Reflections on the role of consultant radiographers in the UK: What is a consultant radiographer?

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Background

The introduction of non-medical consultants in nursing and allied health professions in the UK has been stated1 as a means to 'achieve better outcomes for patients' and to enable experienced practitioners 'to remain in clinical practice'.2 To this extent, a Consultant Radiographer is defined as an individual who: (a) provides clinical leadership within a specialism, and (b) brings strategic direction, innovation and influence through practice, research and education".3

The initial high level of publications around consultancy in radiography has declined in recent years, with only 4 new articles being identified in 2014–2015. Moreover, two of these4 and 5 pertain to role-transition issues, rather than the constitution of consultancy itself. While no specific and definitive role outline and progression pathway is extantly available, key guidelines for the role of non-medical consultants have been documented.6 and 7 The Consultant Radiographer role is generally described within four domains of practice: expert practice; professional leadership/consultancy; practice/service development, research/evaluation and education/professional development.8 Guidelines were published initially to suggest that a minimum of 50% of an appointee's time would be spent in clinical practice,9 with the remaining 50% being spread across the three other domains of practice (contingent upon on local need). There is some contemporary evidence to suggest that research/evaluation is the domain to which the least time is commonly devoted,10 and 11 but little regarding the distribution of investment across the other domains. As such, a national picture of how these roles 'look' in practice remains largely elusive. It is also apparent that the development pathway for consultants is not well delineated,10 and its operations are often ad hoc in nature. 12 In radiography, Price and Edwards13 report that there is a "lack of clearly defined clinical and educational pathways," a view supported by conversant studies, 8 and 14 raising questions over the preparation actually required for a consultant role in the first place. Without precursory clarity regarding the composition of the role (and the four domains of practice therein), it is challenging to specify the exact nature of preparation that would be beneficial.

Given the rather murky waters surrounding issues of role clarity in UK consultant radiography, this paper reports findings from a longitudinal, qualitative study exploring the personal experiences of the consultants themselves. Drawing on accounts of their everyday activity, the scopes of their practice and how their roles have evolved.

Methods

This paper forms part of a wider study, funded by the College of Radiographers Industry Partnership Scheme (CoRIPS). The research reported herein specifically addresses the first and second rounds of in-depth interview, which were undertaken in 2010 and 2011. These focused on the nature of the role in practice, and are context and situation specific, thus reflecting the singular nature of each participant's experience.

All consultant radiographers who were working in the UK and registered with the College of radiographers (CoR) in 2009 were invited via the consultant radiography group (CRG): an electronic invitation was sent via the chair of this group. Initially nine consultants agreed to take part; however, one withdrew before the first interview leaving 8 participants. Two more withdrew after the first round of interviews was conducted. Consequently, 14 interviews were conducted, with six consultants being interviewed twice over a 12 month period, and two consultants being interviewed once. To ensure participants from around UK were able to participate the interviews were undertaken by telephone. All data were recorded using an Olympus VN-731 Digital Voice Recorder to capture both sides of the conversation, and then transcribed verbatim.

Interviews were largely open and semi-structured in form, to facilitate each consultant's capacity to describe their own role in their own way. Topical probing was used to help extend and deepen their narratives where necessary, and iterative interviewing was used to build on the topics covered.15 The interviews moved from discussing role establishment in the first round, to undertaking the role in practice during the second.

Every effort was taken to reduce possible bias in interview questioning and during the analysis of data. An experienced qualitative researcher (a radiographer/academic not involved with the consultant group) undertook all interviews and a second experienced qualitative researcher (also a radiographer/academic; again not involved in the consultant group) analysed the data. This ensured any bias in questioning would be apparent and data removed if necessary. The first researcher reviewed the analysis so that agreement on themes could be established, thus minimizing bias in analysis and interpretation of data. As a final check, interviewees were sent their transcripts to check for accuracy and to establish appropriateness of interpretation.16 Thematic analysis, using a word and phrase level coding process established initial codes, which were then grouped into higher order themes.16 The paper reports on the main themes raised by the consultants, using examples which exemplify points being raised.

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.17 However the research followed good ethical practice guidelines as stipulated by the University of Cumbria Research Ethics Committee.

Overview of findings

The core themes that emerged from the thematic analysis were:

- The role itself:
    - Scope and developments

- Evolution of the role
- Four domains of practice

• Frustrations and inequalities

- Agenda for change and pay banding

These themes are discussed below with reference to pertinent literature, incorporating extracts from the interviews to ground them in the practical experience of participants themselves.

Findings and discussion

During the interviews, participants were asked to describe their role and the scope of their practice. While there was huge variation across the accounts provided, this is consistent with the well-documented knowledge that each such position is unique, and activities are primarily contingent upon the skills and expertise of the individual, and local clinical needs.1 There was clear convergence on the notion that the roles promoted 'autonomous practice', although the specific meaning of this was not substantially unpacked by the participants:

I think as well when you move into these roles you very much … have autonomous practice (1:001)

I would emphasise the fact that I work independently and autonomously … with a big emphasis on decision making and … responsibility (1:005).

It was argued that the role was different from that of an advanced practitioner though, again, the consultants did not develop an account of how these roles diverged. They did, on the other hand, identify 'role expansion' and 'wider, network–level interactions' as key components:

As an advanced practitioner … you don't have such an expanded role (1:008)

I think advanced practice whilst it is starting to identify areas of service need … it would be working within a local area rather than at a network level (1:008)

There was diversification of position as to whether a consultant radiographer undertook the same role as a Radiologist or Oncologist. To some extent this appeared to be discipline-specific. In radiotherapy the role was framed oppositionally:

I have my own discreet set of skills which are synergistic with my colleagues … I have a very definite role which is not a pseudo-oncologist– it is a consultant radiographer role and we all work together (1:005)

If that patient comes in and I suspect they've got anything else going on – any other clinical issues – then they are directed to the Oncologist because I can't deal with that. So our roles are very different (2:009)

With respect to diagnostic specialities, however, and particularly in breast services, this was not viewed as the case. Instead, a much greater symmetry between the roles was posited:

As a breast consultant radiographer, we are working the same as a consultant radiologist … we do new patient clinics … where we see patients with symptoms and breast problems … we do one stop clinics so you do the mammography; report the mammography. If they need ultrasound you do the ultrasound, if they need ultrasound guided biopsy, you do that … if anyone needs stereo guided biopsy for calcification you organise that and you work independently so you are working exactly the same as the doctors in radiology … we head … multi-disciplinary meetings and biopsy results and decide what is going to happen to the patient (1:006)

While each consultant ultimately describes a different role, the sheer scale of practical activities involved is worth revising here, to highlight how far this model of consultancy has progressed since its incipient stages:

I film read … symptomatic and screening. I do breast ultrasound, perform invasive procedures, biopsies, 14 gauge and mammotome. I insert wires for theatre … for chemotherapy patients (1:003)

… reporting all … images; appendicular and axial with a history of trauma … leading a team of other reporting radiographers … report with … registrars 'cos if they've not passed their part A [registrars qualification] they can't verify their own reports (1:004)

… I started doing flexi sigs [Flexible Sigmoidoscopies] … then … small bowel studies … swallowing assessments … .dynamic rectal imaging … Then I learned how to do colonoscopy and therapeutic colonoscopy – that involved giving drugs – and doing some electro-surgery – and then I started to take on parts of the service – small bowel imaging … reported the images … started reporting barium enemas – took on the swallowing assessment service with speech and language … and run that now with them (1:005)

I am the clinical lead for breast imaging … I lead the radiology side of the breast MDT [Multi-Disciplinary Team] weekly here … In fact 85% of the meetings for radiology … I trouble shoot for surgeons for difficult cases (1:003)

Patients who have had a hysterectomy and they have the top of their vagina treated … it involves a cylinder being put in their vagina and being connected up to an 'afterloading' machine and there is a radioactive source in the machine and that passes into the cylinder and treats the patient – now that is completely radiographer led … we do all of that and I oversaw the setting up of that service (1:007)

I do the on treatment review … so that when they are on the external beam treatment they are seen once a week in the review clinic – I lead that … after that I am at the follow up clinic– when they come back they are seen and I work them in conjunction with … a clinical nurse specialist (1:007)

While numerous clinically-related skills were highlighted, all participants considered problem-solving to be a vital underpinning proficiency:

You know, it's not necessarily picking up the protocol and just following it … it's about being able to write these protocols and re-write them; make changes (2:001)

And it's the ability to recognize … when something's … not quite right – about what you need to do to change it and influence people to make that change (2:001)

Advising senior management was also stressed by three of the consultants, providing an indication of the status of these consultants within their respective departments:

I think the consultant needs to be an advisor to the directorate manager (2:004)

Echoing the findings of Price and Edwards,13 participants voiced a very real belief that consultancy roles were breaking new ground in radiography, with each reflecting on specific changes that they had engendered. Some alluded to how they had 'carved out' an autonomous place for themselves, highlighting the preliminary process of role-implementation, and the innovative nature of the roles at that time:

I think it's a very unique post … although you have a job description to work to, a very long job description, you're creating your own position in life (1:003)

I think it's because you're constantly breaking down boundaries in this role and going to places that perhaps no-one has ever been before (1:004)

What was clear was the belief among the consultants that they were positively impacting on the services delivered:

One of the things we have to do in the follow up period is use vaginal dilators … we have revamped that service completely; written new information for them because it was not a very good service before (1:007)

Developing [radiographer led] brachytherapy services – we established those (1:009)

We developed the psycho-sexual information and support for patients (1:009)

Participants in the present research maintained they had contributed to service improvements. While previous studies18 have acknowledged that it is difficult to isolate the unique contributions made by consultants and to demonstrate discrete benefits for patient care, some have to date revealed positive impacts on practice 2, 19, 20 and 21. Rees,6 for example, reports that radiologists who worked with Breast Radiography Consultants agreed the roles made a positive contribution to the department. There was no mention therein of the impact on actual clinical outcomes, however.

Evolution of the role

There was some evidence to propose that roles had changed and evolved. Progressively, some consultants had taken on a greater range of strategic tasks, ultimately at the expense of clinical practice:

My role … now has … taken more of a strategic role … I've ended up doing a lot more stuff for the organisation as opposed to just … radiology (1:004)

As time goes on it's becoming less clinical (1:009).

There was consistent acknowledgement by the participants that responsibility for how their roles developed rested ultimately with them, but it was also noted that sometimes this development was a genuine struggle. As such, the need for drive was recurrently an implicit concern:

We have all developed our posts differently (1:006)

I had to gradually fight to say I want to do this (1:008).

Other components were also reported to have been incorporated into participants' scope of practice, implying that as the roles become established, new opportunities can be identified:

The other thing that seems to be creeping in at the moment … is … a litigation aspect in that I'm asked for my professional opinion … cases that are going for litigation (2:003)

I do an awful lot of liaison work with other departments looking at … their setting up of services (1:009)

It was, however, felt by some that this evolution was not reflected in the original job description:

Since XXX my job description hasn't been changed and I'm doing a huge amount more than is actually on my job description, so it does need looking at (2:009)

I think the reason why it's not accurate is because – the role I'm employed in … what's required of me for our service, is for me to be … flexible - and use the skills I've got in whichever area we need them, for the service at the time; and that's continually changing at the moment, especially in this climate (2:004)

Moreover, levels of responsibility were raised as a key concern in some cases:

Sometimes you think that … it is a lot of responsibility on your shoulders and I think a big responsibility (1:007)

The buck stops with you and that is quite scary – and no matter how prepared you are when you're actually left on your own it's scary (1:008)

Four domains of practice

In correspondence with recent literature,6 the clinical role and leadership were persistently cited by participants as the chief foci of their professional routines.

I think the two most important parts are clinical practice and professional leadership … I think education and research are … important, but they are not as important as those other two (1:005)

The biggest thing for me is the leadership thing … and the fact that we need to start to influence policies and procedures and views (1:006)

Issues germane to the clinical practice have been discussed above. The remaining three domains were also raised by participants when discussing consultant practice and are addressed in this section. Firstly, regarding leadership, Manley, Webster, Hale et al.22 reported that this aspect of the

consultant role has not been explored in depth, despite it being “the key mechanism for achieving and embedding transformation in practice” (p.147). Cantin and Richards23 (p.172) concur, arguing that leadership “underpins all of the other functions” and cannot be considered a discrete phenomenon that we can analytically partition away from the other domains of practice. Hardy and Snaith,8 conversely, maintain that it is difficult to specify leadership as a core function when there remains no agreed definition of what domain-specific leadership actually is. Indeed, this confusion was reflected in a general participant concern that ‘management’ was not supposed to be part of the role, but in reality it featured in some cases:

Mine's got management added into it which I know shouldn't be there … but it is and I can't get out of that (2:003)

I'm the clinical lead for radiology which is their management team (2:006)

I think I probably do more leadership and management now … definitely (2:009)

Such academic and practical debates likely underscore why Forsyth and Maehle11 claim that leadership is one of the “greatest challenges for AHP consultants” (p 284).

Research/evaluation was specified as the domain that was least well supported for consultants, chiefly because it was simply not seen as a priority in the relevant departments (this also corresponds with findings from previous literature6 and 11):

I think it is all very well saying consultants have to do … research, that is not what district general hospitals want – they want people who … do clinical work (1:005)

You know we try to fight to get research– you don't always win … but you have to fight and say look this is core to my role – but I think those aspects of the post are not appreciated when they appoint (1:008)

It's rare that we all have the luxury of being able to do hours of clinical research (1:005)

A recent article by Harris and Paterson7 has shown that although consultant radiographers in the UK have had some research training, the majority (58%) still felt their ability in research was only “average” and 28% considered their ability to be “low”. Only 4% of the respondents characterised their research ability as “high”. Just over half were involved in a research team, but 28% were not involved with research at all, 8% had never been involved in research. 61% received no time allocation for research, and about half expressed the view that research should not be one of the four domains of practice. It would appear, thus, that there are ongoing issues surrounding the research activity of consultants that may need to be explored.

Regarding teaching and development, Rees6 describes how all consultants in her study were committed to the training of others. In the present research, most of the consultants situated education within their role (some in the hospital, and some through links with Universities). One, however, provides an insight into the pressures of competing priorities:

I still really enjoy teaching but I don't get chance to do that so much anymore (1:004)

Due to variations in practice, it is maybe not surprising that there is a certain lack of clarity around consultant practice on the whole, and some uncertainty expressed regarding how the role might be understood by others:

If you asked ten people in the department what my role is, they'd all give you ten different answers (2:004)

There was even a lack of clarity by consultants themselves, both about their own role and those of others:

You realise that each individual consultant radiographer probably has a different idea … about their role (1:003)

You do spend the first year thinking 'what am I doing?' (1:007).

I think people aren't clear themselves about the role (1:004).

This role ambiguity has been highlighted in recent literature4 and 18 which, alongside findings from this study, begins to shine a light on the eclectic nature of the roles themselves, which renders clarity difficult to find.

Frustrations and inequalities in remuneration

With respect to this theme, there was variation across the Agenda for Change pay banding within the participant sample, with a degree of frustration expressed around both the process of being banded and in the final banding achieved. Consultants in this study ranged from 8A to 8C and there was general agreement that Band 8A was inappropriately low for the role undertaken. One consultant reported having taken three and a half years to be moved from band 8A to 8B and then 8C. There was some clear dissatisfaction voiced about levels of pay:

I don't expect to be paid the same as a doctor, I'm not a doctor, but in this small specialty, I do the job as well as the doctors and therefore I shouldn't be getting ridiculously lower pay (2:006)

At least one consultant did express some degree of satisfaction with pay banding, although also expressed concern that the scope of practice was continuing to increase with no further reward possible.

It is of note that, despite the huge scope of practice already evident, participants in this study felt they could be used even more effectively and to even greater extents in the future:

We are good leaders and we should be used better …. I think we have got huge potential (2:006)

Such claims were, however, twinned with recognition that this potential was not limitless, the role itself was not necessarily secure, and resource issues could restrict further development:

At some point we're not going to be able to push the boundaries any further, which … is quite difficult to accept because you're always looking for ways to make the service better (2:009)

There isn't a lot of succession planning … I'm worried we've filled a gap that was there in radiology … as jobs are getting more difficult for radiologists they'll start to come back into breast or plain film reading … because there will be a lot of them that can't get jobs … I'm worried that if we don't make sure there's succession planning for these posts they'll get incorporated back into radiology (3:006).

I would like to see that … the four tier structure continues and it's successful in providing a good skill mix across professions but I think the financial … environment we're in at the moment may well mean that things are done very differently (3:009)

Notwithstanding such concerns there, however emerged a real sense of achievement (and some level of surprise) at what had already been changed:

I mean I was sat … last week reporting mammograms … and I said … you know - twenty years ago we would never have been the two people sitting here– it is just great a great way to be (1:006)

Conclusion

This paper offers a very particular insight into the role of consultant radiographers in the UK, through the shared experiences of eight consultant radiographers. The study demonstrates that the range and scope of their practice is extensive and highly variable, and may prove novel for radiographers in other countries, and also those not familiar with role development at this level. The study shows clear role autonomy, which is distinct from advanced practitioner status, whereas there was a difference of opinion (predominantly by speciality) as to whether or not there was similarity with a medics' role.

The individual nature of the role in relation to local need is evident, as is the evolving nature of the role over time. Problem-solving and advisory roles were commonly reported, there was a prevalent view among the consultants that their roles had positively impacted on patient care.

The dominance of the clinical role within the four domains of practice is clear, with research involvement being given the least priority in terms of time. Lack of clarity about the role, some concerns over remuneration and the sense that even more could be achieved were other themes which emerged and could direct future investigations.

In sum, the definition of consultant practice is someone who: “provides clinical leadership within a specialism, bringing strategic direction, innovation and influence through practice, research and education”.3 This study has demonstrated that consultant radiographers comply, to some extent, with all components of this definition. It also raises some questions around how exerting influence through involvement in research could be more effectively promoted in the future, and whether research at present can truly be seen to be one of the four domains of practice in all cases.

What is clear is that the consultant role is highly complex, and has radically changed the face of radiography in the UK. This study, though small in scale, offers a detailed and novel insight to that role through the eyes of eight consultant radiographers who as trailblazers in the domain, led the way to a new four-tiered profession and who now stand as role models in the global profession.

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