Reflections on the role of consultant radiographers in the UK: The perceived impact on practice and factors that support and hinder the role

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Abstract

Study context

This paper is the third paper arising from a two year long, in-depth case study exploring various components of the role of consultant radiographers in the UK. This paper focuses particularly upon the perceived impact of the role and factors that support and hinder the role in practice.

Methods

A longitudinal case study method was used to explore the role of consultant radiographers. Interviewing was informed and guided by a phenomenological approach to promote a deeper understanding of consultants' experiences in the role. Eight consultant radiographers participated, with six involved throughout the whole study. Over an 18 month period each of those six consultants was interviewed three times. Two consultants only participated in the first interview; these interviews are also reported here. A total of 20 interviews were conducted.

Findings

Interviews explored the impact of the consultant role as perceived by consultants themselves, and encouraged individual reflection on factors which had both supported and hindered success therein. Analysis demonstrated that there was substantial variation in the experiences communicated yet, and without any exception, all consultants reported that the introduction of their role had been beneficial to service delivery and quality of patient care. A number of obstacles were outlined, as well as a range of support mechanisms. Recommendations are thus made as to how the consultant role might be more effectively supported in the future.

Background

The introduction of consultants in nursing and allied health in the UK is well documented,1 and a summary of that history is provided by Henwood and Booth.2 The two main drivers behind the introduction of AHP consultants are reported to have been (a) the achievement of ‘better outcomes for patients’, and (b) the maintenance of experienced practitioners' position in clinical practice.3 Ferris and Winslow4 discuss the importance of oral history and listening to early pioneers in order to learn from their experiences. This paper aims to bring together individual stories from the early innovators in consultant radiography, specifically to learn what supported and hindered them in practice. The paper further reports the consultants' own perceptions regarding how their role has impacted on practice.

While a small body of work using an individual case study approach is extant in consultant radiography practice,5e7 no such work appears to have been published addressing issues that

contribute towards effectiveness, or what inhibits effectiveness in the role over time. One longitudinal case study (documenting the experiences of five trainee consultant radiographers in a single hospital) offers some insight regarding the need to facilitate aspiring consultants; to "explore and enhance their internal career development, offering more time to define themselves and their role".8 Some discussion papers propose conditions of what might be required prior to implementation of the role; for example Price and Edwards9 reported the need to include interpersonal intelligence beyond clinical skills, while Ford10 claimed that consultants had not "grasped the full implications of the leadership and vision needed for these roles" (p.6). No papers actively exploring the ongoing roles of established radiography consultants have, however, to date been published, and there is similarly no apparent empirical literature tasked with exploring these roles (a) nationally and (b) across specialities to identify factors supporting and hindering practice.

Within the limited literature outlining factors which support consultant practice a number of germane issues were found:
_ Personal commitment11
_ Certain personal characteristics2,6
_ Active support of managers,10 though in practice this has been reported to be mixed6
_ Support from senior medical staff, which in at least one study was found to be generally high6
_ Setting clear boundaries, e.g. knowing your limitations and safe scope of practice12

In the domain of nursing, for instance, Graham11 addresses the importance of understanding how one learns as being a key support to role effectiveness and the need for "high quality and skilled clinical supervision" (p.1815). It has been reported, however, that radiography consultants receive markedly little feedback on their performance.6

Pertinently, there is a larger body of literature outlining obstacles to effective practice. These including:
_ "Relentless pressures of service delivery"10 (p.10)
_ Longstanding medical resistance through entrenched hierarchies13
_ A perception that radiographers do not have the required knowledge base to make clinical decisionsc,14,15
_ The requirement for radiographers to follow medical direction16
_ That "some radiologists are still a barrier"12 (p.121) - but it has also been reported that some are fully in support. Indeed the Homerton Radiologists said that they would not meet the 24 h turnaround for accident and emergency reporting without radiographers17
_ Some organisations being reluctant to appoint consultants18
_ Some political influences preventing full development of the role e.g. waiting lists, staff shortages and budgets19
_ The pressure to demonstrate improvement in service delivery18 and to continually demonstrate role and cost effectiveness.1 Though it could be argued, if positive results are gained, that this might actually work towards role effectiveness
_ Necessity of consultants to use time, outside their contracted hours, to undertake the role fully12
_ Lack of existing staff skills19 making it difficult to appoint appropriate people
_ Adverse responses from radiography and radiology colleagues6,12
_ Lack of senior management support6
_ Lack of understanding of role12

Clearly the transition and effective functioning in the role is not always straightforward. Again, in the nursing domain, Graham11 writes of nurses "battling to find achievement and acceptance" (p. 1809). There is some evidence this is also true in radiography.6 Nightingale and Hardy8 outline two Transition Journey Models for Radiography Consultants, both of which show some form of crisis during the journey itself, indicating the scale of difficulty which was supported across the 5 trainee consultants in their study. Hardy and Nightingale20 further report that the transition is a significant life event rather than simply a career advancement, emphasising the need to reflect upon the individual's internal journey alongside their professional progression. Graham11 similarly observes

how new nurse consultants experience conditions under which a "new sense of professional self or 'Me' is realized" (p. 1809); this, it is argued, might be linked to feeling isolated, different and/or alone.

Regarding research around the effects of consultancy roles in radiographic practice, there appears to be a limited body of evidence to conclusively demonstrate that such roles have had measurable impacts in the areas that they were manifestly tasked with improving: patient outcomes and staff retention. Humphreys et al.,21 for example, as an outcome of a systematic review of nonmedical consultant roles in the UK, conclude that "the extent to which these roles add value and provide cost effectiveness has not yet been evaluated." (p 1806). Analogous studies in nursing have also questioned whether actual impact has been demonstrated after introducing consultant roles.22 Humphreys et al.21 do, however, report that some studies23 have reported that consultants themselves "felt they were having significant impact on service delivery" (p 1805). A small number of studies have also claimed some degree of impact24e26 in various spheres, though notably none of them assess cost effectiveness. Kennedy et al.,3 meanwhile, in a comprehensive systematic literature review in nursing, determined that across 36 studies (from 2313 papers retrieved), there was a "largely positive influence of nurse consultants on a range of clinical and professional outcomes". The authors acknowledge, however, that there "was very little robust evidence and the methodological quality of studies was often weak", raising a concern around the confidence with which one can actually assess impact in practice.

Some radiography-specific papers on the impacts of consultant practice have now been published, including empirical analyses27 and reflective accounts of specific consultant practice.7,28,29 In a small qualitative study (involving only two NHS trusts and three consultant radiographers), Price and Miller30 evaluate the impact of the consultant role in radiography. No negative impact is reported therein, but rather the participating consultants were "convinced that benefits and improvements in service delivery had been brought about" (p1), and the trusts themselves claimed that consultants had been "instrumental in bringing about change" (p1). No whole population study was evident in the literature to show wider impact across the NHS. It is against this particular academic backdrop that the research below reports findings from a longitudinal study exploring the role of consultant radiographers. This includes the impacts upon practice that the consultants themselves perceived, and factors they felt either supported or hindered them in making such impacts.

Methods

This paper forms part of a wider study, funded by the College of Radiographers Industry Partnership Scheme (CoRIPS), which explored the role of consultant radiographers. It reports on three rounds of extended, semi-structured interviews which were undertaken in 2010 and 2011.

Participants

All consultant radiographers who were working in the UK and 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.2 Initially, nine consultants agreed to take part; one withdrew before the first interview and two withdrew after the first interviews were conducted. A total of 20 interviews were, thus, conducted with six consultants being interviewed three times over an 18 month period, and a further two being interviewed only at the start of the research. To ensure participants from around UK were able to participate, the interviews were undertaken via the telephone. All interviews were digitally recorded, and transcribed verbatim.

Procedure

Interviews were semi-structured, enabling each consultant to describe their own role in depth and without active guidance. However, gentle probing was used to develop upon the depth and the range of emergent concerns where required. Iterative interviewing (consistent with the techniques of Grounded Theory)31 was also used to build on the range of topics covered as the interviews progressed. This ensured that the matters important to the consultants themselves in situ were placed at the center of the interviews. These topic-shifts included: moving from role establishment and role outline (in interview 1), to undertaking the role in practice (interview 2 and 3), through to obstacles (interview 2 and 3). Thematic analysis, using a word and phrase level coding process was utilized to establish initial codes, which were then grouped into higher order themes.31

Every effort was taken to reduce any possible bias in interview questions and analytic procedure to optimize the trustworthiness of the findings. The first author, an experienced qualitative researcher (a radiographer/academic not directly involved with the consultant group) undertook all interviews. The second author, a qualitative researcher of similar experience (also a radiographer/academic, and not directly involved in the consultant group), conducted the primary analysis. The first researcher then reviewed the analysis such that consensus on the character of emergent themes could be established, and consistency in interpretation of the data checked. Following this, as a "member check",32 interviewees themselves were sent copies of their transcripts such that they could confirm the accuracy of the interview represented. Finally, a third and very seasoned academic in the qualitative field, but one with no connection to the project or radiography itself, was invited to review the redeveloped analysis in a process of triangular consensus validation.33,34

Ethical concerns

The initial purpose of the study meant that NHS research ethics review was not required, as the work fell into the category of service delivery.35 As the project progressed, the research governance arrangements changed, stating that research conducted on NHS staff no longer required NHS ethical review (May 2011).35 Nevertheless, the research followed good ethical practice guidelines as stipulated by the University of Cumbria Research Ethics Committee.

Findings

The core themes to emerge from the analysis are presented in Table 1:

Table 1.
Higher-order themes.

Global theme	Sub-themes
Perceived impact on practice	•Developing new services •Making a difference
Factors that support or hinder consultant practice	•Individual Characteristics •Lack of support •Organisational structures •Resistance •Time and workload •Development activities

These are discussed below, using extracts from the interviews to underscore the participants' own concerns, with reference to pertinent literature.

Discussion

Perceived impact on practice

Conversantly with the findings of Ford,6 all participants in this study expressed a strong belief that the consultant role had a positive impact on practice. Two core-sub themes emerged: ‘developing new services’, and ‘making a difference’. It was clear that the consultants were patient-centred in their approach, and that positive feedback in this domain contributed substantively to their job satisfaction;

Let's face it patients are the centre of all this (1:003)

It has all been patient-centred in that change (1:009)

I love the clinical side of it and I love knowing that I'm making a difference for the patients (1:004)

Despite this, and as outlined above, a coherent body of empirical evidence to demonstrate actual changes in practice remains elusive, though the foundations of such an argument are now being built.27,30 The impacts described here may be related to the strong desire and motivation to change practice, which was discussed by Henwood and Booth,2 as well as perceived pressure to demonstrate improvement in services.18

Developing new services and making a difference

A range of new services were identified by participants. Within these statements were, firstly, generic comments about changing the ‘face’ of service delivery:

Changing the way that service looks (1:004)

We're definitely making it a better service here’ (2:006)

Secondly, specific changes were also outlined:

This week … I did … two back to back, one stop clinics with biopsy facilities' (1:006)

Currently with the head and neck I am in the only person that has the follow-up clinic. (2:001)

When I first went to the department … they didn't have hot reporting, so I did change all that (2:003)

It was clear that consultants were introducing new services to patients, not just extending their role to cover services which were previously offered by other health care professionals. The consultants felt, thus, that they were responsible for driving change:

I am passionate about … providing the best possible service for the patients and I think that has potentially been the driving force behind all of the developments that have gone on (1:009)

There was a sense of pride evident in the achievements discussed, as well as an appreciation of privilege:

I just love everything about it and I feel I am really lucky to have such an active role in helping human beings (1:008)

Factors which reportedly support or hinder consultant practice

A range of sub themes were generated which provided a continuum from support to hindrance within consultant practice. The complex systemic nature of consultant practice is evident insofar as each of the sub theme(s) might act as either a support or hindrance at different times and in different contexts;

many cases thereof are themselves interrelated. For clarity of communication, however, they will be analytically considered here on a one-by-one basis.

Individual characteristics

There were a range of individual characteristics which were deemed to either support (if present) or hinder (if absent) consultants in their role. A number of these have previously been reported. 2 A novel key characteristic herein, however, was self-belief and inner confidence:

You've got to be able to project yourself to have … knowledge; have the ability and the skills (2:001)

You have to have a strong sense of belief about what you're doing… be prepared to challenge (1:004)

Price and Edwards9 also highlighted self-belief and confidence as essential skills, and similarly Graham11 (p.1816) reported "confidence e self-concept as central to the role".

Lack of support

Although a substantial financial investment which had been made in establishing consultant posts, participants reported extremely varied support in practice. On the one hand, and in line with findings from other authors,6,36 poor support was reported.

I wouldn't say I feel well supported (2:004).

Managerial indifference was also claimed and linked, in turn, to issues of personal and professional isolation:

She doesn't do anything to be non-supportive; just she isn't supportive (2:006),

That's why I feel I'm actually really detached e I'm detached from radiography completely (2:006)

A lack of support (and, indeed, active resistance) from radiographic colleagues, meanwhile, may be more surprising, though again this is in line with the findings in the literature6,12:

I have had a lot of bullying from my colleagues … I have been dealing with that … it's been … icy (1:006)

I was down in a meeting … and he … said that as long as this person is in spot you will never have anyone role extending…I find it very … difficult. (1:006)

If a medic is not going to sign up to it and let me develop and they don't want the role to e then you are on a hiding to nothing (1:007)

Rees12 also reports that some radiologists remain a barrier to consultant practice, with a core concern previously being cited as the lack of 'medical background' to handle any complication that might arise,15,16 and an insufficient knowledge base to make clinical decisions.14 Conversely, some reports have identified the nature of the consultants in providing key services, for example 24 h reporting requirement in accident and emergency radiology.17 Either way, one participant maintained faith that the circumstances would change over time:

It will get easier e people will accept you … eventually (1:006)

Crucially, there was a feeling among the participants in this study that isolation from peers and managers may lead to reduced effectiveness:

… you can be kind of left a bit on your own (1:001)

You don't have any other consultant radiographers, there's only me (2:006)

The reasons behind the lack of hierarchical and peer support itself were not pursued within the present study, and no other staff were interviewed to triangulate these findings. It should be noted, though, that Crossman21 Atsalos and Greenwood22 and Graham20 all report physical and professional isolation as problematic phenomena for consultants, and Ford6 elaborates that this may be due to the high degree of self-determination necessary.2 In radiography, the hindering of role-effectiveness might also be related to the novelty of the role itself, resulting in (a) other directorates not understanding its constitution or parameters,12 (b) longstanding medical resistance to change13,16 and (c) a lack of standardised knowledge on 'how' to support new consultantsd:

I don't think they knew how to support me (1:001)

There was not necessarily anyone that you could speak to that was in a similar position (1:001)

I'm quite an independent person anyway that gets on with things so perhaps … nobody feels I would require that support (2:004)

In line with Hardy and Nightingale's37 Transition Model, however, the participants were proactive in finding their own means of support, demonstrating a readiness to problem-solve and practical fill gaps independently. For example, they formed consultant networks, e.g. the College of Radiographers Consultant group. They also actively networked with professionals from other disciplines, though largely as a response to feeling unsupported and isolated. It would be of value to explore whether consultants who were not retained similarly felt that such a potentially deleterious set of interpersonal circumstances had contributed to them leaving their professional role.

Organisational structures

While many specific issues of support and hindrance were heavily anchored to each individual's particular situation, a range of more standardised organisational obstacles were also identified. These included: a lack of understanding of the role and where it fit in the organisational chart; the apparent separation from the radiology department in some cases; uncertainty around line management; shortages of staff; resource constraints and poor communication (including no regular meetings). Organizational structures have been reported in the literature to be a significant barrier to clinical leadership for nurses, showing some correspondence with these findings38 and, in this study and others,39,40 the d The present study therefore suggests that support would be welcomed if it were to be offered. lack of clarity in role and structure was reported to have a universally negative impact on practice. It is also possible, as noted above, that such lack of organisational clarity may lead to difficult personal circumstances at the individual level via inconsistent support, or a lack of any support.

Time and workload

Lack of time, and excessive workloads, are raised as problem issues in extant literature,10 and by all participants in this study. The wide and rather nebulous scope of the role was reported as a driver in consultants feeling 'pulled in many directions':

Because you're working too hard to do all this XXX, you don't actually have time to do your own stuff (2:006)

You know even managers aren't always clear and so you'll get pulled into lots of other things and then you end up trying to juggle too many balls (1:004)

In line with further literature,12 all consultants reported working well over their contracted hours, not taking lunch breaks, working before and after hours two to three times a week, and beyond the remit of the role:

I mean the workload is horrendous e it is so heavy and the hours I work are horrendous as well (1:008)

I think it would be very easy to step outside of the box of clinical competency because very often we are asked to do that, so you would have to … say … that is beyond where I am supposed to be working (1:009)

When I get torn in other directions … and I do find that happens … that's about me then having to say no or try and be quite firm about where my role sits (1:004)

Again the lack of clarity around the parameters of role, and the organisational structure nominally supporting it, appears to contribute to this. This, again, illuminates the interrelated nature of issues in the complex social-organisational system within which the consultants work.

Development activities

Consultants reported of a number of issues related to development, variously indicating how it could both support and hinder practice. Pertinent issues herein included: planning and identifying development needs; whether participants felt activities were 'effective'; support for development (and obstacles restricting it); how they were developing others (and a possible new in-post buddy system for future consultants); and the under-utilization of appraisal in the development planning process. The clear desire to keep developing as a professional was evident, and the regular use of goals to plan development specifically was also highlighted. There was an apparent focus on clinical skills and ongoing competency, with an attendant acknowledgement that leadership development had not been high priority, despite it being one of the four domains of practice. People management was also raised as an issue with which consultants felt they needed further assistance.

It's fair to say I have had absolutely no training at all [in leadership] (1:005)

Price and Edwards9 (p.e65) also report the need "to take practitioners beyond a defined modality to include leadership and people skills" showing some convergence on the need for wider development beyond clinical skills. Moreover, the advice participants would give to new consultants indicated that a wider leadership and development focus, including using coaching support, would be highly beneficial, even though it did not reflect their own journeys:

I would be recommending the personal development and leadership stuff, self-awareness … if there was one piece of advice that I would say to them, to support or … enable them … it would be to get a coach. Not a mentor, a coach and actually formally go on a process of coaching. (3:004)

In this sense, this study offers some of the first empirical evidence highlighting consultants' own need for leadership development training, though the perceived benefit of employing a coach was also outlined by consultants in Nightingale and Hardy's study in 201220 and in the domain of nursing by Davidson et al.38

Conclusion

This study has captured novel data, from role pioneers, across specialities and across the UK, while the role itself remains fairly new. The analysis presented herein offers a specific insight into working practices and corollary personal circumstances, and how these can be more effectively supported, on implementation and over time. The consultants clearly articulated that their roles positively impact on patient care and service delivery, and also offered some specific examples to support that view. They also showed a clear focus on continuous improvement for patients, and highlighted some of the individual characteristics which they believed supported them to be successful in the role. This will be useful in identifying future potential consultants to mentor and encourage over time.

The lack of support experienced by these consultants highlights the need to strategically plan provision for future consultants, so as to optimise their role performance and encourage retention. Consideration, in particular, of how to reduce the sense of isolation experienced would be beneficial. Reflection would also be helpful upon role clarity and the organisational structures which support consultant practice, now and into the future. Equally valuable in the future would appear to be greater investigation of practices that reduce resistance, and more robust evaluation of workload and time commitments, to ensure these are realistic to sustain healthy practice.

There is some evidence that the personal costs of consultancy are too high, and these roles may not thus be sustainable in the longer term if no changes are put in place to enhance support for these senior staff. Additionally, exploring the most effective development opportunities (which extend beyond clinical skills) would be worthy of further exploration, to (a) assess what impact they might have on practice, with (b) a consideration of introducing coaching support for the roles. Despite the many challenges and difficulties identified by the participating consultants throughout their interviews, however, it was heartening that they also developed a clear sense of great satisfaction in the role:

I really do enjoy it, I really love my job (1:004)

Conflict of interest

None.

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