Strategic Initiatives in Interventional Radiology: The Clinical Imperative

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“"The very essence of leadership is that you have to have a vision."”
-- Theodore Hesburgh

“The best way to predict the future is to invent it.”
-- Alan Kay

INTERVENTIONAL radiologists have invented and reinvented their specialty, their practice, and their future since the specialty began in the 1960s. In the process, interventional radiology (IR) has dramatically revolutionized the practice of medicine, the standard of care, and the patient outcomes achieved for many disease processes.

The Society of Interventional Radiology (SIR) Strategic Plan, launched in 2002, set a new vision for reinventing IR’s future (1). SIR’s leadership is swiftly and tenaciously moving to achieve this vision. One of the critical strategic goals in the plan is establishing IR as a clinically based specialty with direct patient referrals. Vital to this endeavor is the coordinated effort with diagnostic radiology to ensure that this is accomplished and that IR thrives as one of the three separate and distinct components within the house of radiology.

The evolution to a clinically based specialty is already occurring, and there are many SIR members who have successfully established clinical office-based IR practices. A key milestone set by SIR is to have 80% of interventional radiologists meet SIR benchmarks for clinical practice by 2006.

This article is the second in the Journal of Vascular and Interventional Radiology Strategic Initiatives in IR series. It will describe progress on SIR Strategic Plan goals since publication of the June 2002 “Strategic Initiatives in Interventional Radiology: A New Vision” (1) and will focus specifically on the goals related to clinical practice.

This commentary includes why interventional radiologists should develop a clinical practice, the importance of diagnostic radiology’s proactive support, the rate of acceptance, and an update on new accomplishments and strategic milestones reached.

Why Interventional Radiologists Should Develop a Clinical Practice

Early pioneers envisioned the need for IR to become a clinical specialty. Dr. Charles T. Dotter, one of the founders of the field, stated, “If we don’t assume clinical responsibilities for our patients, we will face forfeiture of our territorial rights based solely on imaging equipment others can maintain and skills others can learn.” (2) A decade ago, the SCVIR President, Arina Van Breda, MD, also stressed the importance of clinical skills stating, “Acceptance of interventionalists as ‘clinicians’ able to provide not only appropriate diagnostic and therapeutic services but also the associated patient care, must be a priority of our specialty.” (3)

Having interventional radiologists recognized as true “clinicians” has become a critical priority for the specialty. Why? Image-guided procedures have become widespread and indispensable in the care of patients and frequently represent the most clinically significant intervention during the course of a patient’s illness. Imaging remains a defining skill for the safe, effective performance of these procedures. As image-guided interventions have assumed greater importance in the care of patients, interventional radiologists have assumed an ever-increasing role in the clinical management of these patients. Interventional radiologists are now capable, and in many instances expected, to provide preprocedural consultation and postprocedural care in addition to performing interventional procedures. To provide optimum care to their patients, interventional radiologists must provide these clinical services.

Rate of Acceptance

There is convincing evidence that IR accepts the imperative of transforming into a clinical practice model. In the 2000–2001 SIR Socioeconomic Survey (4), data show that 65% of
members surveyed are providing preprocedure visits, 92% are making rounds after the procedure, and 52% are providing postprocedure office visits. Most members have and use hospital admitting privileges, 85% and 74%, respectively. Seventy percent of those surveyed are receiving direct patient referrals, and 74% reported an increase from previous years.

IR practice differs significantly from the practice of diagnostic radiology. Time devoted to direct interaction with patients and their families is critical as is office space for this interaction. However, there is evidence that support from radiology groups needs to be stronger and more widespread. According to SIR Socioeconomic Survey data, less than half of the practices (42%) are supporting interventional radiologists’ efforts to establish a clinical practice. In addition, less than half of practices (43%) are providing interventional radiologists with office space to see their patients. Those groups that do support clinical practice are providing interventional radiologists with personnel (74%) and time to see patients (65%). The potential for increased support from radiology groups in the near future is significant.

Positive Progress

Since the June 2002 article reported early successes in achieving the vision laid out in the SIR Strategic Plan, continued positive progress has been made. Achievements include:

1. The American College of Radiology (ACR) established a task force on clinical resources for interventional radiology. The Substitute Resolution No. 5, entitled “Interventional Radiology and Interventional Neuroradiology Clinical Practice Resource Task Force,” was passed at ACR’s annual meeting in September 2002. (Appendix 1)
2. The resolution called for ACR to develop a white paper and practice standards on clinical practice resources for interventional radiology and interventional neuroradiology.
3. The white paper, “Clinical Practice of Interventional Radiology and Interventional Neuroradiology,” was completed and distributed at the May 2003 ACR Annual Meeting (Appendix 2).

The paper addressed why clinical practice is vital and the economic necessity of clinical practice, provided guidelines for resource allocation, and discussed return on investment for image guided procedures. This paper will be published and is available on the web.

3. ACR is finalizing clinical practice guidelines for IR/INR, and these guidelines will be put before the ACR Council for a vote of approval at the May 2004 ACR Annual Meeting.
4. In August 2002, SIR submitted edits to the basic requirements of IR fellowship training to the Residency Review Committee (RRC). These edits were geared toward ensuring that fellows coming out of existing IR programs would have better clinical experience.
5. In October 2002, SIR submitted a proposal to the American Board of Radiology (ABR) to change IR training to allow 2 full years of related (but nonradiology) clinical training, 2 years of core radiology, and 2 years of IR.
6. SIR has begun the task of developing benchmarks for clinical practice.
7. SIR is working on reimbursement to make IR services provided in a freestanding center economically viable. In addition, through SIR efforts, more IR procedures will be reimbursed in freestanding centers in 2004 with a further expansion anticipated in 2005.
8. SIR is working to strengthen collaborative efforts with ACR and the Radiological Society of North America (RSNA) to ensure the successful transformation of IR to a clinically based specialty.

CONCLUSION

To the founders of interventional radiology, the transformation of IR to a clinically based specialty was a dream. Today that dream is becoming a reality. Interventional radiologists have developed and successfully implemented clinical practice models, and have seen their practices flourish. However, many members still have far to go and many challenges to overcome. The rate of acceptance by radiology groups and the level of their support is a critical factor and will determine to a large extent the speed with which IR successfully transforms into a clinical specialty. Proactive support from radiology groups and the global radiology community is crucial. It is not just a clinical and fiscal imperative, it is a moral imperative. Patients deserve the best care and management that interventional radiology can provide. As interventional management options become more numerous and complex, patients will only be served by an ongoing clinical relationship with their interventional doctor.

APPENDIX

Appendix 1

ACR Substitute Resolution No. 5: Interventional Radiology and Interventional Neuroradiology Clinical Practice Resource Task Force

Be It Resolved, that the ACR establish a task force, addressing interventional radiology and interventional neuroradiology clinical practice resources and business planning in collaboration with the appropriate interventional radiological subspecialty societies. The goal of the task force will be to address the establishment and continued enhancement of IR clinical services within the practice of radiology groups. The issues that would be addressed may include:

- Creation of a white paper by March 2003 and subsequently, a framework for a Standard;
- Establishment of an adequate clinical team (nurse practitioners, radiology assistants);
- Continuous quality improvement program(s);
- Dedication of adequate space for clinical visits;
- Inpatient admitting service;
- Dedicated time for seeing inpatients and patients in a clinic;
- Noninvasive vascular laboratory;
- Clerical services for scheduling, insurance authorization and billing of procedures, and evaluation/management services; and
- Support for time and materials for promotional and educational efforts.
Be It Further Resolved, a preliminary report of the task force including, but not limited to, the white paper will be promulgated to the ACR members by the end of March 2003.

Appendix 2

Dr. Michael Pentecost served as chair of the ACR Task Force on Interventional Radiology that developed the white paper. Members of the task force included John F. Cardella, MD, Michael D. Darcy, MD, Gary S. Dorfman, MD, Paul A. Larson, MD, Curtis A. Lewis, MD, MBA, Matthew A. Mauro, MD, Anne C. Roberts, MD, David Sacks, MD, and James L. Swischuk, MD.

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