Abstract

Background

This paper reports a qualitative study exploring the establishment of non-medical consultant roles in Radiography. Given the difficulties reported in recruiting and retaining staff in these posts, we hope this paper offers a historical documentation of those consultants who were some of the first in post, sharing their stories of how they obtained and transitioned into their roles.

Methods

This paper is part of a two year case study exploring the leadership domain of consultant practice. The focus of this paper is a reflection, by the consultants, of their journey to becoming a consultant; a documentation of some of the practical issues in establishing the roles; and the transition to higher levels of practice.

Eight consultant radiographers participated in the initial interviews (two consultants withdrew from the study subsequent to this). In-depth iterative interviewing was used to explore and record individual stories and experiences.

Findings

The consultants shared their perceptions of being in post, including their own motivation to progress to a new role, how prepared they felt initially, the lack of role models, the lack of clarity surrounding the role and a perception of 'being on display'.

Conclusions

The paper offers insight into the journey of these consultants and some of the common characteristics they share. These characteristics give some indication of what motivated them to step into higher level roles, in particular the need to drive change and improvement. The paper also offers suggestions for how the transition into the role could be more effectively supported.

Highlights

1. Identifies characteristics thought to contribute to effective consultant practice

2. A desire to change practice is a major motivator in applying for a consultant post

3. The consultant role was a natural evolution for some, not a desired career pathway

4. There is recognition that the initial consultants were pioneers for the profession

5. Indications of how role transition could have been better supported are outlined

Title page

On Becoming a Consultant: A study exploring the journey to Consultant Practice

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Background

The introduction of non-medical consultants (from this point referred to as consultants) in nursing and allied health in the UK is well documented [1, 2,3,4]. In nursing, the establishment of the consultant role was announced in 1999[1] and in 2000 two waves of consultant posts were proposed [2,3]. By March 2001, Moore[4] reported that over 500 posts had been approved. The NHS Plan indicated that by 2004 it was expected that there would be 1,000 consultant nurses[5], though in reality only half of this number were actualised[6].

In allied health, the intention to establish consultants posts was first announced in The NHS Plan[5], and was reported again in the NHS Strategy for allied health professions the same year[7]. The final announcement confirming consultant roles in allied health came in 2001[8], with an expectation of 250 posts by 2004[9]. The rate of adoption in practice however has been slow, with less than 60 AHP consultants appointed in the first four years[6]; in radiography, as of September 2014, there were only 83 (plus 2 trainee) posts listed on the Society of Radiographers (SoR) website (this may not reflect accurately the number of post as consultants do not have to be members of the SoR). There are varied estimates of consultant numbers in the literature, showing an apparent lack of knowledge about the number of posts in practice. While total numbers are unclear, Ford[10] indicates that the potential in radiography is not being reached as all available posts have not been successfully appointed to. Ford states that this is, in part, due to there being insufficient suitable applicants and that opposition from radiology colleagues is also an issue[11]. Of some concern is that some of these posts were subsequently lost because no one was appointed [12,13].

The individuals who took up these posts initially in radiography did not necessarily get there via typical advanced practice routes, but through more "tortuous" (p266) pathways followed by individuals developing themselves[6]. In part this was due to a ‘lack of clearly defined clinical and educational pathways’[14] (p.e66) and is perhaps why fewer consultants have been recruited than expected[3].

Price and Miller[13] argued that for consultants to be successful in their role, they need to possess certain characteristics: the ability to work autonomously; confidence to drive an agenda; driving change and the ability to challenge practice. Ford[10] reported these characteristics to be determination, perseverance, motivation, strength of character and emotional intelligence. Similarly in nursing, Woodward, Webb and Prowse[15] included: ability to empower others; determination; self-confidence; collaboration and motivation in their top required criteria list. There appears to be some commonality that a strong character is required for the role, however in practice it has been reported that consultants are unaware of the criteria for success[10]. Virtually no empirical evidence was found that demonstrated which criteria measurably enhanced consultant practice and very little literature was found describing the characteristics of consultant radiographers, opening a gap which this study hopes to fill.

Given the lack of clear pathways and educational requirements for consultant radiographers, the authors were interested to learn about the journey of the early adopters of these roles. Particularly what had enabled them to acquire and mould these posts, along with any challenges faced and what qualities they possessed that helped overcome them. The study

also gave an important opportunity to document the stories of the pioneers of radiographic consultant practice.

Methods

The results presented here form part of a wider study, funded by the College of Radiographers Industry Partnership Scheme (CoRIPS), where leadership qualities were ascertained using the NHS Leadership Qualities Framework (NHS LQF). As part of this study an action learning group was established, executive coaching was offered and consultants were asked to maintain reflective diaries. This paper reports on the initial in-depth interviews undertaken at the start of the research in 2010, to establish how participants had moved into and developed their consultant role and the second interview which was undertaken once leadership qualities had been ascertained using the NHS LQF, 4 months later. Due to the nature of the NHS LQF, this second interview reflected partly on characteristics related to leadership.

All 31 consultant radiographers who were registered with the College of Radiographers (CoR) in 2009 were invited to take part in the study via the consultant radiography group (CRG) at the CoR. An electronic invitation was sent via the chair of this group. Initially n=9 consultants agreed to take part, but prior to the first interviews being conducted one participant withdrew. Two further consultants withdrew after the first interviews were conducted, due to workload. Therefore eight consultants were interviewed initially and six consultants were interviewed in the latter stages of the research.

The interviews were undertaken by telephone, due to the geographic spread of participants. All interviews were audio-recorded and transcribed verbatim. Each interview lasted, on average, 1 hour. An experienced qualitative researcher (a radiographer not directly involved with the consultant group) undertook all interviews and a second experienced qualitative researcher (also a radiographer, but again not directly involved in the consultant group) analysed the data to reduce the risk of any potential bias (i.e. any bias in interview questions would be evident through listening to the interviews or noted within the written transcripts; any affected data could then be removed by the second researcher). The first researcher then reviewed the analysis so that agreement on themes could be established i.e. consensus validation, this offered protection against any potential bias in the analysis or data interpretation[16]. All transcripts were returned to the interviewees for participant credibility checks[16] and the themes were shared with the participants to ensure appropriateness of interpretation.

The open, in-depth nature of the interviews enabled each consultant to tell their own story around a range of general open questions. Gentle probing was used to deepen the narrative and iterative interviewing was used to build on the topics covered as the interviews progressed, ensuring what was important to the consultants was covered in the interviews. This mode of interviewing produces active novelties that more structured methods cannot[17].

Thematic analysis, using a word and phrase level coding process was utilized to establish initial codes, which were then grouped into higher order themes[16].

Discussions with the National Research Ethics Service (NRES) around the purpose of the study determined that full NHS research ethics review (NHS REC) was not required[18]. However the research followed good ethical practice guidelines as stipulated by the University of Cumbria Research Ethics Committee.

Findings

The consultants worked in a range of areas (Therapy - Head and Neck, and Gynaecology; Diagnostic – Breast imaging; Plain Film reporting and Gastro-Intestinal imaging) and had spent between 16 months and five years in practice as a consultant radiographer. One was part time (0.6 FTE). Their ages spread from 30s to 50s and they were all female. The female dominance is not surprising as less than 10% of radiography consultants are male[19], therefore this sample reflects the gender spread in the population. All consultants held an MSc. Year of qualification ranged from 1978 to 1992 (Two of the consultants had taken maternity breaks, so this range does not reflect continual practice in all cases). Their journey into the role is outlined in the table 1.

Participant - 001	Came from a non-clinical role in that she was deputy head of the department (operational management), she had also worked in quality management and at times had acted up as head of department. She was a member of the senior management team and had to work on building up her clinical skills to take on the role.
Participant - 003	Had been a film reader (advanced practice) in breast imaging. She took on more responsibility and eventually argued the case to made consultant when retirement of a consultant radiologist, meant she was left managing cases on her own.
Participant - 004	Had been a clinical tutor who had undertaken the film reporting qualification. She had some experience as a Supt. III in both managing an area and in education (CPD manager). As her reporting role got bigger she took on the consultant role.
Participant - 005 (withdrew after first interview)	Worked in advanced practice in GI studies, clinical need required her to take on more and more GI work e.g. flexible sigmoidoscopy, colonoscopy, reporting, barium swallows so she fought to be made up to be consultant.
Participant - 006	Worked in advanced practice in breast screen (film reporting and ultrasound). She then pushed for more responsibility e.g. stereotactic biopsy etc. The consultant role developed from there.

Participant - 007	Came to the consultant role via a management route after working as a Supt. in treatment planning.
Participant – 008 (withdrew after first interview)	Came via advanced practice (film reading and ultrasound breast).
Participant - 009	Developed from undertaking audits of service delivery in gynaecological oncology. From the themes she identified they trained her to take forward advanced practice and then the consultant role

Table 1: Prior roles to becoming a consultant

Within the initial interviews we asked the consultants what qualities they perceived contributed to their role. The key qualities described are outlined in Table 2. While these qualities were not subjected to statistical analysis, they are arranged in terms of thematic occurrence or frequency, shown numerically here to indicate the number of times they were raised independently in the interviews. In the spirit of qualitative data, where each individual view is deemed to be important, table 2 includes all the qualities highlighted, even when only one person highlighted it once, to show it held some degree of importance to at least one person. Table 2 demonstrates some qualities that were surprising, in that they did not show up more strongly (though it is acknowledged that wording may be used differently between participants).

Getting things done and making things happen (44)	People skills and Emotional Intelligence (36)	Driven (30)
Prepared to speak out and challenge (24)	Strong character (24)	Hard working, committed and will go the extra mile (20)
Get people on board (18)	Team player and builder (17)	Confident (17)
Problem solver, can think on their feet (15)	Desire for continuous improvement (14)	Good communicator (13)
Resilient / persistent (12)	Thick skinned (11)	Think before acting (11)
Strong belief / vision (11)	Clinical expert with experience (10)	Understanding others points of view (9)
Decisive (8)	Leading and being a role model (8)	Ability to see the bigger picture (7)

Positive attitude (7)	Self aware (7)	Know limitations (6)
Patient centred (6)	Motivated / passionate (5)	Listens (5)
Think outside the box (5)	Love the job / interested (5)	Self manages / sufficient (5)
Ability to present (4)	Does their best (4)	Organised / can prioritise (4)
Enabling others (4)	Integrity (4)	See opportunities and have ideas (4)
Adaptable / flexible (3)	Willing to have a go (3)	Encouraging others into the role / promoting the profession (3)
Caring (3)	Controlling (3)	Fair (2)
Able to evaluate options (2)	Academically capable (2)	Prepared to ask for help (2)
Bring value / cost effective (2)	Sense of humour (2)	Innovative (2)
Know your boundaries (2)	Empathy (1)	Approachable (1)
Diplomat (1)	Know what to ask for (1)	Know when to speak up (1)
Handle complexity (1)	Share knowledge (1)	Aware of what is going on around you (1)

Table 2: Key qualities which were reported by the consultant radiographers

Discussion

This discussion describes the core themes, in relation to becoming a consultant, which emerged through thematic analysis:

- Motivation for the role (which includes the qualities thought to be important)
- Transition into the role (which includes some of the barriers faced)

We discuss here the text from the interviews to demonstrate how we identified each category. Each quote is identified using the interview number: participant number. How these categories link to findings in the literature is also discussed.

Motivation for the role

There were a range of sub themes in relation to 'Motivation for the role'. The main areas which emerged were:

- Desire for change:
    - both towards something new (and for challenge and variety) and also away from the existing role
    - a drive to make a difference
    - the clear existence of drive and making an effort; pursuing a passion
    - Natural evolution to Consultant Practice

Desire for change

For some participants the move to consultant practice was about returning to, or building a career, within a clinical route:

> *"I wanted to get back to some clinical* work" (1: 001).

While for others there was a desire to move into something new or to take on new responsibility:

> "*It was something innovative and different"* (1: 004)

> "*I wanted responsibility and so that was my vision to do this"* (2:006).

For others there was a desire for challenge:

> *"I wanted to … have a challenging job"* (2:006)

In the literature it has been reported that not all staff want to progress to this level of practice[14,20] and the consultants also raised this with the interviewer. However, for the consultants in this study there was a perception that without that challenge their role could become boring:

> *"Once you can do the clinical work, it's just not as challenging as it was … I would just get bored"* (3:006)

There was a sense that without the role, they may not have remained in practice as they were not stimulated enough, or were not having enough impact on practice to satisfy them.

There was in some cases recognition that there was a 'moving away from' difficult or monotonous roles.

> *"If I hadn't taken this opportunity I may have had a nervous breakdown in my other job"* (1:001)

> "*Because in a way radiography wasn't enough for me*" (1:006)

Within the consultants' stories, there was clear evidence of the desire to make a difference and to push boundaries. One area where this was evident was in the desire to improve patient care:

> "*I felt that I could maybe make a bit of a difference*" (1: 001)

> *"It was a passion, you know. I could see clearly where the service was falling down and … how that could be improved"* (2:009)

This was also found in a paper of two case studies by Price and Miller[13] who reported the main focus of consultants was on service improvement. Similarly Price and Edwards[14] (p e69) reported that consultants "must continue to carve their own identity as ambassadors for patient services". The consultants in this study appear to be doing exactly that.

There was a recognition that this was done by pushing boundaries:

> "*I was kind of pushing my boundaries and boundaries of practice"* (1:005)

As well as an acknowledgement that the role enabled them to drive change:

> *"I think you've got a better opportunity in a role like this to sort of drive change forward"* (2:007)

What was clear was evidence of a consistent effort over time. Part of this effort included making the most of opportunities which presented themselves:

> *"You realise that actually you should take every opportunity that comes and maybe that's what sets consultant radiographers apart … that you look for every opportunity and grab it"* (3:001)

> *"I kind of always say to the junior staff….there is nothing special about me – I have just taken all the opportunities I have been given and I have made sure I have been in the right place at the right time"* (1:005)

Being alert to opportunities was something all of the interviewees shared, but there was also evidence that the consultants were clear about what they wanted to achieve:

> *"…my vision of where the role is going has always been quite clear. It's not like I came into the 4 tier structure – I grew with it and helped influence how the 4 tier structure developed so I feel very integral…with development of that structure"* (2:009)

There was recognition by the consultants that they were 'pioneers' and 'trail blazers', forging new pathways that had not previously existed:

> *"So I am a bit of a pioneer really ... that's my spirit I think and I like to…push the boundaries a bit"* (1:006)

This was something that, in their view, set them apart from non-consultants and underpinned a sense of confidence in their ability to forge new pathways:

> "*proactive*" and "*not being frightened to challenge people's views"* (1:001)

What was clear was that they were highly self-motivated and constantly pushing themselves to achieve more:

> *"I am driven, yes, I know … I've always wanted to push myself, and I've always ended up gravitating to things that used to be done by the doctors"* (2:006)

There was awareness that extra effort was required:

> *"You have to be willing to go the extra mile – you have to be willing to make some personal sacrifices and I just think that is a given"* (1:005)

For some, it was not enough to just do more, they had to be the best:

> *"If I do something I have to do it the best – to the best of my ability. I have to do it as well as everybody else at least, or I'm not satisfied"* (2:006)

> *"I don't like being bottom of the heap. If I go back to school days I wasn't very happy unless I came top – or at least in the top three"* (2:003)

> *"People have always said I never do anything by halves. If I'm doing something I have to try and do it 120 per cent really…that's the way I am and I think that's the way I'll always be"* (2:009)

But being the best did not just happen, there was clear evidence of the hard work and effort required in order to gain the achievements the consultants outlined:

> *"It has to be months and months of hard slog, but then the rewards I feel are almost later because you've put so much effort in and achieved something that's maybe almost unachievable"* (2:009)

The effort was acknowledged to be easier when the activities were related to areas of passion and interest to the individual. That an inner passion provided huge motivation:

> *"I really do have to have an interest though, so – if I'm not interested in something, if it's not my bag … then I find it very difficult to be motivated"* (2:004)

> *"I think you just need to be passionate about it all the time (laugh) and when you're being challenged and people are not quite so keen to follow, you just need to keep the passion going and hopefully you will be able to influence change"* (2:009)

There was a definite sense of the consultants 'making things happen', through leading and driving change, or by sheer persistence:

> *"I'm also the sort of person who if I see something needs doing and I can do it and I see a way forward with it I'll forge ahead and bring it together"* (3:006)

> *"I was really pushing to get on to the reporting course 'cos I was obviously interested in that clinical side of things and wanted to do a kind of advanced role"* (1:004)

The drive, energy, motivation and enthusiasm of the consultants in the present study is also referred to in Redwood, Carr and Graham's[3] study who report on nursing consultants. There appears therefore to be a certain approach to consultant practice which is consistent across

non-medical consultants, but it is not always easy, and the consultants in this study reported on how they had sought support in order to be able to continue in the role:

> *"Yeah well I find support – if I need it I find it"* (1:006)

> *"I mean one of the things I did do was I found a mentor"* (1:001)

> *"I would say it makes a massive difference to have that support network but on reflection what I would also say now is it's down to you to go and find that network ... you can't sit there and wait and hope it comes and think nobody's supporting me"* (3:004)

While some of the consultants described a deliberate and planned journey to consultant practice, for some the transition to consultant was a natural evolution, rather than a deliberate plan:

> *"I didn't actually set off to be a consultant… It sort of morphed into consultant radiographer*" (1:003)

> *"I didn't intentionally go down this road…think I want to be a consultant radiographer"* (1:007)

> *"I think that it was kind of a natural progression"* (1:005)

When asked about the motivation behind being a consultant, there were a range of issues raised including:

Making things better and job satisfaction:

> *"I think what drives me is the ability to make things better; and also job satisfaction. You know, when you do a piece of work and you do it well, that's really satisfying and you want to move on and do the next bit"* (2:001)

Leaving a legacy and enabling the role to continue also featured:

> *"I want to see all these things I'm doing come to fruition, so I can leave and think yeah I did that, I changed that department"* (2:006)

> *"…what I would like is to have a role that's really impactful in this department and the profession and to make a difference and then when I retire, have them want to replace me"* (3:007)

It was clearly stated that they were not driven by financial reward:

> *"I'm not really interested in money… if I was really financially driven I would have moved on to directorate manager or something"* (1:004)

> *"I'm not in it for the money. I'm in it for the job satisfaction"* (1:002)

The consultants expressed how difficult the roles were at times and felt this impacted negatively on succession:

> *"When … they see how hard it is, see how you've been treated … they're all saying…I couldn't be spoken to like that; I couldn't be treated like that"* (2:006)

> *"You've heard that other people have given up because they're on the verge of a nervous breakdown and I'm not at all surprised … there's a lot of people who want to do a bit of role extension but most don't want to go the whole hog of being a consultant"* (3:006)

Motivation was clearly an essential element of achieving and sustaining consultant practice, without which it is unlikely the staff would have progressed into these new roles. Having reported on what motivated individuals to pursue consultant status, the whole area of role transition became an important part of their stories.

Transition into the role

Preparation for the role was discussed by the majority of the consultants. There was a sense that they did not feel they were well prepared for the role:

> "*Maybe not quite as well prepared as I perhaps thought I was"* (1:001)

> "*It was quite scary and I didn't feel well prepared for it"* (1:005)

> "*I'll just throw my hands up and say I wasn't prepared enough"* (1:007)

> "*That was more or less a baptism of fire in the role"* (1:003)

On further probing it became clear that these statements were not related to the clinical role, but to the other three domains of consultant practice.

In support of these findings Nightingale and Hardy[21] (p. 16) reported that the transition to consultant radiographer was "a highly emotional and intensely stressful experience" partly because of the lack of role clarity. In nursing it has also been reported that initially consultants were not clear on what was expected of them, other staff did not understand the role and there was no infrastructure to support the role[22,23], demonstrating another commonality between non-medical consultants. However, it was also clear in the present study, that the consultants had found a way to gain the support they required and through sheer determination and strength of character had found a way to make the role work, even without initial preparation and clarity around the role.

Due to the very nature of the role, and the fact that they were often one of the first people in that role, the consultants reported feeling isolated, with no-one to seek advice from:

> *"There wasn't a real model to follow. So that's a…bit scary"* (1:004)

> "*You know I have been sort of dumped here"* (1:006)

> "*There was no-one… in front of us*" (1:009)

The lack of clarity and structure around the role posed some challenges and the consultants had to create their own pathways as they went along:

> *"And sometimes when you come out of a strict routine … and go into that you can maybe feel a wee bit like jelly"* (1:001)

> *"Because it was the unknown… it was a new role and we were paving the way"* (1:004)

The scope of the change was also felt to be challenging:

> *"I did find it quite a huge jump from suddenly going from not sitting in any higher level management meetings to being on regional management meetings"* (1:003)

> *"It is taking that extra level of responsibility – whereas I think an advanced practitioner would not expect to be sat in that level of meeting, being got at by three or four surgeons and having to stand your own ground"* (1:006)

There was also a 'pressure' they felt as they were representing the profession and were, in some way, 'on display':

> *"I think it was more of a shock being suddenly in the pressure arena – or much more prominent in the professional arena"* (1:009)

> *"I think coming out on your own and you're suspicious ... and it's not, you're not being prepared for that unless you're sort of really a strong powerful character who's just not going to take any nonsense it can be quite daunting and quite difficult"* (3:007)

Consultants indicated here areas where these aspects of role transition could be supported more effectively, perhaps through the use of mentors and training.

Conclusion

As a case study of a small number of consultant radiographers, this paper does not claim to offer generalisable findings. However, it does offer a deep and descriptive insight into the experiences of these early consultants who pioneered the role in the UK.

The core themes of drive and motivation give an insight into what it took for those individuals to forge ahead roles which were the first in the world. The consultants give us a glimpse of the characteristics they believe they have and which made the journey into the role and the role itself successful. This may help others who plan to follow the same trail and also for those recruiting future consultants. One major driver comes from the need for change and improvement: personally or for their patients and service delivery. Their desire for challenge and variety, the risk of boredom without that, and a passion to make a real difference was

consistent across all the consultants in this study. This study suggests that the clear sense of what they wanted creates the energy, courage and resilience to make things happen in practice and the cost in terms of investment of energy, effort and sheer hard work was evidenced by each individual. It was clear the satisfaction they got from the role and the pride they felt in being a Consultant Radiographer, at least for now, was enough to keep them in post. The findings also demonstrate some of the difficulties they faced when they first stepped into the roles, as well as what helped them, we hope this gives some indication where role transition could be more effectively supported.

Word count - 4000

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