The Revolution within a Revolution: Personal Experiences of a Young Interventional Radiologist

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Abstract

Interventional radiology (IR) has undergone a paradigm shift, and has become more clinically directed. This is particularly true with the new training programs, which are all required to have outpatient clinics, admitting services, and consult services within their hospitals. Despite these changes in education, however, many jobs still require a significant amount of diagnostic imaging work, and many established groups are reticent to allow the time and resources needed to pursue this clinical model of IR practice. This lack of support can lead to frustration for the early career interventional radiologist. This article describes the experience of one early career interventional radiologist, including some of the challenges and opportunities that have arisen from the recent changes in training.

Keywords

- clinical
- revolution
- private practice

“Change is inevitable. Progress is optional.”

–Tony Robbins

Unlike most interventional radiologists, I came to the interventional radiology (IR) world having had a very long, heart-felt love affair with diagnostic radiology (DR). My first exposure to radiology was at the tender young age of 16 years. At a time when the most pressing items on most teenagers' mind are how to attract the opposite sex, or how to look cool, I was instead intensely absorbed and fascinated by learning about the world around me. And it was during my high school senior project in the radiology department of my local community hospital that I had the first opportunity to gaze into the world of radiology through windows of X-rays, CT scans, ultrasounds, and MRIs. As much as can be gleaned by the naive mind of a 12th grader, I could sense the critical role that radiology played in the hospital and the amazing technological wonder of these machines that could see through the human body. Ironically, I paid little attention to the very few episodes of IR that happened while I was there: a fluoroscopic-guided lumbar puncture and a diagnostic lower extremity angiogram. Yet even to my 12th grade brain, those procedures seemed to stand apart from the rest

of the radiology world. They occurred in a white, sterile, brightly lit room far apart from the cozy reading room dimly lit by a few fluorescent film projector panels. Most obvious, the patients were right there in front of us in flesh and blood: talking, alive, scared, inquisitive! They were not in the usual “slice form,” cross-sections or various projections of them neatly laid out in tiny precise black and white anatomical pictures. Even to my young adolescent's eyes, the difference between *procedures* and *images* was so apparent.

In college I continued my journey into radiology by diving deeply into the physics and engineering constructs that enable the imaging machines to work. In medical school, I finally garnered the knowledge of anatomy and clinical pathology to understand and describe the images in the more practical language of medicine. My DR electives in my fourth year (there were no IR electives available at my medical school back then) cemented my view of radiology as an indispensable part of the workup and treatment of nearly every disease. It would be no surprise, then, that I entered radiology residency with an uncommon enthusiasm and twinkle-eyed admiration for the field. The residency match was the culmination of a nearly 10-year journey, and yet I was still just at the beginning of my career! But a

landmark experience at the end of my first year of residency was to completely transform my worldview: my first IR rotation.

Suddenly I was thrust into bright light. A room with a giant claw-like appendage that moved upon command around a flat table where a patient would lie, closets full of hanging white packages of long skinny tubes and wires, needles of varying sizes and shapes, and strange plastic and metallic devices of all kinds. But far from feeling sterile and foreign, the room felt like a tribute to the art of *doing*: a theater where the radiologist and the patient were active actors in a play and the story was the disease and how to fix it. It was a fundamentally transformative idea for me: the radiologist as fixer, not just observer. However, importantly, observation was still keenly critical in this process of fixing.

There was no procedure that did not enthrall me. Each day as I was exposed to the myriad ways in which catheters, wires, needles, and other devices were precisely inserted into the human body through a tiny hole to alleviate a specific problem, I was mesmerized by the combination of patient care, clinical judgment, and technical skill that the IR physicians had to employ daily. We rounded on inpatients just like any other clinical service. We wrote progress notes, procedure notes, history and physical exam notes; we talked and consulted with other specialties as if we were one of them and we spent time explaining and interacting with patients directly. We carried a stethoscope and knew how to use it. We displayed empathy to the suffering patient. We advocated for them so they received the best care. We acted like real doctors! But the fact is, it wasn't an act: we actually *were*.

Going back to my DR rotations became difficult. Observing and describing disease no longer felt like enough. My 8-hour days on my diagnostic rotations dragged and felt exhausting, whereas my 14-hour days (plus middle-of-the-night procedures) on my interventional rotations felt exhilarating and rejuvenating. Eventually, residency ended and fellowship began. And the enthralling experience of IR became even more salient as the responsibility grew. With a complete IR clinic setup and expectations to round on each and every inpatient every day and night, as well as exposure to almost 1,200 cases that year, I felt even more like a true physician. And my clinical judgment and abilities became even more refined and nuanced as did my technical abilities.

Thus, after fellowship I entered the "real world" with not only my 15-year-long appreciation of DR but also my new-found identity as a clinical interventional radiologist. Yet what I found in private practice was an environment in stark contrast to the ideals of my training. Within our specialty, the value of clinical IR is now almost universally recognized. We are all familiar with Dr. Charles Dotter's famous 1968 prophecy, "If we don't assume clinical responsibility for our patients, we will become high-priced plumbers and face forfeiture of our territorial rights..."¹ This quote marked the beginning of a clinical revolution in IR. And as the recognition of the importance of being clinical grew, even formal radiology societies created official recommendations for clinical IR practice guidelines as early as 2004.² However,

as I learned first-hand, the vast majority of the private practice world still does not seriously adhere to this 50-year-old idea. Practices with robust IR clinics, daily rounding, and support for marketing high-end procedures were hard to find. DR and IR were oftentimes conflicting forces who spoke fundamentally different languages of value. In summary, my career thus far has been an amalgam of countless frustrating and disheartening attempts at staying true to the essence of clinical patient-focused IR care while practicing in a fundamentally DR paradigm. Even more disheartening, my conversations with numerous other private practice IR physicians over these years have revealed that many of them have faced these same hurdles (to varying degrees) but are unable to come forward for fear of retribution or ostracism from their groups.

The specific barriers of practicing clinical IR in the context of a DR group are widely known and have been expounded upon in the literature and elsewhere in this journal.³ Reimbursement cuts across radiology have exacerbated the problem of relative value units and productivity, and in this setting virtually all clinically related activities (office visits, rounding, discussions with referring physicians, patient consents) are seen as financial losers to a DR group. Although initiatives such as the American College of Radiology Imaging 3.0 campaign attempt to bring attention to the many benefits that clinical IR can bring to a radiology group, only 4 of their 14 case reports (28%) of thriving clinical IR practices occur in the private practice setting.⁴ Although radiology groups that recognize and support clinical IR do exist, these problems remain endemic to private practice as a whole. A 2017 survey of private practice IRs revealed that respondents considered conflicts with their DR colleagues just as problematic as challenges with competing specialties.⁵

It seems that options for IRs dissatisfied with their private practice groups are limited: leave your group altogether and face uncertain periods of unemployment while you compete for the rare 100% IR opportunity, undertake the substantial financial risk of starting your own practice while fighting noncompete clauses and pseudoexclusive contracts, or stay and face a future of perpetual professional dissatisfaction. ***Is this the best we can do for our future IR residency graduates who will rightfully demand that practices support and value their clinical training?*** We risk betraying the trust they place in our training programs that lead them to believe their clinical acumen and high-end IR skills will have a valued place no matter which practice setting they choose. I see this as a very serious problem for the future of our specialty.

I still look at pictures from my high school senior project with fondness and nostalgia. The intervening 20 years have verified and strengthened my initial fascination and admiration of radiology. But it is now radiology's power to heal that has become my true calling. And even though my early career has been marked by battle scars and my future career path remains uncertain, my passion for IR has survived these challenges and if anything has only been further invigorated. After all, I am not alone. There is a revolution within the revolution of our specialty: a powerful revival of Dr. Dotter's age-old wisdom that our future depends on our willingness

to provide innovative and dedicated clinical care to our patients—this time: no matter where we practice.

Conflict of Interest

The author has no financial or nonfinancial conflicts relevant to this article.

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