

# A Global Podium to the Gold Medallist: My IR Career, Lessons Learned and Future Challenges

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The CIRSE Gold Medal was first awarded in 1997. The CIRSE website states that the annual Gold Medal is awarded to individuals who have made outstanding contributions to the practice and science of interventional radiology (IR) on an international scale. The list of gold medallists since 1997 illustrates very well the above requirement (Table 1). Gold medallists are not necessarily IRs or European. In fact, out of thirty-two gold medallists, eight were either non-European or worked outside Europe for the majority of their IR careers. In general but not always, one gold medal is awarded each year. The selection of Gold medallists is the remit of the CIRSE Honours committee, which consists of a small group of prior Gold medallists. In this article, I will describe my experience on the path to the gold medal, lessons learned on the way and will highlight key areas of challenge for interventional radiology in the next decade.

## My IR Career

I learned at an early stage that there was even more to interventional radiology than treating patients. As a second year Radiology trainee, I presented my first IR scientific paper at the British Society of Interventional Radiology meeting in Stratford-upon-Avon in 1990. This was my introduction to the world of IR outside the boundaries of

my training scheme. I was interested to see the various personalities that I saw on the podium and fascinated by the underlying comradeship and rivalry between different personalities and units around the UK. I attended my first CIRSE congress in Madeira in 1995 and first Society of Cardiovascular and Interventional Radiology congress (SCVIR -later renamed the Society of Interventional Radiology) in Fort Lauderdale, Florida, also in 1995. At these congresses, I realised that IRs on each side of the Atlantic Ocean were working towards the same goals—the sharing of IR knowledge, education, research, professional development and support.

My IR career started with basic training in IR as a radiology trainee in Plymouth and St George's, London. In the early 1990s, you had to travel overseas to join a Fellowship scheme in IR. For English speakers, this meant North America or Australasia. I went to the University of Texas to work for Professor Eric vanSonnenberg. After Texas, I became Professor Andy Adam's lecturer at Guy's and St Thomas's hospital and among other things, performed a live case involving oesophageal stent insertion at the 1996 CIRSE congress in London. From there, I spent two years at St Mary's hospital, London, where I did four and a half days of IR every week, which is a good way to learn your trade, and after that to St George's hospital, London, where I remain today.

I have enjoyed my IR career immensely and my experience has been enhanced substantially by my involvement with IR societies, IR academia and collaboration with other IRs worldwide. Key highlights of my IR career have been the creation of the European Board of Interventional Radiology examination, Scientific Program Chair of CIRSE, eight years on the CIRSE Executive Board

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**Table 1** List of CIRSE Gold medallists

1997	Rolf W Gunther
1998	David J Allison
1999	Anders Lunderquist
2000	Plinio Rossi
2001	E Boijesen, F Olbert, F Pinet
2002	J Göthlin, J-J Merland, E Zeitler
2003	Christoph Zollikofer
2004	Julien Struyven
2005	John F Reidy
2006	Barry Katzen
2007	Andreas Adam
2008	John Abele, Bill Cook
2009	Johannes Lammer
2010	Frederick S Keller
2011	Jim A Reekers
2012	Peter R Mueller
2013	José I Bilbao
2014	Jan H Peregrin
2015	Josef Rösch
2016	Michael J Lee
2017	Dierk Vorwerk
2018	Anna-Maria Belli
2019	Thierry de Baère
2020	Elias Brountzos
2021	Julio Palmaz
2022	John Kaufman, Hervé Rousseau

including the CIRSE Presidency, and meeting IRs all over the world.

## Lessons Learned

### Decide What You Want to Achieve in Your Career

What sort of IR career do you want yours to look like? Consider whether you want to be a practising IR with no significant external commitments, or whether you want to become involved in your IR society, in IR research or both. Although it is not necessary to decide this at the start of your IR career, the earlier that you decide, the better your chances will be to ascend the proverbial rungs of the IR ladder either in research, societal involvement, or both.

### Get Involved

If you want to get involved, are personable and are keen to work, there is no limit to what you can achieve. In terms of

CIRSE, initially you should put yourself forward as a candidate for the standing committee members elections, which take place every two years. “Nobody will vote for me” is not a reason to avoid filling out the candidate election form. Once on the election list, contact anybody you know and ask them to support you. This is even more relevant if you already occupy a CIRSE committee position and are trying for a post on the next level in the society. You have nothing to lose as long as you are prepared to work in the event that you are elected. Finally, there are many aspects of an IR society that do not require election e.g. task force members, reviewers, and editorial board members for one of the journals, which you can indicate your interest in becoming involved to the senior leadership.

## Mentors

These are important for your education and progression both within your hospital and within the wider IR world. Mentors do not usually announce themselves to you as such. They will often be one of your IR trainers or a senior IR in your department. They may also be an IR colleague either in or outside your hospital or even your country. Mentors may offer advice on subspecialisation within IR, potential productive areas of research, whether you should become involved in your IR society and if so how, and other strategic issues for your career. The best mentors continue to be a source of advice even after you no longer work for or with them.

My mentors were Profs Eric vanSonnenberg, Andy Adam, Anna-Maria Belli, Tim Buckenham, and Dr Irving Wells. Special mentions for guidance on strategic issues in my career are due to Professors Michael Lee, Jim Reekers and Brian Stainken.

## Research

Research is a very rewarding aspect of an IR career. If you are not interested in research, at least try to do at least one IR research study. Analysis of outcomes of a specific procedure or use of a novel device in your department is usually a relatively straightforward way to do this. Once you have accrued and analysed the data, submit an abstract for presentation to a scientific meeting and write up the data for submission to an IR journal. Once you have written your first paper and presented the data at a congress, most people want to do another. If you are not interested, then fair enough, you have at least tried it out.

In general, academia is rewarding and is an excellent way to meet other IRs. If you present your work at IR meetings, you will inevitably meet like-minded people and forge relationships that will be long-lasting. Publishing

**Fig. 1** The Executive Committee of CIRSE at the Spring Executive Committee Meeting in Barcelona, Spain, in 2004



your work is also a sign that you are more than just a practising IR.

### Committees and Committee Elections

Most elections for committee member positions are relatively undersubscribed rather than the opposite. Therefore, if you put your name forward, you will have a high chance of being elected. Most committees contain workers and passengers. If you are elected, try to be a worker, as passengers soon become known as such by their peers.

During your first year as a committee member, consider what you want to do next. If you are enjoying your role, decide whether you want to go for a member position on another committee or go for the next rung on the ladder i.e. a committee chair position? Maybe you decide that committee involvement is not for you and do not want to enter more elections. No matter—at least you gave it a go.

If you want to move up the society strata, decide early on when you want to try for a committee chair position. Do not delay thinking that “I am too junior”. You may well be, but the only way to find out is to test the water and apply for a committee chair position.

Election to a committee chair position in CIRSE comes with a seat on the CIRSE Executive Committee (EC). My first EC position was in 2003 (Fig. 1). For the first time, you sit around a table and socialise with other senior members of the society, including the President of the society. Try to steer your own committee along a successful road and produce the required outputs of your committee, which differ depending on each committee.

### Committees and Conduct

To get anywhere in 2023, you need to process and answer important emails in a timely manner. This is no more pertinent than if you have a responsible position in an IR

society. The society’s decisions depend on a rapid response to emails. If you are a committee chair or member, the work rate of the committee is reliant on the speed that important emails are answered and acted on. If you want to do well, you must answer your emails promptly, ideally within three days or sooner. Conversely, if you develop a reputation for failing to answer emails, then this will soon become evident to your colleagues. As a result, you may find it challenging if you want to progress to higher positions.

Also regarding emails, take care not to answer emails late at night, or soon after receipt if an email arouses your ire. It is always better to wait several hours, gathering your thoughts rather than prematurely firing off your response to a perceived infringement on your personality, ability, or authority, which you will often regret after pressing “send”.

Your progress up the society levels will depend heavily on your relationships with colleagues. Fall out with somebody at your peril, as nobody likes conflict or dealing with a difficult personality if yours turns out to be one of these.

### Future Challenges

In 2023, interventional radiology is a mature discipline in many parts of the world. However, there is still work to be done to deliver the benefits of IR to patients wherever they may be.

### Clinical Practice

Although Charles Dotter encouraged ownership of patients in the 1960s, interventional radiologists have been relatively slow to adopt all tenets of clinical practice. Although this has improved since the millennium, this is still a work

in progress in many countries, with many IRs still not seeing their patients in pre- and post-procedural outpatient clinics at the very least.

Ideally, IRs should do even more and take on primary clinical responsibility for patient care. This means that IRs should participate on an equal basis in the decision-making process for patient care to improve patient safety and outcomes e.g. deciding how to treat a specific cancer.

Clinical practice responsibilities for IRs are an important tool to combat the effects of turf issues with competing clinical specialties and to further cement the place of IR in each hospital. Interventional radiology must be acknowledged as having similar status to other clinical disciplines and this will only be achieved if interventional radiologists embrace all aspects of Clinical Practice [1]. In many countries, this will require interventional radiology to become a separate specialty as has already occurred in the United States of America.

### Accreditation

Accreditation of interventional radiologists is essential to herald the fact that IRs have undergone specialist training in IR, in addition to their training in radiology. The SIR was the first specialist society to provide an examination in interventional radiology at the end of IR training in the 1990s. In 2010, CIRSE developed the European Board of Interventional Radiology (EBIR) which is now a mature examination and is available to IRs around the world if they want to take the examination. There are other specialist societies, such as the Japanese IR Society (JSIR) and the German IR society (DeGIR) that also run their own examinations.

In Europe, the EBIR is a voluntary examination run by CIRSE. In an ideal world, IRs should be mandated to take an examination in IR at the end of their IR training before commencing IR practice. This would require a single examination in Europe and agreement by all European countries on the need to take an IR examination, and on the examination itself. The EBIR could be that examination.

Globally, all interventional radiologists wherever they work should also be able to sit an examination to show that they have undergone the requisite training in IR. Ideally, there would be a single IR examination worldwide and not several different ones. However, this would likely be difficult to achieve, but could be an aspiration for the major IR societies to collaborate together on.

The two main barriers to increased uptake of candidates for IR examinations are financial and language.

To increase the ability of IRs in developing countries to take IR examinations, subsidisation of examination fees is needed. Many examinations are now entirely online in format, which presents the opportunity to deliver

inexpensive examinations to a large number of candidates wherever they work in the world. A program of stratified subsidies based on individual economic status may enable economically disadvantaged IRs to take an online IR examination. Although challenging to achieve, it is feasible that societies that provide the main IR examinations could produce a subsidy structure to increase global uptake of candidates.

The barrier of language is easier to resolve. As many examinations are held virtually, it is possible to deliver an IR examination in any language. CIRSE already delivers the EBIR in the German and Spanish languages, as well as in the English language format. Delivery in whichever language is required to cater for candidates around the world, while not easy, should be surmountable with motivation and resources.

### Research and Research Funding

The validation of all IR procedures is dependent on the outcomes of research. Unfortunately, research is expensive. Although funding is available on a national and international basis from governments and the European Union, this is insufficient to cater for all research needs. Governments and the European Union tend to fund trials assessing procedures rather than the efficacy of new devices. The introduction of new devices requires high quality research to assess safety, efficacy and benefit compared with competing technologies. As government research monies are limited, this usually requires significant expenditure by the device manufacturers, often by expensive multicentre randomised controlled trials (RCTs).

This relationship between industry, new devices and IR practice has been called a Faustian pact between doctors and industry. In other words, the body that has most to gain from positive outcomes of a research trial designed to assess efficacy of a new device is the body that actually organises and has oversight of the study. Not surprisingly, there are many scientists who are uneasy regarding the potential conflict of interest that this produces.

Unfortunately, given the enormous amounts of money required to run research trials, this is not an easy problem to resolve. One solution would be if societies organised major trials with funding provided by industry. Another way might be if a society runs a trial in partnership with an industry sponsor. Both of these models already occur on a limited basis. However, it should be possible to organise larger RCTs using either of these examples. A more independent approach to research would be better overall to increase transparency in the validation of therapies for our patients.

## Globalisation of IR

The major societies such as CIRSE, SIR and APSCVIR have a theoretical obligation to convey the key principles of IR to the wider world. This includes the delivery of education and training, and promotion of IR as a clinical entity in countries where there is limited IR practice. This is particularly important for IRs in countries where there are limited resources for education and devices required to practice IR. Regarding education, major societies should (and already do) provide reduced or free registration and travel support to their annual congresses, and free online access to attend congresses travel is not possible. Another example of educational support is outreach training programs where senior IRs travel to a country to deliver education and training, including Live Case demonstrations to IRs and their colleagues in developing countries. I was a member of two outreach programs organised by the APSCVIR (with participation by CIRSE and SIR) to Myanmar in 2018 and 2019, and know how well-received these are by the local recipients.

Lack of IR devices to enable IR procedures is a significant problem in many developing countries. Sending send time-expired, but sterile, devices to developing countries is one solution, although is not ideal. Another method is to use inventive ideas to circumvent the challenge of expensive devices. Professor Vincent Vidal and colleagues have led an initiative to develop, promote and distribute an embolic agent based on suture material to developing countries [2]. This is one example of innovation to supply IRs in developing countries with tools that they require inexpensively. There are likely more similar projects to be conceived if IRs direct their minds to the task.

## Conclusion

It has been a privilege to be able to assist with the development and maturation of our discipline of interventional radiology. Many events have occurred since my first translumbar aortogram procedure in 1988. There is still much to be done, but the machinery is in place to move IR further forward into the twenty-first century and beyond.

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### Declarations

**Conflict of interest** The author declares no conflict of interest.

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