Academic vs. Private Practice: An Indistinct Distinction

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Semin Intervent Radiol 2019;36:10–12

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Abstract

Keywords

- interventional radiology
- private practice
- academic
- education
- clinical practice

Interventional radiology (IR) practices take many forms, but often are distinguished as following either an academic or private practice model. Both differences and similarities are seen when comparing these two general practice categories, and often the line between the two models is unclear. This article reviews some of the commonalities and differences between academic and private practice IR, and provides personal insights from an author who has significant experience in both practice models.

Any comparison between academic and private practices in interventional radiology (IR) must begin with the acknowledgment that the clear distinction between these two broad categories of clinical practice is visible only from a great distance. The closer one gets, the less distinct the boundaries, and when standing in the halls of a specific medical facility, one might find it quite impossible to determine whether he or she is in “The Town” or is surrounded by “The Gowns.” There are, in fact, large academic institutions staffed by self-employed partners in financially independent practice groups and, at the other extreme, small private hospitals staffed by university-employed tenured professors. Some traditional private practices in private hospitals have residents and fellows, while some university hospitals have no trainees.

Even if one eliminates from consideration anything that vaguely resembles an academic practice, tremendous variations exist among the remaining “private” practices. Are military physicians in private practice? What about those who are employed by hospitals or managed care organizations (MCOs)? Even self-employed practitioners represent a spectrum, with some partnered in traditional diagnostic radiology (DR) groups, others partnered in or employed by multidisciplinary nonradiology groups, and still others who are fully independent practitioners with hospital contracts and/or standalone outpatient office-based laboratories (OBLs). The following observations of own experience in making the transition from academic to a traditional radiology private practice may not, therefore, reflect or predict

those of others who make a similar move, and they may bear no resemblance at all to those of someone who leaves a traditional academic position to join a multidisciplinary group or the staff of a Veteran’s Affairs hospital or MCO.

I had never intended to do anything other than academic medicine: when choosing my fellowship, I considered only those that included an academic year. My three career goals were to become an IR section chief, a Fellow of the Society of Interventional Radiology, and a full professor. I was privileged enough over the 13 years after my training to have achieved the first two goals—and I was about to be promoted to full professor—when I unexpectedly found myself both unwilling to remain at my university job and unable to move away from the city in which it was the only academic option. Fortunately, a large private hospital in town was just beginning a liver transplant program and its contracted DR group was looking to replace a retiring IR. This allowed me to move from an absolutely “traditional” academic practice to a similarly “traditional” private DR group practice without also leaving behind the type of clinical work that most interested and challenged me.

The first obstacle I encountered was with diagnostic imaging. Most academic programs maintain a distinct separation between IR and DR, and I had not read any diagnostic studies (including CTA, MRA, and duplex ultrasound) since my board exams. In contrast, the significant majority of IRs in private practice—including all of those in my new group—routinely split their time between interventional and diagnostic responsibilities.¹ Had I been closer to

my training, I would almost certainly have been expected to do this as well, perhaps attending some review courses to bring up my skills. Instead, my new IR partners agreed to pick up additional imaging rotations on my behalf. With this support from my colleagues (and, of course, our new liver transplant program), I was able to demonstrate the value of full-time IR and its ability to grow a practice. We have since been able to increase the volume and complexity of IR work at our facility to the point that all four of us now do 100% IR.

Again, such IR-only jobs in private practice are the exception rather than the rule. This makes it very difficult in most private practices to have the kind of focus on IR that one sees in academics, since members of the IR group likely alternate between IR and imaging work over the course of the day and might be completely out of the IR suites for days at a time. This disrupts continuity and makes it much harder to organize a daily review of cases, a monthly M&M, a journal club, and other peer review or educational activities that are integral to the academic world. It also generates conflicts with regard to call: if everyone in the group does DR but only a subset does IR, is it reasonable to ask the latter to cover both IR *and* DR on call? If so, are the dual-cover physicians somehow compensated for additional burden? And since someone from IR is always on call anyway, should they simply cover *all* of the call work? These are complex questions that are met with a wide variety of answers, and can be a source of significant turmoil within a group.

In addition to separating IR from DR, most academic institutions—including those where I had worked—also divide “interventional” services among various groups: body imaging does CT and ultrasound-guided biopsies, musculoskeletal radiology does joint injections, neuro or neuro-IR does cerebral angiography and spine interventions, etc. These divisions can be extremely rigid: I once found myself in trouble with my Chair at the university for having done a selective carotid artery injection while managing a trauma patient whose chest injury extended to the base of the neck. Though I had done hundreds of cerebral angiograms at a prior institution, the neuroradiologists at the current site had established an absolute cutoff at the clavicle, and I was required to write a formal justification for having crossed that line both figuratively and in fact. Things are quite different in private practice, where all “needle work” is generally managed by the IR service. After my move, I found myself expected to do all of these procedures, many of which I had not done since residency, and some—like vertebroplasty/kyphoplasty—that I had never done because they were developed after my training and offered at the university by a different service. While picking up this skill set was an easier adjustment for me to make than going back to DR would have been, it nonetheless took some effort, and quite frankly left me feeling more than a little embarrassed at times. Ultimately, though, it was a worthwhile process, and I feel like a much more well-rounded interventionalist now than I was in my prior life.

The other major difference between my academic and private practice careers has been the absence of radiology residents and IR fellows in the latter. Working with tomor-

row's leaders and sharing with them the tricks and techniques that I had learned along the way was really the best part of my former job, and was very difficult for me to leave behind. In fact, maintaining that connection was important enough to me that, for several years after having made the move to private practice, I retained an adjunct appointment at the university and went there on my days off to scrub with the trainees as an unpaid volunteer. Unfortunately, this proved a difficult endeavor to maintain over the long term, and after I had been away long enough that none of the trainees remembered my having been on staff, I suspect that some of them began to resent having to work with “that guy.” In fact, on my last visit to the university, I spent the day working on my own, just as I would have at my new practice. Ultimately, I came to appreciate not having to “share the good cases,” as well as the improved efficiency of doing cases without having to let someone try several times to do a critical step before stepping in. Of course, I also have to do all of the paperwork now—consents, post-op notes, orders, and dictations—as well as the low-level cases like tube checks and drain removals that I used to supervise from the control room.

What about research? People often use the phrase “Publish or Perish” as a warning against an academic career, the implication being that research is a burden. Yet, like many (probably most) in academics, I found the opposite to be true: having the time and institutional support to pursue one's ideas, and to be appreciated for doing so (even for ideas that turn out to be wrong) is an incredible benefit. To be sure, research opportunities exist in private practice as well, and some of our greatest innovators have been private practitioners, but it is the rare practice that has the institutional support to make this easy (or even possible). Universities are far more likely to have institutional research boards, statisticians, data analysts, animal laboratories, and the other resources that one needs to maintain a research program. I have had several ideas for studies since I left my academic practice, but pushing them single handedly through our contracted external Investigational Research Board (IRB) proved to be an insurmountable task. The best I've managed to do is to sign on with a couple of multicenter trials, and it shows: when I left academics, my name was on nearly 60 publications; since then, there have been just 6, and none in the past 4 years.

Participation in organized medicine is another area in which significant variations exist between traditional academic and private practices. While it is actively encouraged—and may even be required for promotion—in an academic setting to take an active role in local and national organizations and seek membership on committees, boards of directors, and editorial boards, and also participate in the “lecture circuit,” such activities are often viewed within the private practice community as a distraction. When I was in academia, my contracts included both several vacation days and a separate number of “meeting days.” The latter could be increased as necessary to accommodate a greater degree of involvement in medical societies. No such distinction exists in my current environment: when I was on the SIR Executive

Committee as a private practitioner, and went to its quarterly meetings, I had to use vacation days. And since my current group distributes vacation in weekly blocks, rather than as individual days, a 2-day trip to a meeting required me to commit a full week of vacation. Such obstacles are even more critical for those in solo practices, since they have to close their offices and forgo income-generating work altogether—and also arrange backup coverage—for every such meeting. Every day representing the specialty for these individuals therefore means a day of income lost. It's no wonder, then, that the leadership of medical societies like ours is often disproportionately represented by academicians.

Along with better leadership opportunities, an academic position carries with it an automatic expectation among the lay public of superior expertise. More than once, I've had patients or their families tell me that they have also seen an MD at the University and are choosing to follow his or her recommendation rather than mine. That is, of course, the patients' prerogative, and is certainly appropriate in individual cases, but it is frustrating when the physician in question is someone whom I myself trained or hired for his or her position, who has less experience than I, and whose expertise is simply assumed because of an academic title.

On the other hand, the rigid departmental structure of the traditional academic model presents some competitive challenges for IR that are not present in a private practice. A Chair of surgery might, for example, instruct all of his or her staff to refer every port placement, gastrostomy, and even (perhaps) catheter-directed oncologic treatments to other surgeons rather than IRs, and the staff would be obliged to comply. No such leverage exists within most private practice institutions, and individual practitioners can, and do, refer to whomever provides a better service. Another example: the Dean of a medical school would have no reason to fund competing vascular laboratories in surgery and radiology, but a private radiology group that wanted to increase its vascular diagnostic and interventional work could certainly choose to invest in its own vascular laboratory. Thus, the opportunities for practice development are probably greater in a private practice, assuming that one can convince one's partners to make the necessary investment of IR time and, often, capital.

With regard to the topic of finances, I would suggest that there is no standard by which to adequately compare this variable between academic and private practices. Although traditional academic salaries have usually been 10 to 15% lower than those of private practitioners in the same community, this difference may be exceeded by the salary differential between male and female physicians in the same specialties (with women earning less), and the range of salaries for the same specialty between regions in the United States is actually greater than the variation between

academic and private practice in a region and between genders in a specialty.²⁻⁵ Interestingly, there is no significant difference in salaries by gender in academic radiology.⁶ While they are undoubtedly lower overall than private practice salaries, academic salaries are also relatively insulated from local market forces. The costs of running an imaging practice or an OBL, including equipment costs, malpractice coverage, employee salaries, marketing, etc, are borne by the owners of the group, and hospital contracts are subject to competition from other groups. Pay structure within a private group also varies: some groups distribute all revenues equally among their partners, whereas others use variables like relative value units (RVU) "productivity" or the number of shifts worked to modify individual incomes. Some groups pay extra for being on call, while others do not.

Ultimately, there is no clear map for an individual who is considering a switch from academic to private practice. Rather, one needs to evaluate the specific environment at a given site and determine for him- or herself whether the tradeoffs between the current and potential future sites are going to be acceptable. It is critically important that the provider in question not simply assume that every academic practice has the same problems and every private practice the same benefits (or vice versa). In reality, there might be more overlap between a given academic/private practice pair than between that private practice and another, even within the same city.

Conflict of Interest
None.

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