

EDITORIAL

Creating our future: conformity or change?

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Journal of Medical Radiation Sciences 61 (2014) 63–65

doi: 10.1002/jmrs.55

In the June 2014 issue of the *Journal of Medical Radiation Sciences*, an article by Neep et al.¹ is on the subject of ‘frontline radiographer commenting’, in the context of abnormalities of the musculoskeletal system due to trauma. I would like to use this article as a timely catalyst to debate some of the issues that the profession is currently facing. In this editorial the term ‘radiographer’ will be used to represent the diagnostic sector of the profession, while noting that in New Zealand medical imaging technologist is the term designated by the Medical Radiation Technologists Board (MRTB).

Medical imaging and radiation therapy in both New Zealand and Australia have been exploring for some years the possibility of changing roles and career progression frameworks in line with international developments. These developments have seen radiographers and radiation therapists extending their practice both within their own scopes of practice (role expansion) and into areas previously designated as roles of doctors or other health professionals (role extension). These developments have been in part to reflect the changing nature of health provision, with an advanced practice framework having the potential to be of real benefit to patients, and in part to enable professional development for an important and highly skilled sector of the health workforce. This change has been particularly apparent in the United Kingdom over the past two decades, a significant length of time that has allowed for acceptance, consolidation and research to be undertaken to support their initiatives. This is not yet the case in Australia or New Zealand, where progress has been slower and has yet to achieve a level of acceptance.

In New Zealand progress has been made based on research conducted initially between 2005 and 2008, investigating role development and a possible career structure. The recommendations from this research were formally accepted by the New Zealand Institute of Medical Radiation Technology (NZIMRT) in 2009 and

led to further research conducted between 2010 and 2013, developing profiles and criteria for the formulation of advanced scopes of practice towards the establishment of an advanced practitioner role. The registration board in New Zealand, the MRTB, currently has the development of an advanced scope of practice under consideration as it progresses with reformulation of all the scopes of practice for the profession.

In Australia, a proposed pathway to advanced practice has been distributed to members of the Australian Institute of Radiography (AIR) for consultation (see <http://www.air.asn.au/advanced.php>) and it's roll out is expected to commence in the near future. It was based on a report released by Professor Ian Freckleton SC and the Inter-professional Advisory Team in April 2012. To this end, the AIR has recently released a call for applications for advanced practitioner accreditation via the champion pathway.

In this context, Neep et al.'s article explores radiographer perceptions of their readiness to detect and comment on abnormalities of the axial and appendicular skeleton following trauma, as well as their preferences for two alternative forms of delivery of image interpretation education. It has been well documented, as described in both Neep et al.'s article and the commentary also included in this issue by Woznitza,² that radiographers are capable of high levels of sensitivity and specificity in the reporting of radiographs, not to mention the many other forms of role extension that have been incorporated in advanced practitioner roles in the United Kingdom. Given that there is a solid evidence base to support role extension and the formulation of advanced practitioner roles, the lack of confidence shown by radiographers about their abilities and their reluctance to actually describe what they have detected, raises some professionally focused questions for debate.

Woznitza's commentary reports the findings of Coleman and Piper,³ who compared the confidence and accuracy of

nurse practitioners, junior doctors and radiographers reporting trauma radiographs. They found that radiographers reported lower confidence, even though they had the highest average score and were the only group whose level of confidence correlated with their accuracy. As has been identified previously,^{4–7} there is a culture of subservience and apathy prevalent in the profession, largely due to the background of medical dominance that has persisted since the early 1900s when a hierarchal system was created within radiology departments, bringing about the limitation of the radiographer's role.^{8,9} Lewis et al.⁶ maintain that radiographers report feelings of intimidation, under-appreciation and worthlessness, that they feel 'overlooked', and these factors have translated into the 'just the radiographer' syndrome. While this article was written 8 years ago, this form of identity based on an inferiority complex can still be evidenced in attitudes towards advanced practice, for example, as seen in qualitative comments elicited in the recent medical imaging research for the NZIMRT.⁷ It could be postulated that this may be one of the factors lying behind the lack of confidence of participants describing (as opposed to detecting) abnormalities that characterised the findings of Neep et al.¹

It has also been suggested^{4,5} that radiographers have been socialised into a culture of compliance in order to be accepted as members of the broader radiology team. Conformity and compliance generally lead to conventional behaviour and are not conducive to innovation, risk-taking and improvement. This form of workplace culture does not support high levels of job satisfaction, self-esteem or confidence. Does this mean that given the opportunity to develop and advance, there is likely to be a backlash of resistance? Does this perhaps relate to why radiographers and radiation therapists in Australia and New Zealand have been slow to embrace the changes necessary to support career progression? If professional identity is formed around being 'just the radiographer', then how can a practitioner dare to stand up and offer an opinion that may be taken seriously by medical staff and other health professionals? Unfortunately, remaining restricted in a role undermines motivation and encourages 'mindless' practice.⁴ This professional culture does not encourage critically reflective practice,⁵ teamwork or the ability to effect needed change.

Apathy also has an effect on a practitioner's willingness to engage in the life-long learning (including research) required to fully engage as a professional. Neep et al.'s article suggests that the participants in the research study were willing to consider a short 2-day (or equivalent) course of targeted image interpretation training to enable them to take on a radiographer commenting role. At the same time it was suggested that the more formal

postgraduate requirements for image reporting may be found 'inaccessible due to large time requirements and a substantial financial commitment'.¹ While there was a strong theme evident in the New Zealand role development research¹⁰ that indicated a desire for change that would enhance their professional status, there were many participants who expressed resistance to engaging in further study or taking on additional responsibilities. It is a case of the philosophical 'chicken-and-egg' problem – if radiographers and radiation therapists engage in further education their confidence will improve and they will feel able to take on extended roles that befit their knowledge and skills. How can they be empowered to adopt an active approach to their future, which means being willing to put in the time, energy and financial commitment to lead change, even where the future is still unknown?

To ensure the future of the profession, it is time for radiographers and radiation therapists in both countries to stand up and insist on being seen, respected and having a profile as health professionals rather than being conceptualised as 'allied health technicians' (to this end it is unfortunate that in New Zealand the term 'technologist' is still used, along with the message this sends). Medical imaging and radiation therapy are rapidly developing professions that need motivated and active practitioners if reciprocity with our international colleagues and with other health professions is to be upheld. Neep et al.'s article is a timely reminder that while progress is being made, some radiographers and radiation therapists are still finding a move outside their comfort zone challenging, despite the large body of evidence that they are capable of making that change. At the same time, there are many practitioners in both countries who indicate willingness to champion local change. Our professional bodies (AIR and NZIMRT) need to find ways to encourage and engage these practitioners, both to create change in the professional culture and to progress an advanced practitioner framework.

Conflict of Interest

The author declares no conflict of interest.

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