Editorial

Evolution of a Specialty: The Case for the Association of Chiefs of Interventional Radiology

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Most physicians are students of the history of their profession. Some come by it naturally, others become intrigued during their training, while others simply hear it again and again from their professors until they embody an appreciation for where medicine has been and where it might go.

In the big scheme of things, the history of interventional radiology (IR) is relatively short. Much of the earliest work predates even the definition of the specialty. But defined it became. And like so many other fields of study and practice, it has undergone a series of developments that have led to a maturing specialty that is now better organized and widely appreciated. Form follows function, and the administrative structure has followed device and technique breakthroughs. Academic centers have for quite a while supported increasingly focused IR divisions, while most moderate-to-large size private practice groups restrict the performance of advanced procedures to an IR section.

Studying the development of other specialties and professions and applying those lessons to the current state of IR, we propose that a next logical step is a mechanism to allow IR chiefs to communicate better together, develop and refine skills particular to running an IR division, and facilitate sharing of data crucial to running an effective and efficient practice. We believe a new association, an Association of Chiefs of Interventional Radiology, would best provide such a mechanism. This communication will review the history of IR leadership, look at similar efforts by other fields, provide justification for such a group, and present a proposal for next steps in the process.

The Administrative History of Interventional Radiology

Of course, in the beginning, there was no defined specialty. Angiography was attempted soon after the adoption of radiography into medical practice, but most point to Sel-dinger development of percutaneous vascular access in 1953 as a pivotal development. If anyone could be considered the father of the specialty, it would be Charles Dotter. He performed, attempted, or at least thought of the underlying principles to almost everything we do today. But as is typical in the early days of a specialty, he largely worked alone, as did others with similar interest.

Two seminal events occurred in the early 1970s. The first was Alexander Margulis, then chair of UCSF, suggesting the name Interventional Radiology in an editorial in the American Journal of Roentgenology in 1967. The second was the first meeting of what is now the Society of Interventional Radiology. In 1973, a small number of angiographers led by Stanley Baum recognized the need to meet together and the Society of Cardiovascular Radiology was formed. Two years later, the Florida Keys provided the place for the first meeting. However, this stage of IR history could still be considered the “boutique” or “Mom and Pop” store stage. Not every practice was willing to wade into these new fancy procedures or there just were not enough trained operators to go around. IR in those days usually referred to “that guy on third floor who’s a wizard with a catheter/needle/etc.” Still, the limited administrative support was sufficient

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for new procedures that were headed in an unclear direction.

The 1980s saw another crucial evolutionary step, the opening up of membership in the renamed Society of Cardiovascular and Interventional Radiology. Many of the first generation of Interventional Radiologists not only saw opportunities for new procedural applications but some such as Charles Tegtmeier among others realized that for the specialty to continue forward something new was needed on the organization side. New fellows minted in this second generation, such as the authors of this piece, were strongly encouraged to join the specialty, thereby rapidly increasing the formal number of interventional radiologists. It should be noted that administrative duties were still limited and the title of division or section chief was simply the title bestowed on the senior interventionalist, if indeed there was more than one.

The 1990s might be considered the teenage years. There were periods of intense growth spurts with many emotional highs and lows. Transjugular intrahepatic portosystemic shunt (TIPS), stents, and abdominal aortic aneurysm (AAA) interventions were among the revolutionary advances. The corresponding organizational structure lagged, however. Some larger advanced academic institutions began having IR sections with three, four, or even five attendings, yet the role of the division chief was still in its infancy.

Two significant evolutionary steps that occurred during this period were in the areas of training and certification. At the beginning of the 1990s, there were many good fellowships, but Accreditation Council for Continuing Medical Education (ACGME) was nonexistent. The necessity for basic uniformity of training through ACGME of fellowships was recognized and by the end of the decade, this was the standard for IR training.

Shortly thereafter, subspecialty recognition by the American Board of Medical Specialties (ABMS) and certification through the American Board of Radiology was achieved for Vascular and Interventional Radiology with the first diplomats certified in 1995. Recently, the ABMS has recognized IR as a primary specialty of medicine within radiology, and approved enhancement of training to result in certification in both IR and Diagnostic Radiology (DR). We would suggest that it was during the last decade that the position of IR division chief began to change significantly. This happened almost without notice as IR sections became busier and began to grow in size. Tasks that had been relatively simple such as making out schedules, managing fellows, or standardizing device usage became quite complex. Billing and coding issues, always important, took up more and more time. Training programs, initially handled by the division chief, frequently required designation of another attending as program director. With the IR/DR certificate, the relationship of the IR section to radiology chair and diagnostic radiology program director will be even more complicated. In short, the administrative and managerial requirements of the IR chief position have grown with the specialty. Yet, there is no specific organization that focuses solely on the unique challenges of managing an IR group. This is challenging for experienced

chiefs, but even more so for younger physicians in their first leadership position.

Advantages of Leadership Organizations

Communication

The primary benefit of a leadership group may simply be keeping ones finger on the pulse of their field. There are many resources, particularly in the Internet age, for keeping up with things, but there is no substitute for hearing directly from others who are dealing with the same issues. In the 1980s, national meetings were great opportunities for IR leaders to discuss balloon catheter development, prospects for treating kidney or biliary stones, or the potential uses of stents on the horizon. Today, such discussions are as likely to revolve around billing and reimbursement issues, teaching physician regulations, or the new IR training pathway. Formalization of opportunities for these discussions could be invaluable.

Sharing of Data

No one would argue with the premise that making smart decisions requires complete and accurate data. This is how heads of organizations determine what is really happening and how they can use this in negotiations with others. The gold standard for summary of data from any group is that collected from the members of the group itself. Currently, there is no existing mechanism for such data collection. Society of Chairs of Academic Radiology Departments (SCARD), for instance, adds to data collected and reported by national data organizations by performing its own surveys as necessary on manpower requirements, hiring vacancies, and night staffing practices.

Training for New Leaders

Battlefield promotions aside, the military would never consider promoting someone to company commander without specific directed training. The same is true for most companies. As mentioned above, medicine has a history of promoting great physicians assuming that they will be great administrators. Some, like the Mayo brothers, will be very successful. Others will not. The Society of Interventional Radiology (SIR), Radiological Society of North America (RSNA), American College of Radiology, American Roentgen Ray Society, and Society of Chairmen of Academic Radiology Departments have all begun providing general leadership courses, but none are specifically directed at IR Division Chief issues.

New Initiatives

Associations of leaders not only need to know how to do their current job and have the tools to do it but also they need to be looking to the future to ensure the smoothest and most efficient implementation of new ideas and new requirements. The new IR training that is on the horizon is a great example of the latter. Certainly, the IR program directors will have a lot of work to do and Departments and Medical Centers will have input, but it will likely fall to the IR chief to determine how to maximize the benefits and minimize the

problems associated with this endeavor. Discussion among all IR chiefs as this is developed would seem essential. While reacting to upcoming requirements is important, being proactive for an IR division will ultimately be even more important.

Justification for an Organization of Chiefs of Interventional Radiology

We must now ask the question: Is there sufficient justification for some type of IR chief group/club/society? We believe the answer is yes and will provide three main arguments.

Complexity of the Position

The IR chief is often required to, among other things: negotiate with the hospital; negotiate with the department chair; maximize financial collections and explain any problems; represent the other IR partners; organize the division including scheduling, staffing, and personnel issues; and lay out a 5-year plan for the future. All this must be accomplished while providing teaching, performing research, and doing the clinical work required of any IR physician. Additional resources would be extremely helpful to an experienced division chief and essential for a new chief. The group that would truly be the best "Champion" for these resources would be other IR chiefs.

Expectations of Interventional Radiology Chief Requirements in the Future

There is a saying that people are pretty good at looking 5 years into the future but they are terrible at looking 10 years into the future. Although certainly predictions of the future can be comically wrong, there are advantages to this exercise. We would submit that the most likely future for IR in 10 years is continued growth and innovation with an increased scope of clinical care, all leading to improved patient outcomes. At the

same time, imaged-guided interventions will continue to disseminate into the general medical community, and complex multidisciplinary practice environments specific to IR will become more prevalent. It is hard to imagine such a future without an association of some type of IR chiefs.

Current consensus of IR chiefs: We are convinced there is wide support among division chiefs for some type of dedicated IR chief organization. This has been the topic of numerous individual or small group conversations over the past 3 years at various meetings. The luncheon meeting of IR chiefs at the 2013 SIR meeting had excellent participation. At that meeting, the audience was polled and there was almost unanimous approval to explore creation of such an organization. Subsequently, there was a small group meeting during the Southeast Academic Center Retreat and at the RSNA meeting. Each of these discussions has supported this endeavor.

Proposal for an Association of Chiefs of Interventional Radiology

We believe that the time is right for an organization dedicated to supporting chiefs of IR services.

The SIR has graciously given the IR chiefs a larger time block at the 2014 meeting for continued discussions. An informal working group has developed a draft charter and mission statement. We have also considered how to meet, when to meet, and how to structure such an organization. We plan to distribute this information before the meeting and then put forward at the 2014 SIR meeting a proposal to create the Association of Chiefs of Interventional Radiology. We are open to suggestions throughout the process and encourage any and all who would like to be more involved to contact us.

We submit that given the history and evolution of our specialty, an association for IR chiefs is the next natural step in the development of IR.