ORIGINAL ARTICLE

Interventional Radiology Residency: Steps to Implementation

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Abstract

Implementation of an interventional radiology (IR) residency program requires significant planning, as well as clear communication and consensus among departmental and institutional stakeholders. The goal of this short article is to highlight key decisions and steps that are needed to launch an IR residency, and to illustrate a possible timeline for implementation of the integrated and independent IR residency models.

Key Words: Interventional radiology residency, independent IR residency, integrated IR residency, early specialization in interventional radiology, ESIR, timeline to implementation of IR integrated and IR independent residency programs

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INTRODUCTION

Vascular and interventional radiology has been a subspecialty of diagnostic radiology (DR), requiring a single year of fellowship training to qualify for the subspecialty certificate. Recently, the American Board of Medical Specialties recognized interventional radiology (IR) as a unique primary specialty that requires a new paradigm of graduate medical education (GME). The ACGME has approved the program requirements for the IR residency and stipulated that the vascular and IR fellowship training path be phased out.

The first step in implementation of an IR residency is to understand the fundamental components of the 2 distinct IR residency pathways. The "integrated" IR residency is a 5-year program (after a clinical internship) that includes 3 years of DR and 2 years of IR. The IR residency is separate from the DR residency, but they are very closely aligned during the first 3 years. Implementation of an integrated IR residency requires the cooperation and resources of the radiology department and DR residency. The "independent" IR residency is a 2-year residency taking place after completion of both a clinical internship and a DR residency. The 2-year independent IR residency is separate from the DR residency. An institution may choose to implement the integrated model, the independent model, or both. Steps to implementation will vary depending on the choice.

ENGAGE KEY LEADERS

A key step in implementation is to choose an IR residency program director (PD). The current IR fellowship director will likely transition into the residency director role. The role of IR residency PD has the potential to be significantly more time consuming than that of fellowship PD, particularly for the integrated residency.

For implementation of an integrated residency, the IR residency PD and IR section chief must meet with their department chair and DR PD, to engage in open discussion of the imperative to implement an IR residency program. Because the first 3 years of integrated IR residency are identical to those of DR residency, it is recommended that the DR PD be invited to serve as associate PD of the IR integrated residency. If the DR PD does not wish to assume this role, his/her designee should be appointed.

For either the independent or integrated program, the IR leaders and chair should meet with the training institution's ACGME Designated Institutional Official (DIO), to discuss the American Board of Medical Specialties and ACGME decisions that have taken place, and to indicate the intention to apply for a new residency program. An important point for the DIO to understand

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is that without an IR residency, accredited IR training will be unavailable at the institution in the relatively near future. Open discussion with the DIO is critical for success, because the new residency program must be approved by the institutional GME committee before an application is submitted to the ACGME. In addition, the application is required to be submitted to the ACGME by the DIO, not by the residency PD.

ENGAGE OTHER IMPORTANT STAKEHOLDERS

The IR residency requires educational experiences that are new, including an intensive-care unit (ICU) rotation. The ICU experience is expected to take place in postgraduate year (PGY) 5 or PGY6 of the integrated program, or in PGY6 or PGY7 of the independent program. The IR PD must communicate with ICU director colleagues to determine what opportunities are available, and how residents can best fulfill that requirement.

Patient-care experiences are an integral part of the new residency paradigm, particularly in the final 2 years of training (PGY5-6 for integrated; PGY6-7 for independent). The IR residency requires IR patient-care experiences in the outpatient setting. Thus, a necessary step is to ensure that the department has the space and resources in place for an IR clinic. The IR division chief and/or PD must include discussion of this requirement in the early discussions with institutional leaders.

The IR residents must have inpatient experience with admitting and consult services. Faculty must have and use admitting privileges. These patient-care activities must be documented for ACGME. These requirements mean that programs must develop a system to track inpatient admissions and discharges, and consults.

The program requirements additionally allow for "IR-related" rotations. These rotations may take place within the radiology department or in other departments. For example, IR residents may participate with the body-imaging division in a procedure-dominant rotation; or they can rotate on vascular surgery, oncology, transplant surgery, or hepatology services, to gain clinical experience and perspective in patient-care areas that are closely tied to IR. Decisions regarding development of these "IR-related" experiences are in development and require consensus-building both within radiology and in an interdisciplinary fashion with other departments.

MEDICAL STUDENTS: KEY STAKEHOLDERS

Medical students are perhaps the most important stakeholders in the implementation of the integrated model of IR residency. The success of this model will depend upon the sustained interest of students. As with many other small specialties, no clerkships are required in IR. IR leaders must be proactive in developing ways, locally, to ensure that students in the third year of medical school are aware of IR and have opportunities to participate in IR divisions. One option is to work with the DR clerkship director to ensure that students on the rotation have exposure to IR, through conferences and/or clinical days. A second option is to develop and promote an IR elective. A third option is to mentor students through an IR "interest group." Finally, an IR faculty member who is knowledgeable about the new residency pathways must serve as a medical student advisor, along with the existing DR student advisor.

Nationally, programs are in place to bring the world of IR to medical students. Several institutions have developed well-attended IR symposia for students, and these have been received with great enthusiasm. The Society of Interventional Radiology has a strong medical student program at its annual scientific meeting, which has grown in size every year since its initiation in 2011; 206 students participated in 2015. The resident and fellow section of the society has a very robust website (rfs.sirweb.org), with a large amount of useful material for students, including case studies, lectures, information about the new residency, and practical tips on starting an IR interest group or daylong IR symposium.

PROGRAM APPLICATION STRATEGY

As clearly outlined in the accompanying article by LaBerge et al [1], the ACGME program requirements allow for 2 training paths: a 5-year integrated program, and a 2-year independent program. The application became available on the ACGME website on March 1, 2015. Each department can apply for either one or both residency models. Implementation of both residency models within one department will allow departments the most flexibility to recruit trainees over time. ACGME recommends that programs apply now for integrated programs and postpone applications for independent programs for one year. For departments which follow the two stage application process, a short form application will be available for the independent program accreditation process. Only one site visit will be required. The reason for postponing the independent residency accreditation process relates to the planned national launch date for independent IR residencies (see below). The independent model ensures that applicants who

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