Hallmarks of a Clinical Practice

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ABSTRACT

The American College of Radiology recently ratified a practice guideline on interventional clinical practice that includes very specific details about what constitutes a clinical practice for interventional radiology as well as interventional neuroradiology. Several “benchmarks” were developed. These “benchmarks” are felt to be important in the Society of Interventional Radiology strategic plan. Interventionalists need to establish themselves as disease process or organ system experts to succeed in obtaining clinical referrals. Interventionalists who don’t take the initiative to obtain patients and populate their schedules with interesting, well-reimbursed procedures will be relegated to performing mundane services.

KEYWORDS: Clinical practice, benchmarks, service line

Objectives: Upon completion of this article, the reader will gain understanding of the American College of Radiology practice guidelines and Society of Interventional Radiology strategic plan benchmarks for constituents of a clinical interventional radiology practice.

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The American College of Radiology (ACR) recently ratified a practice guideline on interventional clinical practice. This guideline includes very specific detail about what constitutes a clinical practice for interventional radiology as well as interventional neuroradiology. Several “benchmarks” were developed. Benchmarks were felt to be important in the Society of Interventional Radiology strategic plan.¹ The benchmarks that were accepted by the ACR are as follows: interventionalists in clinical practice should accept “direct referrals from primary care doctors for disease processes which they offer treatment and management for. Namely, they should not expect or require participation by another medical or surgical specialist to implement treatment of these diseases.” Another benchmark is

routinely performing and billing for evaluation and management services routinely done for patient assessment as well as during follow-up care. Third, there should be no “gag order” on what the interventionalist can and cannot say to the patient, dictated by the referring physician. Interventionalists should routinely disclose the full range of treatment options to patients, including interventional options, even when the referring physician does not want them to. That is, there should no longer be referrals that state “diagnose but do not try to fix,” as experienced by Dr. Dotter.² When an interventionalist diagnoses a disease in the course of treatment and establishes a treatment option for the patient, he or she should present it to the patient and implement it, referring physician “orders” notwithstanding.

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The fourth benchmark is that interventionalists should routinely establish treatment plans as the primary specialists and execute those plans according to the best information available to them, to the patient, and in many cases with involvement of the referring physician. However, the interventionalist should not expect or require endorsement or approval of the plan by the referring physician. The interventionalist should answer to the patient. Often, consultation with the referring doctor and discussion of the proposed treatment plan will be in the patient's best interest. However, if the referring doctor happens to offer alternative treatments that the interventionalist feels are not in the patient's best interest, the interventionalist is obliged to inform the patient of that opinion. The fifth benchmark concerns admitting privileges. It goes without saying that for an interventionalist to practice in patient care, admitting privileges to a hospital are usually required. That is, if interventionalists desire to perform procedures that will require hospitalization, they have to be able to take care of the patients in the hospital. Some interventionalists thrive in purely outpatient settings, and this benchmark may not apply to them. However, this is uncommon. Interventionalists should be in the habit of routinely admitting people who experience complications of their procedures to the interventional radiology service, even if they were originally scheduled as outpatient procedures. That is not to say that people who develop medical problems or who present with medical problems prior to undergoing the procedure should necessarily be admitted to the interventional service. It may be appropriate, for example, to have a patient with congestive heart failure admitted to the medical service after an uncomplicated procedure usually done as an outpatient is completed. The sixth benchmark requires longitudinal involvement of the interventionalist and the patient's care over time. That is, episodic care limited to techniques or procedures is not consistent with clinical care. Usually, this requires the interventionalist to evaluate the patients in an outpatient setting on a day prior to the day that their procedure is scheduled. After the procedure is performed, the patient should be admitted to the interventional radiology practice or discharged from the hospital for outpatient procedures. Subsequently, the patient should be followed in the periprocedural period, perhaps within the first week or 10 days. For therapeutic interventions, longer-term follow-up is required to assess the treatment response. This can be done, for example, at 6- and 18-month intervals for many therapeutic interventions. However, some interventions may require closer or shorter-term follow-up, such as perhaps uterine fibroid embolization done for hemorrhage or hepatic chemoembolization. If a problem is resolved and stable for 18 months to 2 years, the interventionalist can tell the patient to contact them if they have any further problems or recurrence of their symptoms, but many intervention-

alists will decide not to follow stable patients who have responded well after this time.

Interventionalists should be clear that consultations are not possible for some patients. For example, often emergent or urgent procedures will simply be called for and evaluated on the spot. Other, less urgent requests that require immediate attention can be seen in consultation on the wards; a decision may be made to treat made on the spot or treatment may follow that day if necessary. There is nothing in the clinical practice guidelines or in clinical practice that requires interventionalists to delay emergent or urgent care.

It is envisioned that interventionalists will continue to cover hospital patients, will perform a wide range of procedures on those patients, will provide urgent and emergent diagnostic procedures as well as therapeutic procedures, as well as perform outpatient work. They will also schedule a large proportion of their day's work ahead of time as elective patients referred by themselves through their own clinics. It is envisioned that a robust clinical practice will have at least half of its work scheduled by the interventionalist for any given day for elective procedures, for example, stenting or embolization procedures.

As mentioned previously, some procedures can be done without a consult. First, there are the "minor" procedures, those that are purely diagnostic in nature and entail no reasonable therapeutic option by the interventionalist. Some examples are myelography or arthrography. These do not require a consult. Second, urgent or emergent procedures may be done without a consultation. Obviously, the interventionalist must become familiar with the patient and perform a history and physical examination prior to performing the procedure, but in many circumstances that will not be able to be done even on the ward. Rather, patients or their representatives should be called for immediately and assessed in the angiography suite. However, any elective therapeutic intervention, such as carotid stenting, renal stenting, iliac stenting, femoral stenting, fibroid embolization, or hepatic chemoembolization, should always be done with a consultation ahead of time prior to the day that the procedure is scheduled. The procedure should be scheduled by the interventionalist on a day that is convenient for the interventionalist, and the patient should be admitted to the interventional service. The patient should then be followed by the interventionalist and disease response assessed by the interventionalist, and further treatment plan generated and followed through by the interventionalists. The interventionalist should maintain contact with the referring physician, provide copies of all reports to referring physicians and other important physicians in the patient's care, including always the primary care physician (PCP). However, the interventionalist should, for many of these procedures mentioned immediately above, be

Table 1 Clinical Practice Model

Procedures feasible without consultation

- Minor
- Diagnostic
- Intervention unlikely
- Emergent

Procedures requiring consultation

- Elective
- Scheduled
- Therapeutic

Features common to both

- History and physical
- Preprocedure evaluation
- Establishment of rapport

the sole specialist making the decisions with the patient (Table 1).

Interventionalists need to establish themselves as disease process or organ system experts to succeed in obtaining clinical referrals. Interventional radiology has developed several important treatments in several organ systems and is well positioned to present itself as experts in treatments for various diseases. The natural service lines that are available to interventionalists for trying to gain referrals include: peripheral arterial disease (carotid stenting, renal artery stenting, iliac artery stenting, femoral artery stenting), cancer management (usually hepatic artery chemoembolization and/or radiofrequency ablation), women's reproductive issues (uterine fibroid embolization), and management of varicose veins and chronic venous insufficiency. If interventionalists do not present themselves to primary care and specialists as experts in disease processes, they will not be considered when referrals from those practices are made. That is, in

the past interventional radiologists have been recognized by the referring community as experts in techniques or procedures. In general, the primary care community does not have the expertise to understand what those procedures are or when they may be indicated. Usually, in the past, the PCP would look for an immediate referral, and the interventionalist would allow the PCP to triage patients to various management options, including intervention. Interventionalists must change the current mindset of the referring community, which holds that interventional radiology is a jack-of-all-trades technical specialty, using ingenious techniques to devise solutions to complex problems presented by clinical specialists. Interventionalists have to present themselves as disease experts. They need to go out and get interesting business to bring into their hospitals. Otherwise, their interventional radiology section schedules will be determined by whatever flows to them through the goodwill of being associated with the hospital. Often, these will be procedures that no other specialty offers or desires to offer. Interventionalists who don't take the initiative to get patients and populate their schedules with interesting, well-reimbursed procedures will be relegated to performing mundane services such as percutaneous intravenous central catheter placement, in-dwelling catheter or tube maintenance, placing G-tubes, and the occasional failed emergency department lumbar puncture.

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