Critical analysis of the argument in favour of radiographer assistants

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Abstract
It is apparent from current literature that Australia, like other countries, is facing an inevitable workforce crisis because of its aging population. It is predicted that, while the patient population will increase, the size of the health care workforce will decline. Health professionals are being encouraged by governments to examine new ways to practice. In the United Kingdom reform and restructuring of the radiography workforce has already taken place, apparently with some success. The introduction of assistant practitioners has aided the development of advanced and consultant practitioner roles. In Australia, health professions other than radiography have had assistant practitioners for many years. It is argued that the introduction assistant practitioners into the workforce has the potential to improve the perceived professionalism of radiographers. The radiography profession has been subject to ‘subordination’ and ‘limitation’ from the medical profession for decades but does not have capacity to formally delegate tasks to another subordinate occupation. With the prospect of health care workforce reform clearly evident, it may be timely for the radiography profession to proactively explore new, more flexible models of practice. The implementation of assistant practitioners may be a widely beneficial component of radiographic workforce reform.

Keywords: assistant practitioners, radiography, subordination, work force reform

Introduction
Arguments for and against the introduction of assistant practitioners into the Australian medical imaging workforce are complex and this is a controversial and potentially polarising debate. The opposition argument generally relates to the threat that the role of radiographers in the health care workforce would be eroded and that employers will be able to choose between employing radiographers or lesser qualified, less experienced assistants to fill the gap when or where more appropriately qualified staff are unavailable. Worse still, there is a perceived risk that new graduates will not be employed if employers have a cheaper alternative, in spite of their lesser qualification. While the author is appreciative of such arguments, there is another side to the debate that needs to be aired, particularly in the light of the predicted future health care workforce crisis.

The crisis facing the health care workforce
There is an increasing awareness of the impending and unavoidable global workforce crisis facing health care. According to Australian Bureau of Statistics (ABS) projections the median age of the Australian population will have increased by 10 years by 2050 compared to 2000. This unprecedented aging of the population has implications for workforce participation. In 2003, people aged 25–54 years made up 69% of the workforce and in the future, as the population ages, this portion of the population will retire and become the patients who will require health and disability services. The prevalence of age-related chronic disease is also expected to increase. Many professions and trades will fail to meet their quotas of entry level workers and the economy as whole will be faced with skills shortages in many areas, a reality that is already becoming evident. It has been argued that, therefore, health professionals need to develop new ways to practice. Some authors have suggested remodelling and redefining of interprofessional boundaries, with the transfer of skills between health professions. Among other forms of skills transfer, Duckett suggested the introduction of both radiographer assistants, to perform some of the basic duties currently performed by radiographers, and advanced practitioners, who could carry out some radiological reporting currently performed by radiologists. Such proposals are not new and, if for that reason alone, are worthy of careful critical analysis.

Radiography workforce reform in the United Kingdom
In the United Kingdom (UK), the ‘four-tier’ medical imaging workforce model, including sub-professional assistant practitioners, has existed since about 2000. Woodford identified the reasons for the introduction of this model as staff shortages, increasing demand for services, rapidly advancing technology, and the need for radiographers to develop new career development pathways. The argument was that, in return for permitting the introduction of the lower level assistant practitioners to perform some of the less complex, more routine tasks, radiographers would be able to develop advanced and consultant clinical practitioner roles. The core of the radiographic workforce remains the accredited practitioner. The introduction of the higher level roles would in turn allow radiographers with advanced competencies and status to substitute for radiologists in some of their less complex, more routine duties, thus freeing-up the radiologists to perform more challenging medically-oriented tasks.

The UK Society and College of Radiographers has been
supportive of this reform and restructuring, as it provided members with appropriate recognition for their contribution to the care of patients. At the same time, the restructuring was supported by the Government, who saw it as a means of addressing current and the future medical imaging (and radiation therapy) workforce crisis.

A recent survey of the uptake and implementation of the four-tier workforce structure across 177 National Health Service (NHS) trusts in the UK by Price and Le Masurier showed that 33% of the sampled trusts employed a total of 158 assistant practitioners. It was also found that 47% of the trusts employed advanced practitioners and 3% employed consultant practitioners, with the total numbers being 623 and six respectively. The authors acknowledged that, at the time of the survey, the number of consultant practitioners was low, although they expected it to increase with the further adoption and diffusion of new roles for radiographers. It was concluded that many of the NHS trusts are developing new ways for radiographers to practice and that the scope of radiographers’ practice has widened considerably since the mid-1990s.

A similar model of workforce restructuring was argued for the Australian medical imaging workforce in 2003 by Smith and Lewis, the introduction of the assistant practitioner level being something of a trade-off for the development of advanced and consultant practitioner roles. However, in spite of the apparent success of radiographic workforce restructuring in the UK, the impetus for change is less intense in Australia. The medical imaging workforce crisis is not as dire in Australia as it is in the UK where the number of radiologists per million population is about one-third lower than in Australia. Nevertheless, Australia is still considered to be undersupplied with radiologists, with mal-distribution of the radiology workforce favouring metropolitan localities.

Another important inhibitor to wholesale workforce restructuring is that, while in the UK the vast majority of radiology is performed in the National Health System, in Australia about 70% of radiologists work in the private sector. The Commonwealth health insurance legislation prohibits radiographers from charging directly for the provision of radiographic services and reimbursement for a service generally requires that a report is produced by a radiologist. The recent Productivity Commission report on Australia’s health workforce questioned the sustainability of this system and recommended changes to the Medical Benefits Schedule (MBS) that would allow access to the billing system by a wider range of health professionals. Under the MBS in its current form it is questionable whether radiographer reporting or other extended roles will develop to the same extent as in the UK.

A further question arises, therefore, as to why the Australian radiography workforce would be supportive of a restructuring that would allow the introduction of assistant practitioners if the advanced and consultant practitioner career development pathways are not opened up or remain difficult to negotiate.

Subordination and limitation as catalysts for change

Although the principal incentive for workforce restructuring and the introduction of assistant practitioners for a profession like radiography is the potential of developing extended career pathways, other incentives may be of interest. Other allied health professions have embraced the concept of assistant practitioners without wholesale restructuring of the workforce. Dental therapists have been lauded for their work in easing the workload of dentists by carrying out routine, non-invasive dental work. Pharmacy assistants have been referred to by pharmacists as a resource rather than a threat. Both the physiotherapy and occupational therapy professions have implemented assistant practitioner roles, and in some locations generic allied health assistant practitioners have long been employed to assist occupational therapists, physiotherapists and speech pathologists across professional boundaries. All of these assistant practitioner roles have the important caveat attached that the assistant can only work under the supervision of a qualified practitioner. Although the professionals have apparently handed over some limited, lower level competencies to lesser-qualified assistants, they have maintained control and assumed a position of dominance over another occupational group. This is referred to in sociological literature as ‘subordination’.

One of the classic examples of subordination cited in the literature is the occupational relationship between radiographers and radiologists. Examination of the history of that relationship reveals that radiologists have successfully both dominated and subordinated radiographers in their respective occupational roles. In the early years, the medical imaging fraternity was a hybrid group of scientists, electricians, curious amateurs and technically minded doctors who might collectively have been called ‘electro-medical practitioners’. It wasn’t until the 1920s that the balance began to shift, when boundary disputes that had been simmering for some time over the sensitive matter of reporting on radiographic images boiled-over. This was an issue of great importance to the doctors who feared loss of control over information that had become vital for diagnosis. The medical profession laid claim to interpretation of radiographic images with the assertion that only a person educated in the practice of medicine could reliably interpret radiographs. The apparently less onerous task of the technical production of the images was left to the non-medical practitioners of radiography.

Although the origins of radiography as an occupation are inextricably linked with the medical specialty of radiology, and in a sense preceded the beginnings of radiology as a unique branch of medicine, the development of radiography has been overshadowed by the relationship with the medical profession. Willis argues that, although the invention of the x-ray machine created the necessity for development of a new occupation of operators, it was a series of social interactions, particularly the dominance of the medical profession that resulted in a system where radio-techners ‘work under the direction of doctors and at much lower pay rates’. According to Willis, subordination is one of the ‘modes of domination’ evident in the radiographer-radiologist relationship, where an apparently less valuable occupation works under the direct control of another more powerful one. Further, one of the processes of subordination is what Willis terms ‘vertical specialisation’ involving the phenomenon he calls ‘pass-the-task’, where less pleasant, more routine and mundane tasks are delegated to the subordinate occupational group. The occupation that is concerned with the design or planning of a task and which has control of the delegation process is likely to be seen as the one possessing the professional expertise.

Professions characteristically use identifiable mechanisms or strategies such as subordination to establish and defend their occupational boundaries. Another mechanism identified in the sociological literature is termed ‘limitation’, by which the dominant profession dictates the administrative, educational or other processes of a less powerful group. This mechanism is
also evident in relation to the historical dominance of radiologists over radiographers in Australia. Until the mid-1980s completion of a radiography education program was marked by the award of a Diploma of Qualification from the Conjoint Board of the Australian Institute of Radiography and the Royal Australian College of Radiologists, which was a requirement for future employment. In 1985 the Conjoint Board was disbanded and the Australian Institute of Radiography set up its own Professional Accreditation and Education Board with no radiologist representation. However, it may be argued that the dissolution of the Conjoint Board had symbolic rather than any practical significance, the subordination of radiographers to radiologists and limitation of their practice role having been institutionalised for about 60 years at that time.

The relevance of the above discussion to the question of the introduction of assistant practitioners into the radiographic workforce is that, although it can be argued that radiographers possess a unique body of knowledge, skill and expertise, a key requirement of professionalism, they have no subordinate occupational group to which they can delegate tasks. In Australia, and in other parts of the world where radiographers are regarded as ‘delegates’ rather than ‘delegators’, this is limiting factor to their professional development. While there is no evidence in the literature that this apparent benefit of the introduction of assistant practitioners has been a motivator in other health professions choosing this professionalisation pathway, the argument is clear. Radiographers have been the recipients of a sound lesson in subordination and limitation from the dominant medical profession. It may be argued that the opportunity exists for radiographers in Australia and elsewhere to use these same mechanisms to develop their own professionalism.

Conclusions

It appears that there are two sound arguments for the introduction of assistant practitioners into the Australian radiographic workforce, in spite of the perceived threat. Firstly, there is the potential to develop extended practice roles for accredited radiographers as advanced and consultant practitioners, as has occurred in the UK, apparently with some success. The second argument has its foundations in the sociological theories of professionalisation. It can be argued that the subordination and limitation experienced by radiographers in the past at the hands of the medical profession could inspire radiographers to use the same mechanisms to advance their own professionalism. It is suggested that other allied health professions have already capitalised on this opportunity, perhaps unknowingly.

The health care workforce is in need of reform if Australia is to meet the demands of aging population for high quality care, a reality that is clearly evident to both the State and Commonwealth health departments. The Productivity Commission enquiry is evidence of this, as is the increasing number of published papers referring to workforce restructuring or reform. The entire July 2006 issue of the Medical Journal of Australia was given over to discussion of redesigning the health workforce, including the introduction of non-professional assistant practitioners with specific competencies. It seems probably that in the next decade (or perhaps sooner) governments will act to mandate workforce reforms out of economic and political necessity, with or without the cooperation of professional bodies. The opportunity exists to be proactive in the management of changes to professional boundaries, as has been the case in UK radiography workforce restructuring. The radiography profession in Australia can take control and offer the governments a reform option that is beneficial to patients, health care administrators, the profession as a whole and to individual practitioners. This debate needs to be had with some urgency, before control is wrested away from the profession and change is implemented regardless of issues of professionalism.

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