Editorial

Are We IOs or IRs?

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For the next Radiological Society of North America (RSNA) meeting, I was asked to participate in a debate with Dan Brown, MD, on whether interventional oncology (IO) should be considered a separate subspecialty field. In particular, I think the debate is supposed to have somewhat of an “IO versus interventional radiology (IR)” theme. I know what my own feelings on the matter are and thought I would write them down here. Plus, it’ll give me a chance to get a baseline for my RSNA slides (which taskmaster Brian Funaki, MD, will be asking for no later than 6 months prior to the meeting), and I hope put to rest some of my angst regarding the debate (Dan Brown is significantly smarter than I am).

The field of IR is clearly changing. First we dropped the “cardiac” (at least from our society’s name), and then we dropped the “vascular.” Many IR divisions have been carved out, financially or otherwise, from their diagnostic departments. Additionally, our training paradigm is set to undergo a tremendous change, one that threatens to pull us even further away from our diagnostic brethren. Personally, I see IR headed in the direction of radiation oncology. By the end of my career, I suspect IR departments will exist as distinct entities from diagnostic radiology departments. So isn’t now a good time to finally drop the “radiology” as well as the other qualifiers from our name?

I find myself a bit of a poser on this one. I never really even did an official IR fellowship. My fellowship, completed at the Massachusetts General Hospital where the Radiology Department was/is organ based, was in “vascular radiology” (which is what it says on my diploma). Although I had 2 months of cross-training in other divisions, my fellowship was heavily vascular focused, including vascular diagnosis as well as interventions. However, even directly out of fellowship I don’t believe I had any problems translating that skill set to other organ systems in the body. But should I have been allowed to make that transition from vascular radiologist to interventional radiologist on my own? What’s in a name, anyway?

It’s difficult for me to understand the opposite side of the argument (I am pro-IR rather than IO, as it stands). Although

it’s true we do many cancer interventions, why would that permit us to call ourselves “oncologists”? My partners and I perform many other types of interventions, but we don’t consider ourselves “venous specialists,” “traumatologists,” “dialysis access specialists,” or “endovascular surgeons” (sorry—couldn’t help myself there). From a marketing and public perspective, I completely understand aligning with the other three pillars of oncologic interventions, but to me the argument ends there, and it’s a rather weak argument at that.

A specific argument I’d like to make is that calling oneself an “IO” severely limits the potential for growth outside of oncology. Wouldn’t a patient be confused if he or she were referred to an interventional oncologist for an angioplasty procedure, a percutaneous biliary drain for benign disease, or for a deep venous thrombosis lysis procedure during pregnancy? We’ve spent a lot of time developing techniques outside of oncology, and we gain significantly more in a branding sense by introducing oncology patients to their IR doctor than by introducing patients with benign disease to their IO doctor.

To my way of thinking, what separates all of us, IRs and IOs alike, from other specialties is our strong imaging background. It’s amazing what we radiologists take for granted. If you ever question that, try to train a clinician with a different background to do image-guided procedures. Frankly, it ain’t easy. And no matter what your background, if you call yourself an “IO” or an “IR,” you must have the knowledge of imaging to guide your decision-making process as well as your hands. Without it, to my way of thinking, we truly have no specialty. We are image-guided specialists above all else, and in 2013 “image-guided” still means “radiologist.”

There are other arguments to be made in the “IO versus IR” debate including the dedication to longitudinal practice, having multiple tools in one’s toolbox, and so on, but with Dr. Brown on the other side of the podium, I’m not about to show all of my cards. And I apologize in advance for what I’ll be doing to him this coming November.

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