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On becoming a consultant: A study exploring the journey to consultant practice

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ABSTRACT

Background: This paper reports a qualitative study exploring the establishment of non-medical consultant roles in Radiography. Given the difficulties reported in recruiting and retaining staff in these posts, we hope this paper offers a historical documentation of those consultants who were some of the first in post, sharing their stories of how they obtained and transitioned into their roles.
Methods: This paper is part of a two year case study exploring the leadership domain of consultant practice. The focus of this paper is a reflection, by the consultants, of their journey to becoming a consultant; a documentation of some of the practical issues in establishing the roles; and the transition to higher levels of practice.
Eight consultant radiographers participated in the initial interviews (two consultants withdrew from the study subsequent to this). In-depth iterative interviewing was used to explore and record individual stories and experiences.
Findings: The consultants shared their perceptions of being in post, including their own motivation to progress to a new role, how prepared they felt initially, the lack of role models, the lack of clarity surrounding the role and a perception of 'being on display'.
Conclusions: The paper offers insight into the journey of these consultants and some of the common characteristics they share. These characteristics give some indication of what motivated them to step into higher level roles, in particular the need to drive change and improvement. The paper also offers suggestions for how the transition into the role could be more effectively supported.

Background

The introduction of non-medical consultants (from this point referred to as consultants) in nursing and allied health in the UK is well documented.[1–4] In nursing, the establishment of the consultant role was announced in 1999[1] and in 2000 two waves of consultant posts were proposed.[2,3] By March 2001, Moore[4] reported that over 500 posts had been approved. The NHS Plan indicated that by 2004 it was expected that there would be 1000 consultant nurses,[5] though in reality only half of this number were actualised.[6]

In allied health, the intention to establish consultants posts was first announced in The NHS Plan,[5] and was reported again in the NHS Strategy for allied health professions the same year.[7] The final announcement confirming consultant roles in allied health came in 2001,[8] with an expectation of 250 posts by 2004.[9] The rate of adoption in practice however has been slow, with less than 60 AHP consultants appointed in the first four years[6]; in radiography, as of September 2014, there were only 83 (plus 2 trainee) posts listed on the Society of Radiographers (SoR) website (this may not reflect accurately the number of post as consultants do not have to be members of the SoR). There are varied estimates of consultant numbers in the literature, showing an apparent lack of knowledge about the number of posts in practice. While total numbers are unclear, Ford[10] indicates that the potential in radiography is not being reached as all available posts have not been successfully appointed to. Ford states that this is, in part, due to there being insufficient suitable applicants and that opposition from radiology colleagues is also an issue.[11] Of some concern is that some of these posts were subsequently lost because no one was appointed.[12,13]

The individuals who took up these posts initially in radiography did not necessarily get there via typical advanced practice routes,

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but through more "tortuous" (p266) pathways followed by individuals developing themselves.[6] In part this was due to a 'lack of clearly defined clinical and educational pathways'[14] (p.e66) and is perhaps why fewer consultants have been recruited than expected.[3]

Price and Miller[13] argued that for consultants to be successful in their role, they need to possess certain characteristics: the ability to work autonomously; confidence to drive an agenda; driving change and the ability to challenge practice. Ford[10] reported these characteristics to be determination, perseverance, motivation, strength of character and emotional intelligence. Similarly in nursing, Woodward, Webb and Prowse[15] included: ability to empower others; determination; self-confidence; collaboration and motivation in their top required criteria list. There appears to be some commonality that a strong character is required for the role, however in practice it has been reported that consultants are unaware of the criteria for success.[10] Virtually no empirical evidence was found that demonstrated which criteria measurably enhanced consultant practice and very little literature was found describing the characteristics of consultant radiographers, opening a gap which this study hopes to fill.

Given the lack of clear pathways and educational requirements for consultant radiographers, the authors were interested to learn about the journey of the early adopters of these roles. Particularly what had enabled them to acquire and mould these posts, along with any challenges faced and what qualities they possessed that helped overcome them. The study also gave an important opportunity to document the stories of the pioneers of radiographic consultant practice.

Methods

The results presented here form part of a wider study, funded by the College of Radiographers Industry Partnership Scheme (CoR-IPS), where leadership qualities were ascertained using the NHS Leadership Qualities Framework (NHS LQF). As part of this study an action learning group was established, executive coaching was offered and consultants were asked to maintain reflective diaries. This paper reports on the initial in-depth interviews undertaken at the start of the research in 2010, to establish how participants had moved into and developed their consultant role and the second interview which was undertaken once leadership qualities had been ascertained using the NHS LQF, 4 months later. Due to the nature of the NHS LQF, this second interview reflected partly on characteristics related to leadership.

All 31 consultant radiographers who were 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. An electronic invitation was sent via the chair of this group. Initially $n = 9$ consultants agreed to take part, but prior to the first interviews being conducted one participant withdrew. Two further consultants withdrew after the first interviews were conducted, due to workload. Therefore eight consultants were interviewed initially and six consultants were interviewed in the latter stages of the research.

The interviews were undertaken by telephone, due to the geographic spread of participants. All interviews were audio-recorded and transcribed verbatim. Each interview lasted, on average, 1 h. An experienced qualitative researcher (a radiographer not directly involved with the consultant group) undertook all interviews and a second experienced qualitative researcher (also a radiographer, but again not directly involved in the consultant group) analysed the data to reduce the risk of any potential bias (i.e. any bias in interview questions would be evident through listening to the interviews or noted within the written transcripts; any affected data could then be removed by the second researcher). The first researcher then reviewed the analysis so that agreement on themes could be established i.e. consensus validation, this offered protection against any potential bias in the analysis or data interpretation.[16] All transcripts were returned to the interviewees for participant credibility checks[16] and the themes were shared with the participants to ensure appropriateness of interpretation.

The open, in-depth nature of the interviews enabled each consultant to tell their own story around a range of general open questions. Gentle probing was used to deepen the narrative and iterative interviewing was used to build on the topics covered as the interviews progressed, ensuring what was important to the consultants was covered in the interviews. This mode of interviewing produces active novelties that more structured methods cannot.[17]

Thematic analysis, using a word and phrase level coding process was utilized to establish initial codes, which were then grouped into higher order themes.[16]

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

Findings

The consultants worked in a range of areas (Therapy - Head and Neck, and Gynaecology; Diagnostic – Breast imaging; Plain Film reporting and Gastro-Intestinal imaging) and had spent between 16 months and five years in practice as a consultant radiographer. One was part time (0.6 FTE). Their ages spread from 30s to 50s and they were all female. The female dominance is not surprising as less than 10% of radiography consultants are male,[19] therefore this sample reflects the gender spread in the population. All consultants held an MSc. Year of qualification ranged from 1978 to 1992 (Two of the consultants had taken maternity breaks, so this range does not reflect continual practice in all cases). Their journey into the role is outlined in Table 1.

Within the initial interviews we asked the consultants what qualities they perceived contributed to their role. The key qualities described are outlined in Table 2. While these qualities were not subjected to statistical analysis, they are arranged in terms of thematic occurrence or frequency, shown numerically here to indicate the number of times they were raised independently in the interviews. In the spirit of qualitative data, where each individual view is deemed to be important, Table 2 includes all the qualities highlighted, even when only one person highlighted it once, to show it held some degree of importance to at least one person. Table 2 demonstrates some qualities that were surprising, in that they did not show up more strongly (though it is acknowledged that wording may be used differently between participants).

Discussion

This discussion describes the core themes, in relation to becoming a consultant, which emerged through thematic analysis:

- Motivation for the role (which includes the qualities thought to be important)
- Transition into the role (which includes some of the barriers faced)

We discuss here the text from the interviews to demonstrate how we identified each category. Each quote is identified using the