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Interview with Prof. J. Reekers, President,.

Cardiovascular and Interventional Society of Europe (CIRSE)

Interviewee:

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Please Give Us Some Background Information on Your Professional Achievements and Current Role.

I have been a full-time interventionalist for over 20 years. My main focus is on vascular diseases. I work as an academic professor in interventional radiology at the University Hospital AMC, of the University of Amsterdam. I see it as my personal achievement that I have been able to work, along with many others, to build the house of IR as it is today. Currently, I am the President of CIRSE.

Your Contributions to the Field of Interventional Radiology (IR) have been Much Honoured – Which if These has been Most Significant to You Personally?

The SIR Dotter Lecture in 2008 was one of the highlights of my interventional career. The understanding that evidence-based medicine is of vital interest to interventional radiology was the topic of this lecture. But the most significant honour any interventionalist can get is the satisfaction that you and IR have made a difference to the patient. That is, after all, the core business. Of the many things I have been working on, if I have to mention one, it is the pioneering work I have been doing on subintimal angioplasty.

The Evolution of Interventional Radiology has been a Relatively Recent and Innovative Branch of Radiology – What Excites You About it?

When Charles Dotter performed the first PTA, 45 years ago, interventional radiologists were already achieving many things before others, like vascular surgeons, “discovered” this new and exciting medical specialty and called it “endovascular surgery”. Interventional radiologists have been innovating for the last four decades. What currently really excites me are the advantages IR is creating in the field of local cancer treatment. We are only at the beginning of a new boom.

Is Interventional Radiology Adequately Funded in Europe? Is it Well Known Here?

In the vast majority of countries, there is still inadequate funding for IR. It is not yet seen and funded as an alternative to surgery, mainly due to the fact that interventional radiologists are not acting or practicing as doctors but more as “skilled hands”, working in the shadow of the clinicians. When this changes, I am convinced the funding will change accordingly. Interventional radiologists are still very unknown to the general public, again, because patients don’t see them as primary care takers. Yes, we have a huge image problem. CIRSE is addressing this by training the interventional radiologist to be a clinician and to promote new IR techniques in the popular press.

You are Leading the Creation of a European Training Curriculum for Interventional Radiology – Please Tell Us About This.

To improve the quality of IR in Europe it is necessary to improve and to standardise IR training in Europe. CIRSE together with the European Society of Radiology (ESR), has produced a basic curriculum for IR. This document is adopted in many European countries. Along with this, CIRSE has produced a syllabus about what IR is and what you should know if you want to be a fulltime interventional radiologist. We hope to work together with UEMS to bring this document to a European level. Finally, we hope that this will lead to a European IR certificate, recognised

throughout the European community.

How can Increasing Educational Opportunities Expand the Future of IR?

We are open to any medical specialist who wants to be trained in IR, according to the curriculum. Education is one of the most important things is this regard. Only through training can we educate enough qualified interventional radiologists to do all the work. It is often the absence of a local and well- trained IR that still supports the use of old and redundant surgical techniques.

What are Your Predictions for How the Range of Treatments Covered by IR will Blossom in the Decades to Come?

It is my solemn belief that IR is here to replace the old techniques, which have been so prominent ever since the days of Billroth. Surgery has been a very important step forward in medicine but will soon be replaced by minimally invasive techniques. Probably this has already happened for most of vascular surgery. Vascular intervention will continue to blossom, independent of who will be doing it. Interventional oncology, treatment of uterine fibroids, trauma care and many others will have a prominent place in our daily work.

Finally, Please Share One of Your Favourite Memories From Your Days as a Trainee.

When I was a trainee, I once visited the famous Prof. Merlant, who was a neuroradiologist in Paris. As a trainee, I accompanied a patient with a vascular malformation, who was sent to him from our hospital for treatment. Prof. Merlant did not treat me like a junior but took my picture for his guestbook, a great honour as I found out many years later, and after the procedure, invited me for dinner. We talked like equal colleagues about the future of IR and new ideas for procedures. He was a very inspiring man, with a huge imagination, who at that time spurred my imagination for new products, techniques and inventions.

By the way, this same neuroradiologist, many years later, was the first to introduce the technique of uterine fibroid embolisation. It not only shows that IR is a wonderful profession but also that being an interventional radiologist is a mentality, a state of mind.

Dear Professor **McCall,**

I wanted to respond to your inspiring editorial in IMAGING Management (Vol 8, issue 3, 2008), to ask for advice regarding radiology training in Malta. As a consultant radiologist in Malta, I have just taken up the post of postgraduate training coordinator for radiology.

Malta is the smallest European Union State. Since joining the EU, there has been a push to organise post-graduate training in various specialties, including radiology. The island's one large and brand new teaching hospital has furnished the department of radiology with RIS/PACS, 1.5 Tesla MRI, 16 slice CT, etc. Although still a bit short on consultant radiology personnel, I believe that we can deliver the majority of general training in medical imaging.

We plan to have five to six trainees for our first intake in October of this year. After that we will probably take three or four trainees maximum every two years. Training will be based on the ESR and RCR curricula. Trainees will be encouraged to sit the FRCR examinations.

Although we can offer the majority of training, I think that our local training will need to be supplemented by further training in specialised centres abroad. My view is that trainees should spend the equivalent of three months a year in the first four years and the whole fifth year abroad. The main reason for this is to obtain experience in areas like neuroradiology, paediatric radiology etc in the pre-FRCR training and to spend 'fellowship-type' training in fifth year.

My vision is that we team up with a centre in the UK, Ireland or mainland Europe and organise an exchange-type programme for trainees. Alternatively, our trainees can spend a training period in centres abroad through mutual agreement between the respective health authorities. The idea is that the trainees get full training rather than simple observer-type attachments. The health department in Malta is funding post-graduate training. It will provide subsidies for trainees whilst they are abroad and pay for any fees that are incurred in the process.

I would be grateful to receive any advice regarding the above and how I could take this project forward.

Yours sincerely

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