



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

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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](mailto: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:

<b>Name:</b>	Andrew Hewat
<b>Organisation Name:</b>	Victorian Allied Health Professionals Association

## Your responses to the preliminary consultation questions

<b>1. Does any content need to be added to any of the documents?</b>
Content is sufficient except where identified in the responses that follow.
<b>2. Does any content need to be amended or removed from any of the documents?</b>
Yes, as per comments in appropriate sections to follow.
<b>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?</b>
<p>Generally, the key capabilities match the threshold level but there are some areas where they extend beyond the relative capabilities at the threshold level and would be better suited to describing an experienced practitioner. For example:</p> <p>Domain 1</p> <ul style="list-style-type: none"><li>• 2g) &amp; 7c) require the practitioner to report any urgent and/or unexpected findings to the appropriate person, with an indication that this could/should be the referring practitioner. In many practices this would not be possible or accord with practice policy, with the requirement being to report such findings to the reporting radiologist, consultant, nuclear medicine physician, etc and that they raise the findings with the referrer or appropriate person managing the patient.</li><li>• Also at 7c) there is considerable concern regarding the contemporary practices in CT where the practitioner is often not in a position to be reviewing images with the intent of preliminary reporting (as is inferred by this requirement). For example, it is common that the lung window images are set and sent as a block to the reporting radiologist without the full set of images even being seen.</li><li>• 3 b) This should be clarified as a “basic understanding”. The disciplines are advancing significantly and it is unrealistic expectation to expect a med rad practitioner to be across the detail of all the disciplines. We are unsure what is meant by ‘simulation’.</li><li>• 4 c) Generally the examination is dictated by the protocols of the practice/employer. Changes may require the intervention of the radiologist, nuclear medicine physician, etc.</li><li>• 5 d) Often the triaging of patients is done at a more senior level than a threshold practitioner, such as the most senior practitioner on duty. This may even be done by an Emergency Consultant, for example.</li><li>• 5 e) While identifying contraindications and limitations of radiation services and then determining appropriate adjustments to procedures should be a key capability for medical radiation practitioners, much of this is gained with experience and few junior practitioners</li></ul>

would have developed this skill, let alone be comfortable or capable (and possibly not authorised) to convey this to the patient. This is not a threshold capability.

- 8) This is a comment on the capabilities and the enabling component. What medicines are being referred to? We are not sure of the relevance of this to general med rad practitioners.
- The optional key capabilities and enabling components for MRI and ultrasound could possibly be extended to include CT. With the increasing complexity of CT scanners and procedures med rad practitioners require significant training before achieving practical capabilities on CT. Thus it should be considered that unless CT is included in their scope of practice, they would not need to meet the capability.
- 9 d) A threshold practitioner would not be expected to collaborate in the design and evaluation of MRI protocols. That is the domain of a senior experienced practitioner.

#### Domain 1A

- It would be useful to add to the header “Key capabilities – What registered medical radiation practitioners must be able to do” – “within the scope of practice”. Some people have been concerned and confused, particularly in reference to the inclusion of “2. Perform diagnostic computed tomography (CT) imaging” when they don’t have access to CT training or ongoing practice. The caveat “within scope of practice” identifies that this required key capability only applies if CT is within their scope of practice.

#### Domain 1B

- For 2 b) and d) and 5 the requirement for CT, SPECT/CT and PET/CT will vary depending on how recent the med rad practitioner completed their undergraduate qualification as these are to some degree relatively new inclusions (primarily the addition of the diagnostic CT component) and even then not all practices will have access to all of these modalities necessitating the caveat “within scope of practice”.

#### Domain 5

- 1 e) “Justification” – it is unclear as to who to justify and by what method, also remembering that often the overseeing doctor has a conflict of interest as the imaging/treatment is a form of income for them.

#### **4. Do the enabling components sufficiently describe the essential and measurable characteristics of threshold professional capability that are necessary for safe and competent practice?**

Please see responses above to question 3.

**5. Is the language clear and appropriate? Are there any potential unintended consequences of the current wording?**

Yes, apart from any questions raised in the responses above, the text is clear.

**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?**

It is possible that RANZCR will see some of the work described as encroaching on their territory.

From an industrial viewpoint, VAHPA would see that as the responsibilities on the practitioners increase that there be a commensurate recognition and remuneration through the appropriate industrial instruments. All changes would need to be within the scope of existing awards, agreements and Federal legislation.

**7. Are there implementation issues the National Board should be aware of?**

VAHPA is concerned that some of the expectations and capabilities are setting practitioners up for failure and potential professional prosecution and may significantly increase liability exposure. This is through what we deem to be increasing the responsibility and scope of expectation as described elsewhere in this response. We have drawn attention to the areas that we feel are better described to match more experienced and advanced practitioners than simply threshold practitioners in the responses above.

**8. Do you have any other general feedback or comments on the proposed draft revised professional capabilities?**

VAHPA's primary concern is with the disconnect between expectation and the reality of busy modern radiation practices. Workload pressures often dictate the capacity of the practitioner to meet just the simple requirements of delivering treatment or providing images for diagnosis let alone going the next step that is implied throughout these capabilities of interpreting and alerting/provisional reporting. It is also important to recognise structural changes to the roles need to have industrial frameworks to support them and create the appropriate space for them within the workplace structures.

VAHPA has already raised concern in the preliminary feedback regarding what we consider to be unrealistic expectations in some case for the requirements for identification of pathologies. This still holds true.