The IR/DR Certificate and New IR Residency

AN INTERVIEW WITH JOHN A. KAUFMAN, MD, MS, FSIR, AND JEANNE LABERGE, MD, FSIR


In 2012, the American Board of Medical Specialties (ABMS) approved interventional radiology as a primary specialty in medicine. In 2013, the American Board of Radiology (ABR) announced that it would certify interventional radiology physicians in Interventional Radiology and Diagnostic Radiology, reflecting that the essential components of competency include both IR and DR. Later that year, the Accreditation Council for Graduate Medical Education (ACGME) approved the formation of a new residency training program in interventional radiology. Successful completion of this training program will qualify graduates to sit for the ABR IR/DR certificate exams.

In this interview, John A. Kaufman, MD, MS, FSIR, chair of the SIR Advisory Task Force to ACGME, and Jeanne LaBerge, MD, FSIR, member of the ACGME Radiology Residency Review Committee (RRC), discuss the IR/DR certificate and the IR residency program.

IRQ: Can you briefly restate why the Primary Certificate in Interventional Radiology and Diagnostic Radiology was pursued in the first place?

Kaufman: Training in IR has evolved steadily since the early 1990s, when fellowships were first accredited by ACGME. Then ABMS recognized vascular and interventional radiology as a subspecialty of DR. Although IR has much in common with DR, especially the necessity for competence in image interpretation, over time the complexity of procedures and the role of the interventional radiologist in nonprocedural patient care have increased so much that IR is now distinctly unique from DR and any other specialty. Approval of IR as a primary radiologic specialty by the other member boards of ABMS was based on the unique combination of training and skills in diagnostic imaging, image-guided procedures, and nonprocedural patient care embodied within IR. In the end, the new training paradigm is intended to ensure that interventional radiologists of the future are prepared to provide excellent care for patients undergoing image-guided procedures.

IRQ: What reaction have you had from the IR community since it was announced? Has the IR community helped shape that development?

Kaufman: A formal poll hasn't been conducted, but reaction in general has ranged from enthusiastic support to enthusiastic opposition. Since the detailed program requirements aren't yet finalized, though, today's opinions may change in the future. When SIR members were polled before the submission of the certificate to ABMS, roughly two-thirds were in favor of an IR-only certificate and even more in favor of a certificate that included competency in DR as well. It was a clear message, so the IR-only certificate was dropped.

Since approval of the certificate by ABMS, SIR has formed a task force comprised of SIR members and stakeholders from key partner organizations. Members of this group have presented in open forums at the June ABR Oral Examinations and at the fall meetings of the Association of University Radiologists (AUR), Association of Program Directors in Interventional Radiology (APDIR) and the Society of Chairs of Academic Radiology Departments (SCARD). We're currently developing Web content to provide a source of verified information and a place that members can post questions or opinions. The SIR task force will provide comments on the proposed training program requirements.

IRQ: How did the AUR, APDIR and SCARD presentations impact the evolution of the certificate?

DISCLAIMER: All information is accurate as of Nov. 24, 2013, but is subject to change until final approval is granted by ACGME.

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Kaufman: These forums let members of the ACGME committee charged with writing the program requirements learn the areas of concern, confusion and potential unintended consequences. As the writing process has been confidential, however, it's not possible to comment on the impact of these meetings until the program requirements have been released.

IRQ: How is the ACGME IR Residency being created? How long will it take?

LaBerge: The process involves many steps:

- Drafting program requirements and obtaining input and feedback from involved parties
- Setting up a procedure log mechanism and rules
- Developing program application forms and site visit templates
- Setting up an application processing and review mechanism within the Radiology RRC
- Getting approval of all these by the ACGME committee on requirements and board of directors

[See the sidebar for the full anticipated timeline.]

IRQ: That's clearly not an overnight process. Why are so many steps required?

LaBerge: The creation of a new residency program within ACGME is uncommon, so it considers the need for any new program application very carefully. Once it's approved, ACGME takes the time and effort needed to make sure it will be implemented wisely. As it fashions a program, ACGME considers input from all of the groups that may be affected by the change in training, working to meet the needs of both trainees and training institutions.

In the case of the new IR Residency, ACGME has asked SIR to form a task force composed of some of the key constituencies that will be affected: APDIR, APDR, SCARD, SIR and ACR. ACGME will rely on this task force for input and to communicate updates on the process to their constituencies.

IRQ: Have any other groups had to go through something similar?

LaBerge: The most recent new residencies at ACGME are the Emergency Medicine residency and the Vascular Surgery residency. The vascular surgery residency, which was approved in 2006, brought dramatic change in the training requirements.

IRQ: The program requirements are still in development, but how would you envision the basic structure of the residency program?

PGY	Rotations		
Year	DR	IR	ICU
1			
2	12	1	
3	12	1	
4	12	1	
5	2	10	1
6		13	
Totals	38	26	1

LaBerge: It won't be a stand-alone program, independent of the DR residency. A clinical internship is required. The first three years of training (PGY 2-4) is focused on diagnostic imaging and is identical to the DR resident schedule. The last two years are concentrated on IR training. A critical care rotation is required. Exposure to outpatient clinics and inpatient clinical consultation and hospital admissions is required. Upon completion of training, residents must have performed 1,000 IR procedures broadly covering the domain of IR. (See Table 1.)

IR Residency Timeline

1. *Program Requirements:* A Radiology RRC task force is currently drafting the program requirements.
    a. January 2014: First draft available for review and comment
    b. February 2014: Review and approval by Radiology RRC
    c. April 2014: Open for Public Comment (45 days)
    d. June 2014: Review by ACGME Committee on Requirements
    e. November 2014: Approval by ACGME Board of Directors
2. In addition to the Program Requirements, the RRC will be preparing procedure logs, application forms, site visit forms and Web site changes to accommodate the new residents.
3. **It is anticipated that programs can begin to apply for IR Residency accreditation in January 2015.** A site visit will be performed and the approval process may take six months. The first programs may be accredited by the end of 2015.
4. Residents may transfer into the program after accreditation is obtained. Residents in years R2-R5 may transfer into the program from a DR residency provided qualifications for transfer are met. Medical students may apply and match into the program following accreditation. The first medical school match will probably be in 2016.
5. The first graduates from the IR Residency will be residents transferring into the PGY6 (R5) year. The first IR Residents may graduate in 2017.
6. Discontinuation of IR fellowship accreditation. Once ACGME has approved the IR Residency, there will be a seven-year transition period after which time **accreditation of 1-year fellowships will be discontinued**. If the IR Residency were approved by 2015, then the last 1-year fellows would graduate in 2022.

Sample Training Options

As written, the Program Requirements are designed to give each department considerable flexibility in fashioning a program to fit their individual institutional constraints while at the same time achieving the required educational objectives of the new residency. Some examples include:

- *Associate PD:* The IR program director (PD) may work with an associate PD with designated responsibility for the first three years of training focused on diagnostic imaging.
- *Call:* Residents must take call throughout the residency; however, the call responsibilities in diagnostic imaging vs. IR is distributed at the discretion of each program. In particular, call in the PGY5 year can be determined by the individual program.
- *IR Rotations:* During PGY 5 and 6 years, training in IR-specific content can be achieved within the IR section or through IR-related rotations outside of the IR section proper. Examples of IR-related activities may include rotations on vascular surgery, medical oncology clinic or interventional procedural services housed within a diagnostic radiology section (e.g., abdominal imaging with exposure to biopsy, ablations, etc.). However, residents must perform a minimum number of designated IR procedures during training. Consequently, rotations outside of IR proper must be carefully tailored to ensure that all of the procedural requirements of the residency are met.
- *Entry Points:* Residents may enter an IR residency from a DR residency at any level (PGY 3–6) provided the resident has the prerequisite training experience. Transfers into PGY6 require at least 13 IR or IR-related rotations and documentation of at least 500 procedures covering the broad domain of IR. It is also expected that residents may transfer from IR into DR at the PGY 3–5 levels

As it is currently envisioned, trainees may enter the IR residency at several points:

- Medical school match into PGY2
- Transfer from DR into PGY 3-6 (provided entry criteria are met)
- Transfer into PGY 6 (provided DR residents have completed 13 IR or IR-related rotations)
- Entry into R4 after completion of a DR residency

IRQ: How flexible will the training requirements be? What options will trainees and training programs have?

LaBerge: ACGME's Next Accreditation System (NAS) emphasizes training outcomes rather than process, recognizing that the value in giving training programs and institutions flexibility to design curricula that work best in their individual circumstances. This approach also provides room for training innovation and improvement over time. The IR Residency is being designed with these NAS goals in mind. [See the sidebar for examples of training options.]

IRQ: What role has the IR/DR Certificate Task Force had in the development of the certificate?

Kaufman: SIR had a key role in the development of this certificate as it made the initial 2007 proposal to ABR, with whom it worked jointly over the next five years. The SIR IR/DR Task Force is not the group that developed the certificate; it is charged to serve as a resource for the ACGME Radiology RRC and to provide accurate information about the new certificate to all key stakeholders. In addition, the task force is working to understand the funding aspects of a new residency.

IRQ: There are apparently rumors that the development of the Certificate represents a split of interventional radiology from diagnostic radiology. How would you address these concerns?

Kaufman: The IR/DR certificate is not intended to split IR from DR. In fact, DR is included in the name of the certificate in order to eliminate any possible confusion about the importance of full competency in imaging interpretation. The structure of the training program requires at least three years of training within a DR program, and the intended organization is for both the DR residency and IR residency to be within the same DR Department, with both program directors reporting to the same DR chair.