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"*Give a man a fish, and you feed him for a day. Teach a man to fish, and you feed him for a lifetime*." Anna Isabella Thackeray Ritchie, "Mrs. Dymond" (1885). (Actual quote is "If you give a man a fish he is hungry again in an hour. If you teach him to catch a fish you do him a good turn.")

The role of radiology (and especially cross-sectional imaging) in healthcare has evolved substantially in recent decades, from an adjunct investigative modality often used to support or confirm clinical diagnostic impressions to a substitute for such clinical diagnostic efforts. In many instances, especially in emergencies, imaging is now used as an initial diagnostic sieve, with patient management and disposition based in large part on imaging findings. This is all well and good, in those parts of the world in which access to expensive, resource-intensive modalities and appropriately-skilled staff are widely available. But what about the two-thirds of the world's population estimated by the World Health Organisation (WHO) to lack access to basic diagnostic imaging, as reported in the Canadian Association of Radiologists Journal by Kamran et al[1]?

Kamran et al[1] have produced a review of the complexities and imperatives that underpin global health radiology, highlighting many of the difficulties inherent in applying developed-world practices to developing world contexts. If imaging access is limited, standards and practices which are taken for granted in some circumstances may be unattainable elsewhere, leading to growing regional disparities in the quality of healthcare available. The 2021 Lancet Oncology Commission[2] on medical imaging and nuclear medicine found that 3.2% of deaths from 11 modelled cancers worldwide could be averted by scaling up of imaging in low- and middle-income countries (LMICs), producing a net return of $170 for every $1 invested. However disparities are to be addressed, whether by large-scale global efforts or smaller, local initiatives, the goal must be to aim for an equivalence of standards, regardless of location.

Global health (in radiology, as in other fields of medicine) should not imply paternalism, with programmes designed by "donor" organisations, and based more on their needs than those of the "recipients." A key message of the paper by Kamran et al is that such efforts are unlikely to achieve sustained success for the target population. Collaboration among participants, recognising the differences that may exist in terms of resources, and adapting to local circumstances to optimise impact and ensure sustainability in outcomes, is key to long-term success. Equipment donations, short-term expert provision, and time-limited workforce training are all potentially valuable contributions, but none will have long-term impacts unless they become endeavours shared with (and co-led by) local participants. The goal should not be to import or impose outside patterns of practice, but to strengthen systems locally by reflecting local needs, resources and priorities.

Point of care ultrasound (POCUS) is an excellent example of how this may work. While the use of ultrasound as a comprehensive diagnostic tool, utilising all its complexities and nuances, should rightly remain the purview of fully-trained imaging professionals,[3] it's impossible to make a credible sustainable argument against specific non-radiology staff usage of ultrasound in appropriate settings, to answer specific questions. In well-resourced environments, it is sometimes argued that ultrasound is an imaging modality best provided and managed by comprehensively-trained imaging professionals. Fair enough, if such professionals are available. But targeted use of POCUS, provided by operators trained in narrow use-cases, can confer great benefit: Kamran et al[1] highlight obstetrical ultrasound use in this context. This is a technology that can be made available at low cost, and for which specific-use training can be provided relatively easily; such narrow use-case utilisation has, in any case, become embedded in much clinical practice also in the developed world.

Artificial Intelligence (AI) offers scope to enhance radiology service delivery in all environments, but its long-term impact remains to be established. Digitization of imaging, in all its manifestations, makes service provision across distance or in remote or underserviced areas easier. However, it's important that any efforts to utilise AI and imaging digitization to increase global imaging access takes account of local infrastructure and governance, and that underdeveloped environments, in which regulatory control may be less established, are not used as indiscriminate testing grounds for tools not specifically designed or adapted for local needs.

Another positive benefit of digitization is the capacity to provide education remotely; this developed rapidly during the COVID pandemic, and in other recent circumstances, such as the

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efforts by many national and international organisations to maintain radiology education in locations subject to war and other situations limiting conventional educational opportunities.

Above all else, the key message of Kamran et al[1] is that global health in radiology must be a collaborative venture, developed and delivered to ensure continuing value, sustainability and local relevance. To this end, they propose five pillars to support the design, implementation, evaluation and sustainability of global health radiology initiatives. Value-based healthcare is an increasingly cited driver of assessment of the impact of healthcare actions, not least in radiology.[4] The fourth proposed pillar, emphasising PROM-informed evaluation, is an excellent example of how the value added by radiology can be assessed and incorporated into future developments; adopting this approach could be useful as much in the developed world as in global health initiatives.

The era in which "global outreach" in radiology was developed and delivered by well-intentioned agencies, but based on the needs and viewpoints of the "donors," is over. Many groups and individuals are now involved in better-designed and -delivered global programmes in radiology, and should be supported and commended for this work. Kamran and colleagues have provided a clear outline of the issues involved in global radiology health initiatives, the potential benefits and drawbacks of some designs, and a clear roadmap for how such efforts should be managed in the future. Above all, global outreach should be meaningful, sustainable in the long term and locally supported and governed.

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