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# Time for IR to Change the Paradigm of Failure

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I wholeheartedly agree with the sentiments expressed in the recent article by Adams and Kenny [1]. The reasons why interventional radiology (IR) should pursue independent specialty status are eloquently presented and argued and will hopefully broker debate within the IR community in Europe and further afield. Although the editorial by Adams and Kenny is based on the experience in the UK, it resonates with the status of IR in other European countries in that no European country has full IR independent specialty status. Unlike the structured training in the UK encompassing 3 years of diagnostic radiology training followed by 2–3 years of funded IR training, in many European countries access to IR training is haphazard, poorly defined and interested parties often have to seek out a mentor who will hopefully allow them to develop the skills necessary to practice some of the IR curriculum. Moreover, many countries do not have structured 1- or 2-year training programs in IR and access to IR training is piecemeal and exposure can be very varied depending on the training institution.

In a recent joint study by the European Society of Radiology (ESR) and the Cardiovascular and Interventional Radiological Society of Europe (CIRSE), a questionnaire was sent to 1180 European heads of departments with a disappointing 8.3% response rate [2].

The main results from the study were that: Bed availability for pre- and post-procedure IR care was poor at 30.9% and run by IR in just over half of hospitals; patients referred for IR procedures are admitted under IR in a third; and 24/7 IR on-call rotas were available in 60.9% of responding institutions. The ESR/CIRSE paper also alluded to the fact that there is a shortage of interventional radiologists in Europe. Unfortunately, the results of the ESR/CRISE study are no surprise to IRs working in Europe and very similar to the results of a survey sent to 1800 CIRSE members in 2008 (response rate 34%) [3]. I am convinced that similar surveys if performed in 10 years' time will produce similar or more depressing results unless action is taken.

The answer to the dilemma that has been plaguing IR over the last 20 years is self-evident, we need change and we need it urgently. We are not competing on an equal basis with other specialties for the pool of medical students and junior doctors interested in a hand on specialty like IR, which leads to a dearth of trained IRs to staff our hospitals appropriately and provide the elective and emergency care needed for patients, particularly in non-academic centers. I believe independent specialty status is the best method to achieve what patients, IRs and healthcare authorities need: a better defined IR training pathway tailored to provide the skills, competencies and knowledge to practice safely; safer and more equitable patient access to elective and emergency IR care; improved workforce planning into the future and more cost effective healthcare resource utilization. In the words of Barack Obama, "Change will not come if we wait for some other person or some other time. We are the ones we've been waiting for. We are the change that we seek."

Let's not wait for another 10 years to act. It is time to take the courageous path and pursue full independent specialty status now.

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