Radiographers and the Use of Medicines: National Scoping Project 2010

Responsible person: Susan Johnson
Published: Wednesday, December 1, 2010
ISBN: 978-1-871101-73-5

Summary

To this end the SCoR has commissioned research with the followings aims:

- to scope the current practice of radiographers in the United Kingdom (UK) with regard to the prescribing, supply and administration of medicines (hereafter referred to as 'the use of medicines');
- to identify possible new roles and ways of delivering the service using PGDs, supplementary and independent prescribing.

Acknowledgments

SCoR is grateful to **Geraldine Francis**, Principal Lecturer, School of Radiography, Kingston University and St George's University of London who undertook the writing up of the results of this scoping exercise. Also other members of the supply, administration and prescribing of medicines group who oversaw this project:

- Jancis Kinsman, Advanced Practitioner, Bristol Haematology & Oncology Centre, University Hospitals Bristol NHS Foundation Trust
- Sarah Griffiths, Advanced Practitioner, Bristol Haematology & Oncology Centre, University Hospitals Bristol NHS Foundation Trust
- Rebecca Vosper, Consultant Radiographer, Department of Medical Imaging, Hinchingbrooke Healthcare NHS Trust, Hinchingbrooke Hospital,
- Nicky Cornelius, Consultant Radiographer, Lincolnshire Oncology Centre, United Lincolnshire Hospitals NHS Trust
- Jane Mathlin, Specialist Review Clinic Radiographer, Velindre Cancer Centre

Also thanks Claire Dumbleton, Knowledge Manager, The Society and College of Radiographers for her expertise on posting the survey online

1. Executive Summary

1.1. For the last decade the Society and College of Radiographers (SCoR) has engaged with its members and with the Department of Health (England) to promote its belief that the authority of radiographers to prescribe medicines would benefit patients, the service and the profession. Current legislation allows radiographers to supply and/or administer medicines using Patient Specific Directions (PSDs) and Patient Group Directions (PGDs) and to prescribe using Supplementary Prescribing (SP) following qualification as a Supplementary Prescriber.

1.2. In phase 2 of the Department of Health AHP Prescribing and Medicines Supply Mechanisms Scoping Project (2009), Independent Prescribing (IP) for radiographers is to be considered. To inform the debate, this research was undertaken to scope the current practice of radiographers in the United Kingdom (UK) in the use of medicines and to identify new roles and ways of delivering the service using PGDs, SP and IP.

1.3. A national survey was conducted over a period of 3 months in early 2010 employing the web-based Survey Monkey (http://www.surveymonkey.com) with the link distributed through a variety of SCoR networks and yielding a response from 169 radiographers. It may be assumed that all had an interest in the topic, although only 67 respondents could be considered ‘active’ in the use of medicines.

1.4. Respondents tended to be experienced radiographers and were non- uniformly distributed geographically but were representative of most of the specialties within radiography.

1.5. PGD dominated practice and 65 different medicines were shown to be provided for patients in this way. 17 respondents were SPs and they identified the main limitations to their provision of care as being delays, inadequacy and logistical issues relating to the clinical management plan.

1.6. In considering how IP might benefit patient services, 3 themes were identified: the efficiency of service, the quality of service and the responsiveness to individual situations. Safety benefits were implicitly or explicitly identified within these themes.

1.7. Examples of improving service through IP by radiographers included improved pain and anxiety management during a range of interventions, reductions in the complexity of care pathways, faster and more holistic patient care, more effective palliative care, one-stop thrombosis diagnosis and treatment and a general increased access to appropriate and timely medication. Professionally, it was identified that consultant radiographers were unlikely to be able to manage their case loads effectively without IP.

1.8. Barriers to service development included lack of support from radiologists, bureaucracy and lack of resource in practice and some scepticism from a small number of radiographers as to the fundamental suitability of this role.

1.9. In conclusion, although from a relatively small professional base, the data strongly supports, the argument to extend IP to radiographers: without this, the opportunity for many improvements, economies and optimisations within current service delivery will be lost.

2. Introduction

Since the publication in 1999 of The Review of Prescribing, Supply and Administration of Medicines (Crown II), (Department of Health, 1999) and in keeping with its policy to support and encourage radiographers to seek opportunities for role development (SCoR 2008), the Society and College of Radiographers has engaged with its members and with the Department of Health to promote its belief that the authority of radiographers to prescribe medicines would benefit patients, the service and the profession.

Current legislation (The Medicines for Human Use (Prescribing) Order 2005, Department of Health) allows radiographers to supply and/or administer medicines using Patient Specific Directions (PSDs),

Patient Group Directions (PGDs) and to be Supplementary Prescribers (SPs). A PSD is a written instruction from a doctor or dentist for a medicine or appliance to be supplied or administered to a named patient. A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment: the radiographer is required to make the judgement that the patient situation and condition conforms to that describing the ‘group’. SP is defined as a voluntary partnership between an independent prescriber (a doctor or dentist) and a supplementary prescriber, to implement an agreed patient-specific Clinical Management Plan (CMP) with the patient's agreement. Independent Prescribing requires that the prescriber takes responsibility for the clinical assessment of the patient, establishing a diagnosis and the clinical management required, as well as prescribing where necessary and the appropriateness of any prescription. Independent Prescribing is not yet an option for radiographers (SCoR, 2010).

In 2009 the Department of Health published the AHP Prescribing and Medicines Supply Mechanisms Scoping Project including the recommendation to allow Physiotherapists and Podiatrists to become Independent Prescribers (IPs); this was adopted under what has become known as Phase 1 of the project. IP for radiographers is to be considered in Phase 2 of the project. It is thus vital to collect compelling and robust evidence in support of the argument that this professional development for radiographers will be of value and benefit to patients and to the service.

To this end the SCoR has commissioned research with the followings aims:

- to scope the current practice of radiographers in the United Kingdom (UK) with regard to the prescribing, supply and administration of medicines (hereafter referred to as ‘the use of medicines’);
- to identify possible new roles and ways of delivering the service using PGDs, supplementary and independent prescribing.

3. Method

A national survey of radiographers’ views and activity associated with the use of medicines was conducted over a 3 month period from February to April 2010. A questionnaire posing both closed and open questions was developed and piloted by the SCoR Supply, Administration and Prescribing of Medicines Group. It was desirable that the survey be accessible to as many radiographers as possible thus the final questionnaire was made available on-line through the web-based tool, Survey Monkey (http://www.surveymonkey.com). The link to the survey was distributed to a self-selecting sample of the membership of the SCoR, accessed through SCoR networks (Supply, administration and prescribing of medicines group, Research Groups, Consultant Radiographers and through Top-Talk). It was anticipated that awareness of the survey would also be cascaded by key members of these groups to others of the radiography workforce involved in this area of practice.

The results of the survey have been mainly displayed using descriptive statistics as tables and Excel graphs. However, in section 4.1 it will be seen that inferential statistics were used to test whether a difference between groups was statistically significant. Here, a Chi-Squared test was used to determine with 95% confidence that the observed difference in the survey sample cannot be explained by random chance and points to a real difference in the radiographic population as a whole. The free text data was themed manually.

4. Results

4.1. Response

A response rate could not be calculated as the number of radiographers who ultimately had access to the survey is unknown, but 169 responses were received and of those, 67 respondents were considered ‘active’ in the use of medicines in that 17 respondents held a qualification as an SP, another 4 respondents were currently training as SPs, 47 were using PGDs and a further 11 were using PSDs. (Note: the break-down figures do not sum to the total ‘active’ as some practitioners use more than one mode).

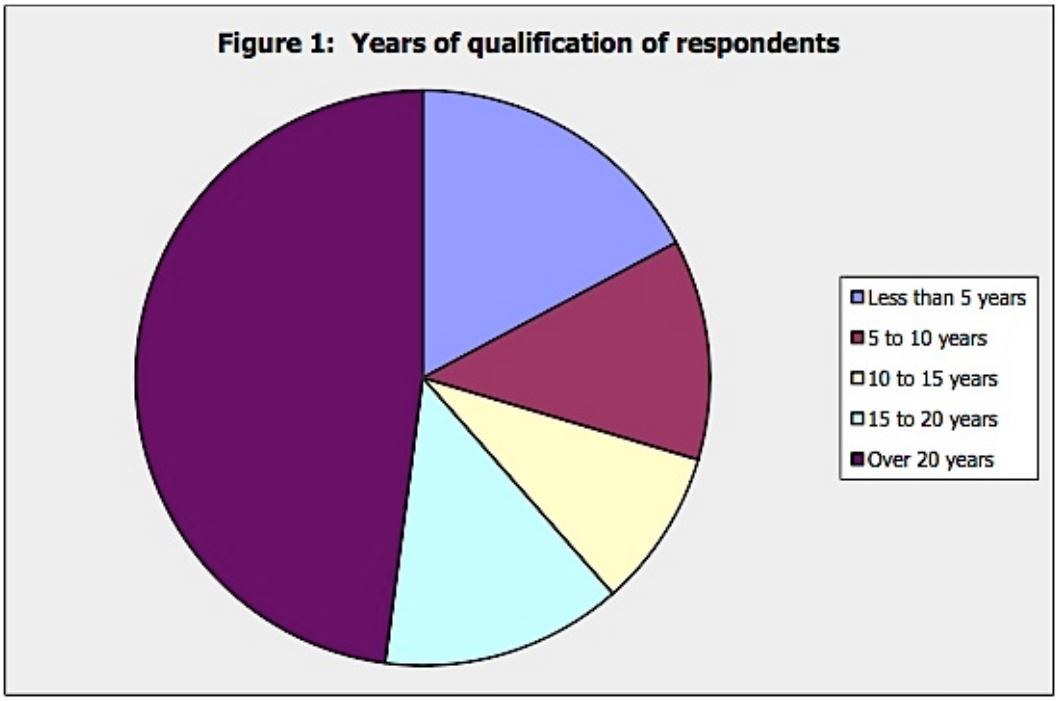
There was an unequal distribution of response across the United Kingdom as shown in Table 1, with 45% from Scotland and 48% from England; the distribution within England also showed some clustering. It was not possible to infer whether these differences were significant, as the responses could depend on how well the survey was circulated in each geographical area but approximately half the respondents from England and from Wales were ‘active’, compared to 21% from Scotland.

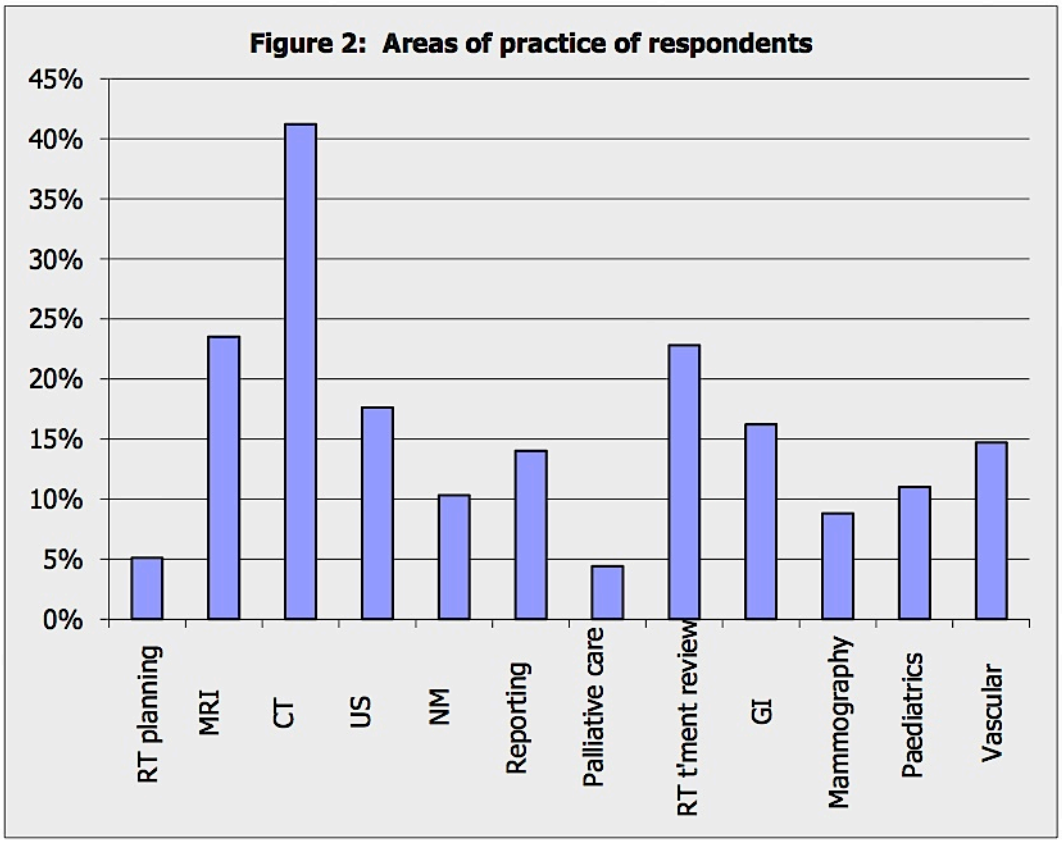
Table 1	Distribution of respondents by geographical area (including correlation with 'activity' in the use of medicines).					
Country	**Total response**	**% Total Response**	**‘Active’ Response**	**Not ‘active’**	**‘Activity’ unknown**	**% 'active'**
England	81	48	44	26	11	54
Northern Ireland	1	1	1			100
Scotland	76	45	16	47	13	21
Wales	11	7	6	4	1	55
Total	**169**	**100**	**67**	**77**	**25**	**40**
England by regions						
East of England SHA	13	8	7	4	2	54
East Midlands SHA	7	4	3	3	1	43
London SHA	4	2	1	1	2	25
North east SHA	3	2	2	1		67
North west SHA	8	5	7	1		88
South central SHA	1	1	1			100
South east SHA	9	5	3	4	2	33
South west SHA	15	9	10	3	2	67
West Midlands SHA	10	6	5	3	2	50
Yorkshire and Humber SHA	11	7	5	6		45

Of the total number of respondents, 71% were diagnostic radiographers (DR) and 29% therapeutic radiographers (TR); within the ‘active’ subset, these proportions changed to 55% DR and 45% TR. Of the 17 supplementary prescribers 5 were DR and 12 were TR.

The response was, on the whole, from an experienced sector of the profession with nearly half of all

respondents qualified for over 20 years (see figure 1); there was also a significant association between a radiographer being ‘active’ and the number of years qualified. Eighty-five percent of responses were from radiographers practising clinically with 61% (98) identifying themselves as advanced or specialist radiographers and 8% (13) as consultants. The specialities within which respondents practised are displayed in figure 2; responses to ‘other’ in most cases were used to more specifically define the practices identified in figure 2. Thus for TR, neuro- oncology, lung, breast, mould room and brachytherapy were linked to treatment review and/or treatment planning while for DR, musculoskeletal, central line placement, cardiology, angiography, forensics and breast intervention were linked to computed tomography (CT), ultrasound (U/S), mammography and or reporting. Practices not subsumed within the main categories shown in figure 2 were Accident and Emergency (n =2), General Practice referrals (n =1) and research (n =3).





4.2. Characteristics of practice in the use of medicines

Forty respondents entered details of 65 specific drugs (21 DR and 45 TR) that were being provided under PGDs (see appendices 1a and 1b): Buscopan was the most frequently cited single drug for DR supplied by 10 out of 24 respondents; contrast agents were the most frequently cited class of drug, supplied by 16 out of 24 DR respondents. All TR respondents cited drugs employed in the management of treatment toxicity with Loperamide cited by 13 out of 16 respondents; 3 cited contrast agents.

Eleven respondents indicated that they were using PSDs and of these 5 were from Scotland, 3 from the South West of England, 2 from Wales and 1 from the West Midlands of England. Eight respondents entered details of 31 specific drugs (10 DR and 21 TR) provided under PSDs (see Appendix 1c).

Thirteen respondents provided 15 examples of the limitations of supplementary prescribing, (see Appendix 2): 4 related to the condition and/or medicine required not being covered by the clinical management plan (CMP); 5 were related to the delays caused by completing the CMP or by CMPs not being completed adequately; 6 comments related to the logistics of practice.

4.3 Developing the service

Thirty-eight respondents provided examples (see Appendix 3) describing how IP by radiographers might impact patient services. These fell into 3 broad and sometimes overlapping themes:

- efficiency of service, where the time taken by radiographers in seeking out medical doctors to sign forms might be avoided, and the consequent freeing-up of medical doctors to engage in what only they were able to do;
- quality of service, where the patient’s experience would be improved by shorter durations of waiting times and procedures, reduction in the number of transitions of care and enhanced holistic care;

- responsiveness to dynamic care interactions, where evolving situations might be better managed by on-the-spot decisions and problem solving involving the use of medicines.

Safety issues were also implicitly or explicitly identified within these 3 main themes for example:

'... being able to prescribe alternatives .....[for] safety due to allergies or sensitivities'.

Twenty-nine respondents provided examples where specific improvements to service delivery and outcomes might be achieved through extending the use of medicines. Many suggestions duplicated the response to the question on the potential impact of IP; examples are provided below:

- *reduction in the care pathway for patients needing anti-coagulants and thrombolytic agents for pulmonary emboli and deep vein thromboses*
- *effective use of specialist and consultant radiographers for example in palliative care [single radiotherapy fraction delivered on a single patient visit] where a CMP may not be appropriate*
- *enabling discharge directly from imaging without the wait for doctors to prescribe To Take Out (TTO) medication.*

The responses suggesting by which mode the use of medicines might best suit the delivery of certain existing services may be seen in table 2. The highest frequency of response was for those related to TR practice; the responses also indicated that all areas of practice could benefit from the availability of IP. Further to this, free text data indicated that DRs found SP to be inappropriate to their role and were awaiting the opportunity to become IPs.

Table 2: Radiographer-led services that could be developed by using PGDs, supplementary or independent prescribing

Options	PGDs	Supplementary Prescribing	Independent Prescribing	Response Count
Pre-treatment review	16	16	19	30
On-treatment review	17	18	27	33
Reporting	5	4	8	13
Self-referral	6	4	8	14
Advocacy	1	1	4	6
Urinary	7	9	8	16
Gastro- intestinal	8	10	8	19
Ultrasound	9	6	5	13
MRI	8	7	6	16
CT	11	9	8	20
Paediatrics	6	5	6	11
Vascular	5	3	7	11
A&E	7	4	6	12

Thirty-nine responses were received in answer to the question on whether barriers existed to the development of the service. Approximately one-quarter (10) considered there not to be any barriers. The remainder (29) identified a range of negative associations; these were:

- Lack of suitable education and training (frequency=2)
- Lack of support from oncologists (frequency=2)
- Lack of support from managers (frequency=4)
- Bureaucracy of working practice and legal issues (frequency=5)

- Scepticism of respondents suitability to role and lack of relevance and usefulness to practice (frequency=6)
- Lack of time, funding and staffing levels (frequency=7)
- Lack of support from radiologists (frequency=9)

Fifteen of the 21 radiographers who were qualified as SPs or in training stated that other professionals following the same programme and being assessed in a similar fashion would qualify as an IP; 4 did not respond and 2 indicated that others would not qualify as an IP.

5. Discussion

5.1. The scope of current practice

In the decade since non-medical prescribing moved into the national AHP agenda, there has been a modest and non-uniform development within radiography. The interest as demonstrated by the number of radiographers (n=169) who responded to the survey represents a tiny proportion of the approximately 26,000 practicing radiographers. However it was anticipated that this would be a self-selecting group dependent upon cascading awareness through the networks and interest groups within the membership of the SCoR and this may explain the geographical variation shown within the UK. The relatively high response from Scotland (76) and to a lesser extent the density of activity within the 3 English regions, while not significant, does appear disproportionate to the number of practising radiographers and may be due to the well-established contact groups and (for Scotland) the strong AHP representation within the prescribing network. Interest in radiographer prescribing has been seen as a local solution to a local problem and often relates to the state of the multi professional teams delivering specific care (Francis and Hogg 2006): for example where acute shortages of radiologists for reporting or where few oncology nurses are employed, the geographical variations may reflect these differences in skills mix and ways of working.

Although the total number of respondents to the survey was 169, only 67 may be considered ‘active’ and the number of responses fell to 47 or less to questions that required specific knowledge and/or experience of the use of medicine. In comparing ‘activity’ as opposed to ‘interest’, geographical variation remained relatively constant although the magnitude of response from Scotland was seen to diminish considerably (to 21%); whilst this may be disappointing as a measure of current activity, it does hold promise for the future if legislation change moves to keep pace with the demands of practice. In considering the response from the two disciplines, as the level of engagement in the use of medicines increased, the ratio of DR:TR response was reduced with the ratio from all respondents at 71:29 changing in the active subgroup to 55:45. The trend was further developed when considering the ratio of DR:TR within SP at 5:12. This probably reflects the variation of opportunity in current practice that has suggested that radiographer prescribing and use of PGDs would more easily translate into the oncology care pathway while many DR practices are well served using protocols. However, this may change if IP for radiographers becomes available.

It was encouraging that 61% of the respondents were advanced or specialist radiographers and this interest in the use of medicine may be viewed as an indicator of a multifaceted role which many radiographers embrace. Thirteen consultant radiographers also participated in the study representing 1/3 of their total number and again prescribing is likely to be considered an important aspect of managing their case load. Both are characteristic of the emerging establishment of the Career Progression Framework.

The length of experience of the respondents may be viewed as a reflection of the demographics of practising radiographers and of the NHS in general with 50% of the respondents having been qualified for over 20 years; it is also consistent with the level of seniority at which the radiographers were practising. It would be unwise to assume that this move into the more supportive and problem-solving patient care roles is coupled with a move away from the high technology arena. Seniority and experience are required but the data also suggests that in order to perform at the highest and most efficient levels, senior radiographers in high-tech areas feel the need to provide

holistic and patient-focused care and not discrete fractions of that care. The areas of practice engaged by the respondents were for DR from across the full range of imaging modalities and for TR in pre-treatment, on-treatment and end-of-treatment review. This may provide evidence that the use of medicines was and should be integrated within most imaging or radiotherapy procedures; without the radiographer's empowerment to provide this element, holistic care will be elusive and the Multi Disciplinary Team's (MDT's) capacity wasted in unnecessary transfers of responsibility.

The respondents who were qualified as supplementary prescribers (17) represent ¾ of those registered with the Health Professional Council (22 radiographers in October 2010). Other professionals were educated alongside the radiographers, taking the same assessment, but whose endpoint enabled them to become independent prescribers. Although it might be argued that the work-based element of the course would have been different for each professional group, it will be important to determine what further qualifications an SP radiographer would need to become an IP if changes to legislation do come about.

PGDs may be considered the prevalent form of use of medicines by radiographers with 47 respondents indicating that they use them. However, once qualified, radiographers tend to use SP exclusively with only 6 out of 17 qualified in SP continuing to use PGDs. Nevertheless, the limited reporting of PGDs may be an indication of their underuse. The extensive list of drugs provided under PGDs (see Appendices 1a and 1b) reflect the dominance of certain aspects of the patient care pathways where use of medicines has been most developed; TR practice used a greater number of drugs, mainly associated with the diverse range of treatment toxicity that falls within oncology practice. However, given the increase in imaging in all areas radiotherapy, it was surprising that only 3 TRs supply/administer contrast agents through PGDs. This need may be adequately met through the use of protocols because at this stage in the patient pathway the imaging needs are likely to be predictable and fully anticipated. Patient Specific Directions were seldom used and when used, it was in particular geographical locations.

5.2. New ways of working with IP

Although the extent of radiographer practice with SP and PGDs appears modest, it has enabled a small number of practitioners to acquire experience that informs their opinion on the use of medicines and their vision for the future development. They have provided insight into the potential impact of IP on the patient experience and service provision: these ideas are discussed in the following section.

5.2.1. Efficiency of service provision

With the introduction of IP, improvements to the efficiency of service were identified that related to reducing the time that radiographers might spend in obtaining the authority from others to provide medicines, rather than engaging in the delivery care for their patients. Efficiencies could also be seen in optimising the skill-mix available to patients by freeing-up of time for medical practitioners to engage in activity that only they could perform and allowing radiographers to fully use their own skills. There were also frequent comments of the duplication of effort and the cumbersome bureaucracy of CMPs.

Typical of comments proffered were:

'Avoiding the patient having to wait whilst trying to find a Consultant or dragging them from a busy clinic...'.

and

'We have experienced many difficulties in implementing the use of CMPs..... despite all staff groups being supportive. Our doctors are very poor at completing drug histories and signing the CMPs. This means that many patients..... are reviewed by a radiographer who then has to go to a doctor for a prescription.

The requirements for the generation of the CMP do not easily translate into the service provision within DR and the initial theoretical match to oncology team working is also being brought into question by data presented here.

5.2.2. Quality of service / Improving the patient experience

Where efficiencies were related not to the time of the health care professional but to reduction in patient waiting times, these were perceived as improvements in the quality of service. The responses were dominated by patient-centred gains and providing a holistic service which patients could understand as being in their own best interest.

DR procedures that provoke anxiety were particularly cited as examples where being able to prescribe anxiolytic drugs would improve the experience and thus the quality of service provided e.g.:

'...being able to prescribe diazepam for women undergoing stereotactic procedures who are needle phobic and get difficult to manage due to their anxiety'.

This suggestion may appear to raise particular issues of safety but should be seen within the individual scope of practice and service and the role of the local therapeutics panel in assessment of risk and clinical need. As mentioned previously, these themes are not discrete entities and the impact of change on all aspects of care should not be ignored: a procedure conducted on a co-operative and relaxed patient will most usually be completed in a shorter period of time and in many cases be performed more safely.

In keeping with the DH initiative to promote a Nurse/AHP led service, 'one-stop' diagnosis and treatment episodes were also identified, e.g.: 'Enable medication to be prescribed directly following certain imaging procedures e.g. anti-coagulants and thrombolytic agents, thus reducing patient pathway'.

It was also seen that only a few patients were currently benefitting from the extended radiographer role and that equality of care should be considered:

'Increased access to medication by all our patients therefore reducing waits for procedures or treatment .....'.

and

'Greater access to timely intervention. With many patients receiving Radiotherapy and Chemotherapy as out-patients it is vital that with increasing numbers these people are fully supported in order to reduce the need for hospital admission'.

5.2.3 Responsiveness to dynamic care

The third theme was that, with IP, radiographers would be able to respond to the needs of the patient in their care as and when those needs developed. The situations cited were not predictable and thus could not be covered by a CMP but nevertheless occurred frequently enough to ensure that they would fall within the competence of a suitably educated radiographer, for example:

'Not relying on PGDs and protocols to give contrast if unexpected findings occur'.

The management of pain was a dominant theme:

'Being able to prescribe analgesia in Minor Injury Unit when undertaking radiographer-led assessment and/or discharge'.

'.....administer pain relief to patients in MRI who have not been adequately prepped by the ward so they can complete their scan when in significant pain'.

The incidence and nature of pain make it particularly difficult to manage through predetermined care plans and if uncontrolled its effect on concordance has significant consequences for most other interventions being managed by the radiographer.

Looking to the future, radiographers proposed several scenarios where radiographers' IP would be critical to an efficient patient-focussed service:

'With the increase in both imaging units and satellite radiotherapy departments there will be an increasing need for radiographers to prescribe as many of these do not have doctors available during all hours of operation'.

'.... if we started anticoagulation drugs where DVT is confirmed in ultrasound, we could scan pts directly from the GP and return with diagnosis and therapy in place'.

There are increasing examples where advanced practice is making significant improvements to the patient pathway (SCoR, 2010) but these are hampered by the current limitations associated with prescribing:

'Review radiographer prescribing hormone therapy for breast cancer patients, instead of making a clinic appointment for the patient to be seen again by the doctor'.

Several comments also suggested meeting the needs of the cancer patient at the end-of-treatment review, an aspect of the cancer journey which has been somewhat neglected in the past.

If consultant radiographers and advanced practitioners are to function at the level intended there will be care episodes as demonstrated above that cannot be covered by PGDs or allow CMPs to be agreed.

5.3 Barriers to current practice and future developments

The demands of service provision and the multidisciplinary delivery of care mean that change cannot and should not occur in professional silos but must be collaborative and respectful of each other's practice. The study has identified a range of factors that already impact on the relatively modest progress being made in the use of medicines.

It should be acknowledged that approximately one quarter of respondents who answered the relevant question did not consider there to be notable barriers to the devolvement of these roles and at face value this must be taken as encouraging. The remaining three quarters of responses were less positive. In DR, a lack of support from radiologists was the most frequently cited barrier to role development and these comments have resonance with the report by the Royal College of Radiologists (RCR) (Adam and Nicholson, 2010) expressing the view that the cost effectiveness and safety of radiographer reporting was unproven other than in the area of breast screening. This has been robustly disputed by the SCoR in Medical Image Interpretation by Radiographers: Definitive Guidance (SCoR 2010) but there are undoubtedly some radiologists who lack confidence in the ability of radiographers to move into related areas of practice, a confidence that can only grow through the excellence of radiographers working competently and effectively within the teams. Lack of support was not characteristic of the case in TR and although proportionately there was more activity in this discipline, oncologists were generally supportive and considered as a barrier in only 2 instances. This perhaps reflects the typical oncology team-working that has enabled the many recent radiotherapy developments such as radiographers reviewing and taking appropriate action on verification images.

Scepticism within the DR profession as to the value of developing this area of practice is of concern although not unexpected and is typified by the comment:

'....Do we have medical history understanding?; Do we understand drug interaction?; Are we properly trained?'

However the bulk of evidence within this study may be persuasive to the unconvinced. The data supports the argument that all areas of radiography practice could benefit from the introduction of IP; DRs were particularly aware of the limitations of SP to their mode of practice hence the relatively reduced take-up of training compared to TR.

Access to appropriate training was also cited as a barrier and might be a consequence of a lack of resources available to radiographers in an increasingly difficult financial environment or of the suitability and flexibility of programmes provided by higher education institutions. A significant barrier to development in DR would be that, if it were decided that a qualification in SP should be a prerequisite to independent prescribing, then according to the results in this survey, many radiographers would be precluded at least initially from this progression as few have considered SP to be suitable to DR practice. Education and training in the use of medicines is an issue of confidence and competence within a defined sphere of practice for the individual practitioner and should not be seen as a hierarchical progression through levels of autonomy.

'If radiographers were independent prescribers, we would not be reliant on doctors to complete forms in order to do our job and patients would get their medication much more quickly.'

The lack of IP appeared to engender a feeling of frustration in practitioners and led to a sense that the skills of the professional workforce were not being fully exploited to the benefit of patient and colleagues. Not least, in the eyes of our patients, interprofessional team working will be seen to be trivialised if radiographers knowledgeably advising and caring for patients are then required to seek authorisation (often by telephone) from a doctor not necessarily fully conversant with the case.

6. Conclusion

The findings from this survey should be interpreted with caution: the study base is limited and cannot be said to reflect working relationships throughout the UK. However, the insight displayed should alert practitioners and managers to potential issues and allow them to be pre-empted and overcome. The evidence also provides a persuasive argument to extend IP to radiographers: without this, the opportunity for many improvements, economies and optimisations within current service delivery will be lost.

Those engaged and experienced radiographers who have demonstrated a clear vision of how hampered they are by current legislation, yet work creatively and energetically to provide best quality care to their patients despite, and not because of, the legal and professional framework by which they are guided. The use of medicines should be limited only by the ability to work safely and competently within a particular scope of practice. This will allow the delivery of an organic service, employing mixed and appropriate approaches and centred on the needs of the patient.

Practice has evolved to accommodate the limitation of PGDs and SP, but this remains sub-optimal for both practitioners and patients with IP seen as the only way to provide the care to which patients should be entitled.

7. References

Adam A, Nicholson A 2010. Medical image interpretation by radiographers: guidance for radiologists and healthcare providers. London. Royal College of Radiologists.

Department of Health 1999. Review of prescribing, supply and administration of medicines: final report. London: HMSO

Department of Health 2009. Allied Health Professions' prescribing and medicines supply mechanisms

scoping project report. London, DH.

Francis F, Hogg D 2006. Radiographer prescribing: enhancing seamless care in oncology. Radiography, 12, 3-5.

Society and College of Radiographers 2008. The Scope of Practice. London. SCoR

Society and College of Radiographers 2010. The Supply, Administration and Prescribing of Medicines; Guidance and advice for the radiography workforce. London, SCoR.

Society and College of Radiographers 2010. An evaluation of the impact of implementation of consultant practitioners in clinical imaging. London. SCoR

Department of Health 2005. The Medicines for Human Use (Prescribing) Order 2005. London: HMSO

Society and College of Radiographers 2010. Medical Image Interpretation by Radiographers: Definitive Guidance. London. SCoR

Appendix 1a

Download Appendix 1a **PDF**

Appendix 1b

Download Appendix 1b PDF

Appendix 1c

Download Appendix 1c **PDF**

Appendix 2

Download Appendix 2 **PDF**

Appendix 3

Download Appendix 3 **PDF**