

# Plinio Rossi, MD

One of the true pioneers of interventional radiology, Plinio Rossi, MD, discusses the survival of the specialty and what it means to be a doctor.



**As one of the cofounders of the Society of Interventional Radiology (SIR), how would you describe the evolution of the society?** The Society of Interventional Radiology started officially in 1973, but earlier, in the late 1960s, the Eastern Angiographic Society had evolved into the National Cardiovascular Society, then into the Society of Cardiovascular and Interventional Radiology, and, finally, into the SIR.

At the beginning, it was a closed-membership society; only a few very qualified people could apply and then possibly be accepted. On one hand, this was a very fruitful period; when you participated in a meeting, you could share experiences with others who were very competent in the field, a very rewarding opportunity for sharing direct information. On the other hand, it was a closed society.

Younger people were accepted after several years only; among them we can mention Barry Katzen, MD, who was eventually brought to the position of President of the society—despite the fact that he had been previously rejected. Things had changed, and a new constitution was required when the society opened to everyone. The Society for Cardiovascular Interventional Radiology evolved into the Society of Interventional Radiology, an open and well-organized society with a Board of Directors and many members.

**What factors do you consider to be critical to the continued development of interventional radiology?** In the beginning, everything was new, and we were pioneers making discoveries every day. Things are more difficult now because the procedures are more sophisticated, and new techniques require more development time. There is tougher competition, and, probably, fewer people devote

their life to research.

In the early years, we simply needed to be good at imaging and good in catheter work. We did not have, in most cases, the full responsibility of the patients. Now, we must be more clinically oriented, able to fully take care of our patients after the procedures, and to establish a direct referral, rather than being referred by other physicians. Obviously, a physician will only send you a patient for a complicated therapeutic procedure when he does not know how to do it himself.

In this process of development and growth, our field has expanded to such an extent that our specialty has completely changed; the training now requires a different background and expertise—both technical and clinical—in imaging. Our catheter skills alone are not enough to guarantee the survival of our specialty. Therefore, the most important factors for keeping interventional radiology alive are research, hard work, and good outcomes. We must maintain our ability to analyze images better than other specialties because our interventional decisions, in fact, derive from our image analysis. It is also politically important that interventional radiologists do not separate from the strong mother society because there are too few interventional radiologists to hold much ground as a separate entity.

**What advice would you give to a radiologist planning the next 10 years of his or her career?** I would encourage young fellows in training to expand their clinical knowledge by joining, for example, a training program in vascular surgery for at least 1 year, to enable them to reach a higher level of working performance.

To advance as an interventional radiologist, one should learn how to talk and deal with the patients, to take care of them with the best clinical and technical expertise, and to personally follow up with the patient after the procedure. I would advise young radiologists to not let the other doctors take their cases, but to care for the patients to the full extent, even though it requires a lot of work and a strong education in the patient's management.

I try to make my patients aware that I am fully responsible for everything and that I am their doctor. We should become primarily “doctors” and should be considered as such and not as “technicians” only. The best compliment for me has always been to be considered as a “doctor.” Recently, a gastroenterologist came to me seeking suggestion for the treatment of her mother and she said, “I am asking you not because you are a radiologist, but because you are a doctor.”

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To reiterate a statement made 30 years ago by Charles Dotter, MD, I would like to remind younger interventional radiologists not to trust their continued success based on technical skills alone because colleagues from other specialties can learn those skills too and can then perform the same procedures on their own patients.

I know an American vascular surgeon who, when applying for a surgical position, included in his CV his vast experience in performing chemoembolizations, thermoablations, biliary drainages, and stentings. This vascular surgeon, like many others in his field, not only does vascular surgery, but also has developed the skills to perform interventional radiology procedures. Interventional radiologists must not cede our patients to this type of physician, but rather demonstrate our expertise so the patient seeks us for the best treatment.

**What is the best approach when treating a patient?** The best scenario would be a group of surgeons, interventional radiologists, and medical doctors under one roof, as partners, sharing the same responsibilities for the patients and deciding all therapeutic strategies as a common and not a single-handed decision. It makes sense, but it is very difficult to realize.

For the interventional radiologist working alone or in a group approach, I believe that specialization in one field of the various interventional branches is more advantageous because our increased knowledge will allow us to offer the best care to the patients. To be good in all the aspects of interventional radiology is very difficult, because you do not have the possibility to acquire the clinical background for every disease.

**What technological advances have had the most significant impact on the field of interventional radiology?** Among the most important technological developments are new imaging modalities with functional and molecular imaging; stents, microcatheters, and guidewires for the treatment of arterial stenoses and aneurysms; and tumor ablation and tumor embolization with microparticles that carry a specific treatment directly into the tumors.

A theoretical advantage of interventional radiologists working outside the US is their access to those technological advances that are not yet FDA-approved in the US. The physicians in the US, for example, must use only FDA-approved stents, which, in some cases, are less adequate as compared with other stents available in the European market.

**How do you see the practice of radiology developing?** I do not see a great future for interventional radiology alone 10 to 15 years from now unless substantial changes in training, a more clinically oriented development, and an integration with other specialties occur. Oncologic interventional therapies can expand only if you integrate them with radiation therapy, receptor-mediated therapy, and nuclear medicine.

James M. Provenzale, MD, stated, "As never before, we radiologists need to link up with individuals of other fields who can provide the expertise needed to shape our own future."<sup>1</sup> ■

1. Provenzale JM. Imagining imaging: Radiology practice in 2050. *Am J Roentgenol*. 2006;187:1399-1400.

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