“We all should know that diversity makes for a rich tapestry, and we must understand that all the threads of the tapestry are equal in value no matter what their color.”

— Maya Angelou
Interventional Radiology (IR) became the 36th and newest primary specialty of the American Board of Medical Specialties, placing it in the major leagues with Radiology, Internal Medicine, General Surgery, and Pediatrics. IR has developed its own residency and board certification, reflecting its semi-surgical culture that has become increasingly distinct from Diagnostic Radiology. As part of its roadmap for independence and growth, the field of IR is confronting its remarkably poor statistics on diversity – only 8% of practicing IRs in the United States are female, and about 11% identify as under-represented minority (URM). These rank IR below traditionally male-dominated fields such as neurosurgery, cardiac surgery, and orthopedic surgery. The Society of Interventional Radiology (SIR) only started collecting demographic data recently, and still has gaps in statistics for URM, LGBTQ, immigrant, osteopathic, and other physicians.

SIR established a Diversity and Inclusion Advisory Group that outlined strategies, goals, action plans, and committees for five main objectives: 1 – recruitment; 2 - data and benchmarks; 3 - health disparities; 4 - awareness and collaboration; and 5 - member education and resources. Progress in the pipeline is already encouraging – 12% of fellowship applicants and 19% of residency applicants are female, and of SIR medical student members, 26% identify as female and 27% as URM. The current and past president of SIR, as well as about 20% of the Executive Council, are female. At the 2019 Annual Scientific Meeting of SIR (for which I was the Program Chair), 23% of invited Self-Assessment Continuing Medical Education (SACME) and Categorical Course faculty and 38% of Plenary session speakers (the highest profile sessions) were female, providing visibility to potential role models for the many excited students and trainees attending the meeting. However, in the volunteer, crowd-sourced, call for session proposals program, only 7% of proposals were authored by women, and 9% by URMs.

Not all of these initiatives have been met with universal acceptance. Some members of well-represented groups, particularly young Caucasian and Asian-American men trying to establish their fledgling careers, felt unfairly excluded when desirable invitations to contribute were extended to members of under-represented groups, some of whom had shorter bibliographies and skimpier academic CVs. However, it is not a zero-sum game where inclusion of some necessitates exclusion of others; the total number of speakers in 2019 was 20% increased over 2018, so more Caucasian and Asian-American men were also invited. More early career, private practice, and overseas faculty, previously also under-represented, were also invited.

Rather than become mired in complex debates about social justice and fairness, I find it simpler to address the issue from a pragmatic point of view. The field of IR has advanced exponentially in 60 years, mostly on work done by Caucasian and Asian, presumably heterosexual men in North America, Europe, and East Asia, but these demographic groups most certainly do not have a monopoly on innovation, skill, compassion, and industriousness. Welcoming previously under-represented groups and capitalizing on these new contributors may be the lowest hanging and ripest fruit to pick to launch IR into the major leagues.

Daniel Sze, MD, PhD
Professor, Interventional Radiology
Stanford Medicine | Radiology
Underrepresented minorities (URM) defined as Blacks, Hispanics, American Indians, Alaskan Natives, Native Hawaiians, and Pacific Islanders continue to be grossly underrepresented in medicine across all levels of training and medical specialties relative to the U.S. population. A study published in Radiology in 2014 found that the field of Radiology ranked 20th in URM representation among the 20 largest medical residency specialties [https://www.ncbi.nlm.nih.gov/pubmed/23901125], and that no progress had been made in academic Radiology in the past two decades [https://www.ncbi.nlm.nih.gov/pubmed/27569677]. Furthermore, a recent 2017 publication by West et al. found that Interventional Radiology (IR) and Neuroradiology demonstrated the highest levels of URM and gender disparities amongst all radiology fellowships [https://www.ncbi.nlm.nih.gov/pubmed/27287279]. The reasons for the relative lack of URM in medicine are myriad, with systemic issues being a major player, a topic beyond the scope of this discussion. However, at the medical specialty level, a major contributor leading to the grave disparities we see between radiology/IR and other specialties is exposure.

From personal experience, I can attest that IR is seldom on the radar in medical school. I had never heard of the specialty, let alone ever met an interventional radiologist. I was introduced to the specialty through the fortunate coincidence of having an instructor in one of my small group first year medical school courses who is an IR. He took it upon himself to introduce me personally to the specialty through shadowing opportunities and encouraging me to get involved in research projects within the division. From the moment I walked into the cath lab as a rising second year medical student, I was in awe and completely fascinated by the seemingly impossible things IRs were able to accomplish, and I never looked back! Biases notwithstanding, IR is a wonderful field and is without a doubt the wave of the future. I am certain if more URM students were exposed earlier on in their medical education, without leaving it to chance, they too would gravitate toward the specialty.

The importance of increasing URM representation in our specialty cannot be understated, because diversity enriches the lives of all of us. Not only does racial and ethnic diversity matter, but gender, religious, socioeconomic, cultural, sexual orientation, language, and other kinds of diversity also matter. Our work force needs to reflect and empathize with the diverse patient populations we serve, and identity has a direct impact on improving the health outcomes of our patients, especially of minority and underserved populations. The perspective offered by having a diverse work force made up of people that can relate to patients from different backgrounds has a profound impact on the way our care is sought and received.

As a specialty, IR has always been a leader in pushing the frontier of medicine through the complex and cutting-edge treatments we offer. Changing the face of the specialty through diversity and inclusiveness should be no exception, so it is a shame that it has lagged behind our counterparts in other medical specialties. That being said, the Society of Interventional Radiology (SIR) is now taking a proactive approach to tackling this issue, having created the Women in IR (WIR) committee, and the Diversity & Inclusion (D&I) committee, now with a new URM in IR Section, amongst other initiatives, all with the goal of increasing the visibility and participation of URM and women. These national efforts...
show true leadership and a strong commitment to this very important cause, but it is also important to consider what we, as IRs in our respective microspheres, can do to also promote this cause. I believe that if we could focus on the following three principle areas, our efforts would go a long way.

First, is a critical need to increase early exposure. Neither diagnostic nor interventional radiology are required medical school clerkships at the majority of medical schools across the country. Through the hard work of a couple of individuals in the Stanford IR section, IR is now offered as an option for a surgical elective available to Stanford medical students during their required surgical clerkship. It is efforts and creativity like this that need to be pursued, in order to increase our exposure to medical students. Secondly, we need to increase our visibility through mentorship. Many institutions have diversity programs housed under the office of Student Affairs or the Office of Graduate Medical Education (GME). For example, here at Stanford we have the GME Diversity Committee which is a resident and fellow led group that focuses on recruitment, mentorship, and organizing community events that promote diversity, unity, and inclusion. Additionally, many medical schools have local Student National Medical Association (SNMA) chapters as a subdivision of the National Medical Association (NMA), the nation's oldest and largest organization representing African American physicians and health professionals in the U.S. Student organizations with similar focuses representing other racial and ethnic minority groups also exist. It is incumbent upon us as IRs to seek out and become active in these organizations in order to interface directly with medical students and residents and provide mentorship. Thirdly, we need to cultivate more role models in our field. Medical students are drawn into specialties where they can picture themselves fitting in, and having role models that students can identify with helps to paint this picture. Despite how accomplished or self-sufficient we may be as individuals, our group identities remain just as important as our individual identities. Medical students and residents on the verge of deciding their career path need to see that if they join a specialty like IR, they will feel a sense of belonging. We need to create more URM leaders in our local spheres of influence that will serve as role models.

Diversity ultimately adds to the richness of our specialty and directly impacts the quality of patient care. It is our duty and obligation as interventional radiologists to be informed and to make a wholehearted effort to improve URM representation in our specialty. We owe it to not only to ourselves, but more importantly to our patients to take this issue seriously.

Ibrahim Adejoh Idakoji, MD
Clinical Assistant Professor
Stanford Medicine | Radiology
Early this summer, an announcement by Dr. Francis Collins, the director of the National Institutes of Health, made rounds on the national news circuit, but it wasn't about a scientific breakthrough. In a statement published to the NIH website, Dr. Collins did not mince words in calling for an end to all-male speaker panels, or “manels,” at scientific conferences. Acknowledging the imperative to promote diverse and inclusive scientific workforces, he stated that he would no longer take part in any speaking invitation where “attention to inclusiveness is not on the agenda.”

In 2016, more than three years before Dr. Collins's announcement, the Society of Interventional Radiology (SIR) decided to visit the “manel tradition” at the Annual Scientific Meeting. This was another facet within several years of effort to address the gender gap in IR, in which women comprise only 8% of the nation's interventional radiologists. In the last decade, SIR formed a Women in IR section and more recently added a Diversity and Inclusiveness committee, both of which have been active participants in the annual meeting and have helped raise attention to related issues year-round. Efforts by the Annual Meeting Committee (AMC) to increase women's participation in the annual scientific meeting were part of SIR’s larger goal to address the gender gap.

Speaking invitations matter because they are an important element in career development, retention and even recruitment. Speaking invitations are a key consideration for rank advancement in academia. In addition, they provide opportunities to disseminate research results and to enhance a physician's professional network. Visibility of underrepresented groups at the podium may also facilitate more diverse recruitment into the field, by signaling to the audience that a diverse group can be successful in a given discipline.

My colleagues and I were interested in looking at the impact of the SIR AMC’s efforts to increase female participation. Our study, a collaboration between Palo Alto VA IR, Stanford IR and Stanford's Office of Faculty Development and Inclusion, was published in the Journal of Vascular and Interventional Radiology and is available here: [https://www.jvir.org/article/S1051-0443(19)30616-5/fulltext](https://www.jvir.org/article/S1051-0443(19)30616-5/fulltext). In 2016, the AMC decided that starting with the 2017 meeting, session coordinators would be provided with names of 1-2 women IRs to include as speakers, and they would be required to invite these individuals. The names provided were gathered informally by peer-to-peer recommendation. The rest of the speakers were up to the coordinator’s discretion, and invited speakers had the option to decline.

What we found is that the initiative worked, but we also uncovered an interesting pattern in how the greatest gains were achieved. In line with SIR’s initiative to promote gender diversity, 2017 and 2018 saw an increase in the number of female speakers, with 13% and 14% of podium presentations being given by women in 2017 and 2018, respectively, compared to 9% in 2016 (p=0.03 and 0.01, respec-
Increasing Women Speakers in Interventional Radiology

Diversity in Interventional Radiology

However, gains in gender diversity were not homogeneously distributed across all sessions, but in fact correlated with the gender of the session coordinator. The number of female speakers for sessions led by an all-male coordinator team remained statistically unchanged ($p = 0.57$) and increased by only 2% in 2017-2018 when compared to 2016. On the other hand, sessions led by at least one female coordinator saw a 10% increase in the number of female speakers over the same period, although the increase did not meet statistical significance ($p=0.40$) when compared to 2016.

Our findings follow a similar pattern seen in the natural and social sciences. Like in IR, women are outnumbered by men in many scientific disciplines. Neuropharmacology, microbiology, social psychology, anthropology, and evolutionary biology, and others, have examined gender diversity at the podium much like we did. They found that that fewer women speak at major meetings than men, and this includes fields with gender parity and those with a female majority. They also found that when efforts are made to recruit women to the podium actively, the greatest gains appear to depend on the gender of the session coordinator. Sessions that include at least one female coordinator have the largest increases in female speaker participation.

It is unclear why coordinator gender has such an impact. Although it may seem like bias, it may be because female coordinators have larger networks of female colleagues from which to invite speakers, or that female invitees may be more likely to decline an invitation, particularly from a well-known male colleague. My guess is that multiple factors are at play, but further study is needed.

Through his stature and prominence in the scientific community, Dr. Collins’s announcement drew national attention to the issue of diversity and inclusion at major scientific meetings, but the conversation should not end there. More data are needed on the multiple factors, large and small, that may be contributing to gender discrepancies in many fields of medicine and science. Inviting more female coordinators and organizers is a prudent mechanism for approaching gender balance at scientific meetings and working to end the “manel tradition.”

Christine Ghatan, MD
Clinical Assistant Professor, Interventional Radiology
Stanford Medicine | Radiology
As a medical student exploring different specialties, I became excited by the diversity of patients and disease processes and integration of technology that defined the field of Interventional Radiology. However, I gradually realized during my training that this diversity of patients was not well reflected in the group of physicians who practiced IR. In the program I rotated through as a medical student, there was not a single female or URM Interventional Radiologist. Enthralled by the practice of IR, I hardly noticed this homogeneity at that time, having little insight into how this may affect my career.

During my residency, I became more attuned to this issue, particularly with reflection on comments from well-meaning female Diagnostic Radiologists upon hearing my career decision to practice IR. These comments often were along the lines of “Are you sure you want to do that?” or the blunter “Don’t you want to have kids?” I did not know how to reply at that time, but if presented with that question today I would forward this informative article published in 2016, available here: https://www.ncbi.nlm.nih.gov/pubmed/27236211 regarding the practice of IR while pregnant. Given the misconceptions regarding exposure to ionizing radiation while pregnant, this survey warrants some review. 532 SIR (Society of Interventional Radiology) members were surveyed, including 337 men and 125 women. While all 68 women who disclosed at least one pregnancy while practicing IR reported using additional protection and monitoring during pregnancy, less than 50% limited their radiation exposure during pregnancy. Most of the women who had been pregnant while practicing IR reported no notable change in their work duties. In only one woman did the dosimeter reading exceed guidelines for fetal exposure. There were no reported mutagenic outcomes reported, and the spontaneous abortion rate in the group matched that of women of similar age and socioeconomic background. Interestingly, a majority of those surveyed who had not worked with a pregnant colleague believed that a hypothetical pregnant colleague would change their work duties noticeably, which is not in line with actual practice changes reported by those who had been pregnant or worked with a pregnant colleague. I took comfort in this article regarding the low risk of radiation to a fetus during the routine practice of IR, which is in line with studies performed on Interventional Cardiologists and flight attendants, although I noted that there is still some work to be done in changing perceptions of colleagues who have not worked with a pregnant IR.

After these comments from my Diagnostic Radiology attendings, I became more observant about the female and URM representation within IR. I feel fortunate that there was one female IR attending in my residency that I could look to as a mentor. Multiple studies, including a recent large study from Yale examining sexual and gender minority specialty choice available here: https://www.ncbi.nlm.nih.gov/pubmed/27726495 found that exposure to gender minority faculty was very important in specialty decisions. This was also reflected in a study specifically examining gender-specific factors influencing medical students’ career choice of IR, available here: https://www.ncbi.nlm.nih.gov/pubmed/31279685. In my personal experience, having a supportive female mentor was fundamental in my decision to pursue IR.
I also began to appreciate how female IRs in academics have an uphill battle with respect to their career advancement. One article, found here: https://www.ncbi.nlm.nih.gov/pubmed/29402668 showed that female faculty, especially those in specialties with traditionally low female representation (which are more likely to be surgical or procedural in nature), receive lower evaluation scores from their trainees than their male counterparts. These evaluations often play a role in faculty advancement and may account in part for the narrowing pipeline of female physicians who advance through faculty ranks. Outside of one's institution, women and URM also face challenges in career advancement through securing high-profile speaking opportunities at national meetings. A recent study available here: https://www.ncbi.nlm.nih.gov/pubmed/30772166 concluded that male faculty dominate as coordinators for the annual SIR meeting despite that the top quartile of published female IRs have academic credentials that parallel those of invited male faculty. SIR is now actively working to increase membership and participation of female and URM members.

While these data may seem discouraging, I feel fortunate to be working as a female IR during a time when awareness and efforts to increase female and URM representation and involvement at SIR are only increasing. These efforts are discussed in detail elsewhere in the newsletter. Through the support of male and female IR mentors, I am confident that IR will continue to diversify to better provide the best possible patient care.

Amanda Rigas, MD
Clinical Assistant Professor, Interventional Radiology
Stanford Medicine | Radiology
This year, we recognized the 50th anniversary of the Stonewall uprising that launched the modern Lesbian, Gay, Bisexual, Transgender & Queer [LGBTQ] civil rights movement. Despite advancements in societal acceptance and legal protections, the size of the American LGBTQ population is still uncertain. Similarly, the numbers of LGBTQ health providers and their contemporary work experiences are also largely unknown. These data are important to obtain for many reasons. Firstly, there is still stigma and discrimination aimed at the LGBTQ population. As a result, there are observed health disparities. In crafting remedies for these disparities, it's important to understand how many people are affected. Further, in our culture, just the act of counting brings valuable visibility to policy makers and the general population. In order to deliver culturally competent care, our workforce needs to reflect the diversity of the communities we serve.

In 2019, the best estimate is approximately 4.5% [14.7 million] of Americans identify as LGBTQ. This percentage may seem small, but the number is significant. To provide a sense of scale, 14.7 million people is larger than the population of 46 of the 50 states. Further, these data only capture individuals who openly identify in surveys as LGBTQ. In essence, this is a measure of “outness” - a “floor” for the size of the LGBTQ population. It doesn't quantify the population whose concealed identities, attractions, behaviors and relationships don't reconcile with traditional models of heterosexuality or cis-gender identity. To gain any insights into the “ceiling” of the entire LGBTQ population, indirect means of measurement are needed.

A recent Stanford study reported while 80-85% lesbian and gay medical students openly-identify, only 45% of bisexual and 34% of transgender students openly-identify. The most common reason for not being out are, fear of discrimination, concern of career options and lack of support.

In October 2018, the Kaiser Family Foundation estimated there to be almost one-million physicians in the US. It is unclear if the prevalence of LGBTQ people in the overall population is reflected at the same rates within the medical profession. There are influences that could affect these numbers in either direction. Using the data from the Williams Institute and Gallup, it can be extrapolated that there could be between 37,000-45,000 LGBTQ physicians in the US. It's estimated there are between 38,000-47,000 radiologists in the US. Using the same logic as before, we can estimate there are 1,500-1,800 LGBTQ radiologists. Currently, 3132 physicians identify to CMS as Interventional Radiologists, suggesting there may be about 120 LGBTQ IRs.

In 2016, a study from Yale University School of Medicine, examined predictors for specialty choice for sexual and gender minority [SGM] students. Prestigious specialties, as measured by an objective index, are perceived by SGM to be less inclusive of SGM. The percentage of SGM in each specialty was
inversely related to specialty prestige (P = 0.001) and positively related to perceived SGM inclusivity (P = 0.01). The “Most Welcoming” specialties were Psychiatry, Family Medicine, Pediatrics, Preventive Medicine and Internal Medicine/Pediatrics. The “Least Welcoming” specialties were Orthopedics, Neurosurgery, Thoracic Surgery, General Surgery and Colon & Rectal Surgery. It concluded that specialty prestige and perceived inclusivity predict SGM specialty choice. Further, SGM diversity initiatives in prestigious specialties may be particularly effective by addressing SGM inclusion directly. While it’s unclear exactly how IR measures objectively in prestige, it has great similarities to the surgical disciplines that were “Least Welcoming”. In the 2018 residency match, IR was by far the top of the list in competitiveness, inferring that it is in fact highly prestigious.

In a time when significantly more than half of medical school graduates are female, underrepresented minorities in medicine, and SGM, the “High Prestige” surgical training programs do not reflect the diversity of medical graduates. The sustainability of this dynamic is uncertain. However, it raises concerns regarding the ability to realize the full potential of the talent pipeline of graduating medical students in order to deliver culturally competent care to the population being served. As a strategic imperative for the future, the procedural disciplines such as IR must reflect on these dynamics in order to remain a vital link in the continuum of robust patient care.

Hirschel McGinnis, MD
Chair, Awareness and Collaboration
Steward Medical Group, Massachusetts
SIR Diversity and Inclusion Advisory Group
Diversity in Interventional Radiology (IR), among countless other fields, is paramount to creating a professional landscape rich with new ideas and perspectives that drive the discipline forward. To this end, there has been a notable effort on behalf of the Society of Interventional Radiology (SIR) to increase diversity and inclusion. This newsletter has provided suggestions to meet this ambition, including the importance of early subspecialty exposure, strategic mentorship efforts, and the critical role played by informal communities to promote diversity including within positions of high visibility.

Historically, the overall proportion of women in IR has remained low, at under 10%.1 The growing diversity of medical school graduates is motivating subspecialties, including IR, to attract more women. In effect, institutions with greater gender diversity are shown to be better able to retain talent.2 I have recently entered the subspecialty of pediatric interventional radiology and while I am not aware of any officially reported demographics data among practicing pediatric interventionalists at large, our division is rather unique in that half the team will be female. Given the lack of reliable data on practicing pediatric interventionalists, I look to broader research in the field of IR as well as my own personal experience within this pathway, to identify the steps we must take to further encourage female participation.

Mentorship has played a significant role in my career development within both the pediatric and adult IR training pathway. This mentorship experience has been in a myriad of forms, from the more traditional mentor-mentee relationships with senior leaders from across different fields or backgrounds, to the often-overlooked but equally vital peer mentorship network. During the early stages of our training, we often strive to identify “mentors” to help guide our careers. Instinctively, we look for those who have already travelled along a similar path and with whom we have shared qualities, traits, or backgrounds. Yet, due to the specialist nature of the field, many of us may find it difficult to identify someone whose journey we can instantly relate or emulate. For example, while I have been fortunate to work with two female leaders in my field, this experience is not the norm for young women. The statistics highlight that there is not an abundance of female mentors in this field, with only 8% of practicing IRs in the US being female.3

However, this does not mean that excellent mentors are not available to women and other under-represented minorities in this field. Prior to arriving at Stanford, I spent six years at Northwestern Memorial Hospital where I completed my surgical internship, radiology residency, and interventional radiology fellowship. During this period of my career, I received mentoring from outstanding physicians.
Diversity in Interventional Radiology

Early Career Lessons:
A creative approach to cultivating diverse mentor relationships as a trainee in Interventional Radiology

from a wide variety of backgrounds. I have carried this perspective with me as I begin my journey at Stanford, garnering guidance and support from exceptional male and female colleagues.

I have also recognized the ongoing importance of maintaining my peer network for mentorship and support. Coming up through my training, my core support was often from three women I met on the first day of intern year. For each other we have been a sounding board, and an important “informal” or “peer” network. The importance of peer networks and mentoring has also appeared in analogous research. Peer-mentoring, where mentor “pairs” are at similar stages in their careers, may provide greater levels of practical and emotional support than senior figures. This informal network has also been shown to influence career decisions in radiology. Research has highlighted that a majority of respondents received much of their fellowship information from peers (68%) and staff radiologists (61%). In addition, research from other fields has indicated that peer mentoring may provide both career-related and psychosocial support for individuals.

Reflecting on the importance that mentorship has had in the evolution of my career has highlighted the positive influence of a diverse support structure. This experience leads me towards two conclusions regarding the role of mentorship in driving increased female participation in IR. First, there needs to be a strong call to action for all professionals to take a shared ownership for emphasizing the benefits of mentorship across disciplines. Second, there must be a conscious push not to put limits on those that can serve as mentors. If we continue to assume that a mentor has to be in your specific field, have a specific shared experience, or holds a more senior role, this will likely distract us from the rich resources we have available to us and the value that a diverse support structure can bring. Under this model, the ability to integrate a wide array of perspectives in support of one’s career path, will drive efforts towards increasing a diverse community within our field.

Victoria Young, MD
Pediatric Radiology Fellow, Future Clinical Instructor
Lucile Packard Children’s Hospital at Stanford | Pediatric Interventional Radiology

As the Society of Pediatric Interventional Radiology (SPIR) celebrates its 10th year of existence this year, there has been much reflecting on where we came from and where we are going as a specialty. A look through the commemorative new book on the first 10 years of SPIR reflects a society that appears to be significantly more diverse than our parent group of SIR. Women physicians make up 16% of the active members of SPIR, with a female physician as the president of the society in 3 of those 10 years. In addition to our current female president, there are 3 additional women serving on the SPIR Board of Directors out of a total of 11 members. Within the member in training category, 20% are female. What factors contribute to this increased prevalence of women within pediatric IR? Overall, pediatric diagnostic radiology has a higher percentage of women compared to radiology with 46% of academic pediatric radiologist identified as female compared to 21% within radiology. Perhaps the higher number of women in pediatric IR reflects the differences in training pathways, since training directly after pediatric diagnostic radiology is a path to pediatric IR. Pediatric IR is not a recognized ACGME subspecialty certificate within radiology and there are very few fellowship programs across the country–11 total on my last review. Training pathways include pediatric diagnostic radiology, pediatric IR, or both, as well as adult IR and any combination of pediatric radiology. A comparative work force survey demonstrated a significant change in these training pathways over the last decade from 46% trained in a pediatric IR fellowship in 2005 down to only 24% in 2015, with a concomitant rise in training in adult IR from 41 to 63%. This is reflective of both the increased need for higher level skills in IR as well as reflective of the higher level of procedures being performed now by the pediatric interventional radiologist. Are women attracted to pediatric IR because it is “easier” than adult IR? That same survey showed that in 2005, the pediatric interventional radiologist averaged 165 days of call per year! That is definitely not easy. Thankfully, that has been reduced with the addition of more qualified physicians into the field to an average of 67 days/year. Overall, with the need for anesthesia and a more operating room like workflow, the hours worked per day have steadily increased.

My personal view behind the reason there are more women in pediatric IR is based on the value of the patient physician relationship. In diagnostic radiology, we are accused of being non patient facing and removed from much of the emotional connection to the patient. Female medical students decide against the field of radiology frequently because this lack of direct patient interaction. For those of us lucky enough to have found the field of pediatric IR, we are directly involved with the longitudinal care of our patients. We literally get to watch them grow up. We get to see them learn to walk, we receive holiday cards, high school graduation announcements, hugs and heartfelt thank-yous. Some days are sad; however, I remind myself there is a 90% overall cure rate for childhood cancers, and we are there to help them along their journey. We offer a kind and understanding experience when they arrive, for both the child and for the parent. Perhaps this is the feminine appeal. Women are only 16% overall, so this is really the appeal to all of us, male or female, and is what drove me to choose pediatric IR after a long career in adult IR. I do not know if it holds true for others. Sounds like another great survey.

Shellie Josephs, MD
Clinical Professor, Pediatric Interventional Radiology
Stanford Medicine | Radiology

1. SPIR: The 1st Decade 2008-2018, available on Shutterfly
2. https://www.spir.org/about-us
The MIPS / Canary Trainees Council presents

**MCTC and Radiology Diversity Committee joint Social**

The MCTC and Radiology Diversity committees are hosting a joint happy hour this month.

*Wear your favorite country’s colors or sports jersey and join us for food, games and drinks to celebrate the diversity of our community.*

**Date:** Friday, Nov 22nd 2019  
**Time:** 4:30 - 6:30 pm  
**Place:** Lucas Expansion, room P083, 1201 Welch Road

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**Check our website:**  
https://med.stanford.edu/mips/aboutus/training-council.html

**Don’t forget to like us on facebook:**  
fb.me/mipscanarytrainees

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Diversity in Interventional Radiology
“The minute we become an integrated whole, we look through the same eyes and we see a whole different world together.”

– Azizah al-Hibri