



Response template for providing feedback to public consultation – draft revised professional capabilities for medical radiation practice

This response template is an optional way to provide your response to the public consultation paper for the **Draft revised professional capabilities for medical radiation practice**. Please provide your responses to any of the questions in the corresponding text boxes; you do not need to answer every question if you have no comment.

Making a submission

Please complete this response template and send to medicalradiationconsultation@ahpra.gov.au, using the subject line '*Feedback on draft revised professional capabilities for medical radiation practice*'.

Submissions are due by midday on Friday 26 April 2019.

Stakeholder details

Please provide your details in the following table:

Name:	Sally Kincaid / Min Ku
Organisation Name:	Australian Society of Medical Imaging and Radiation Therapy (ASMIRT)

Your responses to the preliminary consultation questions

1. Does any content need to be added to any of the documents?
Yes, please see responses in document
2. Does any content need to be amended or removed from any of the documents?
Yes, please see responses in document
3. Do the key capabilities sufficiently describe the threshold level of professional capability required to safely and competently practise as a medical radiation practitioner in a range of contexts and situations?
Not in all respects; please see comments in document
4. Do the enabling components sufficiently describe the essential and measurable characteristics of threshold professional capability that are necessary for safe and competent practice?
No, see comments in document
5. Is the language clear and appropriate? Are there any potential unintended consequences of the current wording?
There are potential unintended consequences in several of the proposed capability statements. These are noted in the responses.
6. Are there jurisdiction-specific impacts for practitioners, or governments or other stakeholders that the National Board should be aware of, if these capabilities are adopted?
See responses in document
7. Are there implementation issues the National Board should be aware of?
See responses in document
8. Do you have any other general feedback or comments on the proposed draft revised professional capabilities?
Yes. Please see responses in document

ASMIRT appreciates the all-encompassing nature of the Professional Capabilities document, the draft of which has been revised since our previous opportunity to provide feedback. The reference to best practice throughout the document recognises the importance of research and evidence-based practice in driving and underpinning clinical practice and practice change in Medical Radiation Practice.

Public Consultation document

Page 4. ASMIRT note that the MRPBA and NZMRTB have been working together to align the arrangements for medical radiation practice in Australia and New Zealand. The Competence Standards for Medical Imaging and Radiation Therapy Practice in New Zealand distinguish the scopes of practice for Sonographer and Magnetic Resonance Imaging (RI) Technologist from those of diagnostic radiographer, nuclear medicine technologist and radiation therapist. The Professional Capabilities document does not appear to do so, rather it appears to expect that all registrants would be equal in these modalities.

Professional Capabilities Document

Page 2. ASMIRT welcomes the inclusion of the description “*safely and competently practise as a diagnostic radiographer, a nuclear medicine technologist or a radiation therapist*” in the purpose of the medical radiation practice professional capabilities. ASMIRT further notes that the Professional Capabilities describe the threshold level of professional capability for initial and continuing registration. There are some capabilities described in the document, such as angiography, which ASMIRT contend are beyond the capacity of a MRP entering the profession to safely and competently perform.

Page 2. ASMIRT welcome the inclusion of cultural competence and cultural safety in the professional capabilities and note that the document indicates that a collaborative project is currently underway to determine how all health professional study streams can prepare graduates to support Aboriginal and Torres Strait Islander patients, and that more content will be incorporated into the professional capabilities and accreditation standards of said professions as this strategy is developed. In the absence of well-defined parameters for the key capabilities, it is difficult to see how MRPs could be deemed to be culturally competent with no clear guide to measure against.

Page 4. The Overseas Qualifications Assessment Panel (OQAP) is the gazetted body for the assessment of MRPs who have qualified overseas and are seeking a visa to work in Australia. Increased co-operation and collaboration between the MRPBA and OQAP would assist in streamlining the processes for registration and immigration.

Page 4/5 ASMIRT notes the separation between the Accreditation Committee and the MRPBA and that the committee is responsible for the accreditation of programs in medical radiation practice. It is not clear how the new elements in the Professional Capabilities

will be demonstrated in the programs, specifically for those students who are in the final year of their program in 2019.

Page 5. ASMIRT note the inclusion of the term competence throughout the document, and the definition of competence used “*Competence refers to the knowledge and skills being applied consistently to the standard of performance required in the workplace*” and further note that the “*enabling components in these professional capabilities describe the threshold behaviours for safe and competent practice*”.

On page 4 it is stated that the Professional Capabilities are used by the Board as a reference point of threshold competence when exercising its statutory functions including for:

- *“registration of individuals who are relying on medical radiation practice qualifications issued in other countries to qualify for general registration in Australia*
- *re-registration of individuals who were previously registered as a medical radiation practitioner in Australia, and*
- *evaluation of a registrant whose level of competence to practise may pose a risk of harm to the public, for example, if the Board receives a complaint or notification about that registrant”.*

Page 7 states that the “*professional capabilities are not designed as a stand-alone means of measuring competence. The document supports the establishment of additional performance indicators and rating scales for valid measurement of a medical radiation practitioner’s performance.*” ASMIRT would welcome further information regarding the additional performance indicators and rating scales which can be used to evaluate performance.

Page 7 Medical radiation practice professional capabilities and practice in ultrasound ASMIRT contends that Sonography is a medical imaging modality utilising non-ionising radiation and as such, Sonography should fall under the remit of the Medical Radiation Practitioners Board of Australia. ASMIRT further contends that Sonographer and Ultrasonographer should become protected titles under National Law. We would welcome the opportunity to work further with MRPBA on this.

Page 7 Medical radiation practice professional capabilities and practice in computed tomography ASMIRT would suggest rewording the sentence “The role of radiation therapists in providing CT scans as part of the radiation therapy patient journey is integral to their role and scope”. This would reflect current standard practice across Australia.

ASMIRT would suggest the inclusion of a further descriptor on page 7: **Medical radiation practice professional capabilities and practice in mammography.**

Capability in mammography is currently only included in diagnostic radiography and is not considered to be an extension of scope. Radiation therapists and nuclear medicine technologists have education regarding mammography in undergraduate courses and have capability in Domains 2-4. As with sonography or MRI, it could be argued that at the point of initial general registration, MRPs of the three clinical strands, have similar experience with mammography. ASMIRT contend that radiation therapists and nuclear medicine technologists could competently perform mammographic examinations. The Graduate Diploma of Mammography provides an additional qualification under the Australian Qualifications Framework to support registered MRPs who are not diagnostic radiographers in undertaking this role. ASMIRT has previously sought the inclusion of this program into accredited courses from the MRPBA. ASMIRT currently provide certification of Mammographers through the Certificate of Clinical Proficiency in Mammography.

Domain 1.

ASMIRT contend that the document should provide greater clarity in regard to when any of the capabilities fall outside of a practitioner's usual scope of practice. This is particularly important when capabilities are applied to all professionals in a given craft group that do not share a blanket set of capabilities. This may include diagnostic radiographers who do not have exposure to - and a subsequent skillset - MRI or CT. Another example of this is radiation therapists who may not have exposure to - and a subsequent skillset - to meet the capability requirement for specialised modalities such as brachytherapy.

Key capability 2 Enabling component b. ASMIRT suggest amending this component to include the requirement for documentation of identified findings i.e. *“Use clinical information management systems to accurately record patient/client history and any examination/treatment provided to the patient/client, ensuring that the correct examination/treatment is associated with the correct patient and documenting any identified findings.”*

Key capability 3 Enabling component c. ASMIRT suggest amending the sentence to *“Understand use of CT, MRI, PET and ultrasound-based imaging for a range of sites, patient/client presentations and radiation therapy planning and treatment.”*

Key capability 3 Enabling component e. ASMIRT suggest the enabling component be changed to *“Operate equipment applicable to their scope of practice”* ASMIRT acknowledge that the scope of practice for practitioners' changes over the course of time. It is not a reasonable expectation that those entering practice will have had necessarily have had sufficient clinical experience to safely and efficiently perform all aspects of

practice. Learning and consolidation of new skills is required throughout an MRP's career. This process should not impact upon patient safety.

Furthermore, ASMIRT is concerned that without clear expectations of what constitutes safe and competent practice in a particular area of practice, practitioners may judge themselves able to undertake a particular scope without having been appropriately trained or qualified and without recency of practice.

Key capability 3 Enabling component e. It is not clear how “*apply knowledge of laboratory procedures to practice when necessary*” is applicable to all medical radiation practitioners. This may be placed more appropriately in the key capabilities for nuclear medicine technologists and require further explanation.

Key capability 3 Explanatory note *Equipment* ASMIRT suggest the inclusion of particle accelerators, Gammaknife and Cyberknife in the Equipment list.

Key capability 4 Enabling component a. ASMIRT suggest amending the component to “Review the patient's/client's clinical history, referral and current medical information (including previously acquired imaging) to confirm the requested or prescribed procedure is appropriate, drawing on knowledge of other treatment pathways.”

Key capability 4 Enabling component c. ASMIRT consider that there may be limits to the professional individual's ability to adapt the examination or treatment. A statement stating that, examinations or treatment are adapted in line with established protocols or evidence-based practice and/or the MRP's scope of practice, would clarify and strengthen this enabling component.

Key capability 6. Implement equipment and techniques for patient/client immobilisation and reproducibility of procedures and outcomes. The word “outcomes” in radiation therapy, particularly in reference to treatment is associated with a prognosis for a patient. Radiation therapists do not wish to reproduce the outcome, but to reproduce the patients' position on a daily basis. ASMIRT suggest replacing the word “*outcome*” with a more specific description of what this domain is trying to convey, such as “*accurate positioning*”.

This should also be amended in the Explanatory note “*Equipment and techniques for patient/client immobilisation and reproducibility of procedures and outcomes*”.

Key capability 7 Enabling component a, and explanatory note “*Recognising and responding to a patient's/client's deteriorating condition*”. ASMIRT notes this enabling component and explanatory note as an area of concern as has been discussed with MRPBA Board members.

The intended audience of the National Consensus Statement is “**clinicians and managers responsible for the development, implementation and review of recognition and response systems...**’ as opposed to practising radiation professionals. In this way it encompasses all clinical staff within large tertiary referrals centres to small district and community hospitals and stand-alone practices. This document will therefore refer to doctors, nurses, allied health and other specialist health practitioners in a broad overarching way that does not identify or account for the different capabilities and scope across each of these specific practitioners. It is obvious that no single practitioner should be accountable therefore for the entirety of the consensus statement, rather, this is a guide to assist managers to ensure they have the correct mix and breadth of scope within their wider clinical staff to adequately manage the deteriorating patient. It is not the appropriate document to base the entirety of the enabling component for this key capability, as it does not recognise the specific scope of a medical radiation practitioner within the wider clinical picture.

MRPs **should be expected** to respond to a deteriorating patient. In the workplace, this would routinely result in escalation to appropriately trained nursing or medical staff. Currently many MRS courses do not offer training and education in monitoring this range of physiological signs. Up-skilling the current registered workforce and maintaining competence to be able to understand and interpret and identify abnormal vital signs such as respiratory rate, oxygen saturation, heart rate, blood pressure, temperature and level of consciousness as outlined in the National Consensus Statement would be challenging. Equally MRPs may not have access to the patient history and knowledge of their baseline physiological parameters. The requirement to document the physiological observations in a structured tool such as an observation chart currently falls outside of the experience of the majority of MRPs and would require considerable education and training to implement. Most workplaces expect that MRPs have the ability to perform CPR as a minimum standard. Clarification of the role of the MRP in recognising and responding to a deteriorating patient would benefit the interpretation of this statement.

On the assumption that this would be required and provided in undergraduate courses, how would the MRPBA anticipate that the training for such be provided to currently registered MRPs? Who would bear the responsibility for the cost of providing the training? Over what timeframe would this change for currently registered MRPs be implemented and how would compliance be measured? How will ongoing competence be determined? For example, radiation therapists would rarely assess the blood pressure, temperature or oxygen saturation of patients undergoing treatment and it is unclear how they would demonstrate ongoing competency.

ASMIRT acknowledges that practice may vary depending on the geographical location, public/private, and hospital based/stand-alone site. However, it is also important to note that the care of the patient is the responsibility of the whole health care team; a team of highly skilled professionals who are equipped to deal with such situations.

Key capability 7 Enabling component b. ASMIRT suggests that a stronger statement requiring MRPs to interpret images and convey information in verbal and written communication be included in this Key Capability. ASMIRT would suggest “**Information may be conveyed verbally or in writing at the time of the examination/treatment, but must be documented, in line with relevant workplace protocols and other guidelines and protocols**”. A standardised system with supporting documentation that meets clinical workload and medico-legal requirements would assist in all MRPs being able to meet this capability. It is, however, not the place of another profession to dictate the scope of practice for MRPs in this key capability.

The “*Taking appropriate and timely action*” explanatory note states that an MRP has responsibilities to notify the appropriate person of a “*medically significant*” finding. ASMIRT suggest that this should be changed to “**an urgent or unexpected finding**” which would be consistent with enabling component b. For example, a finding of cancer is medically significant, but may not be unexpected if the request indicated this as the reason for referral.

This note also states that the family / carer should be informed but does not clarify the MRPs responsibility in this. It also does not deal with the situation where the patient does not wish their family/carer to be informed. Further, relaying even limited information regarding clinical deterioration to the family/carer is currently beyond the scope of the majority of MRPs and almost certainly beyond a practitioner on entering practice. MRPs may not have access to the full patient history, for example knowledge and understanding of the patient’s comorbidities or access to the patient’s advanced care directives. If this cannot be further expanded to clarify the responsibility, ASMIRT suggest this sentence should be removed.

Key capability 8 Explanatory note “*Procedures for safe and effective delivery of medicines*” must be consistent with the National Safety and Quality Health Service (NSQHS) Standard on *Medication safety* and may include double checking products, confirming correct labelling, accurate calculations and measurements, and correct route “**of administration**”.

Key capability 8 Explanatory note ASMIRT look forward to the future where MRPs are able to provide and prescribe medicines from a defined formulary as is done in the United Kingdom, but it should be noted that this is not within the scope of general registration. Additional formal education and training to perform these tasks and duties is required. There is currently variation across jurisdictions as to the administration of medicines, for example, the use of anaesthetic for PICC line insertions.

Page 10. ASMIRT notes the inclusion of optional key capabilities and enabling components for MRPs who include medical resonance imaging (MRI) and/or ultrasound

in their scope of practice, to practise independently and provide safe, quality, patient/client-centred care. ASMIRT contend that these are not appropriate for entry level practitioners and require specialised training, further education and credentialing. It is not clear how an entry level practitioner would have been able to obtain sufficient clinical practice to ensure that they are qualified for safe and efficient practice. This may also apply to more experienced practitioners at different stages of their career.

These key capabilities and enabling components are premised on the understanding that registered practitioners understand the limitations of their knowledge, skills and professional attributes. Again, ASMIRT is concerned that without clear expectations of what constitutes safe and competent practice in a particular area of practice, practitioners may judge themselves able to undertake a particular scope without having been appropriately trained or qualified.

Will there be a requirement to demonstrate this, for example, that further education and training has been undertaken, and that a percentage of CPD and recency of practice in the scope of practice is reflected?

Key capability 9 Enabling component c. Where RTs are performing MRI it is more likely to be associated with use in treatment planning, or with the advent of MRI-linacs, for treatment verification. It is unlikely it will be used to “*achieve optimal diagnostic outcomes*”. ASMIRT suggest amending this enabling component to reflect this.

Key capability 10 Enabling component f. The language around the relaying of findings/interpretations should be strengthened. ASMIRT suggests “**Findings should be evaluated and the real time examination should be documented in the clinical information system.**”

As per the previous comments, ASMIRT suggest adding an additional Key capability for Mammography.

Domain 1A:

ASMIRT notes that this domain lacks the same level of detail as Domains 1B and 1C. ASMIRT suggest that the over-arching statements should include: “**When practicing in ANY of the listed diagnostic modalities/specialties, the required standard of knowledge and capabilities must be met. Appropriate training and supervision is required until minimum knowledge and skills are achieved prior to independent practise. Additional accredited training in specific areas may be required**”. For example, it may not be within a diagnostic radiographer’s individual scope of practice to undertake examinations with contrast. The enabling components suggest that it is routine for diagnostic radiographers to do so.

Key capability 1 Enabling component b. ASMIRT recommends the inclusion of a statement reflecting the special considerations recommended for pregnant and paediatric patients in this component.

Key capability 1 Enabling component c. ASMIRT note the inclusion of angiography in this component and in the explanatory note **Range of settings**. Angiography is a specialised area of diagnostic practice. It would be unlikely that an entry level or early career practitioner would have had sufficient clinical experience to undertake safe and efficient practice in this modality.

Key capability 2 Enabling component a. Not all radiographers will be able to operate CT systems safely and effectively as not all radiographers work in CT. This may be due to their practice setting (i.e. no CT scanner in the practice) or the requirement for CT training to be provided in the workplace. It is impractical for all clinical departments to provide CT experience across all staff. It is in the best interests of the patient to have radiographers who have consolidated their knowledge and skills in performing CT examinations.

Domain 1B

Key capability 5 Explanatory note. *Contrast CT examinations can be performed by nuclear medicine technologists who are qualified to do so.* ASMIRT suggest changing the word “qualified” to “those who are appropriately trained and credentialed by their clinical department”.

Domain 1C

Key capability 1 ASMIRT suggest rewording to “Use equipment and perform techniques to ensure reproducibility of the patients’ position for radiation therapy.”

Key capability 1 Enabling component a. Replace “simulation” with the word “localisation”. This would maintain consistency with the description of this domain and would also encompass conventional simulators and clinical mark up of fields.

Key capability 1 Enabling component b. ASMIRT suggest amending the component to “Perform CT and other imaging modality-based localisation for a range of cancer sites, patient/client presentations and related planning procedures”. This would then encompass the use of other modalities such as ultrasound in brachytherapy.

Key capability 2 ASMIRT suggest replacing “simulation” with “localisation”. This would then be consistent with the description of this Domain at the top of the page. Simulation is an outdated term.

Key capability 3 and Key capability 4. ASMIRT raise this as a point of discussion as one (to date) large Radiation Therapy private provider is departing from rotation of staff

through dosimetry and treatment. This may change/limit the scope of practice for many radiation therapists, who will no longer be able to perform treatment planning or treatment delivery and therefore not meet these capabilities.

Key capability 3 Enabling component a. ASMIRT suggest replacing “*radiation biology*” with “*radiobiology*” as this is a more contemporary term.

Key capability 3 Enabling component d. ASMIRT suggest expanding this component to include “*and undertake quality assurance procedures as per departmental protocol*” to reflect the quality assurance aspects of the role. This includes for example, peer review of treatment plans as an integral component of robust quality assurance.

Explanatory note *Treatment Planning*. Similarly the term “*radiotherapy*” should be replaced throughout with “*radiation therapy*” to maintain contemporary language. The descriptor “*radiosurgery/stereotactic radiotherapy*” is more correctly termed “*stereotactic radiosurgery/radiation therapy*”. ASMIRT acknowledge that treatment planning for paediatric cases requires a specialised skill set and note that not all radiation therapists may have exposure to this patient cohort. The list of modalities does not include treatment planning for electron treatment. ASMIRT also suggest changing “*proton therapy*” to “*particle therapy*” as this term will encompass future planning for particles other than protons.

Explanatory note *Planning procedures* should also include “*and apply knowledge of standard dose and fractionation schedules and dose constraints of organs at risk*”.

Explanatory note *Treatment plans* should also include particle therapy.

Explanatory note *Evaluating radiotherapy treatment plans*. The last sentence should be amended to “*Treatment plans must be evaluated independently by a second radiation therapist to ensure that they are acceptable and safe*”

Key capability 4 The word “*treatment*” is superfluous in this sentence. It is a radiation therapy prescription.

Key capability 4 Enabling component c. ASMIRT suggest replacing the word “*implement*” with “*deliver*”.

ASMIRT suggest adding an enabling component “*Evaluate treatment verification images and correct for any mismatch according to local protocols*”. This is a key component of the radiation therapist scope of practice.

Key capability 5 Enabling component c. Radiation therapists do not adjust dose levels when performing planning CTs because the treatment planning system requires a standard kV for the electron density tables. Radiation therapists do adjust CBCT settings as part of treatment delivery.

Key capability 5 Explanatory note Contrast CT examinations can be performed by radiation therapists who are qualified to do so. ASMIRT suggest changing the word “*qualified*” to “*those who are appropriately trained and credentialed by their clinical department*”.

Domain 2: Professional and ethical practitioner

Key capability 1 Enabling component e. This enabling component requires the MRP to “*obtain informed consent*” whereas the Legal responsibilities explanatory note requires the MRP to “*confirm informed consent*”. These inconsistencies in the wording within the document could lead to confusion over the responsibility.

Key capability 1 Enabling component h. ASMIRT welcome the inclusion of this component: “*Exercise appropriate levels of autonomy and professional judgment in a variety of medical radiation practice settings*”. This acknowledges that medical radiation practitioners are integral members of the team providing care and service to patients.

Key capability 2. ASMIRT welcomes the inclusion of the Enabling component b: “*Apply the principles of cultural competence and cultural safety to practice*” and the definition of cultural competence in this capability.

Domain 3: Communicator and collaborator

Key capability 1 Enabling component b. ASMIRT suggest amending this component to include “*any side effects of the examination/treatment relevant to the anatomy being treated and how to manage these.*”

Key capability 1 Enabling component h. As for Domain 2 Key Capability 1e. This enabling component requires the MRP to “*obtain informed consent*” whereas the Legal responsibilities explanatory note requires the MRP to “*confirm informed consent*”. These inconsistencies in the wording within the document could lead to confusion over the responsibility.

Further, this enabling component is currently relevant to only diagnostic imaging and nuclear medicine. Informed consent for radiation therapy treatment is routinely obtained by the radiation oncologist. It is the radiation therapist’s responsibility to check that the patient has consented to treatment, and that they have an understanding of the treatment risks and benefits before proceeding at simulation and checking again before proceeding at the treatment stage. ASMIRT would welcome a more inclusive approach in radiation oncology, provided that radiation therapists have the appropriate knowledge, skills and experience to obtain informed consent and work within the radiation oncology team.

Key capability 1 Explanatory note Informed consent. The guideline referenced (*General guidelines for medical practitioners in providing information to patients*) appears to have been rescinded and is not available as current when searching on the NHMRC website. Further whilst the sentence appears as “*this guide to the information that practitioners need to give to patients/clients*” the title of the referenced guideline relates specifically to medical practitioners not to all health practitioners.

Key capability 2 Enabling component c. ASMIRT welcome the inclusion of the “*Follow accepted protocols and procedures to provide relevant and timely verbal and written communication*” and the recognition of the knowledge, skills and experience of medical radiation practitioners in the explanatory statement regarding making recommendations about the suitability and application of procedures. ASMIRT would further suggest that a stronger statement regarding the ability of MRPs to interpret images and convey information in verbal and written communication be included in this Key Capability.

Domain 4: Lifelong learner

This domain places an emphasis on a capable practitioner to take responsibility for their own development. This is a professional requirement that is strongly encouraged within ASMIRT membership to facilitate ongoing professional development.

Key capability 1 Explanatory note “*Research design, methodology, analysis, review and publication steps in the research pathway must be understood for participation in research.*” ASMIRT maintain that medical radiation practitioners may be involved in research without having a complete understanding of all of the elements in this statement. This is in keeping with the concept that there is a continuum of practice, and that the practitioner will evolve their knowledge and understanding of research over the course of their career. ASMIRT is pleased to note a steady increase in MRP involvement and leadership in research and contribution to evolving evidence-based practice.

Key capability 2 Enabling component b. ASMIRT suggests expanding this enabling statement to “*Critically reflect on personal strengths and limitations to identify learning required to improve and adapt professional practice and undertake measures to address this.*”

Domain 5: Radiation safety and risk manager

ASMIRT recommends that practices regarding radiation safety and risk management be evidence based.

Key capability 1 Enabling component b. Each state and territory jurisdiction mandates Radiation Management Plans for facilities. Is the intent of this component that the practitioner has knowledge of, understands and complies with the Radiation Management Plan of the facility they are working at? If so, this should be explicitly stated.

Key capability 2 currently relates to the patient/client. This domain should also include the responsibility of the practitioner to those they work with. ASMIRT would suggest expanding Key Capability 2 to read “[Protect and enhance patient/client and healthcare team safety](#)” with an Enabling component “[maintain the safety of healthcare team members in the department.](#)”

Conclusion

The Australian Society of Medical Imaging and Radiation Therapy is the peak body representing medical radiation practitioners in Australia. The Society values the opportunity to contribute to the review of the Professional Capabilities for Medical Radiation Practitioners in Australia, to ensure that our patients are provided with evidence based, high quality healthcare. ASMIRT remain ready to provide feedback on future drafts and reviews of the document.