Transitioning to a Clinical Practice Model in Your Local Environment

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ABSTRACT

Once the clinical practice model is established, transitioning is fairly easy. Office staff such as schedulers and nurse practitioners should understand that all elective therapeutic interventions are to be booked only by interventional radiologists once the interventionalist has done a thorough diagnostic evaluation, including a history and physical in an office environment. To optimize the interventionalist's workload and efficiency, some triaging of patients in the clinical office is necessary. Also, noninvasive testing will need to be made available in the clinical office.

KEYWORDS: Clinical practice model, consultation, triage, service line

Objectives: Upon completion of this article, the reader will gain an understanding of the shifts and protocol and perception likely to occur as practices adopt a clinical practice model.

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Transitioning to a clinical practice mode, for those who have not yet done so, is fairly easy. To quote Nancy Reagan, "Just say no." That is, if a referring doctor calls an interventionalist and requests something that is not consistent with the clinical practice model, just say no. Most specialties support the enhanced patient care that is engendered by such a change. Some specialists may create friction or resistance and there may be political difficulties within the organization, but ultimately, the interventionalist will prevail. Why is that? For two reasons. First, interventionalists can rightly claim that by demanding to practice in a clinical manner, they are improving patient care. Who can complain about interventionalists wanting to provide

more follow-up care? Or about interventionalists wanting to perform a patient evaluation prior to performing an invasive procedure? No one in medicine should support any referring doctor's contention that interventionalists should not do this, and it is obvious when objections are raised that they are not based on concerns for the patient but rather on conflict of interest and turf issues. Second, interventionalists are licensed in their state to practice medicine. They are doctors and practice independently just like other doctors. No one can tell them what to do! For example, interventionalists who previously performed diagnostic arteriograms and interventions under the direction of referring vascular surgeons can divert patients from the procedure schedule to

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a clinic schedule. This is accomplished very simply. The interventionalists instruct the booking person in their interventional radiology section to not accept referrals for therapeutic interventions, like angioplasty or stent placement. Rather, when referring doctors or their designees call the booking secretary to schedule therapeutic interventions, they are told to call the office and given the office phone number. They are instructed that they need to book a consultation or referral prior to the procedure. The interventionalist will then perform the consultation or referral and schedule the patient at their and the patient's convenience. If an interventionalist arrives at work some day and finds that a patient has been referred for therapeutic intervention who has not been assessed by him or her or any of his or her partners for the procedure, due to some administrative error on the part of the hospital staff, they should handle the situation as he or she sees fit. If urgent, the procedure might be done. In some cases, scheduling may permit a consultation to be done on the spot. However, the opportunity should be made to reinforce to the booking people that an error was made, and systems should be put in place so that the error doesn't recur. If the schedule doesn't permit adequate time for full consultation and the clinical scenario permits, the patient should be referred to the office practice at a later date. If booking personnel need an example on how to handle such requests, ask them to listen in as you call the operating room scheduler and ask to schedule an operation for one of the surgeons to perform for you. Booking people in interventional radiology sections should understand that all elective therapeutic interventions are to be booked only by interventional radiologists. Interventional radiologists should understand among themselves that they are to book these elective cases only after they have done a thorough diagnostic evaluation, including performing a history and physical in an office environment.

Many interventionalists prior to embarking on a clinical practice have had reservations about their clinical skill level. This is difficult to understand because interventional radiologists for the past 35 years have consistently taken on clinical challenges and pushed the envelope to develop treatments not previously thought possible. The ingenuity that has been demonstrated in the field is staggering. Interventionalists who have trained recently have extensive clinical training, including a 1-year internship, 4 to 6 months of interventional radiology during residency, and 1 year of interventional radiology fellowship. The total clinical experience is often 2½ years or more. This compares favorably with generally accepted clinical specialties such as internal medicine or pediatrics, especially considering that those specialties allow their trainees to take electives during a 3-year training program. Additionally, performing a history and physical examination is not very difficult. It does not require a complex set of skills,

similar to those required to perform interventional procedures.

Many of the diseases that we treat are readily amenable to physical examination. We are experts in the imaging tests that are used to diagnose the diseases that need more than just a physical examination. Radiology is a very competitive specialty to enter, and interventional radiologists are often drawn from the top of medical school classes. Relative to any specialty, they are extremely capable physicians. When treatment by medical or surgical generalists or specialists of various disease processes is compared with published guidelines, results are poor,¹⁻⁹ even for very common public health conditions such as hypertension, hyperlipidemia, diabetes, and so on. This makes the argument that other specialists are better able to "treat the whole patient" dubious. Simply put, performance of a history and physical examination and development of a treatment plan in keeping with standard accepted clinical practices is clearly within the realm of capabilities of most physicians capable of performing a percutaneous portosystemic shunt procedure, for example.

To optimize the interventional radiologist's workload and efficiency, some triaging of patients in the clinical office is necessary. That is, interventionalists should try to generate referrals only for patients that have treatments that they can administer to help patients with their diseases. That is, an ophthalmologist would probably not accept a referral for evaluation and management of a patient with a liver mass. An office manager should be used to help triage patients when there is any question raised by office staff. If there is no office manager, a nurse practitioner or someone else providing continuity in the office can perform this role. Certainly, policy manuals can be very useful in this as well.

Interventionalists should develop their practices along service lines. They should accept referrals for patients that they want to treat, including those with peripheral arterial disease, uterine fibroids, liver cancer, and varicose veins, for most practices. Some feel that interventionalists should be involved in patient management of a whole host of diseases, including controlling blood pressure and hyperlipidemia. Interventionalists will find it more effective to treat these problems as they arise or as they are discovered to be uncontrolled in some of their patients, but in general to refer these back to the primary care doctor or medical specialist. Additionally, wound care issues, for venous disease as well as diabetic wound care, are best outsourced to other specialists or wound care clinics. All of these issues will certainly arise in practice. However, if one's waiting room is filled with diabetic wound care and hypertension management, it is expected that the general radiology practice will fold up the clinic within a short time. That is, the vision of interventional radiology as a clinical specialty is not one that is competitive with other

medical specialties or with nursing care but one that enhances the traditional framework of the interventional radiology practice, which is performance of interventional radiology procedures.

Finally, the issue of noninvasive vascular testing needs to be addressed. It is impossible to establish one's self in the community as a vascular disease expert if noninvasive vascular testing is not available, especially if it is available in a competitor's office. Noninvasive vascular testing equipment should include the ability to obtain segmental limb pressures and pulse volume recording. Duplex ultrasound, magnetic resonance angiography, and computed tomography are also valuable for noninvasive testing. These are routinely available within a radiologist's practice. Segmental limb pressure and pulsed volume recording equipment costs roughly \$25,000.00 and is a worthwhile expense to support development of this practice.

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