

Scott Goodwin, MD

The SIR President-Elect shares his insights on the future of uterine artery embolization and the field of interventional radiology as a whole.



What are some of the challenges and opportunities you foresee for radiologists in the implementation of the Affordable Care Act?

There is going to be a big emphasis on value—what is the value of what you do? If you look at the entire value equation, including lost time from work and activities, it may encourage the use of procedures like uterine artery embolization (UAE), where the recovery time is much shorter than the surgical alternatives.

I think there is also going to be a trend toward more physicians becoming salaried. Hospitals will look at the amount of work they have in any particular area and use national benchmarks to determine how many salaried physicians they need, then hire that number of people and expect them to be productive to a certain level. If the hospital's business in a certain area grows, then they will hire appropriately to cover that work.

If you look at salaried environments like the VA or Kaiser centers, interventional radiology practices tend to be much more robust than they are in some of the private practice hospitals because you get what you incentivize. If you are in a fee-for-service environment, the physicians are incentivized to do what they are personally capable of doing, rather than referring to someone else. If the physicians are in a salaried environment, they are more likely to refer based on the entire gamut of what is available to a patient at that hospital.

Capitation could also be important to the specialty—I think that the Affordable Care Act will result in a larger amount of capitated care. Again, the value of interventional radiology will be an advantage in that kind of environment.

As a pioneer of UAE, what developments do you think we can expect next in this area? What new embolic materials are being evaluated?

Scientifically, I think what's still missing in the UAE world is a really large, well-designed, randomized, controlled trial, specifically looking at UAE versus myomectomy in patients who desire fertility. There has

been some work there, but not enough. The fertility question, in my mind, is still out there: What do you do with the woman in her late 30s who still wants to have children and has entertained the idea of UAE versus having a myomectomy? The conventional wisdom has been to steer that woman to myomectomy because of the small risk to her ovaries from an embolization procedure.

A couple of years ago, there was actually a fair number of articles looking at a variety of different embolic materials. However, when I gave a literature update at the Western Angiographic & Interventional Society meeting a couple of years ago and again last year, I noticed that the number of articles on new embolic materials had dropped off quite a bit as compared to 2 to 4 years ago—I don't really know why. I will say that I believe there is a high level of satisfaction with the materials that are currently available. However, I think there will absolutely be an ongoing introduction of new embolic materials as we go forward. Exactly what those will be made out of, however, I don't know.

What do you consider to be the most significant barriers to more widespread use of endovascular therapy for these patients?

The biggest barrier is that most patients don't end up becoming informed about UAE when they have fibroid disease. A very significant number of the patients who have fibroid disease who end up undergoing UAE are self-referred. They find out about the procedure themselves by doing research on the Internet; patients are still largely are not hearing about UAE from the gynecology community.

There are a couple of things in play there. One is human nature. An old friend of mine who was Chief of Vascular Surgery at UCLA used to say, "If your only tool is a hammer, the whole world looks like a nail." Physicians tend to offer what they're trained in, comfortable with, and familiar with. Obviously, gynecologists are much more comfortable and familiar with hysterectomy and myomectomy than they are with UAE.

(Continued on page 96)

(Continued from page 98)

I think the gynecology community is also a big believer in the idea that hysterectomy is permanently curative, whereas UAE is arguably palliative—about 20% of patients fail therapy by 5 years after the procedure, meaning they either needed a repeat procedure or they were dissatisfied with the outcome. You don't get fibroid symptom failures after hysterectomy.

The other issue, as I alluded to earlier, is how the incentives are aligned. You get what you incentivize. No one wants to talk about it, but if you are paying somebody to do something, they will do that rather than send patients to someone else.

What are your recommendations for establishing relationships with gynecologists to build referrals for UAE?

The interesting thing about this question is that the handful of gynecologists who have embraced UAE have had marked improvements in the size of their practices. If they market themselves as a minimally invasive specialist in fibroid disease and they partner with an interventional radiologist, a significant number of the patients who come in don't end up undergoing UAE. In my practice, about half the patients I see end up getting something else, whether it be watch and wait, medical therapy, high-intensity focused ultrasound, endometrial ablation, myomectomy, or hysterectomy. About half end up with an embolization, and then, of course, the gynecologist is often significantly involved in the pre- and postprocedural care of the UAE patients, particularly if the patient is one of those 20% who need a repeat procedure or one of the 5% who has passing of fibroid tissue out through her cervix after UAE.

If you're a gynecologist and you market yourself in the community as being interested in minimally invasive therapy for fibroids and you have an interventional radiologist partner, you can build a very big practice. It makes the pie a lot bigger. Many gynecologists view UAE as something taking away from their practice rather than as an opportunity to grow their practice. If you're an interventional radiologist and can persuade even one gynecologist that this is a practice-building opportunity, then that can really help.

Today, you can reach out to gynecologists prospectively. You can ask to meet with the gynecologists at your hospital, give grand rounds, supply them with educational material, go to their office and meet with them one on one, meet with their staff, or send them literature. You can also meet with your marketing department. We had a marketing campaign at my hospital that brought patients into the gynecology practice, and I got patients that way.

What are some of your objectives for the Society of Interventional Radiology (SIR) during your upcoming tenure as President?

We are doing quite a bit of work to educate hospital administrators about what interventional radiologists do, how important the field is to hospitals, and the value inherent in what interventional radiologists do in hospitals.

Congress is very focused on limiting costs in the health care sector, and radiology is squarely in the bull's eye in those efforts. Both the house of radiology and the house of interventional radiology are concerned about what may happen to reimbursement and what that may do to patient access and to people being interested in training in radiology or interventional radiology. Already last year, for the first time in memory, we had open spots in the radiology programs, which is almost unheard of. Medical students pay attention and hear right away when there are big cuts to reimbursement in a specialty.

I remember when it happened in anesthesia years ago—there was a big reimbursement cut, and there ended up being a lot of open spots in the anesthesiology residencies and a subsequent relative shortage of anesthesiologists. I can see the same scenario playing out in radiology and potentially interventional radiology. SIR is working on Capitol Hill to try to educate Congress and congressional staffers about the value and importance of interventional radiology procedures.

SIR recently announced the multisociety guidelines for endovascular treatment of stroke, as well as the multispecialty registry to evaluate the use of IVC filters. What is the driving force behind the efforts to work closely with other specialties, and what other initiatives is SIR involved with to promote collaboration with other specialties?

Many procedures that we do are performed by multiple specialties, and the weight or importance of a guideline document is enhanced if it's contributed to by all the specialties that have a stake in the particular area. If you write a multispecialty document, the FDA, CMS, payers, administrators, Joint Commission, etc., all pay much closer attention than when you have a single-society or single-specialty document.

You also get the benefit of incorporating different points into one effort. The diversity of opinion contributes to a more thorough consideration of all the various issues during the discussion and subsequent writing of the guidelines.

I'm a big believer in the cream-rises-to-the-top idea. The bottom line is the quality of care for the patient. If

SIR is working on Capitol Hill to try to educate Congress and congressional staffers about the value and importance of interventional radiology procedures.

you make sure that you are delivering the highest quality of care and keeping your eye on the ball, then I think you as a physician, your society, or your specialty will be rewarded. The only caveat is that sometimes other groups have a more competitive view of the landscape rather than a collaborative view. If you go to the table with a collaborative view and are negotiating with someone who is coming to the table with a competitive view, it may put your specialty or society at a relative disadvantage.

There has been a lot of work for the SIR—in addition to IVC filters and stroke—on peripheral vascular disease. There have been many multispecialty conferences and documents and many multispecialty efforts at the FDA and CMS.

How do you think the new dual primary certificate of training in diagnostic and interventional radiology will influence the next generation of physicians and clinical breakthroughs?

This is an important step in trying to ensure that interventional radiologists function as clinicians, run pre- and postprocedural clinics, and fully participate in long-term care of patients by serving as consultants. It is important to see the patients in consultation, evaluate and decide what the best therapy for the patient is—whether it be medical, surgical, or endovascular—manage or refer the patient appropriately, and follow-up afterward. That's the model that surgeons and cardiologists practice, and that's the model that we have to practice to be successful. The dual certificate program emphasizes the importance of clinical training and longitudinal care. That is really important for our future. ■

Scott Goodwin, MD, is the Hasso Brothers Professor and Chairman of Radiological Sciences at the University of California, Irvine. Dr. Goodwin will serve as the upcoming President of the Society of Interventional Radiologists. He has disclosed that he has no financial interests related to this article. Dr. Goodwin may be reached at (714) 456-7517; sgoodwin@uci.edu.

VASCULAR JOBS AT EVTODAY.COM

Have a position that needs to be filled in the vascular field?

Try Endovascular Today's online Job Marketplace, offering free classifieds for hospitals, vascular clinics, and industry. Searchable by country, region, state, and job title, the Job Marketplace can help fill positions for interventionists, fellows, nurses, techs, and other hospital staff, as well as a broad spectrum of industry openings.