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The outgoing SIR president discusses his efforts for a primary certificate in IR, boosting the identity of the specialty, and the evolving role of IR in the treatment of PAD.

An application was recently submitted to the American Board of Medical Specialties (ABMS) for a primary certificate in interventional radiology (IR). Why is this distinction important, and how would it affect the specialty?

The application for the primary certificate in IR is intended to provide an additional pathway (not replace current training) for interested medical students to enter this specialty. Currently, the path to IR always requires full training in diagnostic radiology. There are three forces at play here: the continuing shift in IR toward treatment rather than diagnosis, the emergence of a subset of full-time IR practitioners, and the ever-increasing importance of periprocedural patient care for all of IR. By periprocedural care, I mean the evaluation of patients in an IR office or clinic setting before a procedure, the management of IR inpatients, and focused outpatient postprocedural care and follow-up.

There have actually been two prior alternative training pathways developed over the last decade that emphasize periprocedural patient care, the most successful of which has been the Diagnostic and Interventional Radiology Enhanced Clinical Training and Certification (DIRECT) pathway. The DIRECT pathway allows someone with 2 years of training in another specialty, such as surgery, to transfer into a combined diagnostic radiology residency and IR fellowship with an overall training time that is reduced by 1 year (details can be found on the American Board of Radiology [ABR] and the Society of Interventional Radiology [SIR] Web sites).

The primary certificate in IR is simply meant to allow medical students who know that they want to perform image-guided procedures and provide periprocedural care for patients—but do not feel the need to be board certified in diagnostic radiology—to enter the specialty directly from medical school. The graduates of these programs will be able to practice only full-time IR, as their imaging training, although very robust, will not be equal to that of a diagnostic radiologist. For this reason, DIRECT and the traditional training pathways will continue to be supported with vigor by the ABR and SIR, as many IRs will continue to combine diagnostic and interventional practice. More precisely, even with a primary certificate in IR, the ABR will continue to offer an IR subspecialty certificate (commonly referred to as the "CAQ") for graduates of traditional and DIRECT training programs for the foreseeable future.

Primary certificates are offered by an ABMS-recognized board when there is a substantially unique body of knowledge and skills related to that specialty. The ABR has carefully assessed the current and future state of IR and decided that a primary certificate in IR is warranted. However, in order for the primary certificate in IR to be offered by the ABR, all member boards of the ABMS must be in agreement, such as when the ABR supported the primary certificate in vascular surgery. Our proposal is still in process with the ABMS.

What were some of your objectives for the SIR while serving as its president, and how did you go about achieving those goals?

The SIR is a great organization with great staff and volunteer physicians, so my over-arching objective was not to muck it up. The SIR presidency is the culmination of 3 years of service on the operations committee, which is composed of the SIR treasurer, secretary, president-elect, president, and SIR staff. We meet by phone at least biweekly, but often communicate daily. As such, there is tremendous continuity in leadership, and similar continuity in goals from year to year. My personal interests were the primary certificate in IR; the development of patient-focused service lines within IR, as well as the promotion of IR in its entirety as a core service line in medicine; the continued emphasis on periprocedural patient care within the specialty; and the development of an international strategic plan for the specialty. In addition, we have been very focused

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on the economics of IR procedures and the increasing pressures on reimbursement. All of this required the support and effort of my colleagues this year, Brian Stainken (president-elect), Jim Benenati (secretary), Howard Chrisman (treasurer), Tim Murphy (incoming secretary), Scott Goodwin (incoming treasurer), as well as the fantastic SIR staff lead by Pete Lauer.

What can you tell us about the SIR's Discovery Campaign?

The Discovery Campaign is intended to allow increased investments in IR research by the SIR Foundation (SIRF). Research is essential to the future of this specialty. The SIRF has been very successful in leveraging a relatively modest funding budget into substantial research returns. There are currently three prospective, multicenter National Institutes of Health clinical trials on IR procedures that were awarded to investigators who received early support from the SIRF. The Discovery Campaign will ultimately result in more and higher-quality research in IR.

What are some of the approaches that the SIR is advocating for "boosting the identity of IR"?

As in any area of human activity, branding is important. Although IR has the deepest and richest history in image-guided interventions, it has been relatively invisible to patients and many physicians until recently. At one time, a lot of effort was expended on trying to find a new name for our specialty, but of course it was impossible to find one that pleased everybody. It turns out that *IR* is becoming a generally recognizable acronym in medicine, and that *interventional radiology* works as a name provided that we define it properly. We are getting the message about IR out through media, direct interactions with patients, relationships with other professional societies, and collaboration with patient advocacy groups.

It has been reported that the SIR 2009 34th Annual Scientific Meeting had its highest attendance on record. What do you think were contributing factors to the meeting's success?

The meeting was a success in all ways, from attendance to corporate support. I think this was due to several factors, including renewed engagement, optimism and enthusiasm among IRs, the continual appearance of exciting new IR procedures, the extensive educational opportunities provided by Matt Johnson and the Annual Meeting Committee, and the strong support of industry. One of our bigger success stories has been the steady increase in fellows, residents, and medical students at the meeting—almost 200 in all. Also, as someone who lives in a northern climate, I'm sure that being in San Diego in March helped as well.

In what ways did the SIR make this year's annual meeting more eco-friendly? Can attendees expect to see a green initiative in years to come?

The SIR is a socially responsible organization and will continue to look for ways to make the meeting and the daily operations of the society as green as possible in the future. This year, all of the meeting materials from the society were made from recycled or recyclable materials, right down to the pen in the meeting bag. We also replaced disposable water bottles during break times with reusable bottles, courtesy of the Discovery Campaign, and supplied water coolers in all of our meeting rooms and public spaces. Meeting materials were distributed electronically whenever possible to decrease consumption of paper products. At the end of the meeting, extra bags, water bottles, pens, and notepads were donated to social causes in San Diego.

How has the role of the IR specialty in treating peripheral arterial disease (PAD) changed in the past 5 to 10 years? What do you anticipate we will see over the next 5 years?

There is no doubt that our role has changed dramatically over the last decade. Although the statistics show that we are doing more PAD interventions overall as a specialty than 10 years ago, our proportional share nationwide has decreased to about one-third, and in some centers to almost nil. We have been late to the table in terms of developing clinics for patient evaluation, providing postprocedural care, and cultivating referrals. Charles Dotter, MD, urged us to do this more than 40 years ago, shortly after developing angioplasty. A handful of IRs, such as Barry Katzen and Bob White, were early adopters, but it took the enthusiasm of other specialties for performing the procedures that we had developed to shake the majority of IRs into action.

Now, it is unusual for an IR not to provide some form of periprocedural consultation, evaluation, and postprocedural care. This is simply good medicine. The trainees today demand clinic experience and training, acquisition of skills in admitting and managing patients after procedures, and participation in postprocedural outpatient follow-up. Many are intensely interested in PAD and intend to focus their practice in this area. The SIR has recognized the continued importance of PAD in this specialty and made it one of the key patient-based service lines, provided educational courses for practicing IRs, and reinvigorated fellowship training in this area. So, in short, we are here to stay in PAD, and we are willing to do what is required to participate in the care of these patients. ■