MEDICAL IMAGING—VIEWPOINT

The 'Sic Vos non Vobis' of Interventional Radiology – Rebranding and modernising the Interventional Specialities of Radiology in Australia and New Zealand

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Point of view

Sic Vos Non Vobis ('For You, But Not Yours') were the words Vergil wrote on Emperor Augustus' palace doorpost, when Bathyllus, another poet, had plagiarised his work lavishing praise on emperor Augustus.[1] In his famous retribution, he quipped the bees do not produce the honey for themselves, but for others. But maybe it is time for a change?

Interventional radiology (IR) and interventional neuroradiology (INR) have a recognition and branding problem. There is confusion about their identity not only amongst the public but also amongst our medical and surgical colleagues.[2,3] Even amongst radiologists, knowledge of the interventional specialties can be limited. Often, it is not realised that not all interventional radiologists provide the same service. These challenges have implications at many levels: future trainees cannot be inspired without appropriate knowledge of the specialties; challenges exist with accreditation and training; and advocacy of our profession for patients will ultimately suffer.[4]

The purpose of this opinion piece is to stimulate a discussion and reach a consensus on how we view ourselves as clinicians. To modernise the radiological specialities of IR and INR, a unified approach is necessary, without which our ability to influence the perception of others to our profession is limited.

The term 'radiology' resonates with the public and medical fraternity primarily as a diagnostic specialty, recognised as X-rays, ultrasound, CT and MRI – essentially imaging modalities. The term 'interventional radiology' (or other variations) is insufficient for public recognition of what we truly do as interventional radiologists (IRs) and interventional neuroradiologists (INRs). This is particularly important as we transition from being consultants for other doctors to practice, like any other clinician, as consultants to our patients, similar to how Radiation Oncologists practice in the Royal Australian and New Zealand College of Radiologists (RANZCR).

Interventional radiology was born more than five decades ago when the first therapeutic endovascular procedures were performed by Charles Dotter.[5] Ever since, radiologists have been providing minimally invasive image-guided procedures for patients referred by other specialties, performing procedures such as corticosteroid injections and percutaneous biopsies. More subspecialised radiologists might provide direct clinical care to patients and perform advanced forms of treatment such as endovascular thrombectomy for acute ischaemic stroke, intracranial aneurysm treatment, prostatic artery embolisation for benign prostatic hypertrophy or ablation for bone metastases.

A multidisciplinary approach where radiologists work intimately and collaboratively with their referrers is ideal for patient management. However, with little scope for self-referral and patient ownership for radiology, other specialties have increasingly offered minimally invasive image-guided therapies independent of radiologist input. Competing patient interests have added to turf battles with other specialties. Unfortunately, the lack of readily identifiable interventional specialty branding has meant that non-radiologist providers may be chosen by patients to receive minimally invasive treatment options.

Surgeons have a branding that is well recognised. The Royal Australasian College of Surgeons has different surgical divisions, with each division providing a board for training in that subspecialty: including neurosurgery, orthopaedic, cardiothoracic, otolaryngology head and neck, paediatric, plastic and vascular surgery.[6] Each subspecialty is a separate field of specialty practice under the umbrella of the speciality of Surgery, recognised by the public, the Medical Board of Australia, Australian Health Practitioner Regulation Agency, Medical Council of New Zealand, hospital administrators and health networks. Until IR and INR are recognised as fields of speciality practice, they will not fit into the systems and frameworks of the above bodies, thus remaining invisible to health bureaucrats that plan health services and networks.

Renaming the specialty has been suggested. Terms like 'image-guided surgery', 'endovascular surgery' and 'minimally invasive surgery' that have been used represent the specialties of surgery and radiology at their intersection.[7] The Society of Interventional Radiology defines IR as 'minimally invasive, image-guided treatment of medical conditions that once required open surgery' by 'harnessing the power of advanced imaging' thus resulting in reduced length of hospital stays, reduced complications and saving lives.[8] The Cardiovascular and Interventional Radiological Society of Europe omits the term 'surgery', defining IR as a 'radiological subdiscipline providing minimally invasive treatments under image guidance'.[9] The term 'surgery' lends clear public recognition to the specialist in their role as a clinician and proceduralist and may be easier for public to relate to what IR or INR do in daily practice. However, distinct from surgery, where a surgeon incises, dissects and excises tissue, IR and INR are radiological specialties. Overall, there seems to be acceptance of IR and INR despite the relatively poor recognition of the names.

We must do more towards public recognition. Formal recognition of the existing interventional specialties of IR and INR as Radiology fields of specialty practice in Australia can provide a simple yet sensible framework to promote our profession while remaining united and provide a stronger base for developing and recognising future interventional specialties such as Interventional Oncology, Pain and Musculoskeletal IR, Paediatric IR. This approach is already adopted in Europe.[10] Interventional Radiology and Neuroradiology or Interventional Neuroradiology are officially recognised as a specialty or Radiology subspecialty in the United States, Canada and United Kingdom (Table 1).

It will allow us not only to help the public and medical fraternity understand what image-guided treatments IR and INR can offer but also provide an opportunity to show how these have developed and evolved into mature clinical specialities. Like surgeons, specialising in one or more interventional specialties will allow radiologists to better understand the conditions they treat. Greater opportunity for closer engagement with the patient and effective collaboration with other clinical specialists will ultimately lead to improved patient care. As techniques and procedures, along with conditions managed by radiologists grow within the interventional specialties, it is desirable that we position ourselves as independent clinical providers. This will encourage earlier utilisation of effective interventional treatments in patient care, rather than as an after-thought when surgical or medical treatment options have been exhausted.

Technology is advancing at a rapid pace, with artificial intelligence and robotic technology already in use.[11] The practice of IR and INR as distinct clinical specialties is necessary with robust selection, training and accreditation pathways. Training and accreditation at a specialty college level is paramount to accredit radiologists who undertake training to become an IR or INR, especially since workflow pathways for the interventional specialties are different to diagnostic radiology. Acknowledging this difference allows IR and INR to function as clinical specialties with implications for workplace resourcing and key performance indicators. This will enable provisions for trainee positions, junior medical staff and clinical nurse managers, along with admitting privileges, wards, ward rounds and outpatient clinics that accept referrals from all medical practitioners to be incorporated into practice. INR has made inroads in some jurisdictions by setting up such practice units.[12] This raises the visibility of the specialty and improves patient care since clinical decisions are made by INR directly rather than through the prism of another specialty.

The RANZCR announced at the Melbourne ASM in September 2021 that it will seek recognition of Interventional Radiology and Interventional Neuroradiology as two new fields of speciality practice alongside the current fields (Diagnostic Radiology and Nuclear Medicine), under the umbrella of the speciality of Clinical

Table 1. Examples of some countries with Interventional Radiology and Interventional Neuroradiology specialty or subspecialty recognition

Country	1st level	2nd level	3rd level
Australia (Medical Board of Australia and Australian Health Practitioner Regulation Agency)	**Specialty** Radiology	**Field of Specialty Practice** Diagnostic Ultrasound Diagnostic Radiology Nuclear Medicine *Interventional Radiology*† *Interventional Neuroradiology*†	
New Zealand (Medical Council of New Zealand)	**Vocational Scope** Diagnostic and Interventional Radiology		
United States (American Board of Medical Specialties)	**Specialty** Diagnostic Radiology	**Subspecialty** Hospice and Palliative Medicine **Neuroradiology** Pain Medicine Paediatric Radiology	
	Interventional Radiology and Diagnostic Radiology	Hospice and Palliative Medicine **Neuroradiology** Pain Medicine Paediatric Radiology	
Canada (The Royal College of Physicians and Surgeons of Canada)	**Specialty** Diagnostic Radiology	**Subspecialty** **Neuroradiology (includes Interventional Neuroradiology)** Paediatric Radiology **Interventional Radiology**	
United Kingdom (General Medical Council)	**Specialty** Clinical Radiology	**Subspecialty** – **Interventional Radiology**	**Further divisions** – **General Interventional Radiology** **Interventional Neuroradiology**

†The proposal for formal recognition of Interventional Radiology and Interventional Neuroradiology as Radiology fields of specialty practice in Australia.

Radiology.[13] This aligns with the surgical fields of speciality practice and is a timely and vital step. If successful, it will provide transparency of IR and INR to the public, government, hospital administration and the medical fraternity.

Formal recognition of IR and INR will mean that the interventional specialities of radiology will fit into the existing systems and framework of health care. This will allow us to play key roles in health service planning and delivery as well as advocating for funding and resources to meet the needs of our patients. A clear identity and increased visibility will reduce confusion from patients and potential referrers. We will be able to better educate consumer groups, our medical colleagues and health administrators. Improved knowledge about who we are and what we can specifically offer our patients will improve patient access (and choice) to a wider range of minimally invasive treatment solutions. Many of these treatments offer lower risk and faster recovery times, resulting in beneficial health outcomes. Formal recognition will facilitate regulated training and accreditation of Australian and New Zealand centres, inspire future trainees and increase confidence in our ability to provide clinical care, from the start of the patient's journey.

The decisions on governance, credentialing and funding models for care in Australia and New Zealand are made at levels beyond the individual practitioner. Government and hospital administrators are entrusted with the role of deciding what is best for citizens and patients. For interventional treatments to be included as cost effective once the appropriate decisions have been made, IR and INR must exist as well-known entities.[14] We need the evidence behind effectiveness of our treatments to be robust, and the support behind practitioners unwavering. We must consistently engage with administrators in decision-making processes. Unlike other specialties, IRs and INRs have not been able to access similar remuneration for procedures provided in an outpatient setting from private health funds. Some procedures performed by radiologists in outpatient settings attract higher remuneration when performed by other specialties in private hospitals. Acknowledging these barriers and quirks in funding models for health care is important. Our profession is at the critical juncture, and it is vital for all radiologists to work together and advocate for improved delivery of interventional services.

The RANZCR, through the Professional Practice and Interventional Radiology Committees, recently set up a IR and INR training pathway working group.[15] Promoting IR and INR clinical specialty training pathways does not reduce the importance of non-IR/INR trained radiologists performing procedures; rather it ensures adequate opportunities are available for appropriate levels of training, thus strengthening the specialty's importance. This has bearing also on branding IRs and INRs as the specialists with the best training to offer image-guided minimally invasive procedures. All radiologists who desire to perform procedures will have their status and working conditions improved by these reforms.

Although some may find the need for marketing and rebranding of IR and INR as trivial, the perception of the specialities amongst the general public, health administrators, our medical and surgical colleagues, and ourselves has significant future implications. Recognition of the interventional specialities within Clinical Radiology will broaden the horizons of the specialty and influence the perception we would like the public and our colleagues to have of us. With increased awareness and improved access to a wider range of minimally invasive treatment options, ultimately patients will be the main beneficiaries.

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