

Attachment B: Public consultation response template

March 2025

Consultation questions on updated professional capabilities for medical radiation practitioners

The Medical Radiation Practice Board of Australia is conducting a confidential preliminary consultation on updated Professional capabilities for medical radiation practice. The Board invites your feedback on the proposed updated Professional capabilities using the questions below.

Please provide your feedback on the questions in a **Word** document (not PDF) by email to medicalradiationconsultation@ahpra.gov.au by **5pm (AEDST) Wednesday 28 May 2025**.

Stakeholder details

If you would like to include background information about your organisation, please do this in a separate word document (not PDF).

Organisation name
Contact information
Please include the contact person's name, position and email address
Edel Doyle

Publication of submissions

The Board publishes submissions at its discretion. We generally publish submissions on our website in the interests of transparency and to support informed discussion.

Please advise us if you do not want your submission published.

We will not place on our website, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the subject of the consultation. Before publication, we may remove personally identifying information from submissions, including contact details.

We accept submissions made in confidence. These submissions will not be published on the website or elsewhere. Submissions may be confidential because they include personal experiences or other sensitive information. Any request for access to a confidential submission will be determined in accordance with the Freedom of Information Act 1982 (Cth), which has provisions designed to protect personal information and information given in confidence.

Please let us know if you do not want us to publish your submission or would like us to treat all or part of it as confidential.

Response to consultation questions

Consultation questions for consideration Please provide your responses to any or all questions in the blank boxes below. If you would like to include your response in a separate word document, please provide this in word format only (not a PDF)
1. Is the content of the updated <i>Professional capabilities</i> clear and reflective of autonomous and contemporary medical radiation practice? If no, please explain why.
No. - Page 16 = graduates are not capable in CT upon entry to the profession and it is unsafe to expect them to be. CT delivers the highest radiation dose burden and this must be considered when setting expectations for new graduates. This expectation is increasing the speed at which MRPs are becoming button-pushing technicians, rather than educated technologists. The MRPBA is the only entity that can protect the public by ensuring that this threshold is reasonable, and it should not be influenced by workforce shortages. The MRPBA must protect the public by ensuring that MRPs are appropriately trained post-registration in CT in the same way as for DSA, Ultrasound and MRI. I cannot see any justification documenting why CT is considered a first-post competency. The range of complexity in CT imaging is huge and cannot be covered in the few hours of clinical placement undertaken as students, noting that some universities send students on CT clinical placements before they have learned the theory. - Page 21 = I have not seen any evidence to show that the majority of practicing radiographers, and certainly not new graduates, are familiar with normal ranges for the physiological parameters listed. - Page 22 = Should “medically significant findings” read “clinically significant findings”? What are the “relevant guidelines” in relation to documentation of these? - Page 23 = the NSQHS’s Medication Safety Standard is not currently considered by uni’s nor existing medical imaging services.
2. Is there any content that needs to be changed, removed or added in the updated <i>Professional capabilities</i>? If yes, please provide details.
- Page 17 = typo -reference missing and “capabilites” in same sentence. Domain 1 - Key Capability 1, h: We were taught that an adverse reaction to contrast agents was “anaphylactoid,” not “anaphylactic.” Should we not be responding to adverse reactions to any medication? E.g. Adenosine in a nuclear medicine stress test? Beta-blockers or GTN administered during a CT Cardiac Angio? I understand that this is an attempt to specifically address the Coronial Recommendations from the Peta Hickey enquiry. Please clarify why HLTAID010 is recommended? These courses teach management of Anaphylaxis using an EpiPen prescribed for an individual patient with a known allergy, e.g. food/bee sting etc. They do not address contrast reactions. I work for a private imaging company and we have written our own ‘contrast reaction management’ course and teach our MRPs to use an EpiPen even though it contravenes legislation in some states in which we operate. Moving from HLTAID009 to HLTAID010 will be a significant cost increase for the business. - Key Capability 7: Does “physical stabilisation” refer to a technique used in Radiation Therapy? My interpretation of this Key Capability in MI and NM is “immobilisation”, rather than the (ED/ICU) patient being “stabilised” by the medical team before coming to CT... Explained on page 23, but if included in a ‘genera’ domain, it needs to include the term “immobilisation”; otherwise move “stabilisation” to an RT-specific section. - Key Capability 8: Known side effects of medicines needs to be added. We use these to improve our imaging but some MRPs don’t appear to know the difference between a side effect and an adverse

reaction. The explanation on page 23 is a “cop out” and fails to support MRPs in doing the best things for the patient at a national level.

- Key Capability 9: I believe that this needs to be changed to “Perform basic CT imaging.” There is no way that a graduate upon entry to the profession should be performing Stroke Imaging CT angios or CT-guided interventional procedures. I would go as far as to say that they should only be performing CT “under supervision” which may be remote. At a personal level, I have a huge issue with this key capability and can see no justifiable reason why CT is considered easier or safer than MRI. Many hundreds of thousands of CTs are performed annually in Australia, but they are not always performed well because there is a lack of understanding of the clinical requirements and technical capabilities required to answer specific clinical questions from junior staff especially when working alone after hours. There is a huge difference in diagnostic CT versus CT performed for planning, AC correction or localisation, and this is not addressed in this capability. Glad to see that the notes on page 23 state “(entry level capability does not include sophisticated vascular imaging such as brain perfusion imaging or cardiac angiography).”
- Key Capability 9, i: I don’t think this conveys the intent. With dose modulation, we very rarely have to “adjust relative dose levels” for individual patients.
- Key Capability 9, j: Expecting a graduate at entry level to the profession to be able to “collaborate in the design and evaluation of CT protocols” is undermining the profession. This level of capability comes from a combination of post-graduate experience, formal post-graduate education and many years of clinical experience. This must be removed, as it is unrealistic.
- Key Capability 9, l: This needs to be clarified, as I’m not sure that the intent is. The “volume” is the 3D (usually isotropic) dataset acquired. It is post-processed to create MPRs but many other types of formats can be created too, e.g. VR, SSD, vessel tracking.
- Key Capability 9, m: Isn’t this already recorded in Domain 1, Key Capability 1, i? Why does it have to be “recorded” in CT but not anywhere else?
- Page 22 = typo. “x-ray” should read “X-ray.” Replace “bone mineral density” with “dual energy X-ray absorptimetry” as it is used for more than calculating BMD, e.g. body composition.
- Page 23 = contrast media only refers to iodinated contrast. We use barium, water and air so the term contrast agents should be used. Refer to ESUR definitions.
- Page 24 = Add to “Perform MRI” h. Respond appropriately to any MRI Safety incident, e.g. patient in scanner with a pacemaker, thermal burn, initiate a Quench.
- Page 25 = Perform angiography examinations in a range of settings **b.** Consider re-wording to “Effectively communicate as a member of the multidisciplinary team during the review of the imaging request, patient history and previous medical images, as well as during the assessment of the patient to receive care and the planning of the procedure. **g.** Prepare the patient, and prepare delivery systems with the appropriate contrast agent using aseptic technique. I’m not sure why “prepare the patient” is included here, as that is often the role of the referring team, e.g. cannulation. As CO₂ is sometimes used it’s better to use the term contrast agent instead of media. **h.** I don’t think that “prostheses” is the best word to use in this context, perhaps medical equipment and devices?
- Page 26 = angiography locations should also include the coronary catheterisation laboratory; I can’t imagine any scenario where we would perform II imaging in ED, never mind Angio so I suggest that this is removed. x-ray should read X-ray. “Delivery systems” is not the appropriate term here as it implies a machine (e.g. contrast injector) is involved. Please review the intent of this descriptor.
- Page 26 = I would use the term “medical device” as I associate “prostheses” with orthopaedics.

Domain 1A

I’m not aware of diagnostic radiographers “performing diagnostic procedures,” we acquire diagnostic images; the radiologist performs diagnostic (or therapeutic procedures). Or we perform diagnostic imaging examinations using ionising or non-ionising radiation.

- Key Capability 1, **h**: Expecting a graduate at entry level to the profession to be able to “collaborate in the design and evaluation of projection radiography protocols” is unrealistic. This level of capability comes from a combination of post-graduate experience/education and many years of clinical experience. This must be removed, as it is unachievable as a minimum requirement.
- Key Capability 2, **b**: Whilst this may be appropriate in the radiology setting, it is highly unlikely to occur in the theatre setting. The patient is often anaesthetised when the radiographer arrives in theatre so they are not involved in this conversation at all.
- Key Capability 2, **g**: Prepare the patient, and prepare delivery systems with the appropriate contrast agent using aseptic technique. I'm not sure why “prepare the patient” is included here, as that is often the role of the referring team, particular in theatre setting. As CO₂ is sometimes used it's better to use the term contrast agent instead of media. Even in Screening Room setting, we may provide patient preparation information to (out-patients or to ward for in-patients) but we are not responsible for preparing the patient, other than to ask them to wear a gown and remove any (metallic) artefacts from the region of interest. I think this needs re-wording to clarify the intent.
- Add to Key Capability 2: Apply knowledge of occupational radiation safety for staff and radiation protection for patients.
- Page 28 = x-ray should ready X-ray -> “Find and replace all”. Range of settings should replace ED with cath lab. Radiation protection usually applies to patient; but radiation safety to staff -shielding should be used to protect staff, not patients. “Delivery systems” is not the appropriate term here as it implies a machine (e.g. contrast injector) is involved, which is not the case for oral or hepatobiliary. Rectal contrast should be added. Please review the intent of this descriptor.
- Explanatory Notes = From an Accreditation perspective, all new graduates must have experience “in a range of settings for radiography that must include the imaging department or private practice, emergency department, operating theatre, intensive care unit, diagnostic and screening mammography facility and use of mobile systems”. In the same way, all new graduates must have experience “in a range of settings for fluoroscopy that must include the imaging department or private practice, operating theatre and cardiac catheterisation laboratory.” The clinical opportunities that students now experience is insufficient and they are not fit for practice on graduation. Therefore the minimum entry requirements into the profession must be strengthened; if not, the graduates are mere technicians, rather than professionals, as per the [ILO classification](#).

Domain 1B

- Key Capability 2, **c**: Please review the intent of this descriptor as: “Delivery systems” is not the appropriate term here as it implies a machine (e.g. injector) is involved, rather than an anatomical system. “Dosage of radiopharmaceutical delivery systems” does not read well.
- Key Capability 2, **d**: I think this should be re-worded, e.g. Administer radiopharmaceutical using appropriate anatomical system, e.g. intra-venous, respiratory, lymphatic
- Key Capability 2, **e**: I think “other emerging studies” should perhaps read “other emerging technologies.”
- Key Capability 2, **i**: Prepare the patient, and prepare delivery systems for nuclear medicine radiopharmaceutical therapies. I'm not sure what “prepare the patient” includes - we may provide patient preparation information to (out-patients or to ward for in-patients) but we are not responsible for preparing the patient, other than to ask them to empty their bladder prior to scanning and remove any (metallic) artefacts from the region of interest. I think this needs re-wording to clarify the intent. Why is this only for “therapy” and not for diagnostic scans?
- Page 30 = Refer to previous comments re “Delivery systems” and review the intent of this descriptor.

Domain 2

- Key Capability 1, **k**: Should there be a comma between ethics and bio-ethics?

- Page 34 = Add section about Research ethics. Many MRPs are not familiar with the requirement for Ethical Approval and informed patient consent when “trialling new protocols” for vendors nor providing anonymised images for research projects.

Domain 3

- Key Capability 1: I appreciate that it is implied and/or covered elsewhere, but I would like to see it added, that the MRP ensures that the patient understands the information given to them and has the opportunity to ask questions. And that the MRP escalates the questions to more senior colleagues where they don't know the answer or it's outside their scope of practice. I would also like to acknowledge that even when written patient information is provided, the MRP is still required to ensure that the patient understands what's involved by having a conversation with them. Written consent also does not remove the need for this same conversation. And a reminder that the patient can decline, and can change their mind.
- Key Capability 2, **d**: Whilst I wholeheartedly agree with this and I would love to see MRPs advocate for patients more often, the current Medicare system and paternalistic medical model prevent this from occurring in practice.
- Key Capability 3, **a**: Delegation of tasks must occur within their scope of practice, e.g. student MRPs must be directly or indirectly supervised at all times with no remote supervision.
- Page 39 = I can't think of an example where a MRP would refer to another practitioner.
- Supervised workforce = I can only assume that this is limited to students and SPPs.

Domain 4

Domain title should retain some reference to “evidence informed practice” which can only be achieved by “life long learning” because evidence evolves.

- Key Capability 1, **e**: Graduate entry MRPs are not “research ready” and neither are most registered radiographers. This will require a significant upskilling in research principles for the existing workforce.
- Key Capability 4, **d**: I'm not sure why “Assistant workforce” has changed to “MRP assistants.” MRPs should also be involved in providing developmental support for Patient Support Assistants, e.g. porters. There is specific training for MIAs (Cert IV) which includes Group e modules: <https://training.gov.au/training/details/HLT43021/qualdetails>

Domain 5

- Key Capability 1: Add requirement to generate Facility Reference Levels (FRLs) and compare to National Diagnostic Reference Levels (NDRLs), including implementing an Optimisation process where applicable.
- Key Capability 4, **c**: Add requirement to report incidents and near misses in an Incident Management System to facilitate Root Cause Analysis with the intent of minimising the risk of future harm from similar incidents.
- Page 43 = typo: officer instead of office.
- Page 43 = dose limits do not apply to patients.
- Add reference to the impending NSQMIS, as all diagnostic radiographers and nuc med technologists should be familiar with them in order to embed safety and quality in their everyday clinical practice.

Domain 6

This is an unreasonable minimum capability for a new graduate. Please clarify that this only applies to MRPs with more than 1 year post-graduate experience but that new graduates should be working towards this.

- Key Capability 1, **a**: Where is the “science of quality improvement” included in the approved program accreditation standards?
- Key Capability 1, **d**: Add using root cause analysis.
- Key Capability 2, **a**: I would love to see the MRPBA and professional bodies provide access to the iRefer guidelines to support implementation of this capability.

Glossary of Key Terms

- Page 47, **Medicines** = note that DIAS is used as a reference. These standards are currently undergoing major review.
- Page 47, **Physical stabilisation** = Add Immobilisation so relevant to medical imaging and/or nuclear medicine
- Page 47, **Procedures** = This definition is too all-encompassing. NSQHS Standards should be referred to as Standards, including the impending NSQMIS. A procedure in medical imaging implies an interventional procedure which may involve diagnosis or treatment. An examination is the most commonly used term.

Abbreviations

- Page 48 = Add NSQMIS = National Safety and Quality Medical Imaging Standards (will replace DIAS)

Table of changes

- Page 50 = Multiple errors relating to references on page 50.

Appendix D

- Page 70 = typo: comma missing after (CORU)

3. Would the updated *Professional capabilities* result in any potential negative or unintended effects for people requiring healthcare, including members of the community at risk of experiencing poorer health outcomes? If yes, please explain why.

Page 22 = “understanding management outcomes” does not equate to implementing management outcomes, such as the administration of an EpiPen to “buy time” whilst waiting for the medical practitioner/Code Blue team to attend. Some State laws require amendment or stronger wording in these Professional capabilities are required to support MRPs in responding appropriately to a patient experience symptoms of anaphylaxis by administering an EpiPen. ASCIA’s online courses do not address identifying, responding to, or the management of a contrast reaction as they are not written for this purpose. Their website specifically states that the “Anaphylaxis e-training for health professionals” course is for “vaccination management.” I would strongly suggest that the MRPBA provides such CPD for a transition period to bring all existing registered MRPs up to the minimum standard required to meet this capability. Then the CPD & training can be transferred to the professional bodies to maintain.

Page 23 = what are the “Principles of Justice” that apply to selecting appropriate equipment and triaging patients? Do this equate to “Justification” which is described in an entirely different manner? Justification under the ALARA Principle is not supported by Medicare.

Domain 3, Key Capability 1, h: I wholeheartedly agree with the use of official medical interpreters, but this is often considered as “we don’t have time to do this” so family/friends are used which is highly inappropriate. Free translating and interpreting services are available to Medicare card holders, but what happens with private patients?

Agree in principle with responses to Qs 2 & 3 in Appendix C.

4. Would the updated *Professional capabilities* result in any potential negative or unintended effects for Aboriginal and/or Torres Strait Islander Peoples? If yes, please explain why.

No; all people should be treated equally with respect, irrespective of their cultural background. Agree in principle with response to Qs 1 & 4-6 in Appendix C.
5. Would the updated <i>Professional capabilities</i> result in any potential negative or unintended effects for medical radiation practitioners? If yes, please explain why. Page 23 = Justification under the ALARA Principle is not supported by Medicare. Radiographers cannot necessarily undertake the most appropriate imaging in accordance with evidence-based practice “because Medicare doesn’t cover it.” This prevents radiographers from complying with radiation legislation and from acting in the best interests of the patient. Page 36 = Most MRPs in Australia, particularly radiographers, are not aware of the medicolegal aspects of suspected NAI that we may encounter under the heading of Family, domestic and sexual violence. This is in parallel to the technical performance of acquiring relevant imaging. It is understanding the chain of evidence. Page 36 = MRPs in Australia are ridiculed, stone-walled and bullied by their medical colleagues when they try to make Recommendations on alternative patient pathways which is linked to a ‘demand’ service, fuelled by defensive medicine, inappropriate financial incentives for private radiology providers, and the fact that Medicare billing rules are not up-to-date based on evidence-based practice. Domain 4, Key Capability 1, e: This will require a significant upskilling in research principles for the existing workforce.
6. Are there any other potential regulatory impacts the MRPBA should consider? If yes, please provide details. • Domain 1, Key Capability 1, h: Poisons legislation in some states does not allow MRPs to administer Adrenaline to manage a contrast reaction. • There are some minimum capabilities currently listed that it is impossible for new graduates to meet. If these are included to use as minimum professional standards to assess performance of existing registrants or for overseas applicants, it must be made very clear which enabling components do not apply to registrants within 1 year of graduation from an approved program of study in Australia.
7. The draft Low value care statement (Attachment A) has been developed to provide additional guidance for medical radiation practitioners and connects with the requirements of the Code of Conduct and the sustainability principles published by Australian Commission on Safety and Quality in Healthcare (ACSQHC) a. Is there any content that needs to be changed, removed or added to the Low value care statement? b. Are there any potential negative or unintended affects that might arise?
a. I really like the intent of this document. It is long overdue in the Australian healthcare setting. b. Yes... i. Employees will NOT challenge their employer or radiologist. Ahpra needs to provide a pathway for anonymous reporting with a minimum of 3 examples provided. Ahpra, in conjunction with the Dept of Health in that state and Medicare, need to be seen to act together to address the issue with individual medical practitioners that with private imaging companies. ii. MRPs are coerced or bullied into imaging as many patients as possible that walk through the door -there are no consequences for imaging the wrong patient or wrong body part and the imaging company can bill the incorrect exams to Medicare, thereby increasing their revenue.

iii. MRPs will lose their jobs over trying to do the right thing. Medicare needs to address unethical billing in tandem with this document.
8. If updated <i>Professional capabilities for medical radiation practice</i> were to become effective from 1 January 2026 is this sufficient lead time for the profession, education providers and employers to adapt and implement the changes?
Yes, if there is adequate communication. From a personal point of view, educational resources to support employers in sharing the updated Professional Capabilities with their MRP staff would be beneficial.
9. Do you have any other feedback on the updated <i>Professional capabilities</i>?
No.