IR Residency Training: Is It Appropriate for the Private Practice IR?

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Abstract

Keywords

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Interventional radiology (IR) training programs have undergone many changes in the recent past. These changes largely revolve around making programs more “clinical” in nature by requiring each program to have a formal consult service, outpatient clinics, and admitting privileges. Instituting these changes has been challenging, but the programs are up and running. As a testament to the success of these changes, IR has now become one of the very most competitive residencies to enter. This article provides insights into the process of change within the IR training paradigm, and describes the personal experience of one of the architects of the new training programs.

Nobody asks me easy questions anymore. I have been stewing about how to answer for about a year. So here goes.

current paradigm expect a career that includes all aspects of IR as currently defined.

Background Information

Prior to 2012, interventional radiology (IR) was officially recognized by organized medicine in the United States as a subspecialty of diagnostic radiology (DR). In 2012, the American Board of Medical Specialties (representing all 24 member boards) recognized IR as a unique primary specialty in the house of radiology with expertise in diagnostic imaging, image-guided minimally invasive procedures, and the evaluation and management of patients with conditions amenable to those treatment methods. Educational requirements include structured experience in medical decision making and patient care: clinic experience for pre- and postprocedure care, in patient services, and consult services. In 2014, the Accreditation Council for Graduate Medical Education (ACGME) approved program requirements for Graduate Medical Education in Interventional Radiology. The American Board of Radiology (ABR) now offers primary certification in IR and DR. Beginning with the 2016 National Resident Matching Program (NRMP) Main Match, it is now possible to begin a career path in IR directly from medical school. Medical students' response to this change has been tremendously enthusiastic. IR was the most competitive specialty in the 2018 NRMP Main Match. Physicians training in the

The Big Question

Is the new IR Graduate Medical Education (GME) training paradigm appropriate for the private practice interventional radiologist? This question regards a potential mismatch between the career expectations of this new generation of interventional radiologists and the current private practice job market, which has historically hired IRs who trained in the prior paradigm: physicians who decided during DR residency to do an additional year of procedural training in IR. Time, expense, and infrastructure tied to patient management in that paradigm were not uniformly supported by professional radiology practices. How will the new generation of IRs want to practice? Do existing practice models offer what they need/expect/want? Does the expertise of this new cohort of IR specialists meet the professional expectations of existing practices and/or the medical needs of our population?

My Disclaimer

I am the current president of the Society of Interventional Radiology. I am a trustee of the American Board of Radiology. I helped make all this happen. And I have spent my entire career in an academic environment: Washington University,

University of Michigan, and University of Southern California. I have participated in the process of ensuring that SIR leadership includes a minimum of two private practice councilors on the executive council at all times via a societal bylaws change. I very much appreciate the perspective these representatives bring to SIR leadership deliberations and actions. Prior to organizing my thoughts for this commentary, I also read in the last 2 years of the *Radiology Business Journal*, reviewed the practice resources posted on the SIR and ACR member Web sites, and read long discussion threads on SIRConnect related to private practice paradigms.

The Simple Answer

The current GME training paradigm for IR is appropriate, not only for safe and effective patient care but for scientific progress in the field. The practice of IR must include medical decision making and patient care. The specialty of IR has finally reached the level of professional stature that Charles Dotter, Barry Katzen, Bob White, and other IR leaders indicated should be the goal of the specialty for many years. IR has joined the big leagues.

A consequence of this change is that current IR practice includes activities that are reimbursed with evaluation and management codes, rather than simply procedural CPT codes. These activities require infrastructure, time, and people. Medical practices that include IR in their portfolio must accommodate these practice requirements, especially as the new generation of IRs enters the workforce.

The Complicated Answer

The dominant practice model in radiology has been physician-owned corporate partnerships (some large, some small) serving the spectrum of radiology needs of contracted local medical facilities and/or group-owned imaging centers. Most of these practices include procedural IR capability—from complex full spectrum IR to more basic image-guided procedures. IR physicians in most practices have also done image interpretation, an activity particularly important in small practices that do not have a clinical need for full-time IR. But this simple practice model is changing.

Relative value unit (RVU) targets are now a common metric for diagnostic radiologists to maintain practice viability and individual income. IRs may produce fewer RVUs per hour than their colleagues interpreting advanced imaging studies, especially in practices where highly valued IR procedures have been “taken” by physicians in other specialties. This creates ill will within a group of colleagues. Practices running on thin margins may not be willing or able to invest in the infrastructure necessary for a robust clinical IR practice even though the investment is likely to lead to more highly valued procedures. In an effort to create practice

environments with the infrastructure support needed for the contemporary practice of IR, IRs have begun to develop solo and group IR practices, separate from DR. These practices are in conflict with radiology groups holding exclusive contracts in hospitals.

In addition, private radiology practices are now consolidating at a rapid rate into large physician-owned entities and/or are being acquired by private or publicly traded corporations. This trend is fueled by many factors including increased pressure from health systems and payors for 24/7 DR coverage and subspecialty reads, increasing need for tracking and reporting of quality data related to MACRA/MIPS, increasing cost to acquire sophisticated imaging technology and information technology demanded by stakeholders, and recent decreases in physician reimbursement related to bundling of codes. All of these reasons to consolidate make a lot of sense for DR—economies of scale can decrease practice costs and increase quality and efficiency of diagnostic imaging service.

Where does IR fit into the consolidation trend? It is important to note that the specialties most impacted by consolidation are anesthesia, emergency medicine, and radiology. The dominant driver of this in the house of radiology is DR. The common thread between anesthesia, emergency medicine, and DR is that all three specialties deliver care in very short episodes by physicians who do not typically interact with the patient more than once related to that episode—anesthesia for an appendectomy, suturing a laceration in the emergency department, interpreting a head CT scan. Where does IR fit? The modern model of IR doesn't fit easily.

Until recently, IR could coexist pretty comfortably with DR throughout the nonacademic world. This is no longer uniformly the case. The career expectations of the next generation of interventional radiologists will stress these differences more. It is likely that some practice entities will develop ways for DR and IR to remain within a single business. Other models, such as IR groups contracting with multiple hospitals, and IRs working independently in outpatient centers are also likely to gain traction. It is unlikely that a single model of practice will dominate.

So, is IR training appropriate for the private practice IR? Yes. But is private practice ready for the new IR? I'm not sure. We are in a period of change. I don't see that ending any time soon.

Conclusion

Interventional radiology is changing. DR is changing. Leaders in the organized worlds of DR and IR need to continue to work together to ensure that our specialties serve the public and the integrity of each specialty in the best way possible moving forward. This will take conversation, collaboration, communication, and lots of work. I will participate.