BDI Consultants

Interventional Radiology Portfolio Pathway Evidence Map

Use this to test whether your evidence proves whole-role IR consultant practice, not just procedure volume. Always check the live GMC and RCR guidance.

1. Route nuance

Question	Evidence implication
Clinical Radiology or non-CCT IR?	Confirm whether the application is broad Clinical Radiology with IR evidence or non-CCT Interventional Radiology.
Closest SSG	Where no separate SSG exists, use the closest matching specialty guidance. For IR, Clinical Radiology remains the anchor.
Clinical Radiology foundation	Keep evidence of diagnostic radiology, reporting, imaging selection, protocolling and image quality.
IR-specific CiPs	Add proof of patient management and image-guided therapy: CiPs 13 and 14.

2. IR-friendly post checks

Area	What the post should produce
Elective and emergency lists	Planned cases, urgent work, out-of-hours escalation, prioritisation and case selection.
Vascular and non-vascular range	A procedure index by service line, urgency, role, access route, imaging modality and outcome.
Clinic, ward and follow-up	Pre-assessment, consent, complication management, ward review, discharge and follow-up.
MDT and referral triage	Decisions about whether IR, surgery, oncology, medicine or conservative care is appropriate.
Governance	M&M;, audit, infection control, device governance, radiation protection, contrast safety and service review.
Diagnostic connection	Reporting, acute imaging judgement, protocolling, image quality and diagnostic breadth.

3. Evidence that is stronger than a logbook

Evidence type	What to include
Procedure log	Indication, urgency, role, access, imaging guidance, device used, outcome and complication.
Case narratives	Complex cases showing decision making, MDT context, consent and follow-up.
Structured reports	Referees who can comment on IR skill, diagnostic radiology, governance and whole-role consultant practice.
Audit/QI	Radiation dose, complications, infection, access pathway, patient flow, device use or procedural outcomes.
Reflection	Complications, consent difficulty, escalation, decision not to intervene, and learning from outcomes.

4. Next 30 days

- Decide whether the intended application is Clinical Radiology with IR evidence or non-CCT Interventional Radiology.
- Build a procedure index that includes clinical indication, urgency, outcome and follow-up.
- Add evidence from clinic, ward review, consent, MDT, emergency work and governance.
- Check that diagnostic radiology evidence has not been neglected.
- Brief referees on the need to comment on whole-role consultant practice, not just technical skill.