“My Two Cents”

In the past 10 years, the practice of interventional radiology has undergone a fundamental metamorphosis. In response to both the increasing complexity of procedures and the advent of turf battles, nearly all practices have increased their “clinical” responsibilities. Some interventional radiologists have little or no interaction with their diagnostic radiology counterparts or have left these groups to establish their own clinical practices. Most interventional radiologists now see patients in a clinic, admit patients, and make rounds.

In the current issue of *Seminars in Interventional Radiology*, Drs. Murphy, Soares, and others analyze this trend in vascular and interventional radiology and present compelling arguments for the continued evolution toward fully clinical practices. This series of articles includes essays devoted to both the rationale for and the strengths of clinical practices. They appraise the technical practice model, explore the potential for interventional radiologists in peripheral vascular disease, discuss marketing the specialty to the community, and cite the hallmarks of a clinical practice.

Some of you may agree with the opinions expressed in this issue; others will not. We are a diverse group and debate is healthy. I have my own opinions, too. A robust clinical practice is least susceptible to loss of turf particularly if it culls most patients from primary care physicians. I believe that fully clinical practices are clearly the best means to provide care and secure patients with peripheral vascular disease, symptomatic fibroids, and varicose veins among others. We *can* compete with other specialties in these areas and we are best suited to manage patients who receive appropriate image-guided interventions. Patients with these disorders are also currently underserved and represent an enormous potential for growth. However, the current scope of interventional radiology includes other services as well.

As a referral-based specialty, we typically perform procedures on patients sent by physicians who are either unable or unwilling to provide our services. In this issue, the guest editors have focused on peripheral arterial disease, uterine fibroids, and cancer care as those areas where interventional radiology clinical practices can thrive. In some other areas of interventional radiology,

the clinical practice model could have little or no effect on referrals. For example, it is unrealistic to assume that this model will prevent incursions by interventional nephrologists in dialysis-related interventions. Dialysis access interventions are usually scheduled urgently, and the opportunity for elective consultation and longitudinal care is less than other disease processes. If a group of nephrologists hire an invasive nephrologist, guess where all the referrals will go? These patients comprise one group that receives most of their care from specialists, not primary care physicians. When one group of physicians has both the means and the incentive, financially or otherwise, to treat patients themselves, they often do so, even if their care is inferior to what could be achieved by others.

Furthermore, interventional radiologists as other clinical specialists do have limitations and we need to recognize these. We are not universally suited to manage all patients who undergo our procedures. We need to collaborate with other specialties and consult them as needed to ensure the welfare of our patients, just as our colleagues in other clinical specialties routinely do. I believe, as do Drs. Soares and Murphy, that interventional radiologists should not try to be all things to all people and that when available, a multidisciplinary approach is in our patient’s best interest, with each member of the clinical team “doing what he or she does best.” Interventional radiologists would be well advised to consult other experts liberally when dictated by the situation, as all practitioners should.

The enclosed articles primarily address the growth of clinical interventional radiologists in the outpatient setting and are focused on several diseases that interventionalists are particularly skilled at managing over time. There are numerous other procedures that are done in the hospital, including diagnostic and adjunctive procedures like arteriograms, biopsies, and central venous access. The clinical responsibilities required for interventionalists who perform these procedures are less demanding because these patients almost always have other physicians managing their care. Outpatient referrals and consults, as well as continuity of care over time after the hospitalization by the interventional

radiologist, in these cases are often impossible or redundant. This is not to say that we shouldn't have clinical input in these patients—we should. But these are important services that are largely performed in a technical practice model and that is unlikely to change.

Increasingly, “superspecialties” of interventional radiology have developed—the editors have alluded to similarities between interventional radiology and general surgery. Perhaps we will reach a stage in our development where we will have predominantly “general interventional radiologists” and “subspecialty interventional radiologists,” much like general and vascular surgeons. I don't think we're quite there yet—most practices that I have seen cover the gamut of interventions and many interventional radiologists continue to interpret diagnostic images. I do not support those who seek to dissolve the ties between diagnostic and interventional radiology, and neither do Drs. Murphy, Soares, the American College of Radiology, or the Society of Interventional Radiology. I became a radiologist because I enjoyed interpreting diagnostic images—I still do. I interpret the follow-up cross-sectional diagnostic studies on my patients who have undergone both vascular and nonvascular interventions. Although I perform clinical consults and increasingly admit patients, I also like diagnostic radiology and am not prepared to give it up. I believe that my ability to interpret diagnostic

studies is one skill that sets me above other “clinical” specialists who lack this training. I like what I do and plan to continue my practice in this manner, and I believe that this is compatible with being a clinical interventionalist, as long as when I accept a referral for an ambulatory patient who may need an elective therapeutic intervention, I can manage that patient's care and am accountable to them for their outcomes over time.

I do not pretend to know the future or the best approach for our subspecialty. But I do believe that there is enough room in interventional radiology for many types of practices. The Guest Editors note that the “most important reason” for increasing our clinical presence is to improve patient care. I share this belief. Increasing our clinical responsibilities is obviously in the best interest of our patients, and the participation of interventional radiologists in clinical decision making is essential to provide the highest level of care. We know what we can provide and when our services are appropriate.

One thing is clear and supercedes all others. All practitioners should strive to provide better patient care, and increasing our clinical responsibilities is one step toward doing this.

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