Interventional Radiology Private Practice Patterns

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Abstract

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- ▶ independent IR

Private practice interventional radiology (IR) in the US takes many forms – from specialty coverage with traditional diagnostic radiology (DR) models and hybrid IR/DR practices, to multispecialty groups and independent IR practitioners. The purpose of this article is to understand the value each of these current IR models offer and predict their future viability.

Data provided by the Society of Interventional Radiology (SIR) identifies 60% of SIR membership employed in a nonacademic practice. These practice models range from varying percentages of interventional radiology (IR) being performed in traditional IR/DR (diagnostic radiology) and multispecialty groups to independent IR practice paradigms. The following articles are authored by experienced IR physicians (>10 years from IR fellowship training) in varied private practice professional experiences addressing the following basic questions:

1. What are the strengths and weaknesses of your practice model?
2. What are the opportunities and challenges for IR growth?
3. What do you see as the future of your current practice model?

Dr. Peck—Working within a Diagnostic Radiology Group

The most common practice model in private practice radiology, for small to moderate size groups, is part-time specialty coverage. Academic and larger groups can increase subspecialization, but for many smaller groups, cross coverage to include diagnostic imaging (DI) is more economically efficient.

As a practicing interventional radiologist (IR) since 1995, my scope of practice has always included some general or DR.

For the past 12 years, I have been part of a private practice group in Northern Colorado that has grown in size from 20 radiologists (with 4 CAQ IRs) to 45 radiologists (expanded to 8 CAQ IRs). Currently, we cover a total of four hospitals, ranging in size from 50 to 200 beds, as well as a variety of smaller hospitals/clinics that do not do much IR. As is typical of most private practice groups, all radiology subspecialists spend time away from their chosen specialty and understand the importance of cross coverage. Practicing IR part-time has allowed me to maintain and develop my diagnostic skills, while spending approximately 50 to 70% of my work in IR rotations.

I believe it makes more economic sense for small to moderately size private practice groups, in less populated regions, to utilize a unified DR/IR model, whereas larger groups may view anything less than 100% IR as suboptimal—because they can afford to do so. In smaller practices, the economics do not support this model and our IR radiologists are able to produce more relative value units (RVUs) by multitasking between the IR suite, while also helping with DR. The obvious drawbacks of this model are that it does not allow IR to become wholly specialized, and there are not enough resources or staff to develop a fully matured IR service. Still, IR and DR need to be viewed as synergistic, since both parties benefit.

IR benefits from DR referrals and DR benefits from the goodwill and community connection that IR provides. A

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simple example is when DRs steer ordering physicians to IR for the treatment of vertebral fractures (1), submassive PE, bleeding varices (2), arterial stenosis, and DVT. Still more important is the IR synergy outside the group. For example, we have partnered with the hospital and general surgeons to open an outpatient vein clinic for the treatment of superficial venous disease, which also functions as a clinical site for interventionalists who want to consult patients for deep venous disease treatment in the hospital. Our IR department has also cooperated with interventional cardiology, cardiovascular surgery, and vascular surgery to form a multidisciplinary vascular clinic (MDVC). In the MDVC, IR sees all the venous cases and peripheral aneurysms, but also shares the peripheral vascular disease (PVD) and visceral arterial work with the other disciplines. With time and cooperation from other departments, we were able to use our call coverage as “leverage” to gain access to more elective work. As part of the MDVC, we participate in bimonthly case conferences and share responsibilities in sponsored seminars with the other specialties. Our access to the elective work is limited only by our group’s ability to set aside time for IRs to cover MDVC clinic coverage. The door has been opened for us to fully engage and increase our profile in the hospital.

As the population of Northern Colorado grows, we will need to increase the sophistication of our IR practice to remain competitive. Currently, our scope of practice includes advanced cases in the areas of PVD, visceral arterial interventions, interventional oncology, venous interventions, thoracic duct interventions, dialysis access interventions, spine interventions, visceral embolization (including prostate embolization), as well as routine computed tomographic (CT)-guided biopsies and drainages.

The investment necessary to increase the scope of our IR practice will require DR cooperation within our group, which may be difficult to obtain since IRs value is often less tangible. IR consistently ranks near the bottom of RVUs due to the nature of the work. While diagnostic radiologists are reading imaging studies and producing RVUs, IRs may be spending an afternoon in clinic, on the phone with a referring physician, or traveling between cases. However, DR radiologists need to keep in mind that the very thing that makes their RVUs appear so high—their ability to work remotely—may also lead to their demise. Remote practitioners are easily replaced, whereas strong interventionalists are not. DRs hopefully can understand both the tangible and intangible value that IRs bring to the group, and financial reports need to take into account the less obvious benefit generated from the IR specialty.

Given our group’s recent growth, I believe that it is time for us to expand our consultation services and promote our complex IR cases, which will represent found revenue and enhance our reputation. Currently, our IRs spend a large percentage of time doing small cases, such as lumbar punctures or paracenteses, which do not allow us an opportunity to differentiate ourselves from the competition. We need to hire midlevel practitioners (e.g., physician assistants and nurse practitioners to do the small, “lab test” type cases. Revenue from these cases will cover their salaries and free the IRs for complex cases and more time in the hospital’s

already existing MDVC, and eventually, perhaps, a clinic of our own. This will ensure that our IR practice develops into a high-profile consultation service, which will further establish our entire group as valuable.

Dr. Van Erp—Practicing in a Diagnostic/Interventional Radiology Group

During my career as an IR, I have experienced the evolution of our practice in western Michigan from a 10-physician hybrid DR/IR group with no advanced practice practitioners (APPs), in which duties were reasonably similar to one of the largest private practice groups in the country, to a group with 17 full-time IR physicians, 126 diagnostic radiologists, and 23 APPs. We now provide IR services in some form at 10 campuses, from “IR Lite” at more rural locations to full service IR at larger facilities. Has it been a challenging, interesting ride? Yes. Has it been gratifying and satisfying? Absolutely.

Currently, the 17 IR physicians in our group have an assignment involving some form of IR nearly every work day, with a few rare exceptions. Internal moonlighting is always available in our practice, and most of the diagnostic shifts pursued by IR will fall into this category (with frequency determined by youth, mortgage, and brand of automobile purchased upon completion of fellowship). During our IR shifts, the expectation, appropriately so, is that we contribute to the diagnostic workload when not consumed by the IR schedule, and our ability to successfully fulfil this expectation varies, of course, with the individual physician, the location, and the daily schedule. Our “IR Heavy” model has provided benefits over the years. We have successfully recruited fellowship-trained IR physicians when needed, in large part due to the fact that western Michigan is attractive (my colleagues in Florida, Colorado, and Hawaii, are laughing right now), but also because newly trained IR physicians want to do IR! They’re young, strong, and they want to use their skills. This leads me to another benefit of our model: skill set preservation. Concentrated IR exposure helps avoid that uncomfortable “I haven’t done this in forever” situation, which, frankly, was a part of our practice during early days with the IR/DR hybrid model. A related potential benefit is that of turf preservation. If you do something frequently, you do it better. If you do it better, the likelihood of keeping the business is greater.

We all know that, in our current climate, last statement isn’t always true ... but it certainly doesn’t hurt. Additional benefits that are related more to the size of our IR staff rather than concentrated IR exposure would include staffing flexibility and legitimate “time off.” We have been able to successfully “flex” with changes in volume and physician availability by tapping into our own internal resources in the form of post-call and pre-call assignments, and vacation “sell back.” Our large size successfully dilutes the potential negative effect on individual physicians. And, unlike the early days of our small practice, being off means being truly “off” without a significant likelihood of getting tapped on the shoulder to contribute to a situation. Large size also allows us to hand the baton of an expanding or new service line to three or four physicians rather than putting it on the shoulders of

one person, again enhancing the ability to turn the phone/pager off.

The suboptimal aspects of our “IR Heavy” practice are admittedly significant. Our schedules and daily practice experiences differ significantly from the diagnostic radiologists in our group, and this has generated a handful of contentious situations over the years. There is also significant variation among the IR physicians as well, depending on location and schedule. When our group consisted of 10 physicians with no real formal subspecialty interpretation, our assignments were nearly identical. Half of us rotated on the IR call schedule. Half of us did not. Simple. Today, that’s no longer feasible. Because our experiences are now fairly different, we suffer from the “greener grass syndrome,” and our available metrics such as “time spent” and “RVU generation” fall short as modifiers. Another significant limitation within our IR practice is diagnostic skill set atrophy. With frequency and repetition comes efficiency, which can be difficult to maintain when the percentage of diagnostic interpretation falls. This has fallout when combined with the distinct physical “wear and tear” of an assertive IR practice, as aging IR physicians consider methods of extending their career in a reasonable fashion. The lifestyle sacrifices of an “IR Heavy” practice cannot be overlooked. IR call, of course, is challenging as the expectation continues to outpace the resource. As we pursued a broad IR footprint and made the decisions to expand to locations outside of our region, this came with a potential penalty: travel to and from practice sites. At times, it meant a *lot* of travel. To those of you who have spent time in Michigan in winter, enough said.

The opportunities for growth in our practice are, and always have been, substantial. The large diagnostic contingent of our group does very well with enhancing/promoting referrals to IR. They frequently contact us to discuss what options may be available in a given case, often adding the details to their report and contacting the referring service. Our large IR footprint with coverage of multiple smaller hospitals provides a referral pipeline, and we can subsequently control which cases are completed at the peripheral locations and which cases are performed at our larger hospitals. Our IR physicians, to some degree, are “auto-selected” in that our recent hires specifically chose a practice that is nearly 100% IR, which means for the most part that they’re enthusiastic regarding pursuit of new IR volume. This began, in my opinion, decades ago with a “how can we get that done?” attitude rather than the “how can I get out of this” approach that plagues some practices.

The limitations to growth are also numerous. Although we’ve been successful with recruitment, it has, at times, taken far too long to hire the right person, and we’ve had physicians leave for various reasons. During these understaffed intervals, expansion has been difficult. It’s hard to stay hungry if your plate is already full. And, contrary to my statement earlier, there is a slow but distinct paradigm shift away from the “macho” days of IR toward a kinder, gentler, more-relaxed IR. IR physicians don’t necessarily want to be the hardest working people in their group anymore. Is this a good thing? Maybe. The constant increase in coverage expectation and the borderline-ridiculous modifications in process

(redundant documentation, off-loading of tasks to the physician, and inadequate staffing by hospitals relative to increased volume) have stymied our expansion at times. And of course, as always, turf issues challenge our growth in that any procedure that is desirable to IR is also attractive to other subspecialists who may in fact benefit from the referral patterns that are established by mutual hospital employment with other services.

Where will our “IR Heavy” practice be in 5 years? It’s unclear. As always, flexibility will be critical. I would predict a continued emphasis on concentrated IR for perceived quality maintenance but also a resurgence of the “IR Lite” physician, as the strong push for patient convenience and decreased length of stay creates demand for minor procedures at a greater number of smaller institutions. This will come with a continued increase in emphasis on nonphysicians/APPs to perform IR procedures (a topic that could be the focus of another round of *Seminars in Interventional Radiology* opinions). Regarding content, it’s doubtful that our scheduling boards will be very similar to what they are today. They’ve changed consistently over the years. I only know that those boards will be full. And fulfilling. We’ll lose turf but we’ll find more work. We are the equivalent of the North American coyote (*Canis latrans*) in that our diet may vary but we never go hungry. It will be an interesting time, and I’m looking forward to watching it all unfold.

Dr. Watabe—Working within a Multispecialty Group

A multispecialty group is defined as a medical group offering integrated medical specialty care within one organization. It is largely recognized that the first medical group practice model originated in Rochester, MN, at the Mayo Clinic in the late 1800s. Mayo grew to an integrated medical practice of 386 physicians and dentists by 1929.^a Since then the multispecialty group model has grown throughout the United States.

The trend for physicians migrating into larger group practices was shown in a recent survey in 2016 by The Physicians Foundation Survey in which 20% of respondents reported practicing in large groups of 101 physicians or more, up from 12% in 2012.^b In the same survey, 57.9% of physicians were practicing as hospital or medical group employees compared with 43.7% in 2012. Today, more IRs than ever are joining hospitals or large multispecialty group practices as an alternative to traditional fee-for-service private practice groups.

Some physicians are leaving private practice in search of more financial stability and job security at a time when physician reimbursements are in flux and takeover of small radiology practices has become more commonplace.

^a *Physician Group Practice Trends: A Comprehensive Review*, Journal of Hospital & Medical Management, Bita Kash and Debra Tan, March 21, 2016, Insight Medical Publishing.

^b *2016 Survey of America’s Physicians: Practice Patterns and Perspectives*, The Physicians Foundation, September 21, 2016.

Advantages of Multispecialty Group Practices

In general, multispecialty group practices offer the possibility of increased financial security, job security, and better control of lifestyle than small private or group practices because of a larger pool of physicians and patients. The sharing of resources lowers costs and reduces financial risk across the entire medical group.

Practice Development

For IRs, there is a large built-in referral base from physicians in the medical group and a captive patient population. This provides a steady stream of referrals relatively free from competition and a fertile environment for growing an interventional practice.

Competition

Since physicians are salaried partners in a medical group, there are fewer financial incentives for turf battles or competition for patients.

The removal of financial barriers frees referring providers to refer otherwise contested interventional procedures such as uterine artery embolizations (UAEs), and renal or hepatic tumor ablations without financial liabilities. This more congenial and collaborative practice environment can be highly professionally rewarding.

In addition, competition with other local or regional IR practices is virtually eliminated in a captive multispecialty group health plan.

Staffing

Each medical group has standard staffing models based on workloads and the number of member patients covered by the medical group. New IR staff hires are selected through input from the IRs and the radiology group, but need final approval from an executive committee of the multispecialty group. This model generally provides optimal IR staffing.

Workloads and call can vary considerably from practice to practice, but the large size of multispecialty groups provides advantages over small practices. While many IRs also interpret DR studies in addition to their interventional duties, IR call is separate from diagnostic call in most multispecialty groups. Likewise, weekend DR shifts are generally covered by the diagnostic radiologists.

Retirement

The sharing of financial resources allows most multispecialty practices to offer generous defined benefit plans in addition to 401K, health insurance, and other retirement benefits. Defined benefit retirement plans are one of the main incentives for interventionalist radiologists practicing in a large group practice and are difficult to match in smaller private practice groups. Typical defined benefit packages reach maximum values near the end of a physician's career, thereby incentivizing the IRs to remain in one group for a substantial portion of their career. Defined benefit plans can provide a substantial boost to retirement savings and a hedge against untimely fluctuations in equity markets. Like any

other financial instrument, the fiscal health of each group's plan must be evaluated individually.

Administrative and Clinical Support

Another main benefit is that multispecialty groups provide administrative support such as billing, management, advertising, human resources, and IT support that would normally need to be provided by a private radiology practice. This can result in a substantial time and cost savings to IR physicians.

In addition, the clinical responsibilities of providing pre- and postprocedural patient care are distributed throughout the entire medical group rather than the individual IR attending. This can significantly reduce after-hour call-backs, rounding on patients and postprocedural clinic visits.

Stability

According to a survey of private practice radiologists at a 2011 AMCLC meeting, 16% of respondents had been part of a practice that had lost its hospital contract and 31% reported major hostility from hospitals.^c The large size and partnership structure of multispecialty groups generally insulates IRs from aggressive takeovers by rival organizations. It is uncommon for an entire radiology group to be displaced by a rival group within a multispecialty group practice.

Salaries

Interventional radiologist's salaries in multispecialty groups are generally close to or above the national median. Many multispecialty groups such as Kaiser Permanente use a national multispecialty group median salary provided by the MGMA, or Medical Group Management Association, to provide annual benchmarks for determining physician compensation in their group. Incentive bonuses may be given related to the financial performance of the overall multispecialty group.^d

MGMA-based salaries are variable based on location and a variety of other factors. Since the source of revenue is predominantly from the health plan membership fees, multispecialty group IR salaries tend to be more insulated from fluctuations in Medicare reimbursements.

Defined benefit plans have a variable vesting period, but it typically takes around 5 years to become vested.

Intradepartmental Issues

Intradepartmental disputes over individual IR revenue generation and RVU comparisons that can occur in private practice are generally not relevant in multispecialty groups. There is little debate over income production, since salaries are fixed.

^c Harolds J, Kaye A, Adams MJ. Challenges to Radiologists: Responding to the Socioeconomic and Political Issues Keeping Radiologists Up at Night: The Third Annual Open Microphone Sessions at the 2011 AMCLC. *Journal of the American College of Radiology*. 2012;9(1):20–26.

^d Radiology Salaries Showed impressive Gains in 2016, RSNA News, Richard Dargan, July 27, 2017.

Challenges

The main disadvantage of multispecialty groups is the loss of autonomy for decision making. For example, IR hiring is approved through the medical group human resource department and executive leadership. This can slow down the hiring process when compared with a smaller group or private practice. To counter this, many interventionalists take on administrative roles within the medical group to remain involved in the decision-making processes that affect them.

Another potential challenge for physicians practicing in a multispecialty group is to keep everyone motivated and growing professionally while being salaried. Productivity can wane unless physicians remain self-motivated. Medical groups can counter this through annual physician peer-to-peer surveys, which enable physicians to rate the skills, service, and congeniality of all their colleagues. This generally encourages physicians in the group to remain motivated, challenged, and collaborative.

Support for research and publishing is also available to encourage continued innovation and growth.

Entrepreneurial ventures are restricted within multispecialty groups. For example, it is generally not possible for interventionalists to increase individual income by creating free standing outpatient IR centers.

Like all health care organizations, multispecialty groups are not immune to financial challenges or bankruptcy. The financial stability of each multispecialty group and hospital is highly variable depending on local economics and management. Even large multispecialty groups and hospitals can be displaced in any region; so, the long-term fiscal health and viability of each medical group must be assessed individually.

Summary

In summary, multispecialty group practices offer the chance for stable employment, a collaborative work environment, steady income and attractive retirement benefits with potentially fewer clinical, and administrative demands. Financial risk, call, and rival practice takeover risk can be lower, translating into a potentially more manageable, stable lifestyle when compared with smaller private practices. Salaries are usually near the national median, but are often larger when including defined benefit retirement plans. These advantages are offset by some loss of autonomy and revenue-generating financial ventures.

Dr. Costantino—Working Independently

My current practice model is a physician-owned IR group with multiple outpatient laboratories. I would estimate less than 5% of IRs are in this practice model. Though I don't love this analogy due to the image that it conjures up, it can be best described as a franchise. I operate independently and am solely responsible for the clinical practice (100% owner), but the business side of the practice is co-owned with Comprehensive Interventional Care, or CIC (which is owned by Joel Rainwater, MD). The IR physicians in this network can own, open, and run freestanding laboratories. In my

local laboratory, I am the sole provider and make the medical/clinical decisions as well as many business decisions. This includes the day-to-day operations, staffing, service-line development, local marketing, device selection, product/supplies, design, space utilization, growth, etc. My business partner (i.e., CIC) has provided the infrastructure for my practice, including but not limited to electronic medical record selection, corporate marketing and Web site development, employee training, billing and coding, credentialing, and volume-based ordering. I believe that this arrangement is the best of both worlds: corporate infrastructure with freedom to develop and run my laboratory however I see fit.

Through the years I have been in the following environments:

1. Employee of a traditional hospital-contracted DR group.
2. Owner/founder of an independent hospital IR group (with three IRs).
3. Employee of an outpatient DR group.
4. Owner of an outpatient IR laboratory (office-based laboratory or OBL), with a physician corporate partner.

My first job out of fellowship was with a traditional hospital-based DR group. Two years later, frustrated due to the typical issues, I made the move to start an independent IR practice. For business purposes, I moved on from this situation after 8 months, with many lessons learned. Next, I started a conversation with an outpatient DI group with the intent to provide a few IR services (veins, biopsies, etc.) while I built my own UAE practice. My plan was to rent office space in a gynecologist's office and just see what I could do. As it turned out, the DI group decided they wanted to include this (nonexistent) UAE practice in their business model. I started with no patients, but after 2 years I felt that we were on solid footing. The next logical step was an OBL. I researched this option, listening and learning, attending meeting after meeting, talking with anyone and everyone, and did several off-site visits, meetings with vendors, all while still running the practice. I was primed to open a laboratory with a corporate partner who ended up buying/partnering with my DI group. In the year that we were negotiating, this physician-owned opportunity presented itself. At that point, I had spent years preparing for an OBL; so, it was fairly easy to make the decision to select this model.

The biggest strength of this model is that all owners are physicians. In the business of OBLs, practice structure boils down to one question; do you own the entire enterprise yourself, or do you have a partner? If you own the entire enterprise, you provide the capital (often in the 1–3 million range), but you answer to no one. Likewise you have no support.

If you have a partner, the two most common situations are to be partnered with (1) a “management” company, or (2) investors. Your partner brings capital and (so they purport) “business expertise.” In the model that I selected, the “management company” is physician-owned; thus, the business expertise and clinical support arises from an understanding of the business of IR, and not from the pure investment-oriented model of a venture capital-based/investor manager.

The concept behind CIC and the MD-owned model is that the work that IR does builds IR solely, and the people who actually do the work get paid for it. I did not want to have my practice solely driven by loss and profit statements, nor did I want my work funding more administrative positions or building better headquarters for said administrators.

In this practice model, there are a multitude of payment models. Proformas based on my past performance did not demonstrate a significant take-home pay difference between the model where I was partnered with a venture capital-owned management firm versus a physician owned. In any OBL, the idea is to capture the technical fees that would otherwise go to the hospital (and I'll mention, the entire system saves in various ways when cases that be done outside of the hospital are done in OBLs). But, in the MD-owned model, the trickle-down income returns to the IRs. In my OBL model, there is no salary, that is, if you don't work, you don't get paid. Vacations turn out to be quite expensive when you have to shut the laboratory down. Meetings, travel, anytime away from the laboratory are costly. In my previous practice models, I had a salary with set vacation, and that stayed the same regardless of my volume or procedure mix.

One strength of this model is accountability. If the marketing team was not performing, could I effect change? Or was I going to be regulated to the "doctors' work" while the business partners handled the business decisions however they saw fit? If I wanted to build prostate artery embolization (PAE), but the marketers just weren't interested in spending the time, I needed to be able to change marketers. If there were information technology issues, coding issues, billing issues, etc, I wanted to determine what the issue was, solve it, and move forward. If it's "not my department," then I could have no impact on change. I wanted my priorities to be the priorities of the practice, and not the administrators. This is very important in the practice lines that I have built (and, of course, am still building). UAE, venous disease, cosmetics, and, hopefully soon, PAE and gastric artery embolization (if it pans out) are all procedures that rely on direct-to-patient marketing and education. In a hospital-based practice, this marketing is not particularly necessary. As the MD who does all of the consults, talks to my gynecologist and primary care physician (PCP) colleagues, I know what misconceptions are out there, and I need the marketing team to help me educate as I see fit, and not the other way around.

A potential weakness of this model is that for some, a more hands-off approach may be a better fit. I like to be involved, dive deep, effect change, lead my laboratory, and assign my particular values to my practice. I want medicine to always come first, and I just don't want to hear at this stage in my career how my prolonged office visits "are not cost-effective." It takes time, freedom to operate, and commitment. I was looking for this level of personal involvement; however, others may be more interested in a hands-off approach. For example, in my current UFE practice, I know every one of my patients well. I do hour-long consults with each patient and family, with the primary purpose being to educate the patient, and discuss the symptoms and choices. I like to think I provide an excellent level of customer service; education-heavy phone calls when needed, my cell phone

number given out, and mostly just caring. I'm very protective of my patients and have worked extra-hard to create environments that allow the patient to relax during what is, for them, a stressful experience. Each UAE patient is seen at least four times (and usually five). It's usually a bit sad at the final follow-up when I no longer get to see them; however, I do get letters, photos, sweet gifts, and follow-up phone calls up to years later. I've never saved a card from my personal life, but I have every card any patient has ever sent. Without sounding Pollyanna, this is a very satisfying job. My primary motivation in building an OBL was to take control of the treatment environment one step further. I make sure when I'm finished caring for my patients that they have appropriate care with a PCP and gynecologist. I've detected a wide variety of comorbidities and get the patient to the appropriate MD as needed. These all take lots of time, and though clinic visits and consultations are billable, the additional level of care and customer support is not. I needed to be in a practice model where I felt I could remember why I went into medicine.

Another strength in this physician-owned model is that I have the clinical benefits of medical collaboration with colleagues that I trust. As it happens, CIC has put together a skilled group of physicians with varied expertise. I trust and rely on the medical experience of my colleagues. I have worked as a solo IR for the last 7 years, and I think IRs in larger groups may take for granted the side-by-side availability of a skilled IR colleague. I wanted my partners to be able to "talk IR," and I feel fortunate to have the opportunity to work with this group of forward thinking IRs.

I believe that in this physician-owned practice model, both my business partner and I have nonmonetary considerations that outweigh the monetary ones. Exceptional clinical work, direct patient care, providing a service to our communities through access to IR procedures at a reduced cost, and the ability to provide a level of customer service that has otherwise been difficult to find are at the forefront of this model. My hands are not tied by administrators, investors, or partners with a different vision. I am well-aware of what we as IR can offer to the medical community, and I want to see IRs have an impact.

In the future, I imagine that many IRs will gravitate toward this model, which represents a major shift in the paradigm in which most IRs work currently. While many IRs have gratifying jobs in more traditional models, as IR continues to lose endovascular dominance, we produce more fellows with a strong clinical background, and more IRs by necessity learn the business of medicine (I may be biased), but I think this model makes the most sense. I imagine this model expanding over time until it becomes the dominant model of outpatient IR.

Suggested Reading

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