Marketing the Interventional Clinical Practice to the Referring Community and to Patients

Timothy P. Murphy, M.D., F.S.I.R., F.A.H.A., F.S.V.M.B.,¹
and Gregory M. Soares, M.D.¹

ABSTRACT

If interventionalists are able to set up clinical practices and promote themselves along service lines, especially peripheral arterial disease, it is likely that they will have some market share and that market share will grow as new devices and technologies become available. The key to success will be changing the impression of the referring community that interventional radiologists are technical specialists and don't see patients. Marketing experts tell us that several impressions are required for a concept to stick with the target audience. One of the most important points that an interventionalist can make to establish themselves as a clinical specialty is high-quality work and effective communications.

KEYWORDS: Branding, service lines, marketing, communications

Objectives: Upon completion of this article, the reader will gain an understanding of "service line concept" and the need for consistent branding and promotion of interventional radiologists as clinical disease specialists.

Accreditation: Tufts University School of Medicine (TUSM) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Credit: TUSM designates this educational activity for a maximum of 1 Category 1 credit toward the AMA Physicians Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity.

Interventionalists must maintain consistent branding of themselves as disease or organ system experts. If interventional radiologists (IRs) are promoted as dabblers in numerous disease processes, jacks of all trades and masters of none, they will reinforce the image of interventionalists as technicians. Along those lines, some interventionalists believe strongly that interpretations of computed tomographic angiograms (CTAs) and magnetic resonance angiograms (MRAs) can help to build practice. They draw an analogy from vascular surgeons using a noninvasive vascular laboratory to promote expertise in vascular disease, and would like to do the same with computed tomography and MRA.

There is some significant appeal there, as internists are very comfortable and understand readily how to interpret the anatomic images generated by these imaging modalities. This model of imaging consultation without direct clinical patient evaluation will in all likelihood persist in the short term due to the current professional profile and the existing training structure of most IRs. However, it can be a double-edged sword, as providing interpretations of MRAs and CTAs requested generically, that is, not done as part of a medical patient referral, can reinforce the image of the interventionalist as a diagnostic imager and that is the impression that interventionalists must change. To establish expertise as a

Clinical Practice Development; Editors in Chief, Brian Funaki, M.D., Peter R. Mueller, M.D.; Guest Editors, Timothy P. Murphy, M.D., F.S.I.R., F.A.H.A., F.S.V.M.B., Gregory M. Soares, M.D. *Seminars in Interventional Radiology*, volume 22, number 1, 2005. Address for correspondence and reprint requests: Timothy P. Murphy, M.D., F.S.I.R., F.A.H.A., F.S.V.M.B., Associate Professor of Diagnostic Imaging, Brown Medical School, Rhode Island Hospital, 593 Eddy Street, Providence, RI 02903. ¹Brown Medical School, Rhode Island Hospital, Providence, Rhode Island. Copyright © 2005 by Thieme Medical Publishers, Inc., 333 Seventh Avenue, New York, NY 10001, USA. Tel: +1(212) 584-4662. 0739-9529,p;2005,22,01,034,038,ftx,en;sir00286x.

clinical specialty, it would be preferable for interventionists to have the patient's referred to their clinic and then have the interventionists order the MRAs or CTAs. If interventionists want to interpret those, they are free to and it is unlikely that this will degrade their image. However, interventionists who want to interpret the CTAs and MRAs that are referred by primary care doctors or other specialists, expecting to generate clinical referrals via these studies, may be placing the cart before the horse.

Specifically, interventionists who are very busy in clinical practice almost by definition will not have time to do a rotation through a CT or MRA division. They will not have sufficient time on dedicated clinical days to give full attention to both aspects of practice. The service lines that can be promoted in almost every community include atherosclerotic disease and cancer treatments. Uterine fibroids are a very common problem with ~200,000 hysterectomies done annually for that condition in the United States. The middle-aged population has approximately a 35 to 65% incidence of varicose veins. Interventionists could focus their efforts along these service lines, including peripheral arterial disease, venous disease, cancer treatment, and uterine fibroids. It is likely that in the future the combination of carotid artery stenting, renal artery stenting, iliac artery stenting, and superficial femoral and popliteal artery treatments such as cryoplasty, bare metal stents, drug eluting stents, distal embolic protection, and endografts, as well as venous disease management, could be bigger than everything else presently encompassed by interventional radiology. Due to competition from cardiologists and vascular surgeons, many interventionists have thrown up their hands on peripheral vascular disease.

It is likely that we are on the verge of an explosion in technology in the peripheral vascular arena and a wholesale paradigm shift on the management of patients with vascular disease. Interventionists who walk away from vascular disease at the current time may be leaving a lot of opportunity behind. It would seem to be preferable to begin efforts to promote the practice in peripheral arterial disease by directly competing with those who have taken over or encroached significantly on the turf. At least this way there will still be some recognition of them as being practitioners in the field when the new technologies take hold. Interventionists who wait for business to find them will find it difficult. They need to promote themselves with their referring community as disease experts. In many communities, they have a tremendous amount of opportunity to present themselves as peripheral vascular disease experts. This is the disease process for which most interventionists are most capable of providing clinical care, best understand the disease, are most adept at performing the physical examination, best understand the diagnostic test, and are best equipped to understand the treatments, complica-

tions, and outcomes. If interventionists are able to set up clinical practices and promote themselves along service lines, especially peripheral arterial disease, it is likely that they will have some market share and that that market share will grow as new devices and technologies become available and as interventionists continue to get the word out on what they can do.

There are number of ways to promote a medical practice to your target audience. For many direct marketing via the public media are not fruitful. Although adopted by numerous other professions, including the legal profession, direct to consumer advertising in medicine is still not widely accepted and often felt to be unprofessional. Practice promotion is best done more discreetly and via educational events and personal meetings with potential referring doctors. Having said that, the internet is an arena in which many physicians have been successful in getting information about their practices out to the public as well as referring doctors. Also, certain patient-referred services, such as varicose vein management and uterine fibroid embolization, may be better suited for some form of direct marketing to the lay public.

Many radiology practices employ marketing staff, virtually always hired to promote the imaging services component of the practice. If available, these staff are invaluable in gathering information about potential practices to target for promotion. Often, decisions about where to refer patients for diagnostic tests or referrals comes through the office staff, office managers, nurses, and so on who work in the office. The relationships between the radiology group marketing staff or practice managers and these people is often already in existence and usually very good. Staff who call on doctor's offices should in the course of their work mention that the interventional radiologists want to be the vascular specialists of referral for the practice. They should note that they do noninvasive vascular testing and disease management. Business cards and/or Rolodex cards should be left behind with the telephone number and contact information for referrals. Interventionists themselves can call on these offices and spend time with office staff and even occasionally the doctors. However, the doctors are often very busy trying to see patients. A trip to an office spent educating the staff is not a wasted visit. Often these meetings may be held over lunch and can be very fruitful. If the doctor manages to stop by and say hello, a quick sound bite summary of the purpose for the visit is useful but don't be dismayed if the doctor doesn't sit for the entire presentation.

On the other hand, referring doctors are often very interested in dinner programs. Presentations can be given by local interventionists, and often financing for the dinner can be done by industry partners in care. Industry partners are often very interested in promoting the work of the interventionists locally and have

marketing budgets and are very easily able to absorb dinners, including even a large number of potential referring doctors.

Sending promotional and marketing material may also be useful. A lot of this marketing material is available through the Society of Interventional Radiology (<http://directory.scvir.org/eseries/store/index.cfm>). The key to success will be changing the impression of the referring community that interventional radiologists are technical specialists and don't see patients. Marketing experts tell us that several impressions are required for a concept to stick with the target audience. Perhaps a newsletter distributed on a regular basis would be useful. If not a newsletter, letters sent perhaps quarterly to discuss the various services that are offered may help. These often can be tied into promotion of research projects if they are being done.

Repetition is the key. Results should not be expected with the first letter or the first office visit. This can be very labor-intensive for doctors. It is useful to employ business office staff, especially dedicated marketing people, to work on these impressions with the office staff. If business or marketing staff are not available for this task, the practice should consider hiring a consultant to help with these efforts. A full-time person may even be brought on to help with the marketing plans specifically for interventional radiology, depending on practice size. Doctors should contact important medical organizations locally, including state and regional medical societies, chapters of Academy of Family Practice, podiatry society, and so on, to offer to provide lectures at continuing medical education meetings. This is often the best way to establish oneself as a disease management expert. Lectures to the community can be done for topics of interest to the lay public (for example, venous disease). Of course, marketing efforts to doctors should include providing grand rounds and dinner lectures that focus on disease management and clinical services that might differentiate interventionalists from the competition. Attendance routinely at interdepartmental meetings, such as medical grand rounds, can help to establish the physician's profile.

Often, when dinner meetings are held for doctors, it can be useful to bring in an outside expert to discuss a new treatment. This is especially true if that expert is, for example, someone of similar background as the referring community and if that expert is known to speak favorably of an interventional treatment option. On the other hand, the opportunity for the local interventionalist to establish credibility is also present in such forums, and therefore the interventionalist should usually arrange and/or introduce the speaker or perhaps give a second lecture at the same venue with speaker brought in from outside. Interventionalists should be aware that many of the industry partners in patient care have promotional brochures and slide sets for various diseases. The Society

of Interventional Radiology also has several presentations available on the website (www.sirweb.org). Sometimes, sales representatives from industry partners are also willing to call on doctors' offices and help with the advancement of interventional treatment options. However, this is potentially a double-edged sword and some referring doctors may react negatively to this type of promotion. Obviously, publications in medical journals can be distributed, especially if they are written by the practice's doctors. The local interventionalists can try to get articles such as timely reviews in local medical journals. Although not widely circulated, local doctors often are aware of the publications in such literature.

Involvement in research is tremendously important not only for the viability of the specialty as a whole but also for practice promotion of the practice locally. Whenever possible, interventionalists should try to participate in industry and the National Institute of Health research. This provides strong evidence of expertise in management of diseases that are being studied. It is notable that other specialties have seized on the research angle to insinuate themselves in the treatment of numerous interventional conditions, including peripheral artery disease interventions. Medline searches of "iliac artery stent" or "renal artery stent" results in hits from numerous specialists other than interventional radiologists. These other specialists recognize that to establish expertise in disease management, research is essential. Interventionalists must maintain a similar approach.

Successful involvement with research should be featured prominently in interaction with referring doctors. Research is done in numerous settings outside of academic medical centers; indeed, community hospitals often do a better job of recruiting patients with appropriate diseases into research studies. Research staff can often be supported by a few research projects and are very suitable for the private practice environment. Interventionalists should interact with the sales representatives who call on them and ask about potential research projects that their companies are conducting, to see whether they can become involved. Once research is done successfully, communications can be done to the potential referring community, seeking patients for various research studies. This helps to establish the expertise of the interventionalist among the referring community.

A research interest in a specific area can be a very strong factor to differentiate an interventionalist from his or her competition. Vein ablation services can be marketed toward referring doctors and also toward self-referred patients. Public health awareness campaigns such as Legs for Life (www.legsforlife.com) can be helpful in promoting interventionalists as vascular disease experts. As always, communications with referring and primary care doctors must be of high quality and should be done often and liberally when involving their

patients. This is perhaps the best form of marketing. When a patient is referred from a specialist, it is important to carbon copy other doctors involved in the patient's care, especially the primary care doctor, for reports of consultations and procedures.

Naming of the practice is also important. Interventionalists as part of radiology groups do not need to practice under the name of that group. They can file paperwork with the state's secretary to do business as another name. Many interventional radiologists who seek to establish themselves as vascular disease experts like to present themselves as having a "vascular institute." Any office outside of the hospital setting can be named anything that the proprietors desire. A medical office of interventionalists seeking to gain referrals for peripheral arterial disease could name their practice the "local" vascular institute. Interventionalists originated this name and are free to use it, regardless of whether or not vascular surgeons or cardiologists are involved. The name has recognition among referring doctors and speaks to dedication and expertise.

One of the most important ways to market oneself is to directly meet the doctors from whom you would like to receive patients. This will allow doctors to get to know you and to become comfortable interacting with you. The value of this is enormous. Physicians are often reluctant to refer patients to doctors they have not met. As mentioned previously, keep the business managers and office staff in the loop. They usually have more time than the doctors and are often integral to the referral patterns.

Along those lines, interventionalists should always seek to define themselves to the referring community. In the past, interventionalists have not interacted directly with the referring community and have let other specialists define interventional radiology for them. This is bad marketing! Who would let their competition define them to their target audience? This would be like the Democrats allowing the Republicans to put out marketing material on them without response. The information is very biased. Interventionalists need to speak up for themselves. They need to tell the referring doctors what they are capable of and that their procedures work. Many of the procedures have been smeared by specialists with competing treatments. Interventionalists need to get out and defend themselves! Again, most of the randomized experiences support intervention as the superior treatment. This is what should be emphasized for the referring community. Many primary care doctors familiar with some of the issues on vascular disease have been "educated" (brainwashed) that patency is the only important issue for vascular interventions. The vascular surgeons have told them that this the gold standard, the benchmark by which vascular interventions should be managed. That is ludicrous! Patients in particular are much more sensitive to morbidity and

mortality than they are to patency. Indeed, percutaneous interventions are usually easier to redo than the original procedure, entail less risk, and offer greater technical success. Conversely, surgical procedures are much harder to redo than the original procedure, are associated with poorer patency, and have more complications than the original procedure. Patency for interventional procedures simply is not as big an issue as morbidity and mortality. If patients are told that there is a 15% chance that they will need to undergo a reintervention for their stent procedure within 2 years but their chances of dying within 30 days are reduced 90%, it is obvious which procedure they will choose. Interventionalists need to redefine the talking points regarding their specialty. When angioplasty and surgery are compared head to head,¹⁻⁴ patency differences are not strong. However, differences in morbidity and mortality favoring intervention are substantial. It should be noted that this is "level I" evidence, gathered from adequately powered, well-designed, randomized clinical trials. The information from these trials is more important than all of the case series and review articles combined. One should not allow a case series from a single institution without a control arm to refute data achieved in level I studies. The fact is, vascular surgeons have presented a highly jaundiced view of interventional radiology to the referring community over many years and have been allowed to do so. In fact, a leading vascular surgeon recently said, "The surgical community as a whole completely failed to understand the potential of PTA [percutaneous transluminal angioplasty]."⁵ That same surgeon said that the surgeon's dismissal of interventional techniques "represented, without a doubt, one of the most refined expressions of collective stupidity . . . ever exhibited by a professional group."⁵ Interventionalists should seize on this information and present it to the primary care community, and surgeons themselves, when highly biased information against them is presented.

One of the most important points that an interventionalist can make to establish themselves as a clinical specialty is high-quality work and effective communications. Patients shouldn't be allowed to fall through the cracks. The specialists should contact the internist with updates about the patient's condition, not vice versa. Success in medicine is dictated by the three A's: availability, affability, and ability, in that order. Interventionalists should always be available for consultation and should be friendly, sociable, and congenial. Often, interventionalists learn their training programs as diagnostic radiologists that they should raise barriers to patient referrals. This mindset needs to be completely reversed. Interventionalists need to accept problems when contacted by potential referring doctors. They should seek to minimize the effort level required by the referring physician to refer the patient, and they should accept the problem from the referring doctor, follow it over

time, and be accountable for its outcome. They should keep in contact with the referring doctor about progress on the management of the problem.

The importance of positioning oneself to accept primary care referrals cannot be overstated. Once the primary care physician is "reached," the likelihood of establishing a successful referral pattern is high. Primary care physicians intuitively avoid referrals to surgeons, and they are often concerned that referrals to cardiologists may result in lost patients. Interventionalists pose no such threats and can correctly present themselves to the primary care doctors as managing patients in collaboration with them. Internists can often be reached by mailings, as noted above. However, try to get one point across at a time. Because people are busy, letters with more than one vertical inch of text are often thrown directly in the trash. Also, don't try to cross-pollinate service lines in the same practice promotion. When trying to promote oneself as a stroke prevention expert, mentioning varicose veins and fibroids in the same breath will not result in the impression that desired. A good strategy is to ask about referral patterns for vascular specialists and vascular diseases. Bring brochures or other informational materials to them. Try to use the term "vascular specialist" and let them know that you would like to see their vascular patients in consultation.

Always be sensitive to how the referring doctor wants to be involved in the management of each issue. Referring doctors vary as much as interventionalists do. Some want to be involved in all the decisions. Others want everything to be done and the patient returned with the problem solved and the reports in the chart. As a general rule, they expect management to be limited to interventional areas of expertise. They do not expect interventionalists to routinely adjust diuretics or insulin doses. Many will be offended if this is done in the office without their knowledge, and rightly so. That is the domain of the primary care doctor. That is not to say that if a patient has a poorly controlled lipid profile, the

interventionalist should not contact the primary care doctor or referring doctor about starting statin therapy; however, the default assumption (which obviously must be followed up on) by the interventionalist should be that the management will be performed by the primary care doctor. If the interventionalist writes the prescription for the statin, it should usually be done as a convenience. There are few practices in the United States where the interventionalist will actually monitor the response and complications of statin therapy, for example.

Interventionalists may also find it useful to discuss the merits of the primary care doctor with the patients, if possible. This reinforces the position of the interventionalist as a partner and collaborator, rather than a specialist who is trying to replace the primary care doctor. Patients appreciate the positive impression interventionalists may have about their doctors.

REFERENCES

1. Weibull H, Bergqvist D, Bergentz SE, Jonsson K, Hulthen L, Manhem P. Percutaneous transluminal renal angioplasty versus surgical reconstruction of atherosclerotic renal artery stenosis: a prospective randomized study. *J Vasc Surg* 1993;18:841-850
2. Wilson SE, Wolf GL, Cross AP. Percutaneous transluminal angioplasty versus operation for peripheral arteriosclerosis. Report of a prospective randomized trial in a selected group of patients. *J Vasc Surg* 1989;9:1-9
3. Wolf GL, Wilson SE, Cross AP, Deupree RH, Stason WB. Surgery or balloon angioplasty for peripheral vascular disease: a randomized clinical trial. Principal investigators and their Associates of Veterans Administration Cooperative Study Number 199. *J Vasc Interv Radiol* 1993;4:639-648
4. Yadav JS, Wholey MH, Kuntz RE, et al. Protected carotid-artery stenting versus endarterectomy in high-risk patients. *N Engl J Med* 2004;351:1493-1501
5. Criado FJ. Reinventing the vascular surgeon. *Endovascular Today* 2004;March:75-77. Abstract