Robert L. Vogelzang, MD, FSIR

A Past President of SIR and the recipient of the 2016 SIR Gold Medal reflects on physician values and medical tribalism and how they affect patient care.

How do you foresee a new, separate interventional radiology residency having an impact on the specialty?

We're looking at a development that has been previously replicated in multiple specialties—emergency medicine, vascular surgery, urology, neurosurgery. A knowledge base arises, develops, and has value, and ultimately, it requires its own training path because of its unique attributes and advances in patient care. Interventional radiology is on that path. It's also interesting to see the parallels with other specialties and observe how the parent specialties have a great deal of angst about the separation of their "child" from the family.

Thankfully, we've been blessed with terrific leadership in radiology and interventional radiology who have seen the process through, and despite some concerns on the part of radiology leadership, have been supportive all along. I think implementing this process and rolling out interventional radiology residency programs will be bumpy, but we have a method.

The biggest difficulty for interventional radiology training programs is that there will be a period of time when several pathways to become certified in interventional radiology will exist. There will be programs like mine that will simultaneously have residents and fellows and will need to transition over the next few years, but we'll work through that. Program directors will need to decide if they want to create a residency path and then go through the process of applying and establishing training guidelines. Another problem is a potential reduction in the number of interventional radiology graduates, because not every program that is currently a fellowship may decide to become a residency. That will be a challenge to supply and demand for patient care.

Overall, I believe that this is the right thing to do. This represents the future of interventional radiology as a full-fledged clinical specialty, and most importantly, it exposes us to a much larger pool of medical students who are interested in surgical and procedural specialties. I think this will be a real positive for us.

Where do you think the interventional field is falling short when it comes to evaluating the quality of endovascular procedures and outcomes? How do you think this can be improved?

We have all seen underqualified and poorly or minimally trained physicians in all of the interventional specialties (vascular surgeons, cardiologists, and interventional radiologists) performing procedures that they should not be doing, which results in very poor outcomes. I think we owe it to our patients and the public to ensure that we have a method of policing this bad behavior. Too often, I believe, we've said that we think we're doing fine overall, and there are a few people who need better training, but I disagree. I think we need to address this in a very direct fashion.

I think it behooves the individual societies to designate what represents an appropriate practice, what skills you need, and what you should or should not be doing. Those are hard things to say to physicians who want to build their own practices, but I think they must be said.

Further, at the local level, I think hospitals are responsible for not simply saying that they need an endovascular specialist, and any warm body will do, but rather look at the case volume and ask granular, detailed questions to themselves and their physicians about their experiences and outcomes. For example, I

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think there are other specialties that have established outstanding track records for top-notch care. I have an abiding admiration for hand surgery. These physicians are extremely well qualified, and if you go to a hand surgeon, you're going to get outstanding competence. I think we should aim for that.

How do you think the viewpoints on physician ethics need to be adjusted in order to better prioritize physicians' most important values?

I think that many of the regulatory and Sunshine Act requirements are problematic because they are viewed by many as pivotal ethical issues. Most physicians who I talk to disagree; they believe that, for example, conflict of interest is ever present, but it is not a core issue. The reality is that doctors completely understand they may have some conflicts of interest, but they believe they can manage them without compromising patient care. Although it's not true in every situation, it points out that doctors see themselves as having much more important values and virtues that uniquely identify themselves as physicians—virtues such as loyalty to their patients, practice, and specialty—virtues such as doing the right thing and treating all patients equally. These are constant and universal values that need to be identified, celebrated, and encouraged.

One thing I am actively exploring now is a set of values with which physicians actually agree. Loyalty is a big one—doing the right thing by and for patients. A series of these values, if identified, then align physicians much more closely and doesn't create this discrepancy between what they have to do for regulatory or legal purposes, such as disclose conflicts of interest, and the way they see themselves as physicians. It's a far more profound and important discussion about who physicians are.

How would you define the term *medical anthropology*, and what is your specific focus in that idea?

For a long time I've been interested, just as an observer, in how medical specialties are the basic units around which physicians operate. As it turns out, if you ask your physician what he/she identifies most closely with, the answer will almost inevitably be the medical specialty. They do not define themselves as physicians but rather as cardiologists, nephrologists, internists, or interventional radiologists. There is a lot of evidence and literature that points out that identification with a group is an extremely important part of the physician.

Along with a colleague, I set forth to look at some of the differences between these various medical specialties in how they think about their practice and patients. We used a method called *grounded theory*, which has been widely used in anthropology and uses a specific methodology to seek to understand the meaning behind the words. We all use certain words and sentences, but as we all know, there is encoded meaning behind them. In an evaluation of gynecologists, interventional radiologists, and vascular surgeons about how they see patient care using this grounded theory methodology, we found that they all had very distinct ways of speaking that were as different as you could possibly imagine when speaking about the same subject.

For example, gynecologists often talked about their relationship with a patient, the longitudinal care relationship with a patient, and much less about the specific or individual procedures or surgeries that were performed. Their language was always in service of defining a patient who was satisfied with the interaction and whether the doctor was doing the right thing for patients. For example, hysterectomy was often referred to as a definitive procedure because gynecologists felt that it was the best thing in order to maintain the long-term relationship with the patient.

On the other hand, interventional radiologists would talk about patients as candidates for procedures and would have a much more specific procedural orientation than gynecologists. Vascular surgeons defined themselves largely in terms of disease entity. Although they talked about patient interactions, it was always in terms of whether the patient had a certain disease and how the disease would be managed. If you compared the transcripts of each specialty, you would absolutely know that they are three extraordinarily distinct subgroups.

Understanding how we think about patients and the language that we use about patient care is very important. Physicians find it difficult to talk with different specialists because they don't understand the other physician's language. It turns out that language is very specifically encoded; it has meanings that are relevant to each specialty.

As we find ourselves in large health care systems where *integration* is the watch word and the mandate, we need to understand that specialists talk about things differently. This also has implications, for example, in how we train young physicians and give them a professional identity specific to that specialty.

The overall phrase that I've used and think is very applicable is *medical tribalism*. There is not a more fundamental division among groups of humans than the tribes that they belong to, and I think that's absolutely true among physicians. Medical tribalism can be a real problem as we navigate this, where the interest in the specialty may sometimes outweigh patient interest. Intertribal disagreements may lead to stalemates and failure to deliver optimal care because physicians from different specialties don't agree, and tribal loyalty trumps patient care. We have to acknowledge that it's a powerful force in medicine, and the more we can understand, the better we're going to be able to manage and deal with it.

What are your current research interests?

My current research interests focus on the areas of practice in which I've spent most of my time—treatment of vascular malformations—and I think we're finally making some significant progress. We're getting traction with some very effective methods that work and cure arteriovenous malformations, something that we thought impossible not too long ago. My work for the past 20 years has also has been on fibroid embolization and management of uterine fibroids. ■

Robert L. Vogelzang, MD, FSIR, was Chief of Vascular and Interventional Radiology at Northwestern Memorial Hospital in Chicago, Illinois for over 30 years. He has stated that he has no financial interests related to this article. Dr. Vogelzang may be reached at vogelzang@northwestern.edu.