
CIRSE 2014: Multidisciplinary Teams: IR Needs to Step Up



Taking part in a multidisciplinary team is "the greatest educational experience you can have as a practising clinician", said Professor Andy Adam, speaking at the Cardiovascular and Interventional Radiology Society of Europe (CIRSE) congress in Glasgow this week. Interventional radiologists need to join colleagues as professional members of multidisciplinary teams (MDT), and not just be consulted as a 'technician', urged Adam. With MDTs being commonplace and even legally mandatory in some countries, such as the UK, the interventional radiologist needs to be an integral part of the team, said Adam.

He elaborated by saying that it means working side-by-side with other disciplines on an equal basis, as a complete clinical service. It does not mean providing a purely technical service without being involved in clinical decisions. He proiled the IR 'technician' as a procedural expert who loves operating, considers outpatients and ward rounds a waste of his or her talents, is uninvolved in follow up, and expects referral to come as a matter of course and complains they they don't.

MDTs are mainly found in interventional oncology. IR should be considered as a mainstream discipline alongside other methods of treatment. Decisions taken by the team shgould be based on the best available evidence and patient preference.

Adam acknowledged the obstacles. These can include the patchy availability of procedures, no clear path for referrals, unreliable follow up, the absence of 'cinical letters' and lack of orderly referral to other clinical services.

However, he urged interventional radiologists to step up - the interventional radiologist should be on a par with other members of the MDT (ordinary is good) - not a curiosity, optional extra or choice of last resort.

Adam referred to CIRSE's work on training, with the establishment of the European Board of Interventional Radiology in 2010. Training leads to credibility. Also needed in the mix is funding on the same basis as other disciplines, QA outcome measures and clinical responsibility. He noted that the importance of QA should not be underestimated, in what it means for credibility and for patients.

CIRSE is committed to developing a QA system, and there are lessons to be learned from other disciplines such as surgery and radiation oncology.

Adam ended on a practical note, with recommended actions for the interventional radiologist:

- **Practise as a clinician** - do ward rounds, do outpatient clinics, write letters and don't just rely on reports.
- **Attend multidisciplinary meetings** - you have to be there if you want to be a full member of the team.
- **Be a physician not a technician** - discuss cases like a real doctor rather than an 'imager'. Don't dwell on insignificant findings. Consider the overall effect on the patient, not only feasibility of the procedure.
- **Be aware of the rules of membership of the MDT** - IR is a 'twin track practice' - if the patient is primarily your responsibility you should assume overall care. If the patient is referred for a specific technical service e.g. a central venous catheter, then temporary responsibility is appropriate and accepted.
- **Don't ask for permission** from another disciplines to carry out a procedure like a technician.
- **Consider the role of other disciplines.** Accept a supporting role when appropriate, and accept skepticism regarding IR techniques - others will judge you only on the evidence and your track record. Keep databases about your own practice and use them. Don't just refer to the literature.

Being in a MDT does take time and effort. It does mean time away from the procedure room. However, it increases credibility and knowledge, and improves patient care.

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