



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:	Ivan Williams
Organisation Name:	Australian Radiation Protection and Nuclear Safety Agency

Your responses to the preliminary consultation questions

1. Does any content need to be added to any of the documents?

Please provide clarification regarding requirements for any of the three divisions to perform any of the optional capabilities.

What are the expectations on an individual so that they can demonstrate that engaging with an imaging modality which is “in your scope of practice”?

2. Does any content need to be amended or removed from any of the documents?

Domain 5, Key Capability 1, Component e: Review the referral and procedures

We recognise that the intent may have been to refer to protection of patients and not to protection of staff. If this is the case, limitation is not appropriate and the definition of optimisation should be changed to focus on tailoring patient dose to the clinical objective. Justification is the responsibility of the radiological medical practitioner, but the task may be delegated through site protocols to guide MRPs when reviewing referrals.

If the mention of “procedures” is also meant to include work arrangements and facility policies that impact on radiation protection for staff, then we would recommend that this be explicitly stated as a separate item.

We summarise below the aspects of the principles of justification, optimisation and limitation that are relevant to medical radiation practitioners in the two separate contexts of protection for patients and protection for staff.

1. Protection for patients

Justification – primary responsibility rests with the radiological medical practitioner (radiologist, oncologist, nuclear medicine physician, cardiologist, etc) and the referrer. Medical radiation practitioners are typically at the front line but should be reviewing justification in the context of guidance provided by the radiological medical practitioner and should refer problematic or doubtful cases to the radiological medical practitioner.

Optimisation – using appropriate technique factors for that patient and procedure, including tailoring technique to patient habitus to ensure acceptable image quality without excessive dose (imaging) or desired target dose with minimised dose to other tissues (therapy & treatment planning).

Limitation – Not relevant for patients. Dose is dictated by clinical requirements.

2. Protection for staff & others

Justification – Decisions about whether particular types of procedures should be undertaken at all are matters of policy for a facility or the medical profession as a whole. Medical radiation practitioners contribute through their operational and radiation safety expertise.

Optimisation – minimising degree of exposure, number of persons exposed, likelihood of exposure. Examples include: contributing to improving work practices, and ensuring that only staff & others whose presence is necessary are subjected to incidental exposure from the conduct of a procedure.

Limitation – Observing legislated dose limits for occupational exposure, contributing to and complying with operational dose constraints for occupational exposure set by the facility, complying with dose constraints for carers and volunteer research subjects.

<p>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?</p>
<p>See comment 1.</p> <p>This is especially relevant in relation to US and MRI for radiotherapists who will inevitably expand their operational scope to include using these modalities are part of their normal work, albeit for specific presentations and probably clinic dependent – i.e. local protocol.</p>
<p>4. Do the enabling components sufficiently describe the essential and measurable characteristics of threshold professional capability that are necessary for safe and competent practice?</p>
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<p>5. Is the language clear and appropriate? Are there any potential unintended consequences of the current wording?</p>
<p>Yes, we the think that we understood the document.</p>
<p>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?</p>
<p>We do not have the expertise or knowledge to comment on this, but recommend engaging with the Radiation Health Committee, https://www.arpana.gov.au/about-us/advisory-council-and-committees/radiation-health-committee, to identify such complications.</p>
<p>7. Are there implementation issues the National Board should be aware of?</p>

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

We suspect that the document as written does not recognise the dynamic nature and rapidly changing clinical practice in which Medical Radiation Practitioners work. It is highly likely that many MRPs will be working with modalities and technological advances to existing modalities which are not scoped by this document. In some ways, the previous version of this document recognised the dynamic reality more accurately with a broader role being envisioned for each MRP specialty and the migration of technology between historical discipline boundaries. We therefore suspect that the documents as written may hinder professional development or be disregarded when clinical practice requires MRPs to work across historically and conventionally defined disciplines.