I work in a DGH and do some IR. How does the new status affect my practice?

This will not alter any current setup. DRs who do some IR work will continue to do so as usual, indeed it is important that this does continue. The proposed arrangement will take 5-10 years to have a significant effect in any case. The expectation is that IR specialists will offer further resilience and support for people doing more "core" work (such as biopsy and drainage) along with expansion of clinical and interventional work.

IRs will continue to contribute to relevant aspects of DR. The intended increase in IR specialists will guarantee the excellent work done by the present generation of radiologists with the intention of safeguarding against the risk of service collapse.

Am I still allowed to do IR procedures even if I do not want to label myself as an IR?

This activity is very important and any DRs, who is competent, and wishes to continue to provide IR activity will be supported by the IR community regardless of the speciality status.

I do a lot of diagnostic radiology beside my IR practice. Does the new speciality prevent me from doing DR?

Absolutely not. Diagnostic skills are central to IR and will continue to be an integral part of the training and practice of IRs.

We work within the radiology department and we have good relations with our diagnostic colleagues. How can this relation be maintained?

The natural place of IR is within the clinical radiology department which is reflected by the intention that the specialty of IR will remain a part of the RCR. As the speciality develops, admin, governance & safety and an effective tariff/revenue stream will develop in a parallel fashion. IRs working within radiology will bring income, visibility and stability which will be of mutual benefit to all members. This endeavour should be seen as an opportunity to expand the role and influence of radiology in patient care at all levels.

I am a fellow of the RCR. In which faculty will I be sitting?

You can be in any faculty, and the faculties will be within the same Royal College. Naturally, if you are doing IR procedures you will need to be governed by the guidelines and quality care indicators set out by the IR faculty.

I work in a DGH and do some IR procedures as well as diagnostic radiology. What benefits will this new status bring to me personally?

It is intended that there will be several benefits. This will include; enhanced recruitment and better workforce planning should eventually improve staffing and make on-call rotas less arduous and more resilient. It also allows clearer recognition of the day to day interventional activities currently performed by radiologists with an IR interest.

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I have been practicing DR and enjoying doing IR procedures for a good number of years. Why do not we keep the status quo?

In view of growing healthcare cost pressure, expanding services and fierce competition from other specialities, the current status of IR limits the future. With the rapidly developing field of AI and the natural continuously changing landscape, we are at risk of a situation where we struggle to recruit to radiology in general, and IR in particular, at least in part because of uncertainty and lack of confidence in the future. It is also important for patients to have visibility of, and be able to, access the innovative techniques IRs perform and allow direct referrals from primary care, in a more cost-effective model.
Also, the creation of IR speciality under the umbrella of RCR will add strength to the Royal College of Radiologists, as well as an additional dimension.

What benefits will the suggested speciality bring to our practice in a DGH?

It will enhance recruitment and give more visibility to IR as a career. At the DGH level this expansion will facilitate regional networks for support and emergency rotas, IR organisation and governance, and paves the way for further expansion of current services to improve patient safety and care.

I am concerned that the new speciality will increase the friction with other clinical specialities.

There is inevitably some friction in the majority of workplaces. Creating a stronger speciality will actually make the relationship with other colleagues more balanced with IR being able to provide full clinical care. It will help to foster mutual respect and collaboration, based on this more equal profile.

What are the economic benefits of this model?

A fully recognised IR speciality is the way to allow fair and appropriate tariffs and remuneration of services that we offer. The number, variety and level of complexity of IR procedures are ever expanding. The current system is impeding a viable future, at least from the economic point of view, unless IR as a recognised speciality takes clinical, administrative, and educational leadership. An example of the significant changes can be seen in the United States where IR became a speciality recently. Recruitment and retention have massively increased to the point they are the most sort after speciality.

Why is it not possible to provide an effective clinical service under the current model of practice in IR?

In order to provide a safe and effective service, an interventional radiologist has to undertake the necessary clinical work outside the procedure room, including ward rounds and outpatient clinics. As there is an acute shortage of radiologists, both diagnostic and interventional, most clinical directors find it difficult to justify allowing interventional radiologists time to run outpatient clinics rather than report diagnostic investigations.
Performing such procedures without the skillset required to offer peri-procedure care for patients is becoming increasingly difficult to sustain, particularly given the guidance from the GMC regarding consent and good clinical practice.

I work in a large teaching centre and comfortable with the current status quo. What does the speciality status bring to me?

The IR speciality status brings benefits to patients, individual IRs, DRs and healthcare system;

- Make IR much more visible
- Better workforce planning and strengthening the RCR.
- Give us a better understanding of how many IRs there are and make a stronger argument for greater training numbers for IR
- Have dedicated training numbers for IR
- Make IR more attractive and allow us to select appropriate trainees (IR now number 1 specialty in the US following change to separate specialty 2 years ago)
- Improve training by developing programs and curriculums relevant to IR
- Support and enhance IR focused research
- Allow IRs to take primary responsibility for patient care including treatment and follow up
- Create more focussed governance structures for IR
- Ultimately improve patient safety and quality of care