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The IR Residency: Ideas and opportunities

The cohort of medical students entering IR is very different from those seeking well-established, mature residencies like general surgery or internal medicine. Young, aspiring IR trainees are actively involved and *want* to steer the field. A progressive and important aspect of IR that I've observed is how open the leaders are to the opinions of those who are early in their career and even in their training. As a result, trainees feel empowered to develop and propose ideas that may enhance our very own training experience.

Many trainees have hopes and dreams of what the IR Residency could be. "Clinical IR" is a pillar of the IR Residency that many of us have latched onto. We agree wholeheartedly that rounding on IR patients, attending outpatient clinic, seeing consults and contributing to multidisciplinary conferences is a necessity for the specialty to thrive.

We also recognize, however, that to be competent and confident in these settings, IR residents and fellows must ensure that their clinical medicine skills are robust. Many of us in the SIR Resident, Fellow and Student Section (RFS) see this as the greatest challenge to help address and solve. The IR Residency is new and ripe for augmentation; this is the perfect time and opportunity to implement a training model that will allow IR trainees to sustain their clinical skills well after they have finished intern year.

In the current training model, IR residents will have 1 ICU month in their PGY-4 or PGY-5 year. While this month will certainly be helpful, 3 years will have passed between the end of internship year and the ICU month. That is a long time to forget clinical medicine. Without continued exposure to clinical medicine in the R1–R3 years, that lone ICU month may not be enough to increase our clinical confidence and competence. Indeed, many of us fear that, despite our desire to practice clinical IR, we may not have the continued clinical exposure to feel confident doing so. The RFS may have a potential solution.

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To stem this atrophy of clinical skills in the R1–R3 years, several trainees have successfully incorporated ICU months or even regular ICU weekend call into their PGY 2–4 years. Even one weekend every other month (or one weekend every month for the more ambitious trainee) in the ICU can refresh clinical knowledge and skills. The ICU is the perfect setting to learn clinical medicine. The acuity of the patients demands attention to detail and forces the trainee to develop a clinical knowledge base that encompasses every organ system. If consistently exposed to the ICU setting throughout one's IR residency, we believe IR trainees will enter their PGY 4–6 years far more confident and comfortable in the clinical setting. There are also advantages for the IR department: a regular IR presence in the ICU can improve interdepartmental relationships, increase IR's visibility in the hospital, generate referrals and bolster lines of communication.

This is not a new paradigm in residencies. Surgical subspecialties have been taking this approach for years: emergency medicine residents cover the ICU, oral-maxillofacial surgery residents cover the trauma surgery service, orthopaedic surgery residents cover the general surgery service. The logistics of this model can be worked out through a discussion with the institution's critical care, internal medicine or surgery departments. Staying under duty hours is typically not an issue given that most radiology residents usually work well under the average 80 hours/week limit. Most critical to the implementation of the ICU call model is support from the trainee's radiology department.

Trainees who desire to take this approach need to accept that they will work more and give up what would have been free weekends. But this is the price to pay for staying clinically confident. We understand not all trainees may be as excited about this ICU call model. To ensure no trainee feels forced to work off-service, this model would have to be purely elective. But for those of us who are aggressively trying to maintain our hard-earned clinical skills from intern year, we hope the option is there.

As with anything new, this model will require troubleshooting and feedback. There will be inevitable bumps in the road and failed attempts at setting up such a model. Nevertheless, we believe this will be a step in the right direction towards clinical IR.

We hope the IR leadership and the residency programs around the country will assist in making this a reality and supporting us when the time comes.