Editorial

Confidence, in Relation to the Practice of Interventional Radiology

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Currently, I am sitting on a plane on the way to an SIR-sponsored meeting in Egypt. It is my first time in the Middle East, and I'm looking forward to both the experience of presenting at a conference in this part of the world and acting as a tourist. Both should be very rewarding and learning experiences.

Two other speakers are on the same flight, and I was cogitating on one of them. One, who asked to remain nameless, is a professor of radiology in the division of interventional radiology at a high-profile institution. While I knew that he has been at this institution for some time, and I have always associated him with that institution, I didn't realize until he told me today that he has been there his entire career. I was amazed that he had been there that long; I knew we were contemporaries, but I didn't realize that our careers were essentially of the same length.

One of the best aspects of traveling to speak at conferences is that the speakers all get to know one another; in some cases for me I get to know individuals first as co-presenters, then as acquaintances, then as friends. Two of my closest friends I got to know in this way. I have also gotten to know Dr. Nameless in the same way, and our friendship continues to develop. As I've gotten to know him through the lecture circuit, I am impressed by several things. First of all, he has a phenomenal sense of humor, and is quick with his wit. Second, he is an extremely positive person; although his fellows (and family) most likely get to see a different side of him, I have only really seen the glass-half-full side. Third, the man is brilliant, and not just in our scientific field. I have had several discussions with him when he has said something off the top of his head, and I'll admit that—because when I shoot off my mouth I'm usually full of crap—I will go home and look it up. Invariably, predictably, annoyingly, he is always correct. But finally the characteristic that I am most struck by with him is his sense of confidence. It isn't arrogance, but simply a confidence that is quiet but complete. Those of us who have seen this individual in action at conference panels get to

observe all of these characteristics in play—none more than his degree of self-confidence.

Thinking about this person got me to thinking about our field as a whole. We have always struggled as a field with self-confidence. That self-confidence is not just something that affects us as individuals, but also as a medical field. Concern over this reaches a level such that SIR leadership made it one of the pillars in their strategic plan from 2012. I am not sure from where this lack of confidence arises. Perhaps those of us who are older remember being made to feel badly from our other clinical colleagues when we would have a complication. Amazing how nowadays when these non-IRs have the exact same complication, it is considered simply a “known side-effect” of the treatment (and, ironically enough, a complication often treated by—you guessed it—IRs). Maybe because of this, we feel badly and apologetic every time a patient of ours has a complication, and in the worst example we pass that emotion on to our trainees. And the death spiral continues....

The other day I was sitting with one of my fellows, and we were discussing the fact that we had a pneumothorax arising from a lung biopsy. The patient had developed a broncho-pleural fistula and was in the hospital for several days. The fellow was bordering on inconsolable, made worse by the fact that the referring service was appalled that we could put a patient through such misery. When I reminded the fellow that because of the location of the lesion the only other option for the patient would probably have had a pneumonectomy at worst or a lobectomy at best, and by the way what would the recovery have been in that instance(?), I was disappointed that this realization didn't really change his mood all that much. Since the patient was ours primarily I gently mentioned that he should tell the referring and consulting service that they should go and do anatomically impossible actions on themselves and the horses they rode in on. I'm not sure he took heed of my advice, which I guess in the long run is best anyway.

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Or is it? Would standing up to those who continue to treat IR with less respect than we deserve be a bad thing? Shouldn't we, gently or not so gently, remind the surgeons when they come down that we are keeping score and by the way we save your butts far more frequently than you save ours? And for the nonprocedural cognitive specialties, perhaps we should remind them that they aren't even being taught to do thora- or paracenteses anymore, so please don't tell me how easy it should be given the CT scan ("Why can't

you just slide it through here? It's only 16-cm deep." IR reply #1: "Let me educate you on what a caput medusa looks like on CT scan, Doctor Smith." IR reply #2: "Dumbass. No."). What would be so terrible about that? Should we not let the rest of the medical world know that what we do is life-saving, minimally invasive, cheaper than the alternatives, and by the way the coolest aspect of medicine. Why not? What have we got to lose—other than our fear? And what do we have to gain, other than our self-confidence?