Setting Up a Medical Clinical Office

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ABSTRACT

The lack of clinical office space is the biggest Achilles' heel of interventional radiology and establishing an office eliminates that weakness immediately. Many interventionalists practice within a hospital setting; however, setting up a clinical office outside the hospital offers more flexibility. There are several reasons why interventionalists who set up clinical practices will succeed well into the future. Also, the American Board of Medical Specialties offers the fully trained interventional radiologist board certification in interventional disease management.

KEYWORDS: Office space, marquee, competition, patient care

Objectives: Upon completion of this article, the reader will understand the benefits of establishing a freestanding clinical office component to the interventional radiological practice.

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Although there are numerous reasons supporting establishment of a clinical office-based practice, all of them involve improving patient care and allowing patients better access to the number of services that interventional radiologists offer. Politically, having an office provides tremendous merit in dealing with other competing specialists. The lack of clinical office space is the biggest Achilles' heel of interventional radiology, and establishing an office eliminates that weakness immediately. Additionally, even if the office practice is modest, its existence provides tremendous potential. Other specialists recognize this. In the hospital environment the interventionalist's practice is easily monitored and tracked by competing specialists. Conversely, in the nonhospital clinical space there is little opportunity for other specialists or competition to gather information

about the type of practice that is ongoing in the office. This separation makes the office a formidable political benefit. Even in the hospital environment, having a patient base in a clinical office changes the dynamic between the hospital and the radiologists. Rather than being a captive audience, the radiologist now can be viewed as little bit more of a free agent, providing patients to the hospital rather than just benefiting from patients that the hospital receives.

Many interventionalists practice within a hospital setting. Often, this is acceptable. Usually, these practice arrangements are acceptable when interventionalists are on salary as, for example, at academic institutions. If interventional radiologists practice in a group and are reimbursed separately from the hospital, the setting up of offices in the hospital without due consideration could

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result in the interventionist running afoul of antikickback legislation. That is, by law the hospital is not allowed to provide anything of value to referring doctors in exchange for referrals or hospital admissions. If a hospital sets up an "office space" and helps to subsidize it without charge to private practice physicians, then a violation of antikickback legislation is likely present. Whether the hospital sets up the space or not, certainly the space needs to be adequate for clinical patient management. It should have a comfortable waiting room of adequate size, and there should be consultation rooms and examining rooms. Equipment and supplies are necessary for routine patient management and minor wound care. Staffing needs to be available. Certainly, none of this can be done in an angiography suite or radiology department. If done in the hospital, clinical space should be in space dedicated for this use, often in clinics where other specialists also see patients. If done outside of the hospital, usually a physician's office building is desirable.

Setting up a clinical office outside of the hospital offers tremendous flexibility. The political environment can be easily navigated as hospital rules don't apply. Doctors' offices are loosely regulated by states. Resources can be put in place by the practice without having to go through hospital committees or command chains. Setting up an office outside of the hospital, especially in a physician's office building, attests to the sincerity and earnestness of the practice in taking care of patients. It provides a marquee or flagship for the interventional practice that is recognized favorably by referring doctors.

Often, non-interventional radiology partners will express resistance to setting up an office-based practice. There is overhead involved, leases to be signed, and staff to be hired or reallocated to help with the office. Although these are considerable expenses, they pale in comparison to the expenses associated with setting up a radiology office. Probably in most cases the key element to inducing the resistance is a strong cultural conflict. Non-interventional radiologists have difficulty grasping the interventional radiologists' need for this component of their practice. Most of them were never exposed to the clinical practice model of interventional radiology in their training and are out of touch with changes in interventional radiology and the contemporary practice of interventional radiology in general. It is not that they don't mean well. Many would like the interventional radiology practice to thrive. However, because they are adept at running a radiology practice they may think they know better than the interventionists how the clinical practice should be administered.

Often, medical practices are expected to be profitable from day one. It may take 6 months or more for the practice to truly get going, with a steady stream of referrals of desirable patients. Partners should be con-

vinced to exercise patience and to understand that if you build the office practice appropriately, patients will be referred. Usually the procedure volume easily justifies the office, even though the office may lose money compared with other radiology services. Non-interventional radiologists need to focus on those procedures and understand that they would not be there if not for the office. Indeed, interventionists themselves often have some inertia when it comes to establishing clinical practice. Many who have become ingrained with the hospital-based franchise model are concerned about their ability to compete in a competitive environment. This is despite the fact that there is a critical shortage of interventional radiologists in the United States. Health care is in high demand and growing rapidly. We have an aging population. Our procedures are becoming increasingly recognized by the referring community and the public at large. The technology continues to move forward. Despite all these market forces driving the success of interventional radiology, many interventionists are still fearful of their prospects.

There are several reasons why interventionists who set up clinical practices will succeed well into the future. Their services offer low morbidity and mortality compared with surgical alternatives, and when compared head-to-head, have almost always been proven favorably and shown to be superior to surgical alternatives.¹⁻⁴ As alluded to earlier, referrals to minimally invasive procedure specialists are attractive to those trained in internal medicine, who have an aversion to surgery. Patients are also increasingly aware of the risks of surgery and many are sophisticated enough to seek out interventional radiologists. There is a natural alliance between interventional radiologists and internal medicine because both seek to reduce the use of open surgery. Surgeons are poor gatekeepers for interventional procedures and can be presented as such to the referring community. They make their living by operating on people and will often triage to surgery patients who would benefit from interventional consultation and treatment.

Even when other specialists traditionally involved in management of patients with vascular disease provide interventional treatments in local markets, interventionists have a potential competitive advantage. Interventionists have a longer history and are well established in the delivery of minimally invasive therapy. They are more often involved with the newest therapies and research and can legitimately present themselves as local experts in the treatment of the diseases they manage. Finally, fully trained interventional radiologists have actual board certification by an American Board of Medical Specialties subspecialty certification in interventional disease management. Presently no other specialty can say that. The credentials of other "endovascular" interventionists remain "unaccredited" by the American Board of Medical Specialties.

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