Should Interventional Radiology gain specialty status within the Royal College of Radiologists?"

On November 14th 2019, the annual British Society of Interventional Radiology (BSIR) held a vote on whether the BSIR would advocate for interventional radiology (IR) to become an recognised specialty within the Royal College of Radiologists (RCR). This would result in the RCR housing three specialties – clinical radiology, interventional radiology and clinical oncology. The debate received overwhelmingly positive support with 80% of members voting for this. However, this proposal has created controversy within the radiology community. In this essay, I explore the debate around specialty status for IR.

Interventional Radiology started in 1964 with Charles Dotter. Prior to this, the field was 'angiography' which involved using a catheter to inject contrast and obtain images but not treatment. Dotter performed the first angioplasty in 1964, and since then, advancements in medical devices and imaging have allowed the field to expand exponentially. Modern IR practice includes treatment of conditions across many different specialties, including stroke, vascular disease, cancer and dialysis.

In the UK, Interventional radiology is currently recognised by the General Medical Council (GMC) as a sub-specialty of clinical radiology. In order to get into interventional radiology, a trainee must first get into a radiology training programme, and then selection for IR occurs locally at the ST4 level. Demand for IR procedures has hugely increased over the years, but there is expected to be a shortfall of 37% by 2024 (1). Therefore, it is vital to ensure that the field can recruit more trainees in order to provide a safe level of IR service across the country.

The USA is the first country in the world where IR has achieve independent specialty status. In 2012, the American Board of Medial Specialties approved interventional radiology as the 37th medical specialty, and the combined interventional & diagnostic radiology training program began. Since this change, the IR training program has been one of the most competitive medical specialties in the USA (2). The success seen in the USA has sparked debate in many other countries on whether IR should be recognised as an independent specialty.

The rationale for change

The biggest reason for the change is for patient care. Although radiology has played a role in patient treatment for years, perceptions from those outside the field are that the field plats a 'diagnostic' role in patient care. Establishing interventional radiology as a therapeutic specialty will allows the radiology department to shake off these dated perceptions, and this would make it easier for the radiology department to get clinic space, build radiology day case units and take a more active role in clinical management of patients.

The future of IR depends on adequate recruitment of trainees. The current model of local sub-specialty recruitment at ST4 means that the number of training positions fluctuates year on year. Creation of IR as a specialty will secure a certain number of spots per year in a

national selection process and ensure that there is a continuous supply of IR trainees and address the shortage. Additionally, another advantage of this model of recruitment is that the visibility of IR as a career is increased and recruitment can occur from all doctors who complete the foundation programme as opposed to current radiology registrars. Enhancing the visibility is likely to attract talented candidates who would otherwise apply for other procedural-based training programs such as core surgical training.

Creation of a specialty is also expected to increase recruitment of women into the specialty (3). The most recent example of this in the UK is in vascular surgery. Vascular surgery was historically a male-dominated field, with just 8% of consultants being female. Since the creation of vascular surgery as a separate specialty from general surgery, the gender imbalance has shown signs of improvement, with 55% of the intake in 2013 being female (4). The reasons for this are multifactorial, but possible reasons include more security in training program and easier access to mentors & role models. Overall, recruitment of the most motivated trainees and ensuring that there is diversity and equal access irrespective of gender, race or any other factor not related to merit alone is critical for the field as a whole.

A third key reason for change is that establishing IR as a specialty ensures that radiology is not 'taken over' by other specialties. The development of radiology is unique for a medical specialty in that it is modality/technique-based as opposed to being system or patient population-based. However, it is easier for an existing medical specialty to learn image interpretation for a given patient population. Cardiology is a prime example of this, with cardiac imaging and intervention almost exclusively being performed by cardiologists. Developments such as point-of-care ultrasound mean that more and more non-radiologists are learning medical imaging techniques. Establishing the role of radiologists as therapeutic as well as diagnostic ensures that for a given condition or patient, treatment options include a 'radiological' strategy, not just medical or surgical. However, this is only possible if radiologists are given clinic space and patient units – a process would be significantly easier if IR is established as a specialty.

However, there are some important issues with the proposal to create a new specialty. The major concern is that there will be dilution of diagnostic radiology training if this was to occur. In order to be an interventional radiologist, understanding diagnostic imaging is critical. The only differentiating factor between a radiologist vs another clinician is this training, and it is important to ensure that the quality of diagnostic radiology training is not affected in any future plans. A possible solution would be to increase the length of training overall – this would ensure that the DR training is kept the same as the current position but allows more time to ensure that comprehensive patient-facing skills are also included.

Conclusion

Overall, there are many advantages of IR becoming a specialty within the RCR. The initial success seen in the USA has shown that specialty status is vital for recruitment as well as patient care. There are important issues to be addressed going forwards, and collaboration is required to ensure that the quality of diagnostic training is not reduced and that clinical radiology & interventional radiology work together under the umbrella of the RCR. The

debate is not about rejecting the identity as a radiologist – all surgical specialties are surgeons; cardiologists and gastroenterologists are still physicians; interventional radiologists are still radiologists. But creation of a new specialty is important for radiology as a whole, and most importantly, for patient care.

References

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