“What is Best in Life, Conan?”

“To crush your enemies, see them driven before you, and to hear the lamentation of their women.”

—Gov. Arnold Schwarzenegger as Conan the Barbarian

As an interventional radiologist, I’ve often asked myself, what is it that I really like about the specialty? I think it is a question that we all ask ourselves from time to time. Occasionally, when I am tired and fed up, I ask, “Why am I doing this to myself?” or “Isn’t there an easier way?” These are some of life’s basic questions that each of us faces from time to time and ones we must answer for ourselves.

As a group, interventional radiologists are a motley crew (without the umlaut) with many different personalities, backgrounds, and interests. These disparities are further magnified by variability in our patient populations and practices. At times, I am amazed we can put aside our differences and ever come together as a coherent, unified entity. I think the discrepancies in large part reflect the diversity of the field and are also intimately tied to the appeal of the specialty itself. For me, I love the diversity of the specialty. Maybe that reflects my short attention span or my tendency to get bored with anything I study for too long. Perhaps it is my schizophrenic background—I’m part Japanese, Irish, French, English, and German. My wife is Irish, German, Scots, English, French, and Iraqi (I’m not even sure what our kids are). I was a political science and natural science (“prelaw, premed, what’s the difference?”) double major in college, and I currently cover both abdominal imaging and interventional radiology in a pretty hectic academic practice. I’ve always liked variety and balance—maybe that makes me a jack-of-all-trades and a master of none. I don’t know.

This past weekend on call, we were pretty busy. My fellow and I did an islet cell transplant, arterial thrombolysis, abscess drainage, gastroduodenal artery embolization in a patient with upper gastrointestinal bleeding, and an inferior vena cava filter. This was

fun—or at least as fun as something can be on-call. One of the strengths of our hospital from a training perspective is that we continue to treat patients with a wide variety of disorders in interventional radiology. Relative to many places, we continue to have a reasonable relationship with most referring physicians and specialties, even in this difficult era of turf battles. Not that it is always smooth or easy—far from it. We have our disagreements but we manage to solve most of them without bloodshed.

I recently read an interesting debate between Drs. Fritz Angle and Riad Salem about subspecialization in our field. Among other things, Fritz noted that subspecialization creates logistical coverage nightmares and the one thing that unifies all of us is our skill set. Riad argued that subspecialization is needed to advance the field and in larger practices is a practical strategy. I was left thinking that subspecialization is inevitable to some degree and has always occurred in many practices. Whether or not it is good for the field as a whole is unclear to me. We have always had and will continue to have people who choose to pursue one focused area of our field. The successful people who fall into this category typically lead clinical development and research in that area and often become the leaders of the field. That being said, subspecialization is not good for me personally. Why not? It is simply not what I want to do. One of my former colleagues recently commented on my practice, “No offense, but I’d go crazy if I had to do dialysis interventions all day long.” I had to agree with him—I don’t think he had a clue what I actually do in my current practice but I was flattered that he was familiar with some of the papers I’d authored or lectures I’d given in the field of dialysis. I think he assumed it is all that I do. Quite the contrary, I would also go crazy if I had to do nothing but dialysis interventions. I would say the same about arterial work, or abscess drainage, or transjugular intrahepatic portosystemic shunts (TIPS). I don’t like *any* one thing that much.

Everyone tends to apply their own relative value system to interventional radiology. For example, right

¹Section of Vascular and Interventional Radiology, University of Chicago Hospitals, Chicago, Illinois.

Address for correspondence and reprint requests: Brian Funaki, M.D., Section of Vascular and Interventional Radiology, University of Chicago Hospitals, 5840 S. Maryland Avenue, MC 2026, Chicago, IL 60637.

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now, arterial interventions are among the desirable procedures in our field. So desirable, in fact, that other specialties now compete with us for them. One side effect of this turf battle has been the movement to become "clinical" specialists. I think this is clearly a good thing and long overdue. I like arterial work too. Among my group, I probably do the majority of it. Then again, I also like nonvascular work. I see no reason to denigrate the latter just because many of these procedures are not faced with the same degree of contentiousness or require the same degree of "clinical commitment." I get irritated when I hear someone say, "You had better develop your clinical practice or (God forbid) you will be reduced to placing gastrostomy tubes, performing central venous access, and other less desirable pursuits." Well, why don't we all just kill ourselves now and avoid the unbearable agony? Am I the only one who likes this stuff? Possibly, but I doubt it. Moreover, would an earlier transition to clinical practices have prevented incursion of turf by other specialties? Personally, I doubt it. When any specialty that controls a subset of patients has a desire to treat these patients themselves for

monetary gain, lack of other work, megalomania, or other reasons, the best interest of the patient are often pushed aside.

The current reality of vascular and interventional radiology is that some of us have entirely clinical practices, some more traditional ones, and others, like myself, have something in between. In my "hybrid" practice, we see and admit some of our patients (e.g., arterial interventions and fibroid embolization) but also still function as a "gun for hire" (e.g., central access, biopsies) in other instances. And in some cases, we participate in care as part of a multidisciplinary team (e.g., interventional oncology, dialysis, TIPS, transplantation). Personally, I've always believed that this latter approach is best for patient care, although realistically, a multidisciplinary team is a fragile unit and in my experience I have found that anything we do successfully will ultimately engender competition from others. It is a reality of medicine and one we will just have to get used to.

Brian Funaki, M.D.¹
Editor in Chief