

Title: Steps the SIR Can Take to Improve the Ability for Independent Interventional Radiologists to Obtain Hospital Privileges.

Note that this is being posted simultaneously on SIRConnect <https://connect.sirweb.org/> OEISConnect <https://connect.oeisociety.com/>, LineMonkeyMD.com <https://linemonkeymd.com/> and BackTable Podcast “How to get independent IR hospital privileges” <https://www.backtable.com/> and various other social media platforms.

Attachments include the SIR position paper, ACR position paper, SIR 2018-22 strategic plan.

Problem: For decades, the SIR has encouraged IRs to have a clinical practice. Although some IR/DR groups have embraced this idea with robust clinics and inpatient rounding services, many IRs are either not interested in or not allowed to have a clinic. Instead, they spend significant time reading imaging studies and performing commoditized and mundane image-guided procedures. With the rise of private equity-run groups, demands to increase productivity have resulted in IRs interpreting even more imaging studies for the sake of RVU production. Folks who choose that model should be free to, but others may want to practice independently from a radiology group to build a longitudinal clinical practice and improve access to critical interventional radiology services. Because most radiology groups are contracted with the hospital for radiology services, they commonly have an exclusive contract to provide imaging services. “Interventional Radiology” is typically included in that contract. However, over the past several decades, most high RVU minimally invasive image-guided procedures have been performed by other specialists despite this contract being in place. In most hospitals, non-radiology specialists can perform any interventional procedure they want. So, in reality, these IR/DR groups have an exclusive DR and nonexclusive IR contract, hence the term “pseudo-exclusive.” The problem arises when an IR, not an IR/DR group member, applies for hospital privileges, and the group invokes its exclusive contract to block the IR. An independent IR is commonly blocked at all hospitals in an entire city because of this, while other specialists are free to perform interventional procedures wherever they want. Some may say, “Why don’t you just work in an OBL or an ASC and stay away from the hospital?” Although some states allow this, many require hospital privileges to open an OBL. Furthermore, insurance companies often require hospital privileges to become contracted.

The above environment, in large part, blocks clinical IRs from thriving in the United States. The SIR has identified this and recently released the third version of a position paper on exclusive contracting. This states that if non-IRs perform interventional procedures in a particular hospital, independent IRs should be allowed to perform these procedures. Even the ACR recently released a position statement that says the same thing. The SIR’s 2018-22 Strategic Plan’s #1 goal was “IR Physicians will thrive in their chosen practice model leading to high-quality patient care,” came and went with little change. What change did occur was by hard-fought battles by individuals on a local level. The SIR has adopted a laissez-faire approach. That is probably because the largest due-paying constituency to the SIR is hospital-based IRs in an IR/DR group.

People have asked, "What can the SIR do?" and this is the primary reason I am writing this. If they had done more, I would not still discuss this after a 31-year career. This is what I think the SIR can do to improve independent IRs' ability to get on staff at hospitals:

1. Use their bully pulpit at every opportunity to promote a clinical practice with longitudinal care, especially those independent practices that are pure clinical ones. Part of that bully pulpit is to be intolerant of the ubiquitous practice of radiology groups blocking independent IRs from getting hospital privileges at facilities that otherwise have an open staff policy for interventional procedures (essentially all private hospitals in the USA). They should also use the bully pulpit to criticize the IR groups without a clinical practice.
 2. Identify the states where an OBL can be opened without hospital privileges so IRs can move there.
 3. OBL sessions at the SIR annual meeting (currently in process).
 4. Encourage IR residents to spend time in OBLs for clinical training and learn procedures they may not be exposed to, such as PAD and SVI.
 5. Help develop staffing and financial models to staff IR coverage for hospitals. Currently, IR co-coverage is just a freebie thrown as part of an IR/DR contract, which is incredibly devaluing to IR. Whether part of an IR/DR group or independent, IR services should be able to negotiate a professional service agreement.
 6. Develop a "How to get on staff" lecture at SIR annual meeting, which I gave in 2018
 7. Be honest with med students: "There are very few jobs where you can practice full-time clinical IR. And if you want to develop your own practice, you will most likely be blocked from getting on hospital staff by the radiology group. Other specialties get on staff without a problem and do whatever procedures they want."
 8. There needs to be a change in IR leadership makeup. Currently, there is no independent IR on the Executive Committee.
 9. Showcase clinical success, including OBL/independent IR at the annual meeting and "The Wire."
 10. Pay for an Amicus brief on the legality of the so-called "Exclusive" contract that allows everyone except independent IRs to get on staff at hospitals.
 11. Showcase legal successes (and their lawyers) of independent IRs obtaining hospital privileges when opposed by radiology groups or the hospital.
 12. Terminate SIR membership for those IRs who do not have a clinical practice or who block independent IRs from getting on staff at their hospital in direct violation of the SIR's recommendations.
 13. Promote separation of IR from DR much like radiation oncology has split from radiology.
- I have written about this before and encourage interested readers to check out a recent AJR article on this topic. <https://www.ajronline.org/doi/10.2214/AJR.23.29815>

Additional thoughts: Other societies would have never let this fester so long. If their people were blocked, they would have taken to the airwaves, called stakeholders, filed lawsuits, etc. What has the SIR done? Approve a position paper and otherwise sit idly by while a group, largely without longitudinal clinics or rounding services that mostly read films and perform low-level procedures, block purely clinical independent IRs. Why does the SIR not support the ones who

want to practice IR like the society recommends we practice? Which group will make the SIR proud and help create IR leaders in our communities? There will be some who will say, "Let's study this" (some more). To that, I would say this is a decade-old problem that has not changed much since Jerry Niedzwiecki and I brought it up at the 2004 Phoenix SIR Annual Meeting Business Session. At that time, a significant number in the audience of thousands booed us. An entire generation of IRs have been affected by this problem and have had their options limited. Most of the SIR membership has either blocked the independent IRs, were complacent, or, in some cases (academics mostly), were unaware or did not care.

These actionable suggestions should serve as a roadmap for the leaders in IR to correct course. However, If the consensus is to talk about it some more or do nothing, medical students who want to pursue clinical IR should consider applying to other specialties without the current barriers to a clinically oriented independent interventional radiology practice.

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