Perspective

Implications of IR Being a Primary Specialty on the Professional Organization Relationship between Interventional and Diagnostic Radiology

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ABSTRACT

The recent elevation of Interventional Radiology (IR) to primary specialty status prompts a reevaluation of the historical interplay between IR and Diagnostic Radiology (DR). This transition underscores the need to reassess how professional organizations representing these two specialties can foster greater collaboration and partnership, thereby enriching the experiences of their members and benefiting patients.

To facilitate this objective, focus should be directed towards several organizational strategies. Firstly, efforts should be consolidated towards advocacy and government relations to amplify the collective voice of both IR and DR practitioners. Secondly, there is a necessity to develop innovative practice models that foster harmonious working relationships between IR and DR professionals. Lastly, emphasis should be placed on generating comprehensive data that elucidates the value proposition of IR beyond mere work relative value units and professional revenues.

By adopting these strategies, organizations representing IR and DR can cultivate an environment conducive to enhanced collaboration and mutual benefit. This proactive approach has the potential to fortify the future of both specialties, facilitating synergistic partnerships that optimize patient care and professional development.

Keywords: Professional development, Interventional Radiology (IR), Diagnostic Radiology (DR)

Introduction

With the recognition of Interventional Radiology (IR) as its own primary specialty, the American Board of Medical Specialties validated the clinical value of IR while also presenting radiology practices with a challenge of how to adapt to this new IR training pathway, board certification, and clinically focused practice paradigm. At a time when academic departments and private practice groups are both consolidating and being asked to manage growing diagnostic imaging volumes, interventional radiologists are also growing their ambulatory practices and needing more time to provide evaluation and management services and longitudinal patient care [1].

How are these above mentioned dynamics affecting the organizational relationship between IR and Diagnostic Radiology (DR)? Let us begin to answer this question by bringing up 5 points for context and perspective

■ The society of interventional radiology and american college of radiology have complementary missions and visions

The Society of Interventional Radiology (SIR) consists of more than 8,000 practicing interventional radiologists, trainees, medical students, scientists, and nonphysician and PhD clinical associates, with a mission "to improve lives through image-guided therapies" and a vision "to optimize minimally invasive patient care." SIR advocates with the government and legislators on behalf of its membership [2].

The American College of Radiology (ACR) consists of approximately 42,000 members and is the largest radiology-centric organization in the United States that advocates with

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government officials and legislators on behalf of interventional and diagnostic radiologists, nuclear medicine physicians, radiation oncologists, medical physicists, and their members-in-training. Its mission is to be "the voice of its members, empowering them to serve patients and society by advancing the practice of radiological care," with a vision to have its "members thrive, improving health and leading through excellence in radiological care." Although SIR and ACR do collaborate on some government-related advocacy efforts, there are organizational opportunities to further leverage the relationships SIR and ACR have cultivated with specific governmental agencies and legislators to create a louder and more singular advocacy voice.

Given that the specialty of IR grew out of the specialty of DR and many interventional radiologists are part of larger radiology departments or practices, many interventional radiologists are members of both SIR and ACR [3]. However, at a time when diagnostic imaging volumes are starting to overwhelm all types of practices and the need for more diagnostic radiologists has become very apparent, many interventional radiologists, especially more recently trained interventional radiologists, are requesting and deserve to have dedicated clinic time, admitting privileges and time to see patients in consultation. Indeed, more and more interventional radiologists are embracing their clinical calling and significant growth in evaluation and management billing charges and work Relative Value Units (RVUs) are being realized. However, this conundrum is creating tension in some, if not many, radiology practice models. SIR and ACR have an opportunity to take the lead and work with their memberships to define and develop more creative and flexible practice models that make sense and are financially viable for both interventional radiologists and diagnostic radiologists and their practices [4].

■ All things considered, we are living in a very prosperous era of IR and DR

With the increasing prevalence of patients with more chronic diseases and comorbidities, both IR and DR are witnessing an increase in demand for their services. Both IR and DR are projected to continue to thrive and grow. The Data Bridge Market Research estimates a U.S. dollar value of 25.0 billion for the IR market in 2021, with a compound annual growth rate of 7.13% from 2022 to 2029, growing to $43.3 billion by 2029. Grand View Research also shows a favorable market for the growth of DR, with a dollar value for diagnostic imaging of 117.6 billion in 2021 and a compound annual growth rate projection of 4.2% from 2022 to 2030 [5].

We should also recall that medical imaging was extolled as being one of the 10 greatest medical developments in the past thousand years. Appropriate use of diagnostic medical imaging has been linked to greater life expectancy, declines in mortality rates, reductions in unnecessary hospital admissions, and decreases in hospital lengths of stay. Similarly, IR services have helped to minimize patient morbidity, mortality, and costs and dramatically affect patient care, with approximately 8% of hospitalized adult patients in the United States requiring at least 1 IR procedure . IR services have also been shown to be less costly than more invasive surgery, reduce length of hospital stay, improve inpatient progression toward discharge, and reduce waste [6].

■ SIR and ACR have a major opportunity to work together synergistically in strengthening governmental and legislative relationships and advocacy efforts

Legislative actions often have the biggest effect on all of our IR, DR, and DR/IR practices, both financially and operationally. In addition, lobbying efforts do make a difference and can impact decisions that can significantly affect IR and DR. Many different entities in health care expend valuable resources lobbying to influence legislative decisions. For perspective, U.S. health care lobbying expenditures increased from $358.2 million in 2000 to 713.6 million in 2020, with pharmaceutical and health product companies spending the most. Providers and payers have also invested heavily in advocacy and lobbying.

■ The many changes occurring in IR and DR practices

The many changes occurring in ir and dr practices are creating opportunities for sir and acr to work together to create a diversity of new options/models that allow for more inclusiveness and greater success for a variety of ir, dr and dr/ir practices.

In his book, Drive, Daniel Pink talks about the 3 things that motivate us: autonomy, mastery, and purpose. Most successful people are driven by

these 3 motivational factors, and interventional radiologists and diagnostic radiologists are driven to succeed. In particular, interventional radiologists want the autonomy to provide longitudinal care for and develop relationships with patients, not at the expense of efficient patient care or having a good business model but in conjunction with both of these things. This type of practice model also provides an IR with their sense of purpose and mastery in their specialty. Diagnostic radiologists and groups dominated by diagnostic radiologists should recognize this desire of their IR colleagues or risk depriving them of what motivates them [7].

If radiology groups and diagnostic radiologists within those groups support and invest in their IR colleagues, the return on their investment will be new business and referrals for both diagnostic imaging and image-guided procedural services, better and stronger relationships with providers and hospital administrators, and added value to the health systems with improved morbidity, mortality, patient care progression, and decreased hospital lengths of stay [8]. These are all factors that will further strengthen the group's contract with their health system and gravitas with the local community. With more diagnostic radiologists wanting and choosing to work remotely, the onsite presence of interventional radiologists also provides an added benefit to the radiology group. In addition, the retention of patients and new referrals that result from the presence of interventional radiologists helps to keep patients in and reduce transfers out of their health system, which further improves the group's standing with the system's administration and provides cascading professional and technical revenues to both the group and health system-revenues that cannot fully be measured by the work RVUs generated by the interventional radiologist.

■ There are many advantages for the members of SIR and ACR to work together

There are many advantages for the members of sir and acr to work together to use their common missions, visions, talents, resources, skills, gravitas, and wisdom to develop and adapt paradigms to drive the mutual success of ir, dr, and dr/ir practices and focus on our common problems (eg-mpfs), rather than expending energy focusing on our differences.

Former President of Chrysler Corporation once said, "The secret is to gang up on the problem, rather than each other." When groups within a larger organization feel as if they are not being heard and/or are being mistreated or disrespected, there is a tendency for these groups to develop an us-versus-them attitude, which can lead to divisiveness and tribal-like behaviors. However, if these groups (eg, IR and DR) can reflect on what it is they really want and how can they achieve their goals, they will often realize that the real problem is not the differences between them. Rather, the problem is the direction of health care. In the book No Margin, No Mission, the authors talk about how the U.S. health care system ignores universal patient access, siphons health care resources into the pockets of investors and administrative executives, and strips away the patient–physician autonomy as it subverts the ethical value of caring for the individual.

If interventional and diagnostic radiologists can understand that the real problem is not the relationship between these 2 specialties but, rather, the issue is with legislators, government agencies such as Medicare (Centers for Medicare and Medicaid Services), private payers, and hospital and health care administrators, we may be able to better focus on meaningful solutions [9]. If interventional and diagnostic radiologists invested more time and energy in furthering their alliances, seeking new common ground, and knowing there is strength in numbers, rather than closing the rank and "bearing arms" toward separatism, then perhaps they could join to create a stronger solidarity capable of offering creative solutions to benefit IR, DR, and DR/IR practices. Clearly, we do not want to circle the wagons and start shooting inward [9, 10].

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