

Commentary on “Vascular and Interventional Radiology Training: International Perspectives and Challenges”

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As Interventional Radiology (IR) takes its place alongside other medical and surgical specialties, it is important to reflect on how we as IRs mentor, influence and attract the next generation of IRs to this vibrant specialty. The attraction of IR to future generations of medical doctors is self-evident in that it is a high-tech specialty, which has made the leap from a technical specialty to a full blown clinical specialty with patient beds, ward rounds, teams and outpatient clinics. Moreover, with many countries now having obtained specialty status [1] for IR and implementing dedicated training programs for IR (usually with a mixture of clinical practice, diagnostic radiology and dedicated IR training), it is imperative that students and young doctors who are interested in “hands on specialties”, know of, and are exposed to, IR.

The paper by Makris et al. [2] in this issue of CVIR is of interest in that it tries to assess the influence of exposure to IR training, on a global basis, for residents in diagnostic radiology (DR) in pursuing a career in IR and secondly the authors assessed the training satisfaction rate of those who were in an IR training program or recently completed an IR training program. A questionnaire was sent to eight different global IR Societies (see Appendix A. Makris et al. CVIR).

The important results from the study are that early exposure to IR training in DR residency has a positive impact on choosing a career in IR. More than 50% of

respondents stated that “exposure to IR during core radiology training was the main inspiration to chose IR as a career”. Promoting IR to medical students and DR trainees are the two main ways we will attract IR trainees. Early exposure of radiology trainees to IR is key in career decision-making. US respondents stated that “86% had spent at least 4 weeks in IR during their first year of residency”. This rate was much lower for trainees in other parts of the world. It is important that training programs ensure, and IR staff assist, in making access to training blocks in IR available for trainees early in their DR training.

In contrast, few respondents indicated that they had enough exposure in medical school to inspire them to pursue a career in IR. Unfortunately, exposure to IR in medical school remains poor across the globe [3]. The latter is a trend that must be reversed if IR is to compete with other “hands on” specialties. In a world where we are seeking specialty status and dedicated DR/IR training programs, we need medical students to declare their interest in IR at an early stage. Stoking interest in IR can be achieved by formal teaching of IR to medical students, offering elective placements in IR, IR case of the week uploaded to student platforms, IR symposia for medical students as well using other online tools.

In terms of those who were in a dedicated IR training program or had recently completed an IR training program, overall satisfaction with training was high in all global regions. However, the old chestnuts of competition from other specialties, lack of endovascular training in peripheral arterial disease, variability in the time spent dedicated to IR, lack of clinical practice training and reduced time spent in dedicated IR call during training crop up time and time again in these surveys. The above items are difficult to

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address without properly designed IR training programs built on a bed-rock of specialty status with the support of the DR community.

Interestingly, 73% of the participants stated that “there was lack of exposure to some aspects of IR at their training institution”. These included pediatric IR procedures, stroke thrombectomy and IR research. These could well be addressed by properly structured and cohesive training programs where IR trainees would rotate to different institutions for exposure to various aspects of IR not available at their parent institution. These “networked” training programs are evolving in many parts of the world because of increasing specialization of hospital groups into centers of excellence for certain disease entities (e.g., cancer centers, pancreatico-biliary centers, transplant centers) so that trainee rotation to other centers is a must for curriculum based training. In addition, as more countries obtain specialty status for IR and begin to set up IR training programs, the network model of training will become more prevalent to fulfill curriculum requirements and to ensure accreditation of training centers.

Interestingly, over half of the respondents indicated that they intended to sit the EBIR examination as an exit examination. Clearly, any IR training program must have a curriculum and an exit examination to assess competence. The CIRSE curriculum and EBIR are fast becoming recognized as the global standard for IR training in many parts of the world where no exit examination is available [4].

Lastly, I’m heartened to see that 32% of the respondents were female. The lack of women in IR and indeed in surgical specialties in general has been stark over the last ten to twenty years. In one study from Australia a survey

was sent to junior doctors before commencing specialist training. Women were much less likely to choose a career in IR than men (13.1% vs 29.7%, $p < 0.001$) [5]. The latter finding is despite receiving the same exposure and to IR (which was poor overall). Although I am encouraged that a third of the respondents were female, more mentorship and advocacy are required to attract women to the specialty [6].

Compliance with Ethical Standards

Conflict of interest None.

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