Developing an Interventional Radiology Varicose Vein Practice

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ABSTRACT

A varicose vein or phlebology practice can be incorporated into an outpatient interventional radiology practice with some proper planning. For an established interventional radiology clinic practice, the barriers to entry into such a phlebology practice are actually fairly low. A critical component in this process is establishing a business plan. An intact business plan can provide the proper foundation for any business venture, including a successful phlebology practice. Key steps in any business plan include an evaluation of the proposed venture, proper planning, organization, implementation, and periodic review. In this article, I describe how an active varicose vein practice was established in our outpatient radiology office in Charlotte, North Carolina, as well as highlight several important features that could, and probably should be, incorporated into any phlebology practice.

KEYWORDS: Varicose, vein, phlebology, practice, development

Objectives: Upon completion of this article, the reader should be able to (1) describe important steps in developing a varicose vein practice and (2) understand the importance of a business plan in establishing a phlebology practice.

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Traditionally, the treatment of varicose veins has been incorporated in either a vascular surgery or dermatologic practice. Attention to venous disorders has been previously discussed in the vascular surgical literature as a way to develop a vascular practice.¹ Varicose vein treatment can occupy anywhere from a small percentage of a vascular surgery or dermatologic practice to the entire practice in a free-standing "vein center." Often, varicose vein treatments are offered as part of family medicine, internal medicine, or obstetrics and gynecology practices. Advances in the treatment of venous insufficiency have also created an opportunity for interventional radiologists to play a significant role in the treatment and

management of varicose veins and to develop their own varicose vein treatment centers.

Over 35 years ago, Charles Dotter made his prophetic remarks about the importance of interventional radiologists (at that time referred to as angiographers) accepting the clinical responsibilities of their practice.² It has been only in the past decade or two that this concept has been embraced by many interventional radiology (IR) practices. For these practices, the IR clinic has been central to their evolution by providing an opportunity for longitudinal patient care, whether hospital or non-hospital based. The importance of an IR clinic has been described in several previous articles.²⁻⁴

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An indirect benefit of an established clinical practice is that new procedures and practices can easily be incorporated into the clinic model, often with minimal additional expense.

This article presents the author's personal experience and that of his radiology group to exemplify techniques that can be used successfully in the development of a phlebology practice.

PRACTICE BACKGROUND

Charlotte Radiology, P.A. comprises more than 60 radiologists with diverse training and subspecialty expertise. We are one of the largest radiology groups in the Southeast, performing more than 650,000 radiologic procedures each year. Our current IR practice encompasses the full gamut of both inpatient and outpatient IR procedures. There are currently six full-time and four part-time interventional radiologists who perform procedures at four different hospitals within the Carolinas HealthCare System. Carolinas HealthCare is the largest health care system in the Carolinas and one of the largest publicly owned systems in the nation. It includes Carolinas Medical Center, an active level one trauma center that includes The Children's Hospital at CMC. Our hospital-based IR clinic is located at Carolinas Medical Center, adjacent to the IR procedure area. The hospital IR clinic space consists of two offices and two examination rooms. Our second clinic area, the outpatient IR clinic, is located at the Charlotte Radiology Diagnostic Imaging Center (DIC). This center provides diagnostic radiology services and offers the convenience and comfort of an outpatient setting. Procedures include computed tomography, magnetic resonance imaging, ultrasonography, fluoroscopy, urography, Doppler ultrasonography, hysterosalpingography, and routine x-ray procedures. The Charlotte Radiology-DIC is the primary location of our varicose vein practice. Within this outpatient location we have access to a large waiting room, several changing rooms, a dedicated office consultation area, two procedure rooms, and an additional diagnostic ultrasound room. At this time, five of the six full-time interventional radiologists rotate to provide services at the vein practice.

EDUCATIONAL AND PLANNING STAGES

The process of establishing a vein center began for our practice in early 2001. Initially we considered introducing radiofrequency ablation of the saphenous system as our method of choice (the Closure procedure, VNUS Medical Technologies Inc.). A presentation on endovenous laser treatment (EVLT, Diomed Inc.) by Robert Min, M.D. at the Advances in Vascular Imaging and Diagnosis Conference sponsored by Montefiore Medical

Center, however, helped shift our focus to endovenous laser technology.

One of the key factors in our decision to pursue laser technology was the improved safety profile. At that time, the radiofrequency technique had several documented cases of nerve injury and pulmonary embolism. The laser technique had no such complications reported in the literature. Another factor in our decision was the decreased procedure time with the laser technology. In the radiofrequency technique the catheter is withdrawn at 2 or 3 cm/min. This compares with a pullback rate of 2 or 3 mm/sec with the laser technique. Over a long segment of vein, this can result in a significant difference. In addition, the laser technique was able to treat larger vein diameters than the radiofrequency technique recommended. A final factor in our decision was that there would be marketing advantages for our practice with the laser technology because we would be first to market in our area with this technique.

The ensuing months comprised the education phase of our practice development, which consisted of review and discussion of the literature at section meetings, review of competing technologies, attendance at various conference presentations, and didactic as well as hands-on training offered by the different company representatives.

Within this early educational phase, initial plans for development of the practice were formed. A sound knowledge base was established, which not only laid the groundwork for the clinical aspects of the phlebology practice but also assisted in the preparation of a business plan for the vein practice, which was in turn presented to the management committee of Charlotte Radiology, P.A. the following spring of 2002. The coincident timing of the Food and Drug Administration's approval of EVLT in January 2002 provided our section further assistance in this planning process.

The specific details involved in creating a complete business plan are outside the scope of this article, but resources for business plan development are widely available. The early practice development questions listed in Table 1 are important in a standard

Table 1 Questions That Need to Be Answered in the Early Phase of the Practice Development

Early Practice Development Questions

1. Will this be a primary versus part-time practice?
2. What type of practitioners will be involved in the practice (MD, PA, NP, RN)?
3. Should strategic alliances be made?
4. Where should the practice be located?
5. What resources will be available?
6. What personnel will be needed to staff the practice?
7. What equipment will be used in the practice?

business plan model, which needs to be formulated at this stage of the planning process. The most critical steps in business planning can be achieved by honestly answering these basic questions, including evaluation of the proposed venture, planning for the proposed venture, as well as practical and financial organization.

For most interventional radiologists, a varicose vein or phlebology practice will be a part-time venture. This was the case in our practice. Initially, the consultation and procedure volume required and justified only a half-day per week of physician presence in the office for one of our interventional radiologists. I accepted the role as a point person in the vein practice for the first 6 months to be able to provide consistent and focused patient and practice support. As we were operating in a functioning and established diagnostic radiology office, we had the immediate availability of front office support staff. Our decision to develop our practice in our outpatient imaging center was made after consideration of several different scenarios. The availability of the support staff, technologists, nursing, and high-quality ultrasound equipment at the imaging center significantly reduced our start-up costs and decreased the potential financial risk involved in establishing a free-standing center. We agreed early on that our phlebology patients would be better served and accommodated in this outpatient office, removed from the potential drawbacks of a hospital-based practice. This approach has the added financial benefit of allowing the radiology group to capture both the profession and technical fees for the procedure.

Initially, our practice made use of several strategic alliances. Although many vein practices plan on opening their doors offering a complete spectrum of phlebology procedures, we decided to focus initially on the treatment of symptomatic patients with large vessel reflux using the endovenous laser catheter technique. Our local medical community contained several dermatology groups that were willing to accept our patient referrals for ambulatory phlebectomy and sclerotherapy following endovenous catheter ablation of the greater or lesser saphenous veins. The benefit from these early alliances was that our practice was perceived as complementary to their practices and nonadversarial. These relationships allowed us to concentrate our efforts on the EVLT procedure at a time when endovascular obliteration of saphenous reflux was receiving favorable support in the literature.⁵ As our practice expanded and evolved, we began offering ambulatory phlebectomy as well, driven primarily by several patients' desire to complete all of their treatment within our clinic.

Additional items to be considered in the early planning stages include basic marketing strategies, evaluation of market share, expected competition, expected patient and procedure volume, and expected overhead expenses. Addressing these issues honestly will help

Table 2 Questions That Need to Be Answered prior to Implementation of a Business Plan for a Varicose Vein Practice

Questions Regarding the Financial Plan

1. What will be the cost of the capital equipment and supplies?
 2. Will financing be required?
 3. What will be the charges for services provided?
 4. What is an expected breakeven point?
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address questions in the financial data portion of the business plan for the practice (Table 2).

IMPLEMENTATION PHASE

When our business plan was presented to the group's management committee, it included a list of initial capital equipment and supply costs, expected costs of disposables, procedure charges, estimations of cost and profit per procedure, an expected breakeven schedule, and a procedure volume projection point. Vendor assistance at this phase of the process is extremely valuable: not only can the planning and organization burdens be lessened, but also equipment vendors can provide invaluable marketing exposure through their own in-house marketing divisions. Our vendor, Diomed, provided us with useful background information, including regional demographic data, projections of procedure cost, and equipment financing options. Although our practice's business plan was already formed, the company was also able to provide a basic business plan template that served as an additional guide and checklist for us to compare our plan with. The vendors of competing venous ablation devices provide similar support for their buyer physicians.

If a radiology group has an existing clinic for its IR practice, whether outpatient or hospital based, the barriers to entry into the practice of phlebology are fairly low. The physical office space and the requisite waiting room and front desk area in an existing practice clinic should provide an acceptable experience for most patients. However, the absence of such an environment can be problematic. As noted by Siskin et al, "Based on past experiences with physicians, a patient expects a defined clinical space with a receptionist and a waiting area. In fact, the reception area is often central to an outpatient office, and a cordial and efficient reception area is typically the best way to provide a favorable first impression to patients."² As this infrastructure was already present in our outpatient imaging office, the process of incorporating the phlebology practice was fairly straightforward (Figs. 1 and 2). Overhead expenses related to this process were, as a result, very low. The only significant additional expenses were those of converting an administrative office to a dedicated consultation office space. We also modified, slightly, existing space in two

Figure 1 Diagnostic imaging center waiting room.

ultrasound examination rooms in the initial renovation process. The larger of the two diagnostic ultrasound rooms became our primary procedure room (Fig. 3).

An additional benefit of retrofitting an existing outpatient radiology imaging office is that most contain several of the otherwise expensive diagnostic tools necessary in evaluating patients with venous disorders. Duplex ultrasonography allows noninvasive imaging of the deep and superficial system and provides the ability to map the sometimes complex anatomy of the varicose veins in each patient. Our practice had two high-quality Acuson Sequoia™ 512 ultrasound system units, which were already present in our imaging center and available to the vein practice from the outset at no additional up-front cost. We also had available a Parks Flo-Laboratory 2100 Vascular Laboratory system and plethysmography unit to assess calf pump function further as well as obtain

arterial ultrasound evaluation in patients at high risk for or with symptoms of peripheral arterial disease. This ability to provide a comprehensive approach to lower extremity vascular disease has been an important reason for many of the referrals our office receives from the local internal medicine and family practice physician groups. Again, as this was an existing vascular laboratory unit in the imaging center, no real additional cost outlay was required. Although many varicose vein practices do not support both plethysmography and duplex ultrasound in house, both are particularly important for an IR phlebology practice as they enable a more complete understanding of the underlying superficial or deep venous system dysfunction and, as a result, help guide a more comprehensive treatment plan.

As already described, we use the ELVT unit from Diomed for large vessel ablation procedures. This unit

Figure 2 Diagnostic imaging center front desk reception area.

Figure 3 Diagnostic ultrasonography and phlebology practice procedure room.

and 10 initial laser fiber procedure kits cost approximately \$35,000 in the summer of 2002 and constituted the bulk of the initial expenditure to Charlotte Radiology in establishing the phlebology practice. Since that time, several vendors have developed leasing arrangements that could significantly reduce this initial cash outlay, a particular benefit in smaller practices.

Important ancillary equipment to consider in the development of a vein practice includes adjustable examination tables, a digital camera with photographic archiving or printing capabilities, and a visual magnification system (e.g., Loupes) if you are planning sclerotherapy. If you plan to provide ambulatory microphlebectomy in the office, phlebectomy hooks and forceps are another necessity.

Manual phlebectomy hooks are widely available and fairly inexpensive. There are numerous different configurations and sizes, and each individual operator grows to prefer a certain style. The best advice in this regard is to order and experiment with a variety of phlebectomy hooks until your practice finds a level of comfort with a particular type or size of phlebectomy instrument. As we had an autoclave device available in our clinic, no additional significant cost was incurred for the sterilization equipment required in reusing phlebectomy hooks.

In addition to manual phlebectomy, there exists a powered phlebectomy unit called TriVex (Smith & Nephew Corp.), which is used in some practices. The TriVex system allows one to target a varicose vein segment using an irrigated illuminator and quickly ablate it using a powered resector. The system is quite a bit more invasive than microphlebectomy but can more quickly treat very extensive varices. To date, we have required only the use of manual phlebectomy hooks in our practice.

Par levels for disposable items used during procedures and evaluation should also be established. The disposable items required are typical of many IR procedures and include needles, syringes, additional guidewires, intravascular sheaths, gauze, bandages, and medications (including sclerosants, local anesthetics, anxiolytics, etc.). Typically, our patients receive 5 to 10 mg of diazepam prior to our procedures as well as 1000 mg of acetaminophen. The sclerosants used in an individual practice have to be identified. Because of the relationships we fostered with area dermatologists, we did not provide sclerotherapy early in our practice.

MARKETING AND PROMOTION

Once the groundwork is complete, financing has been arranged, and office personnel have been trained, attention should be focused on marketing and promotion. Effective marketing ensures that potential patients and referring physicians are informed of the availability of the services you are providing. Patient brochures are a simple and effective first step and are widely available from equipment vendors and from the Society of Interventional Radiology. Your practice may decide to host educational symposia, host lunch or dinner meetings with potential referring professionals, or attempt direct-to-consumer advertising through various media. In developing a marketing strategy for our vein practice, we first utilized more of the low-cost, conventional methods available, then expanded our marketing efforts as the practice grew. Diomed's marketing was instrumental in obtaining both air time on local radio stations and coverage by local television programs. Our in-house marketing team also assisted in the initial marketing efforts. A one-page description of the endovenous laser procedure was mailed to every physician in our database.

This served to educate potential referrers and to inform the local medical community of the new treatment option available for their patients. We also sent a similar information letter in mailers to our company employees. Charlotte Radiology had over 300 employees during the summer of 2002, and given the percentage of people affected by venous disease, we were able to identify a large number of potential patients from within our own organization. Several company employees who were found to be candidates for the EVLT procedure volunteered to be our initial patients. This, in turn, enabled us to receive early and honest feedback from their experiences as patients coming through our office.

Another early marketing strategy for our practice included screening patients for venous disorders at our annual Legs for Life[®] Screening in the fall of 2002. This effort resulted not only in the evaluation of potential vein patients but also in the addition of an important component to our Legs for Life[®] Screening program. We were now able to provide a more complete evaluation of lower extremity vascular disease. This effort was recognized nationally with the addition of the Venous Screening Component to the Legs for Life Program the following year. Our practice provided several of the office documents and materials that were incorporated into the Society of Interventional Radiology's Legs for Life[®] Program in the fall of 2003.

As our practice grew and the number of procedures began to increase steadily, we dedicated more resources to our marketing efforts. In the spring of 2003 we employed a local medical marketing company to develop the advertising campaign that is currently in effect for our practice. This campaign includes inserts for local subscribers of popular women's issues and sporting magazines.

Currently, the availability of medical information on the Internet is widespread. This provides an additional vehicle for our marketing strategy. Our company Web site is able to provide patients and referring physicians with further information regarding not only the phlebology practice but also many of the other procedures we are performing in the hospital-based part of our practice. Our Web site also provides patients with the opportunity to review photographs of our radiologists and to read a brief summary of their training and experience.

EVALUATION OF PRACTICE PATTERNS AND MARKETING

To track referral patterns and results of marketing, an data entry log should be made available to front desk personnel. This log should be maintained from the onset so that interval reviews can be performed. Our practice had a binder available to the front desk employees and

schedulers that served to collect patient data including name and address, contact numbers, source of referral, and date of contact. Eventually, this was converted to electronic data entry format. Patients were asked basic screening questions to assess need for IR consultation versus referral to our dermatology associates for sclerotherapy.

We had identified early in the practice that we would concentrate our practice primarily on patients who had symptomatic varicose veins (e.g., with pain symptoms or thrombophlebitis history). This focus served to maximize the percentage of consultation patients who were candidates for the endovenous laser ablation procedure, and the early referrals of asymptomatic patients to our dermatologic colleagues served to solidify our professional relationships. Our initial focused approach also allowed us time to grow and expand the practice without the initial additional obligations required in opening a full-service vein center from the start. There are many markets across the United States where this approach is not feasible or may even be counterproductive. In our regional metropolitan market, however, this approach helped us achieve legitimacy with many of our referring physicians and strategic partners. Despite previous reports of patients' satisfaction with outpatient sclerotherapy alone,⁶ our local medical community was more receptive to our approach of addressing the great saphenous vein reflux that was most often the etiology of their patients' venous pathophysiology.

OFFICE PERSONNEL

The staff employed in an outpatient clinic plays a tremendous role in contributing to the overall tone of a medical practice and the satisfaction of a patient with the physician-patient relationship established during an initial office visit.² The relationships established with patients in an outpatient setting have changed given the extremely busy nature of most physicians practicing today. Instead of patients simply having physician-patient relationships, the bonds formed with patients can now be more accurately described as practice-patient relationships.² It is therefore critical that everyone involved in the phlebology practice understand the conduct expected from them and that only staff who are properly suited to the type of practice are hired. When our practice first opened, the support staff consisted of a clinical nurse specialist, two ultrasound technologists, and a dedicated front desk administrative assistant. All of the phlebology practice participants were already employed by Charlotte Radiology, P.A. and, as a result, new costs to the practice itself were nominal.

The May 2003 American College of Radiology document concerning IR clinical practice recommended that consideration be given to adding a clinical nurse

specialist, nurse practitioner (NP), or physician assistant (PA) to practice staff to develop an outpatient interventional clinic.⁷ Such a specialist may be particularly invaluable to a phlebology practice. The cost-versus-benefit ratio is very favorable. In our practice our clinical nurse specialist has been part of the practice from the onset. She has been involved in the care of almost every single patient, from consultation to postprocedural follow-up. Primary responsibilities include obtaining preprocedural consent, administering procedural medications, preparation and marking of patients for procedures, preparing the tumescent anesthesia, applying postprocedural bandages and compression stockings, providing postprocedure instructions, and initial handling of all postprocedural phone calls and questions. When we first started our practice, our clinical nurse specialist was also involved in most of the patient scheduling as well as the initial insurance precertification process for procedures. As the practice began to build, however, we were required to expand both the front desk and scheduling staff as well as hire an administrative director of the phlebology practice. As Charlotte Radiology, P.A. had a superb coding and billing team in house, we organized a focused team within our billing office to which we would direct all of the phlebology practice's billing and collection data. By including a representative from the billing office in administrative practice meetings, we were able to ensure that proper evaluation and management codes, as well as procedure codes, were being used for the practice and that the preauthorization process was completed properly. It has been shown that providers who can effectively manage the preauthorization process have the opportunity to transform an administrative burden into a competitive advantage.⁸

In the past year, the addition of a procedural assistant and the expansion of the scheduling team have freed our clinical nurse specialist to spend dedicated time on quality assurance issues and outcome analysis. Recently, we have had two PAs—who were already employed by Charlotte Radiology P.A. as hospital-based IR PAs—trained in sclerotherapy procedures and we are now able to provide this additional service within our practice. Each individual phlebology practice can dictate the particular nonphysician provider mix. As Medicare and most third-party payers reimburse for services provided by an NP or PA, this may provide an additional source of revenue for a practice.² In our particular vein practice, our physicians have had the primary responsibility for initial consultations, endovenous ablation procedures, ambulatory phlebectomy, and follow-up examination. Although this is somewhat less efficient, our patients are very receptive of, and responsive to, the physician-patient relationship that we try to foster, and this is often the most important reason for patients deciding to receive care in our office rather than a

competing vein center. This is a decision that each practice's clinical director has to weigh.

One of the most significant additions to our staffing was the hiring of a dedicated administrative director for the phlebology practice in the fall of 2003. Her responsibility is to ensure that the entire process, from scheduling to consultation to procedure to follow-up, is as expeditious as possible for our patients and to serve as a liaison to the practice's physician clinical director. At the conclusion of their office consultation, patients meet with our administrative director and begin to work on issues including expected costs, insurance coverage, and payment options. Our administrative practice director also assists with reminder phone calls and rescheduling patient cancellations to improve office efficiency as well as coordinating marketing efforts with our marketing team. Monthly, we receive a projection of appointment and procedure wait times and use this information in staffing assignments. This is especially important in phlebology practice, given the previously documented effects of seasonal variation in referrals.⁹

Our current wait time for consultations is ~2 months, with a similar wait time for procedures. As follow-up appointments are made at the time of the procedure, there is never a delay in patients receiving our standard follow-up. This follow-up consists of an ultrasound examination at 2 weeks, ultrasound and physician follow-up at 4 weeks, and final ultrasound and physician follow-up at 6 months. If patients have significant residual varicosities present at the 2-week follow-up, they are given the option of having ambulatory phlebectomy at the time of the 1-month follow up.

THE PAPER TRAIL

Office documents basic to a phlebology practice include patient information brochures and/or packet, an office intake questionnaire, a focused history and physical sheet, an ultrasound worksheet (to document anatomy, areas of reflux, and vein diameters), prescription pads for compression stockings, pre- and postprocedure patient forms, and an informed consent form. There are many templates available for these documents that can be easily tailored to an individual practice. It is important that these forms are available from the onset and that they are familiar to, and used by, all of the medical professionals in the practice. The end result, of course, is that the documents become part of the patients' medical record. The medical chart, including documentation of the discussion of the risks, benefits, alternatives, and the procedures, is well known to be an important factor in malpractice risk management. Pre- and post-treatment photos are additional crucial pieces of a modern phlebology practice. A particular challenge to insurance reimbursement for phlebology practice patients with

medical indications for care is the justification of medical necessity with the medical chart to obtain adequate payment coverage. Having an organized approach from the onset facilitates both initial reimbursement efforts and the appeal letters required for addressing the inevitable insurance denial letters that have become a not-uncommon part of the reimbursement process.

PAYMENT

Prior to seeing the first patient in the office, consideration should be given to patient payment options. Practice location, individual insurance company policy, and type of phlebology practice determine whether and how much insurance reimbursement is available. In general, coverage is usually limited to large varicose veins, especially those associated with pain that is unrelieved by conservative measures, edema, preulcerative skin changes, phlebitis, hemorrhage, or ulceration.¹⁰ Most treatment for telangiectasias is considered cosmetic.¹⁰

A fee-for-service pay structure may not be part of your current IR practice but can be easily structured. This option should be coordinated with legal council, as your existing insurance contracts may preclude your seeking direct patient payment for covered patients without first pursuing insurance coverage, even if the insurer in question has determined in previous cases that your treatment is not a covered expense. For uninsured patients and those with denied authorization, a credit card magnetic swipe reader was installed in the center to allow patients to take advantage of promotional percentages rates on their credit cards.

As described previously, we were able to utilize a focused in-house coding and billing team for the phlebology practice. This team works through our administrative practice director to address any insurance billing or collection issues as well as indicate when appeals to denial letters need to be generated. Attention to this part of the practice early may alleviate some of the potentially difficult discussions regarding cost that most primarily hospital-based interventional radiologists may not be initially comfortable with.

PERIODIC REVIEW

Charlotte Radiology's management committee, as well as all of the physician stockholders, received quarterly financial statements from the phlebology practice. The statements included patient statistics such as number of consultations and procedures as well as an accounting of overhead costs and profit/loss analysis. This quarterly exercise proved invaluable to the growth of the phlebology practice. Increasing volumes helped to justify the addition of support staff as well as increased IR coverage at the center. As the data from each quarter were

presented, it became more apparent to the other radiologists in the group that we had developed a successful model. Interestingly, the most common question I now receive is, "How can we get the interventional radiologists to spend more time in the outpatient vein practice"? Not surprisingly, our section was authorized recently to hire an additional interventional radiologist.

CONCLUSION

As interventional radiologists, we are very well suited to the practice of phlebology, particularly because of the diagnostic skills we have available and because of the practice referral patterns that are already often in place. With proper planning and marketing, a successful phlebology practice can be organized within the framework of an IR practice. In practices that have already established outpatient IR clinics, the transition can be fairly straightforward. Generating a proper business plan and attention to many of the issues raised in this article will help to facilitate this process. Local market and regional attitudes will undoubtedly shape a particular phlebology practice and may cause some modification of initial plans. Attention to external forces early in the process can help guide the development of the phlebology practice from planning through implementation and also play an important role in the periodic review process. The benefit of the availability of a low-stress outpatient practice for our phlebology patients has become clear. Our practice not only serves to reinforce in the community the commitment of the modern interventional radiologist to patient care and long-term patient relationships but also is in line with the Society of Interventional Radiology's current Membership Strategic Plan.

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