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## Guest Editorial

# What is the point of role development for therapy radiographers in the UK? The case of breast simulation

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## INTRODUCTION

The trend towards radiographers extending their roles, into what have traditionally been medical fields, is gathering startling momentum. In the wider health context, however, it is not novel but closely reflects the pattern of other professions such as nursing where there has been a gradual blurring of professional boundaries for some years now — what Dowling et al.[1] refer to as the: "quiet revolution... in the division of labour".

Consequently it is pertinent for us to draw parallels and look towards these professions for insight into our own potential for professional development.

Therapy radiographers now have scope to move into several areas of role development. Many centres have radiographers in specialist roles and there is increasing evidence that a number of radiographers are now embracing advanced levels of clinical practice by operating beyond their traditional skill base and encompassing tasks and skills previously undertaken by clinicians. Such role extension activity is commonly focussed on three broad skill areas — delineation of volumes during simulation, patient review, and treatment verification processes. Our experience of introducing a scheme where radiographers are trained to undertake breast simulation has prompted much local discussion and debate which perhaps reflects issues currently being debated by our professional body and the profession as a whole.

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## BACKGROUND

There are many reasons why role development for individual professionals, and indeed skill mix as a whole, has been given increasing priority in the health care arena over recent years. Health economics have had an increasing relevance since the health reforms of the late1980's and early 1990's and the latest political spotlight on the NHS has added increased urgency for further reforms and so called modernisation. For the health professional, this has meant that we are all as familiar with terms such as 'waiting targets', 'efficiencies' and 'cost effectiveness' as we are 'patient care' and 'quality'.

With this political driving force behind reforming the NHS, it is easy to see why skill mix has become the 'buzz' issue of the late 1990's. However in clinical oncology it is also recognised that economic factors are not the only impetus for role and skill changes. The Royal College of Radiologists[2] also cites clinical, epidemiological, professional and educational factors which are creating demands for change. Similarly, the Calman-Hine policy framework[3] clearly asserts that improved patient care requires an emphasis on education and multi-disciplinary teams of staff operating with different levels of expertise to facilitate a comprehensive service.

It is also the case that there is some opposition to changes in deeply ingrained professional boundaries by those who argue that it is merely a political cost saving exercise which will dilute the strength of professional identities. Melanie Philips[4] writing in the *Sunday Times* expresses concerns about the "dispersal and devaluation of medical expertise"



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and argues that changes in medical and health professional clinical boundaries are:

> *"the outcome of the vacuity and relativism of the age. The mantra of modernisation conceals a vacuum in which intellectual, moral and social values have been junked and replaced by a new pseudo-creed of computers and the 'knowledge economy'".*

Whilst this may be considered a particularly journalistic viewpoint it is nevertheless true that the NHS has historically been subject to various political trends and influences.

Whatever opinion one has about the appropriateness of changing professional roles and boundaries there is no doubt that the direction is already set and change is well underway. It is therefore relevant to debate the issues and explore the potential advantages and disadvantages of the revolution in health care delivery which we are about to experience.

## POTENTIAL BENEFITS OF ROLE DEVELOPMENT

> *"Skills mix should be patient–focused in that it's primary purpose should be to maintain and continue to improve standards of care" (Royal College of Radiologists)*[2]

By extending the role of the radiographer in the simulator it is essential that we address the potential benefit to the patient. Of course, one of the key political and economic reasons for extending the role of the radiographer is better utilisation of personnel skills and equipment in order to maximise throughput and hence reduce waiting times. Clearly there are many ways in which radiographer led breast simulation can potentially do this. Simulator sessions where doctors are not available can be utilised or sessions outside normal working hours can be organised. Such schemes must undoubtedly be attractive given the government's target of a maximum waiting time target of two weeks for all cancers by December 2000. Political gains aside though, there is no doubt that waiting for cancer treatment to commence is a most stressful time for patients and reducing that time can only serve to reduce anxiety.[5] Utilising simulator sessions where medical staff are unavailable and where equipment would otherwise be standing idle is also sound economic practice.

Further waiting time for the patient has traditionally arisen when they arrive for their simulator session. Waiting for medical staff availability in order to define the breast volume has, in our centre, created inefficiencies within the simulator suite – quite apart from the frustration caused. We have found that in beginning to implement radiographer led breast marking, sessions run more smoothly and result in less waiting around for individual patients.

It is an interesting suggestion also, that the quality of the patient experience of the simulator may be enhanced if the same radiographer gives them information, defines volumes, and is present throughout the whole process — possibly undertaking the consent process too. Clearly, patients often encounter medical staff in the simulator whom they have not met before and are often introduced to them whilst lying on the simulator couch. This scheme then gives us opportunity to develop the quality of the simulation and consent processes, assuring sensitivity, continuity and consistency of information and personnel. Developing a rapport with the patient should be easier and with fewer personnel, the risk of conflicting information should be reduced. Luker et al.,[6] in looking at nurse prescribing initiatives, noted that extra levels of involvement of the nurses enhanced the nurse patient relationship and facilitated patients discussing issues which may otherwise not have arisen. It is easy to identify potential parallel gains in radiographer led role extension activity within the simulator and it will be interesting to see if these are realised.

Whilst acknowledging the benefits as far as the patient is concerned, it is also important to acknowledge the potential for the individual professional involved. Training and educational opportunities associated with breast simulation role extension should be prioritised by Trusts. Such role extension supports the philosophy of continuous professional development in its truest sense — developing work based skills within the clinical setting.

From the clinicians point of view, the time released should enable them to apply their clinical



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expertise more appropriately and offer a more cost-effective service to the Trust.

## POTENTIAL DIFFICULTIES CREATED BY ROLE EXTENSION

Even if we embrace wholeheartedly that there are multiple benefits to be gained from skill mix and role extension activity, it is nevertheless realistic to acknowledge that the process of expanding professional boundaries can be painful and involve many difficulties.

Role extension undoubtedly offers professional challenges and stimulation for some, but for other individuals can be seen as a threatening and unwelcome change. Individuals may not see the need for role development and be unwilling to participate. Our own scheme requires the completion of a 15 credit M Level work based unit of study, incorporating both academic and clinical components. Some radiographers may lack the confidence to undertake such study and many still have little or no experience of undertaking Masters level work. It may be the case then that some staff are discouraged from participation because of the academic demands of the training. Managing a rapidly changing clinical and professional environment whilst successfully valuing the diversity of individuals within it, will undoubtedly prove challenging for radiotherapy managers.

Obstacles could also emanate from the medical profession who may see our role development as a potential threat though this does not seem to be a major issue in reality and in our centre we have had an extremely positive response from the medical staff.

Managing the role extension training and education programmes can also be seen as an additional burden on Radiotherapy managers or senior radiographic staff. With an already stretched workforce,[7] and restrictions on the time and resources available for further study, there is potential for such changes to create increased stress related symptoms in staff. Radiotherapy managers need to ensure that not only are the individuals who participate in role extension capable of taking on such new and diverse roles, but that the burden of training and educational development is not merely shouldered by a few already saturated individuals. Role extension must be a shared issue addressed by the whole department supporting each other by fairly distributing tasks and responsibilities.

Medico legal issues must also be addressed in the context of role development. For any individual taking on new and extended roles it is crucial that the lines of responsibility and accountability are documented clearly and unequivocally. At the moment, role extension schemes are operated under strict delegation agreements where the consultant retains overall responsibility. It remains to be seen if the individual health professional does gain greater autonomy whether we will need greater personal responsibility for the insurance of practice.[8] It has also been argued that litigation within the health service is increasing and is perceived as a very real threat to individual practitioners.[9] This point is debatable and the weight of evidence seems to be that the risk of an individual health professional being the direct subject of litigation at the moment is more perceived than real.

## PROFESSIONAL ISSUES

From the perspective of the individual therapy radiographer, there is no doubt that role extension presents an exciting and promising opportunity. For a long time some radiographers may have worked in frustrating situations observing junior medical staff being taught breast simulation procedures knowing full well that they have both the knowledge and experience to do this job effectively. We have also spent many long hours waiting for busy clinicians to arrive and define the breast volume knowing that our time could have been spent more efficiently and the simulation undertaken more quickly.

It is clear then that a level of professional satisfaction is there to be gained which we have previously been denied; a degree of independence and autonomy, which can be stimulating and challenging. However, before we become carried away on a wave of professional self-adulation we must also look at the clear realities of the role development situation. We are perhaps ignorant if we believe that our desire for professional advancement has been the main driving force



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behind role extension activity. In my experience it has been the economic factors and the need to reduce the less skilled medical tasks undertaken by doctors in order to maximise patient throughput which has been the significant driving force behind radiographer led breast simulation in this department. It may also be the case that the extent to which radiographers achieve autonomy in their extended practice will be carefully controlled and directed by the medical profession. Carter[10] suggests that such patriarchal attitudes are deeply interwoven in the definition of professionalism. Indeed, much of the terminology inherent in the role development debate is based upon the notion of 'delegation'[11] — the giving of responsibility, i.e. the implication is that the clinicians are 'allowing' us to develop in these areas. In our own professional literature however, the situation is often portrayed as radiographers achieving emancipation from medical control and establishing new heights of professional autonomy. Fell[12] explores this concept of the continuum of autonomy and suggests that we are heading towards a new level of decision making. Our local role development initiatives have been very rigidly protocol driven and although Fell suggests that such frameworks enable the practitioner to feel confident in new roles, it could be argued that this indicates the difference between our level of practice and that of our medical counterparts who have resisted clinical protocols and exerted their 'clinical freedom'. Are we as therapy radiographers entering new heights of advanced practice and decision making or are we merely adhering to a rigid set of pre-defined guidelines designed and agreed by clinicians? My own opinion is that the answer lies somewhere between these two extremes. Clinicians are now themselves being required to standardise their practice and work within clinical protocols and guidelines demanded by Clinical Govenance.[13] Similarly my own experience of breast simulation is that whatever guidelines are agreed and delegated, in the real world individual patients present unique difficulties and this is where the radiographers advanced level of decision making and clinical practice become evident.

The question is then — does it really matter what the catalyst for role development is, if, in the end it creates a mutually beneficial situation for all professionals and patients involved? We perhaps need to concentrate on proving that radiographers are capable of operating and leading a smooth and effective simulation service.

It is perhaps also relevant, at this time of change, to discuss the potential impact which role development may have on our professional profile. Our diagnostic colleagues have a long history of specialist roles (MRI, CT, Ultrasound etc.) but it is a relatively immature concept in the therapy scenario. Now, however, we in Oncology are beginning to develop specialist roles with a vengeance — counselling and information radiographers, research radiographers, specialist site radiographers, to name but a few. The advent of advanced clinical practice in areas such as simulation adds a further dimension to this trend. It remains to be seen however, whether the advanced clinical role will result in a new professional stratum. Will therapy radiographers with extended skills, qualifications and responsibilities, create a new hierarchy within a radiotherapy department and if so, how will this be recognised? Such a radical new job demarcation will surely need to address the issue of financial reward. Job and professional satisfaction may not be sufficient for the radiographer applying specialist skills in the clinical setting. The Society of Radiographers[14] is currently debating the issue of grading and financial equity within the context of role extension in a bid to develop a suitable structure in times of professional change and diversification. It remains to be seen, however, if Trusts will recognise advanced practice with appropriate rewards — this is by no means a certainty. Although often argued as a cost cutting exercise it has already been recognised that skills mix may not always result in financial savings for the service.[15] Amidst the debate currently raging about skills mix initiatives at the entry of the profession it now seems particularly important professionally to ensure that as much effort and debate is directed at shaping appropriate role opportunities which are suitably rewarded at the other end of the professional scale.

It may also be the case that increasing specialisation may lead to fragmentation of what needs to be a cohesive working environment. Changes in roles and responsibilities and pay differentials may lead to disagreement and dissatisfaction and there is no doubt that it may lead to a less flexible workforce as generic skills are lost amidst the race for specialisation.



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## CONCLUSION

Role development opportunities such as breast simulation offer, on balance, many opportunities which ought to be grasped at both the individual and the wider professional level. The nature of the evolution of local schemes to develop advanced levels of practice is often complex and shrouded in historical and political conflict. Nevertheless there are clear benefits to be gained by all parties concerned, not least the patient. It is clear then that the 'point' of radiographers becoming advanced practitioners in areas such as breast simulation, is that they are poised to facilitate and lead the development of a seamless service, promote the quality of the patient experience and maximise professional and personal development – goals which remain at the heart of our profession.

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