

# Janette Durham, MD

The outgoing President of the SIR shares her thoughts about multidisciplinary collaboration and the current state of her specialty.



## **Why do you think training programs in both vascular surgery and interventional radiology (IR) have had trouble filling positions in the past few years?**

The SIR has done a lot of work to try to understand this issue and to reverse this trend. One important factor is that we are selecting candidates out of radiology and the radiology jobs right now are good financially and offer very nice lifestyles. For young physicians, lifestyle is a critically important factor. Even though we are well reimbursed, IR is an arduous specialty. Residents coming out of radiology programs today find they can be satisfied by doing other subspecialties that are also very interesting, very lucrative, but not as arduous.

Another factor has been an uncertainty about the role of IR in the future. How will we get along with cardiology and vascular surgery? Will we have enough work? That uncertainty has influenced enrollment in, not only our training programs, but also those of vascular surgery. The good news is that we have as much medical student interest in our specialty right now as I have ever experienced. In our own program, we have two or three medical students a month coming on to our service who want to find out about IR. I think that interest in IR is a cyclical thing; influenced by reimbursement and confidence in the specialty.

## **What are the initiatives that the Society of Interventional Radiology (SIR) is taking to transform IR into a more clinical discipline, and in what type of practices are IR physicians engaged?**

One of the really exciting aspects about being the President this year has been the opportunity to witness all the ways that IRs are practicing. There are many vari-

ations and themes: traditional IR practices that are hospital focused, outpatient practices, partnerships with cardiology, partnerships with vascular surgery, totally academic practices, one practitioner covering two hospitals, etc. This variation in practice models is great. No matter what the local politics, you are going to find a way to contribute to the care of patients using interventional techniques. Everyone's practice is also a little different from the standpoint of their involvement in the clinical management of patients. Some radiologists remain very technically focused; others provide longitudinal care to all of their patients. Providing longitudinal care is very important if we want to have a stake in those areas where there are multiple specialties participating. If IRs are going to continue to take care of patients with atherosclerosis, they will need to develop referral patterns from some source other than their competitors. To do that, they will need to be able to pick up a phone, answer the questions of both patients and primary care referral doctors, and offer to manage the patient throughout the periprocedural period.

Our society needs to educate our members how to do that. Longitudinal management of patients has not been a part of our education in the past. At the SIR annual meeting this year, every section will have the clinical care of the patient discussed. That is a significant shift from when I started practice and education consisted primarily of learning how to do a procedure. This same focus is intended in all of the SIR educational programs and enduring materials. With the addition of the new direct pathway, our fellowship programs are also changing to include a focus on the skills required to provide longitudinal care. As academic practices develop the infrastructure to provide clinical care, the Fellow's education continues to improve. For those members in practice, SIR is developing a practice manual, which is a hands-on guide to setting up an office and starting an inpatient service. We are trying to give our membership the tools they need to successfully build a practice.

## **What is IR's role in today's multispecialty work on carotid artery stenting (CAS) and its success with payment strategy?**

Anytime that we have an opportunity to work with multiple specialties and it is actually successful, we

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should highlight that result. CMS has recently published a guideline on how they are going to pay for carotid stenting. We have been able to get multiple societies together to comment on this proposal as a group, in addition to commenting as individual societies. The fact that this group could get together so quickly, write a letter to CMS, and outline what we could agree upon was a tremendously important step in building future relationships, particularly after so much bickering about who should be doing carotid intervention..

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**Do you see evidence of the same type of cooperation being directly applied to the issue of training and credentialing?**

I would like to say yes, but the answer right now is that it is going to be difficult. We have vastly different experiences. A typical IR who is doing cerebral work, which is almost all IRs in private practice, is doing 50 to 100 cerebral arteriograms per year and has been doing that every year of their practice. A neurointerventional is doing 200 or 300 cerebral arteriograms per year, and is putting wires and catheters up in the brain daily. There is such a large difference in the experiences of those two groups, compared to that of cardiologists and the vascular surgeons who want to perform CAS, that it would be inappropriate to say to a patient or to a credentialing body that this experience makes no difference. The patient should be aware that there are people whose livelihood involves putting catheters in the brain, that there are very high risks associated with doing this, and that expertise makes a difference in outcomes.

This is not to say that there are not cardiologists and surgeons who have similar expertise, certainly these individuals were instrumental in the development of CAS. But carotid intervention will take a commitment to acquiring adequate skills; we do not want to make it look like a person who has never done a cerebral arteriogram in his life and one who does 250 a year are on

the same playing field—they aren't. I don't think we are able to come to consensus on this issue at this point in the deployment of this new technology, and I don't think it is appropriate for patient safety that we do.

**From a patient treatment perspective, it would seem that a multidisciplinary team approach, in which facilities invest heavily in providing expertise from three or four specialties to their patients, might work best. Currently, it seems as if, depending on where a patient's lives or what the community standard of care is, the patient might not be aware of the different skill sets among the specialties. Is this type of collaboration the most sensible?**

In my career, I have been through a decade of protecting turf and a second decade of discussing competition, but I think we are facing a future of collaboration. What does it mean to collaborate as physicians among the specialties? All of the challenges we face are going to drive this collaboration—manpower shortages, limited resources, and diverse expertise. If we just look honestly at what we are good at doing, and ask what is best for the patient, and how can we impact the most patients with the best outcomes, we would collaborate.

At our center, we have a cardiac and vascular center that was established to manage hospital resources between the three specialties of cardiology, radiology, and surgery. Our approach to carotid intervention is that every case that presents to the cardiac and vascular center will be presented to a team in which all three specialties are represented. When the team decides to perform a case, the case goes to the best-equipped room for the procedure and a neurointerventional radiologist and an interventional cardiologist get it done. Anyone else who is interested is invited. The neurointerventional radiologist understands the vasculature, the cardiologist understands the protection device, the IR understands the large stent technology, and the surgeon understands the disease. All carotid intervention at the University of Colorado will be handled in this manner for the near term.

There are going to be some financial outcomes of this approach that will need to be resolved (ie, who gets paid and how). Resources will need to reward all three specialties for their contribution to the care of that patient. We've had some success with this approach with aortic aneurysm repair. We still team up to do each case with a vascular surgeon and that approach has led to excellent outcomes for the majority of our patients. Until everyone's experience is such that the patient can expect the same level of care no matter where they present, I think collaboration is very important. ■