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LETTER TO THE EDITOR OTHER

Response to Understanding Leadership and its Vital Role in the Growth of Interventional Radiology

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The article by Clements [1] concerning leadership and its role in the growth of interventional radiology (IR) adds a valuable element to the IR canon. Dr Clements distinguishes leadership from management and recognises its independence from organisational and hierarchical seniority. He rightly points out that leaders and leadership can be found across the career spectrum, from students and trainees to senior staff. Wherever leadership is to be found, however, he highlights the necessity for those in leadership positions to present new and challenging ideas based in research. The emergence of IR from its diagnostic radiological lineage within existing clinical and governance structures can only be achieved through leadership that is not afraid to challenge current paradigms. This is a timely charge to all working in IR.

Naturally enough, Dr Clements casts his arguments from a doctor's perspective; management and leadership functions of IR environments are traditionally vested in interventional clinicians. However, the IR ship cannot sail without its interdisciplinary crew, and if, as Dr Clements contends, leadership potential is universal, we must also recognise the possibility of its existence in any of the nursing and allied health professions within the IR team. Moreover, such non-medical leadership must also be empowered to 'challenge the status quo'.

The evolution of nursing leadership has seen the discipline emerge as an autonomous profession. Through nursing leadership, nursing practice has become empowered to make and take responsibility for clinical care decisions. Prominent examples include the emergence of nurse practitioners who hold prescribing rights for medications and requesting rights for imaging examinations. Halai et al. [2] demonstrate the benefits of distributed leadership through the development and appointment of clinical nurse specialists (CNS) in interventional oncology (IO). CNS-led clinics have replaced consultant-led clinics, reducing pressure on consultant services and providing continuity of care. As an appropriately credentialled senior member of the IO team, the CNS provides 'specialist education and guidance to nurses and junior doctors', taking on roles traditionally vested in senior medical staff.

Albeit with significant international variation, radiographers are also emerging from the shadows into similar positions of autonomy. The four-tier model of radiographic scopes of practice in the UK [3] empowers suitably qualified and experienced radiographers to take leadership positions in areas of healthcare previously held by doctors, including in reporting and vascular access procedures [4, 5].

Dr Clements rightly contends that leadership potential is independent of experience, position or grade. It is also independent of profession. Outward-facing leadership, representing the IR entity to the broader healthcare community, must always lie at the medical interface between clinicians requesting IR services and the IR clinicians providing them. However, inward-facing leadership must recognise, inspire and empower all members of the IR team to contribute to its leadership evolution. IR nursing and allied health leadership must develop the research-led evidence required to improve 'governance, cost-effectiveness, and quality' [1]. Leadership for advanced scopes of practice in nursing and radiography have a place in contemporary IR, but are we mature enough to recognise,

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value and nurture such leadership? The current status quo of medically-dominant interprofessional dynamics, roles, expectations and responsibilities within the team must also be challenged if we are to achieve IR's ultimate goals.

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