THE CHANGING ROLE OF THE RADIOGRAPHER UNDER IR(ME)R 2000

S. Barlow
College of Radiographers, London, United Kingdom

Abstract

This paper deals with the way in which the College of Radiographers has used the new Ionising Radiation (Medical Exposure) Regulations 2000 [IR(ME)R] to promote role development among its 17,000 radiographers in the UK. It aims to show that the resultant role development will have a beneficial effect on the radiation protection of the patient in diagnostic radiography.

1. Aim

To keep radiation doses as low as is reasonably achievable whilst maintaining diagnostic efficiency.

The College of Radiographers, which is the professional body of radiography in the UK and boasts over 90% of all state registered radiographers in its membership, has taken the above statement as their theme over the last year in conjunction with the introduction of the new legislation IR(ME)R 2000.

IR(ME)R 2000 is the statutory legislation, which was laid before parliament in April 2000 and is designated as the Ionising Radiation (Medical Exposure) Regulations 2000 which is based on the adopted European Directive 97/43/Euratom.

The objective of the professional body, which in the United Kingdom is the College of Radiographers, has been to reintroduce radiographers to a sense of personal responsibility for radiation exposure, which is, in fact, part of their Code of Professional Conduct. [1] The subject of this paper is the importance of the changing role of the radiographer in diagnostic imaging due to the implementation of IR(ME)R.

The introduction of IR(ME)R legislation in May 2000 has given the College of Radiographers the opportunity to run country wide seminars to introduce members to a new interpretation of their responsibilities.

Under the previous legislation POPUMET (Protection of Persons undergoing Medical Examinations and Treatments Regulations 1988) it seemed possible to defer the responsibilities of physically directing radiation to a third person, the clinically directing radiologist.

The new legislation, IR(ME)R, has a far more robust framework and sets out much more clearly the areas of responsibility for each duty holder post, these being the practitioner, operator and referrer.

These duty holder posts are defined as "a health professional who is entitled in accordance with the employer’s procedures to take responsibility for an individual medical exposure" (practitioner). "Any person who is entitled in accordance with the employer’s procedures to carry out the practical aspects" (operator) and "a healthcare professional who is entitled in accordance with the employer’s procedures to refer individuals for medical exposure to a practitioner" (referrer) [2].
The policy of the Society and College of Radiographers states [3] "Under these new regulations a radiographer is able to act as a referrer, practitioner, and operator within the field of specialisation defined by his or her expertise, training and continuing professional development. Only these personal attributes and circumstances determine which healthcare professional in any team assumes the role of operator, practitioner or referrer. Profession or discipline alone should not be used to determine duty-holder roles."

The new legislation has led to an unprecedented level of cooperation between some of the professional bodies associated with healthcare in the UK. The Dept of Health (DOH), Institute of Physics and Engineering in Medicine (IPEM), British Institute of Radiology (BIR), Royal College of Radiologists (RCR), Society and College of Radiographers (SCOR) and the National Radiation Protection Board (NRPB) all worked together in the early stages of consultation of the Draft regulations and suggested a number changes which were indeed incorporated in the final Legislation. Following on from that, implementation of the legislation is being expedited by further collaboration of the same working group to firstly identify any training needs of the post holders and secondly to set national Diagnostic Reference Levels (DRL) for as many examinations as seems practical.

The change of emphasis from POPUMET to IR(ME)R has led to the responsibility for the exposure of the patient to doses of ionising radiation becoming the remit of the Operator (notwithstanding that a Practitioner has already carried out justification).

Radiographers are by definition operators and their appraisal of the relevance of the request to the particular individual patient is probably better than most other healthcare professionals. If the duty of the practitioner in justifying the examination is also carried out by a radiographer, and this is quite likely in some modalities, then the likelihood of patients undergoing an individual exposure to radiation that is unnecessary could be considerably lessened.

Under IR(ME)R the radiographer can take on the role of referrer, practitioner and/or operator and it may well be that, whilst not all radiographers will do all of the above, this reallocation of roles will provide continuity and establish good quality decisions about patient examinations across the board. Ionising radiation is not always the correct diagnostic tool and a referral to, perhaps, Ultrasound or Magnetic Resonance Imaging may be the more suitable course of action.

A radiographer as a practitioner will be named by the employer as such in his or her own field of clinical specialism and would not be expected to perform that role in any other area of work. This will ensure that clinical expertise is used judiciously and in the best interests of the patient. It is acknowledged that even senior experienced radiographers might need a little more clinical training before becoming practitioners and will certainly have to be able to prove ongoing competence with continuing professional development.

The new regulations place a far greater responsibility on the employer to ensure that protocols and standard operating procedures are in place. This will be best achieved by calling in the expertise of the radiographer working in that modality and providing input into the content of these standard operating procedures. The duties of the referrer, operator and practitioner need to be defined, explained and training undertaken locally so as to comply with the local procedures and protocols. These should be written in a way that allows a radiographer to make a professional judgement on supplementary views. The radiographer's skill and experience in this field is vital in making IR(ME)R workable. Few other clinical staff can make these
judgements safely. The professional judgement used by radiographers as operators must be protected in spite of local "written protocols" if we are to maintain the ethos that "all radiographers are legally accountable for their professional actions and for any negligence by act or omission or injury" (Code of Professional Conduct) [1].

Para 2.7 of the Society and College of Radiographers Guidance for Radiographers [3] states, "the actions of other professionals do not absolve the radiographer of this responsibility". This will be achieved by rigorous and regular audit of systems and procedures including looking at the relevance of referral criteria and the right to refuse a request if it is inappropriate or not justified.

From all of the above observations it may be surmised that by compliance with IR(ME)R in the workplace, having due support from the employer down through all the duty holders, then radiation dose to the patient may be consistent with the ALARA (As Low As is Reasonably Achievable) principle. This should result in recordable and hopefully diminishing doses to individual patients.

References