Practical tips on how to build a referral practice

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Disclosures

Speaker name:
Gerry O’Sullivan....................................................

I have the following potential conflicts of interest to report:

- Consulting- BSCI BD Cook Medical Medtronic Cordis Whiteswell Creganna Philips,
- Employment in industry
- Stockholder of a healthcare company Marvao Medical, Orthosensor, Vetex
- Owner of a healthcare company
- Other(s)

☐ I do not have any potential conflict of interest
Decide on your likely level of commitment

- Are you very busy with arterial/aorta/oncology etc?
- How many in your practice?
- Are others interested in venous?
- Can you collaborate with other specialities?
- Do you have time in your week for a clinic and rounding?
The biggest factor determining how much venous (or anything else) you can do will NOT be your “competition”- it will be your “colleagues”
Practical step 1- form good working relationships

• With Haematology so YOU refer them patients just as they refer you
• With Oncology- they may know you as biopsy or RFA person and be unaware you can perform venous magic!!
• With Vascular Surgery/IR/Cardiology/Angiology: essential for you in my opinion
• With DIAGNOSTIC Radiology: so you can get good quality imaging- MR, CT, US
• With the Vascular Lab technicians/radiographers
• With the ED so they think of YOU first
Practical steps 2

• Attend Vascular Out Patients
• Read lots
• Focus on specific topics
  – Varicose veins? Acute DVT?
  – Deep Venous Reconstruction/ Chronic/ venous Ulcers/Malignancy?
  – Pelvic Vein Embolisation? AVMs??
  – Clinical Management +++++
  – Haematology aspects
Practical steps 3

• Read lots!!
• Attend conferences- general initially
• Attend venous dedicated conferences
• Bring your complex cases along and ask the “experts”
• Consider doing short “visits” to expert centres- 2 days to 2 weeks
Practical steps 4
Next or in tandem

• Try and set up practical protocols in YOUR hospital with respect to:
  – Referral pathways
  – Imaging- which modality for which patient?
  – Think of practicalities of seeing patients- Where? When? How often?
  – Make your imaging as efficient as possible- stepwise
    • US → CTV/MRV → IVUS/Venography
Practical steps 5- Now consider:

- Grand Rounds to hospital
- Lectures to GPs
- Discuss with Pharma
- Get help from device companies
2007

Invitation to all GPs and Consultants within 100 miles of Galway in 2007
3 nights in a row
About 10 consultants and 8 GPs turned up
It was a start.........
My experience over time:

• St George’s (1995-1998) 95% arterial
• Stanford (1998-1999) 70% arterial
• Chicago (1999-2002) 60% arterial 20% venous and clinical
• Galway 2002 50% arterial 50% diagnostic radiology
• Galway 2019 75% venous and CLINICAL
But obviously I have had to give up stuff as well.

- EVAR
- TEVAR
- Carotids
- Most PVDz

– Would you be comfortable with this???
There are PLENTY of patients out there- you really do NOT need to get “turfy”!!
Why do I like Venous Disease?

• Undertreated
• Patients are so grateful
• I have seen incredible improvements in patients in short periods of time- it is very rewarding
THANK YOU