private practice representation at the SIR Executive Council level. The task force came together for multiple impassioned conference calls regarding the difficulty in defining private practice, the unique needs of those members, and how SIR might help meet those needs. Born from this was also the need to address where and how future trainees would practice in the new IR model setting.

To help assess the private practice needs of the IR community, later that year the task force conducted a survey. The group quickly realized that accurately defining "private practice IR" is made difficult by the incredible variety of practice types, a view confirmed by the myriad survey responses received. While respondents confirmed that most private practice IRs indeed work with diagnostic radiology colleagues at a community hospital and contract with a hospital, an eye-opening one-third of respondents reported that they were not part of a group with a hospital contract for IR and imaging. The survey also shined a light on how unique IR practices can be, and how they vary in ways that may seem counterintuitive. For example, some IRs who staff university hospitals with a full complement of trainees consider themselves to be in private practice because they are not employed by the hospitals and instead operate through professional service agreements made between these hospitals and their independently owned physician partnerships.

Many other IRs are solo practitioners, or work in IR-only practices that contract independently with one or more hospitals (or even with corporate entities).

Still others have joined forces with vascular surgeons, cardiologists, and other specialists with whom they relate more closely than with diagnostic radiologists, and thus formed partnerships that do not require their doing diagnostic imaging. Some private practice IRs are directly employed by hospitals or multidisciplinary practices, while others own such practices and employ physicians who are not radiologists.

In short, the reality seems to be that while a traditional academic practice can generally (although admittedly not always) be clearly defined, private practice IR cannot. In addition, the survey showed that although private practice IRs have varied clinical practice models, they do share common concerns and issues. The most significant factors for choosing private practice include salary, location, and having the autonomy to build a clinical practice. The principal concern, not surprisingly, was needing help in providing more clinical services. Perhaps the most striking finding from the survey was that the challenges presented to respondents by conflicts with their own diagnostic colleagues were nearly equal in importance to them as were "turf battles" with other specialties like vascular surgery and interventional cardiology.

Based largely on the survey results and task force discussions, the Private Practice Task Force recommended the creation of a dedicated private practice position on the Executive Council. This was approved in 2016. The SIR Executive Council appointed Gerald A. Niedzwiecki, MD, FSIR, as private practice councilor (ex officio), for a 1-year term, followed by a 1-year term by this author. Having a voice at the Executive Council has proven to be crucial to bring to light many issues that private practice IRs face that may be unbeknownst to many of our academic colleagues. Following a successful bylaws change at the 2018 SIR annual meeting, this will now convert to two separate voting positions with 3-year terms.

Having established formal representation for IR private practice on the Executive Council in the form of two voting members in the coming years, SIR's Private Practice Advisory Committee members will be tasked with figuring out the most pressing issues (and addressing them). One of the foremost questions we will have to figure out is how we can reconcile creating a fertile landscape in private practice for the new generation of clinically oriented IRs to grow this ever reinventing field of IR.

Conflict of Interest
None.

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