Taking personal responsibility for role extension

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Introduction

Role extension [1] and/or advanced practice [1] are concepts that have almost become mantras in the radiography profession. The international movement was brought to South Africa (SA) in 2007 and 2008 respectively. During two international conferences hosted in SA, respectively in Cape Town and Durban, South African radiographers were introduced to some of the perspectives of role extension and/or advanced practice, specifically from the United States of America (USA) and United Kingdom (UK). In addition a peer reviewed article on this topic was recently published in SA [2]. Having been introduced to these perspectives always makes one long for 'what you are missing out on'. With the latest developments in the radiography qualifications in SA, there may even be a more intense desire of 'we want to do more' among radiographers.

Instead of providing answers, all the information that I received, as well as recent interactions with radiographers at CPD mornings, created more personal burning issues. I could not help pondering about some of the practical aspects associated with role extension and/or advanced practice, in particular pattern recognition. Luckily I was fortunate to meet Paul Bartholomew from Birmingham City University (UK) in early June 2009 at a symposium in Aegina, Greece.

Paul, himself a radiographer, has climbed the ranks first as a radiographer and thereafter as an educationalist in the Teaching and Learning Centre at Birmingham City University. Although he has gravitated towards education, he maintains close ties with his first love: radiography. He is involved in the design and presentation of specific modules on pattern recognition. Paul was then secretively identified as the victim whom I could use to bounce off personal radiographic burning issues. He then patiently, energetically and passionately responded to the burning issues.

Questions and answers regarding taking responsibility for role extension

So here is Paul's version in a nutshell of taking of responsibility for role extension; in this case pattern recognition.

Question. Paul, you were interested in pattern recognition before the role of radiographers extended formally into image reporting. Tell us where exactly did your interest start and what sparked your interest?

Answer. *When I first qualified as a radiographer in 1992, it was into a clinical environment where the 'red-dotting' of images, that is to say the application of a sticky red dot onto those film packets of examinations which radiographers regarded as abnormal, was fairly common place. The introduction of 'red-dotting' at the hospital where I worked led to a phenomenon which I think was fundamental in sparking my interest in image interpretation; the act of applying red-dots as a marker of potential abnormality catalysed a great deal of new discourse between the referring Accident and Emergency clinicians and radiographers. We would apply a red-dot and they would often wish to clarify what we had seen and would come around to the x-ray department to have a conversation about what we thought we had seen.*

As a radiographer, you had a number of choices in these situations – you could just say something like 'It just didn't look right to me – you might want to discuss it with a radiologist' or something like 'I think this linear radiolucency here is a fracture, especially given the amount of overlying soft tissue swelling'; as experience and confidence grew, radiographers became bolder with their opinions – for example 'I red-dotted it for this – I think it's a fractured hook of hamate'. In some hospitals, the practice was to place the red-dot directly on the image, adjacent to the area of concern – I can see the logic to this but I would imagine that this didn't catalyse nearly so much discourse.

Speaking from a personal perspective, having these conversations with clinicians led to a lot of learning for me; I identified a need to be able to be quite specific and to learn to articulate the rationale behind my decision to red-dot.

Question. What did you do then?

Answer. *Now that I am an educationalist I would say that I appropriated the specialised language of the domain! In practice what I did was to be quite methodical in following up on each and every image where I had seen something that I had considered to be abnormal; I would note down the details of the examination and seek out and read the report once it had been made by a radiologist. If the radiologist's report just said the image was normal, I'd retrieve the examination and show it to a radiologist to ask specifically about the appearance that had given me cause for concern.*

When in 1997 the hospital I worked at took a decision to formally train some radiographers to report on images, I was one of four radiographers chosen to expand my role. I certainly found that my proactive approach in pattern recognition stood me in good stead when

I undertook my postgraduate certificate in radiographic reporting.

Question. How did you obtain radiologist buy-in at your hospital?

Answer. *Actually the initiative at my hospital was jointly led by a consultant musculoskeletal radiologist and the superintendent in charge of Accident and Emergency imaging so there was radiologist buy-in right from the beginning. My understanding of the drivers for the introduction of this role extension was that with expanding numbers of machines of other modalities and an expansion of radiology into the treatment of a number of conditions through interventional techniques, plain film reporting had begun to suffer which caused some delays in trauma images being reported; all of this was in a context where there was plenty of evidence elsewhere that radiographers could alleviate some of these pressures. Consequently, there was never really an issue with radiologist buy-in, since they had a vested interest in getting the plain film reporting work covered so that they could be freed up to move into these other emergent services.*

Question. Looking back, is there something that you can share with radiographers and or students as three areas of responsibility in attaining the goals in the same way as you did?

Answer. *If I had to pick three top-tips, I'd say:*

1. *Know your anatomy really well – the specialised language of image interpretation is so intrinsically linked with good anatomical knowledge – this is simply an absolute prerequisite.*
2. *Actively follow-up on anything you aren't absolutely sure about at all times, even outside of a reporting context.*
3. *Make sure you get into conversations with people, both as a student and as an expert. Learning is a social activity and is best facilitated through having plenty of rich discourse with people who know more and know less than you.*

Concluding comments

It is hoped that you have learned from Paul's responses as I have done. More so I trust that you have also found the responses motivating and encouraging. I have once again realized that as radiographers, no matter what category we are practicing in, we will have to fully accept the responsibilities accompanying the 'new' roles that we so much desire to move into and when we do it, then do it proudly.

References

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