Top 5 Reasons Why You Can't Blame Interventional Radiologists for Neglecting Clinical Duties for So Long

If my fellow angiographers prove unwilling or unable to accept or secure for their patients the clinical responsibilities attendant on transluminal angioplasty, they will become high-priced plumbers facing forfeiture of territorial rights based solely on imaging equipment others can obtain and skill still others can learn.

—Charles Dotter

American College of Surgery meeting in 1968

I swear, I've seen this quote about a million times by now. Usually, it is mentioned to either: (1) demonstrate the prescient ability of one Charles Dotter, the widely held father of interventional radiology or (2) show what boneheads the rest of us are in that we didn't heed his warning until it was too late. The conventional wisdom applied to Dr. Dotter's dire prediction is that we, as interventional radiologists, ignored our clinical duties for so long that referring physicians became weary of sending us their patients and decided to either send their patients to physicians who provide more comprehensive care or do these procedures themselves. Moreover, by becoming high-priced plumbers, we let our guard down and some of our turf was taken from us.

I may not know much about predicting the future. But I do know a lot about sports. One of my favorite shows is called *Top 5 Reasons You Can't Blame . . .* For those of you who don't have ESPN Classic on your TIVO, this 30-minute segment examines the people and events "who over the years have been blamed for either a team's failure, their individual failure, a bad trade, a bad draft pick, or the demise of a franchise." This is revisionist history applied to sports and makes for interesting debates. Some topics have included, *Why you can't blame . . . The U.S. golf team for its 1999 Ryder Cup*

Celebration, Jerry Krause for the break-up of the Bulls (now that is a stretch—the Tyson Chandler for Elton Brand trade was even worse), and *Bill Buckner for the Red Sox losing the 1986 World Series* (I'd have to ask Peter Mueller his opinion on that one).

I've always enjoyed flying in the face of reason. So, here are "Top 5 Reasons You Can't Blame Interventional Radiologists for Ignoring Dotter's Advice and Neglecting Clinical Duties for So Long."

1. *Charles Dotter wasn't exactly a conventional guy.* Sadly, I never had the opportunity to meet Dr. Dotter but from all that I've been told, he was truly a unique individual—very passionate or a little crazy, or possibly both depending on your viewpoint. This man once presented an oral abstract on pain and sedation complete with tape recordings of screaming patients. Although I assume this made for good theater, I would also concede that it is clearly a little left of normal. Dr. Dotter obviously had an unusual insight into our field; nonetheless, it is hard to argue that his speech in 1968 was conventional wisdom from a conventional guy. It is not difficult to see why everyone didn't rush out and accept the truth in this statement. Who has ever heard of a *low-priced* plumber? Even Nostradamus was wrong most of the time (he predicted the world would end in September of 1999—last time I checked we were still here). Besides, for awhile there, things were pretty good and it took at least 25 years before Dotter's prediction took shape.
2. *Adopting clinical activities earlier wouldn't have prevented incursions on our "turf."* Many people assume that if we had only espoused clinical activities earlier, the turf battles would have been avoided. Nonsense. One of the simple facts of life is that any procedural-based specialty pursues procedures and

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acts in its own best interest. Moreover, if that specialty has patients with a problem that can be treated, that same specialty will tend to want to treat these patients themselves. Cardiologists take patients away from both interventional radiologists and vascular surgeons. I don't think anyone has ever accused vascular surgeons of not adopting clinical activities. Moreover, for years, we incurred on the "turf" of others, particularly surgeons—chest ports, inferior vena cava filters, embolization for hemorrhage, and so forth. These specialties didn't lose turf because they weren't "clinical" enough.

3. *How can you blame us if nobody likes clinical work, not even clinicians?* One of the reasons clinicians supposedly hesitate to send us patients is that they will have to take care of these same patients after the procedures. We have all the fun while they have all the work. There is some truth in this statement. More and more, even clinicians are limiting their scope of practice by sending patients to hospitalists and so forth. The reality is that no one can be all things to all patients—Henry Ford figured that out a long time ago. Many of us still don't like clinical work—if you look at "clinical" interventional radiology practices, many have NPs, PAs, APNs, and other acronyms who help interventional radiologists avoid clinical work. We are radiologists after all. Very few of us chose radiology initially because we enjoyed rounding on patients.
4. *Multidisciplinary care always has been and always will provide the best overall care for patients.* In the field of peripheral vascular disease, many interventional radiologists were part of a multidisciplinary team that fell apart. Plain and simple. I don't see too many conferences these days on the merits of vascular centers. Although this arrangement can work with the right people, the problem with this concept is that many physicians are too selfish to be team players. The patient's best interests take a backseat to their own. Many teams fell apart because some teammates didn't get the ball enough and decided that they could do it

alone. Everyone wants to be Michael Jordan. That being said, are patients really better off having vascular surgeons doing angiography and interventional radiologists managing their cholesterol? Wouldn't it be best for patients if every treating physician did what he or she did best? Can't we all just get along?

5. *Technology is to blame.* Technology is our ally but also our enemy. The tools and techniques to perform percutaneous procedures have revolutionized the way we do things. For example, when I trained, inserting a renal stent was a technically challenging procedure fraught with peril. A renal angioplasty and stent was easily a 1- to 2-hour case. We had to get through the stenosis with large wires and catheters, crimp the stents on balloons, pray that the stent would deploy in the right spot without slipping, hope the balloon wouldn't break, and hear the voice of Tom Sos echoing through our brains. The other day, I stented both mesenteric vessels and both renal arteries using mostly CO₂ in a gentlemen with severe vascular disease in under an hour (I know, some of you are saying to yourselves, "What took so long?"). Although my skills have improved somewhat since my fellowship, this improvement is dwarfed by the progress of equipment. Do you think for one second that there would be as much interest in percutaneous procedures if they were impossible to master? Why do you think that the interest in golf has exploded in this country? Perimeter-weighted cavity back clubs, graphite shafts, 460 cc drivers—all these things have made it easier to play well and encouraged many people to play who otherwise wouldn't.

So there you have it. Brilliant, inane, ridiculous, controversial, all of the above? You may not agree with all (or any) of these assertions (I'm not sure I do either), but at least it opens up the topic for debate. Discuss among yourselves.

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