British Society of Interventional Radiology

Position Statement on the Role of Allied Health Care Professionals in the Interventional Radiology Department

The British Society of Interventional Radiology (BSIR)
28th October 2023

Interventional Radiology

Interventional radiology (IR) has developed over the past 70 years to be an image-guided surgical speciality. Interventional radiologists perform a huge variety of image guided procedures, often as lead clinician in a day case environment, and interact with most other clinical specialities providing important aspects of clinical management. The Royal College of Radiologists (RCR) and the Cardiovascular and Interventional Radiological Society of Europe (CIRSE) curricula have set the standards of training and the level of qualifications needed to practice interventional radiology.

The enormous success of IR can be seen by the exponential workload growth and the embedding of IR within many national guidelines e.g. major trauma. IR services now provide clinical care in virtually all clinical specialities. However, the lack of investment and resources, especially within workforce, allocated to radiology departments and the lack of dedicated IR departments has reduced the ability to respond to the rapid changes over the last couple of decades.

Allied Healthcare Professionals

We are aware of concerns about the employment of other healthcare practitioners, such as physician associates, within radiology and other departments; in particular the sometimes-negative comments on social media. The BSIR has recently undertaken a survey of its membership's opinions on this topic. In this statement, the Executive Officers of the BSIR wish to set out our position to support our membership, which include consultant radiologists, radiology trainees, radiographers and interventional radiology nurses.

The BSIR recognises the role of Allied Healthcare Professionals (AHP). We believe that physician associates (PA), clinical nurse specialists (CNS) and advanced IR radiographers can play an important role in supporting clinical IR departments, IR consultants and trainees.

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Developing these roles to support clinical activities, such as patient pre-assessment and workup, pre-procedure preparation, sedation and post-procedure follow-ups for a large number of procedures, can play an important part in improving patient care and experience, as well as enhancing department efficiency. Furthermore, their support in collecting important patient outcome data through audit will ultimately improve clinical outcomes. Additionally, these AHP roles, depending on local needs, could assist with a number of relatively simple procedures, freeing up consultant time for increasingly complex interventions. Examples of potential procedures could include: peripheral vascular line insertion, biopsy of superficial structures, NGT insertion, lumber puncture, feeding tube exchanges, nephrostogram, linogram, and exchange of nephrostomy tubes.

In order for AHPs to work effectively within the IR team, formal operating procedures need to be in place for AHPs to define extended roles with specific specifications, training, teaching, clinical governance and consent procedures.

There should be a defined structure in each department with a designated supervising consultant and line manager for each AHP. Moreover, all AHPs must be employed by the radiology department. We do not believe that AHPs should be the primary operator in specialist procedures such as percutaneous angioplasty. AHPs should also be encouraged to engage in various research activities including the conduct of clinical trials.

We acknowledge the critical shortage of IR nurses and radiographers and as such, support the development of new roles for AHPs in IR departments. However, we believe that there needs to be a sensible balance between supporting existing roles and the development of new ones. Training of AHPs and AHPs undertaking/assisting in procedures in IR departments must never lead to the compromise of training of IRs and other radiologists.

Interventional radiology practice involves a complex combination of technical and clinical skills, communication with various clinical teams and in-depth radiation protection knowledge within a team setting. Any practitioner embarking on image-guided procedures independently must attain this high level of competency.

All AHPs working in IR services should have a clear pathway of training with a purpose-designed curriculum. All AHPs should be regulated by the Health and Care Professions Council (HCPC). We do not believe that the current proposal by the GMC to regulate PAs is appropriate. PAs are not medically trained and therefore should not be regulated by the GMC, nor given a GMC number in the same format as doctors. This will only create further

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confusion for other health care professionals and, more importantly, could mislead the public.

The BSIR will endeavour to collaborate with the RCR to develop standards of training and required clinical skills to be achieved by AHPs. In this way, we can ensure that we are expanding IR teams with valuable members to help our patients and deal with increasing workload, while maintaining the safety and quality of IR service provision.

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