

## **NATIONAL REGISTRATION AND ACCREDITATION SCHEME FOR**

### **MEDICAL RADIATION PRACTITIONERS**

#### *Consultation Response from the Australian Institute of Radiography*

The Australian Institute of Radiography (AIR) welcomes the introduction of the Health Practitioner Regulation National Law Act 2009 (the Act) and appreciates the opportunity to respond to the consultation paper on the following proposed mandatory registration standards for Medical Radiation Practitioners:

1. Continuing professional development
2. Criminal history
3. English language skills
4. Professional indemnity insurance; and
5. Recency of practice.

There is, in addition, a call for consultation on the proposed registration standard:

- Grand parenting and general registration eligibility.

We will address the five proposed mandatory standards in turn and then comment on the grand fathering issue where we have some very specific concerns.

#### **1. Continuing professional development (CPD)**

With respect to CPD we understand that the Board seeks advice on:

**1.1 The advantages and disadvantages to the proposed requirements for a practitioner to undertake a specified amount of CPD hours versus a requirement for CPD points, and**

**1.2 The advantages and disadvantages to the proposed CPD hours.**

The debate between hours and points is one in which there are some entrenched attitudes as to which offers the easiest process for recording CPD. In part this goes to the heart of the role of the Medical Radiation Practice Board of Australia (S1, 3,2(a)), namely to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered. The Act is silent in terms of any detail on CPD which is presumably part of the basis for this call for consultation.

The Act is not silent, however on some specific powers of the Ministerial Council to give directions to a National Board. The section of concern to the AIR is that which states;

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The Ministerial Council may give directions to a National Board about the policies to be applied by the National Board in exercising its functions under this Law. This is stated in Part 2, 11, 2 and goes on to read;

- (3) Without limiting subsections (1) and (2), a direction under this section may relate to—
- (a) a matter relevant to the policies of the National Agency or a National Board; or
  - (b) an administrative process of the National Agency or a National Board

We would see the policy and the process of CPD as potentially attracting the attention of the Ministerial Council. Our key concern here is that it is not unreasonable to note the power of the Ministerial Council to work towards a basic standard with the clearly stated aim of enabling the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners. The application of the word 'innovation' offers considerable latitude in both meaning and consequence for the profession.

It is our view that an "hour's based" CPD programme is one which is only suitable for basic standards. Under an "hour's based" scheme it would be possible for a practitioner to achieve almost all their CPD requirements through one event, for example attendance at a national conference. An hour spent attending a conference, possibly not even focussed on the speaker for all of the time, cannot be the equal of one hour spent delivering a well-researched key-note address. The hour is a simple foundation quantifier of basic activities and it is our submission that an hour based system is insufficiently flexible to recognise other activities which should be accredited to earn CPD value at a higher rate.

As part of our review of CPD we have noted that older schemes tend to emphasise quantitative inputs expressed as a number of hours to be spent on courses or other verifiable learning events, or time to be recorded by taking part in approved activities. Although relatively crude - the measure doesn't relate to the quality of learning or its individual relevance (or even whether learning takes place) - it provides the assessing bodies with a means of gauging participation and, if necessary, taking sanctions against members. With the concept of sanction in mind it stands to reason that a Registration Board might favour this approach.

As the largest professional body for Medical Radiation and complementary Imaging Practitioners it is incumbent on us to establish and support the highest standards of practice within the profession. The AIR has played a key part in a long tradition of the ongoing evolution of professional standards in recognition of changes in education, technology and healthcare expectations. CPD needs to be divided into varying activities and needs to ensure that activities are focussed around evidence based practice; that is research should be well rewarded to promote reflective practice and life-long learning.

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This process is a continually evolving one and one in which the professional body with the dual responsibilities of professional governance and oversight, has both the responsibility and ability to move with much greater flexibility than a statutory body, constrained as they must be the legislative structures and the apparent need to maintain consistency with the other thirteen nationally registered professions. With these objectives in mind the AIR favours a credit based system of CPD, one which has evolved from the 12 points per year (36 in a triennium) to one which can transparently equate with what might be the requirements of the MRPBA; presumably something centred on a concept of 20 hours per year. To provide a clear example of how this might work we attach an actual member record (with their permission) as shown in the table below;

Date Completed	Group	Activity	Duration Hours (MRPBA)	Points (AIR)	Categ
2011/4/19	Organised program	Attend conference	21	5	A
2011/4/15	Professional activity	Participate in CPD survey	1	5	B
2011/4/16	Professional activity	Chair session – national conference	1.5	2	A
2011/6/9	Writing	Complete substantial report	2	2	B
	Formal education	Reading professional publications	2	2	B
	Professional activity	Write articles for spectrum x 2	4	4	B
<b>Total</b>			<b>31.5</b>	<b>20</b>	

This clearly shows how the points currently accrued through the AIR CPD programme fully comply and indeed exceed the possible requirements of the MRPBA hour's based CPD plan if 20 hours per year is the expectation.

The current revision of the AIR CPD programme under discussion throughout the membership is directed towards a system which will better reflect the range and diversity of competency and best practice CPD, and encourage a clear reflective component. It will also better identify that element of the current programme recorded as "other". The principle underpinning these changes is one of ensuring that the AIR programme for CPD more than meets that required by the statutory authority, the MRPBA.

Above all CPD points should encourage professional presentations and publication. This will promote professional development and also ensure that the quality of these activities will improve. For example an appropriate presentation of some 20 minutes duration, or a publication, requires a minimum of 30 to 40 hours of research and preparation time. This needs/must be reflected in the allocation of CPD points.

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The fairest and most effective way to record the enhanced range and diversity is through point's accrual rather than an hour's base. The design principles which emerged from our initial consultation and development process were:

- enabling practitioners to retain control of what and how they learn
- ensuring that recording requirements prompted learning and reflection while imposing a minimal administrative burden
- addressing the practitioner responsibility to integrate new, emerging and complementary technologies and knowledge into their practice.
- focussing on learning and development rather than learning events or activities.

We would strongly argue that the MRPBA adopt a similar system.

It is our sincere hope that the AIR system is one which the MRPBA can recognise is a program with strong evidence based requirements, properly audited and assessed. It offers a standard of which both the AIR can be satisfied meets our professional requirements for best practice and that the National Board can approve.

**1.3 Whether or not a specified proportion of an individual's CPD should be dedicated to their current scope of practice.**

The concept of a proportion of CPD dedicated to an individual's scope of practice is well established. The New Zealand Medical Radiation Technologists Board for example prescribes eight scopes of practice, but the use of these is more directed to the present practice of each registrant. In broad principle the AIR recognises that such prescription of scope of practice has value in identifying the roles and activities of practitioners, but the scope of practice approach must not evolve into one in which they restrict the evolution of practice or technology. The developments of ultrasound and the hybrid modalities such as PET/CT and MR/CT are obvious examples.

Should a practitioner be asked to provide a proportion of their CPD to a defined scope of practice, such scope ought to be both broad enough to avoid unnecessarily restricting the CPD – so for example an educator practitioner such as a tutor radiographer with the scope of diagnostic imaging must have the breadth to be able to have educational activities recognised. Equally the breadth must, within the Australian context, be able to accommodate the 'isolated practitioner' and their unique issues in accumulating CPD credit. Enforcing a 'measured portion' of CPD to a Scope of Practice may not reflect an individual's needs in the workplace.

With these caveats, the AIR would generally support the requirement for some acknowledgement of scope of practice within the CPD record. The other challenging issue is that of apportioning the proportion itself. This again is an area in which evidence is relatively scarce, although all professional associations are offering suggestions as to how

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best to address this. In many situations the proportion can be best defined by categorising the CPD; such as that of the Society of Hospital Pharmacists who require 50% of CPD to come from Group 1 activities. Reflective work in this instance is in Group 2.

It would seem to the AIR that the MRPBA should be seeking, at a minimum, something like a proportion of 25%; this would allow for a broad range of activities to be covered. We have noted that in many instances for other professional groups their frequently asked questions on their websites are dealing with the difficulties their members report of achieving proportions approaching 50%. One sensible option is that a program participant should be able to offer a reflective submission on their choice of CPD should it be questioned. This would act as a deterrent to 'unrelated activities' but encourage activities to benefit individuals.

**1.4 Situations where the Board should consider exempting a practitioner from the requirements of the registration standard.**

Superficially there are a number of situations in which the MRPBA might consider exempting a practitioner from the requirements; such as maternity leave, travel, and non-medical radiations secondment. Arguments can be mounted for exemption in these cases but they beg the question about the purpose of CPD. Continuing (or continuous) professional development has been described as "the maintenance and enhancement of the knowledge, expertise and competence of professionals throughout their careers according to a plan formulated with regard to the need of the professional, the employer, the profession and society" (Madden & Mitchell 1993, p12)<sup>i</sup>.

It is clear that some practitioners fail even to maintain an acceptable level of competence. Rogers & Shoemaker described a model of innovation more than thirty years ago in which a small minority of people drive innovation and change, a larger minority of 'pacesetters' quickly follow in taking it up, and a middle majority move forward more gradually. Bringing up the rear are those who are either left behind or move only when compelled. Although this is in some respects an oversimplified conception of change, it provides a pragmatically useful perspective from which to view CPD. One of the main objectives of professional bodies in encouraging CPD is to move those left behind and reluctant to embrace change, and the slower of the middle majority further up the spectrum. This agrees with Madden & Mitchell's findings, where bodies which confer a licence to practice tended to adopt a sanctions approach to promoting CPD which might be expected to cajole those resistant to change more than encourage pacesetters.

It is the AIR's view that there should be no exemption from CPD other than on a case by case, situation specific need. We would include some accommodation for the management of maternity leave here. We would not wish to see practitioners lost to the profession through a restrictive process and in this case, while not technically part of this request for

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submission we would argue that a limit on points of 1 point/month for the period of a twelve month maternity leave should be maintained.

The role of CPD in maintaining the necessary professional knowledge and skills cannot be understated. Should a practitioner be travelling, on secondment or on maternity leave they can never know when they may wish to resume their practice and the only certainty of competence they can offer is their proof of full CPD credits.

We are sometimes asked if a member can complete a pro rata level of CPD so as to reflect their pro rata work life. This is refused on the grounds that a practitioner cannot be only 25% competent (or 50% or 75%). The purpose of CPD is to maintain skills and knowledge and they must be at 100%. It would be our view that should the MRPBA endorse exemptions from this standard they would be derelict in their prime function under the Act (S1, 3, 2(a)).

**1.5 The type of CPD activities practitioners should be undertaking**

The AIR would not favour any restrictive approach to identifying the 'type' of CPD activities practitioners should be undertaking. It would be our view that a CPD programme needs to move practitioners away from cataloguing day to day and project-specific learning. We would suggest that practitioners should be focussing on where there is a significant improvement in ability or knowledge and the learning outcome is identified.

This definition can be related to Gear et al's<sup>ii</sup> notion of learning projects, as well as to their distinction between specific learning and general and developmental learning. While at this stage in the AIR's CPD development it has been decided to avoid introducing the idea of learning projects, the following three categories of learning would be a most valuable way of indicating the types of activities that practitioners should be undertaking:

1. Specific learning concerns; particular cases or problems, typically 'finding out as you go along:' seeking information regarding specific objects or problems, asking colleagues about treatments, checking sources of supply, and so on. This kind of learning is important for day-to-day practice but often becomes out of date quickly. It should not normally be included in a CPD review, unless it has a longer-term impact on an individual's work or leads to findings which are of more general interest.
2. General learning concerns; keeping up-to-date and abreast of trends and developments in the profession and affecting it. This kind of learning might involve reading journals and email discussions, networking and discussion with colleagues, and attending courses and conferences. This type of CPD review should show that practitioners are keeping up-to-date in their field, without needing to cite every example in detail.

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3. Developmental learning is learning which takes forward the professional's practice, creates new opportunities and develops extended professionalism. It may involve undertaking a major study, an advanced course or a programme of research, be generated through a new job or major project, or stem from becoming involved in activities outside their normal work. Although it is useful to plan developmental activities, the value of developmental learning is often only apparent on reflection. Increasingly CPD expects a reflective component and it is important that the MRPBA provide for this in their detailed expectations.

The AIR would like to comment briefly on a further element of the Consultation document where it identifies the following "Requirements" for CPD, stipulating that Practitioners must:

- (a) complete a minimum of 60 hours of CPD activities over a three year cycle, with a minimum of 10 hours in any year or comply with the requirements of a CPD program approved by the Medical Radiation Practice Board.
- (b) for each additional discipline for which registration is required, an additional 10 hours of CPD will be required per year or compliance with a CPD program approved by the Medical Radiation Practice Board.
- (c) make a declaration of their compliance with CPD requirements at the time of annual renewal.
- (d) maintain their own records detailing their CPD activities for audit purposes.
- (e) produce evidence of their CPD activities when requested to do so by the Board.
- (f) when a person registers for the first time, or has his or her registration restored after it has lapsed, the number of CPD hours to be completed will be calculated on a pro rata basis, according to a formula published by the Board.

Given our view that an hour's based system of record does not effectively acknowledge the breadth and variety of CPD which should be encouraged from all practitioners, we would look at this Requirement on an 'equivalence' basis. A good comparator might be the syllabus used in universities where in a degree programme subjects are allocated credits – for example a 24 credit subject being equivalent to 240 hours of all aspects of study, that is one credit equals 10 hours. In the CPD environment where we are trying to acknowledge the component parts of various aspects of learning, the ratio might work in reverse offering more credits to the hour. It may well be that contained within an 'hour' the equivalence could equal 1 credit for writing, 1 credit reading the literature and 1 credit for reflective thinking. This is grossly simplified for the purposes of this exercise but on such a basis a 60 hour requirement would be the equivalent of 180 credits.

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When we look at item (b) above, “each additional discipline for which registration is required, requires an additional 10 hours of CPD”, then the flexibility and effectiveness in identifying categories offered by a credit record becomes evident. The practitioners can readily accrue their CPD portfolio in a manner which fully identifies the breadth and depth of their on-going endeavours.

Requirements (c) and (f) create no difficulties for the AIR but with those requirements (d) and (e), touching as they do on the provision of records and evidence, we would ask the MRPBA to think deeply about mechanisms which could facilitate an acknowledgement of the structure and processes inherent in a CPD programme approved by the Medical Radiation Practice Board. We would have no difficulty with the MRPBA seeking to be assured that our audit and review programme was rigorous and transparent and would like to suggest that there would be some cost savings to the MRPBA and indeed AHPRA, if they were to accept that a member of the AIR having completed a duly approved and audited programme would meet the obligations of the requirements (d) and (e).

So long as the MRPBA satisfied themselves that the AIR CPD process did indeed meet the requirements of the Registration Board in this respect, they could safely note that some 6,000 registered practitioners were compliant with the Boards CPD programme.

## **2. Criminal History**

With respect to Criminal History we note that the MRPBA proposes to seek Ministerial Council approval for this registration standard to apply to the medical radiation practice profession. This is the only mandatory registration standard that is the same for all ten National Boards.

The AIR would fully support all aspects of this Standard without change or amendment.

## **3. English language skills**

With respect to English language skills we understand that the MRPBA seeks advice on:

### **3.1 The proposal to accept English language test results obtained in multiple sittings providing they are obtained within the 12 months preceding the application.**

Currently the AIR will only accept English language test results attained in one sitting, not multiple sittings within a 12 month period. There is an attraction in allowing a pass in each element individually, the English language test is a demanding assessment for candidates and we are well aware of a number of individuals who have gained passes in each element at different times but struggled to gain them in one sitting. The question before the MRPBA is one of the integrity of the English language assessment itself.

The AIR uses the Academic IELTS as the preferred English language test and in checking with the British Council (one of the owners of the IELTS scheme) it would not be possible to

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accept results obtained in multiple sittings within a 12 month period as the final band score is an average of the score for each of the 4 skills of listening, reading, writing and speaking. The proficiency of the candidates can only be judged based on his/her final band score and to break up the result would invalidate the test. Research has shown that people can increase (via practice) or even decrease (via infrequent use of the language) their proficiency level from time to time.

**3.2 The proposed requirement for practitioners to achieve scores of 7 or above in all four bands of their English language test.**

This is currently AIR policy, in line with other clinical health professions and we would not support any change. The policy is 'a score of Academic IELTS 7 in each of the four elements gained in one sitting'.

**3.3 Whether or not there is a need to accept English language tests other than the proposed IELTS or OET tests.**

The AIR will accept either IELTS or the OET assessments but the most common is IELTS. This would appear to be driven by the wider availability of these tests for individuals and perhaps the wide recognition of meaning the IELTS has for applicants. It seems that it is the preferred test for the serious applicant.

**3.4 Any additional situations where the Board should consider exempting a practitioner from the requirements of the registration standard.**

The ability to communicate clearly and accurately between patient and professional is one of the fundamental obligations of good practice. The AIR would not generally support the exemption of a practitioner from this standard. The MRPBA makes it clear that the exemptions proposed are very specific, that the Board may grant an exemption from the requirements where the applicant provides that:

- (a) they undertook and completed secondary education that was taught and assessed in English in one of the countries listed below where English is the native or first language; and
- (b) the applicant's tertiary qualifications in the relevant professional discipline were taught and assessed in English in one of the countries listed below, where English is the native or first language:
  - (i) Australia
  - (ii) Canada
  - (iii) New Zealand
  - (iv) Republic of Ireland
  - (v) South Africa
  - (vi) United Kingdom
  - (vii) United States of America.

The Board may also grant an exemption from the requirements where an applicant applies for limited registration in special circumstances, such as:

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- (a) to perform a demonstration in clinical techniques
- (b) to undertake research that involves limited or no patient contact.

These special circumstances exemptions will generally be subject to conditions requiring supervision by a registered health practitioner and may also require the use of an interpreter. These are acceptable restrictions and controls to this standard and would be supported by the AIR

#### **4. Professional indemnity insurance**

With respect to Professional Indemnity Insurance we understand that the MRPBA is seeking advice on:

##### **4.1 Whether or not to specify a minimum level of PII cover and if so, why this would be important.**

This standard is essential to sound professional practice and to the protection of the public. The AIR has provided Professional Indemnity Insurance as a mandatory component of membership for a number of years and would strongly support the provision of mandatory Professional Indemnity Insurance. The minimum level of cover is important if the standard is to be effective and the MRPBA must continue to review that level of cover as events, risk and costs change.

##### **4.2 Whether or not to specify a specific number of years that the PII run-off cover should apply and why.**

The AIR requires as part of membership, and would support unlimited run off cover. We recognise that this may not be an option for the MRPBA since it would impose a restriction of trade which may then attract the interest of the competition watchdogs. Given the nature of the equipment and the ionising radiation with which our members of the profession work and live, it is a simple reality that there be unlimited run off available in the event of something emerging many years post service delivery.

It would be the AIR's view that the MRPBA would be derelict in its responsibilities under the Act not to set at the very least a significant number of years for run off cover. That being said it would seem that the current wording of the Standard is sufficient to make the intent and expectation clear surrounding the need for unlimited run off cover.

## **5. Recency of Practice**

With respect to Recency of Practice we understand the MRPBA is seeking advice on;

**5.1 Whether or not an absence from practice for three years (but where the practitioner has three or more years' experience prior to the period of absence) should require the practitioner to undertake a mandatory amount of CPD within a specified time frame or whether the mandatory CPD requirements only be applied after a five year period of absence.**

The AIR indicated earlier in the discussion covering CPD that we did not favour or support a situation where a practitioner might participate in a partial form of CPD during any absence from practice. The MRPBA can take this to mean that should a member of the AIR maintain their membership and at the same time be absent from practice for an extended period, then they would still be required to maintain a normal members CPD requirements. That said, it would appear to us that this question is exploring whether a mandatory amount of CPD might substitute as a return to practice pathway. If the CPD undertaken was to comply with the CPD standards and had been applied and maintained systematically and steadily throughout the period of absence, then there would be a reasonable argument that the practitioner had maintained their learning and knowledge.

The question of the technical competence and skill remains and would still require some form of review and assessment before the practitioner should be deemed fully acceptable to return to unsupervised practice. CPD without clinical application is not of appropriate value and should not be relied on solely as a pathway to return to practice. The MRPBA suggests under the draft Standard that *"3. Applicants previously registered but having not practiced for three years are required to complete a minimum of one year's amount of continuing professional development (CPD), consistent with the Board's Continuing Professional Development standard, in the 12 month period prior to returning to practice. This CPD is to be relevant to the intended scope of practice and designed to maintain and update knowledge, clinical judgment, technical skills and other relevant professional attributes."* Our understanding of this is that the CPD would commence 12 months in advance of the intended return to practice date and while a commendable aim, it is our experience that many people neither plan nor think that far in advance. To support this item in the Standard we believe that the MRPBA would have to take demonstrable steps to ensure that any intending absentee from practice for a period of three years was clearly advised of this requirement in advance of their taking absence. It would be a more tidy option to make it clear that any person who held the title of medical radiation practitioner or medical imaging sonographer (see note), was expected to maintain their CPD standards irrespective of whether they were in practice or not. We realise this opens the question as to 'when is a medical radiations practitioner a medical radiations practitioner?' which is the perennial issue for any regulatory authority dealing with protection of title.

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**5.2 Possible pathways for re-entry into the profession for practitioners who have had a period of absence from practising the profession greater than three years.**

The AIR provides a well-established pathway for re-entry into the profession with a competency based assessment (CBA). This is, as with most processes, a continually evolving mechanism for assisting to determine the competence of someone re-entering professional practice. With the evolution not only of the technology to deliver services and treatment but also the technology for teaching and assessment, we believe that the MRPBA should set the standard at the higher end of description, rather than being too prescriptive and therefore limiting in expectations. Possible pathways should then encompass clear evidence of a practitioner's knowledge and understanding in their particular area of practice (by which we mean diagnostic imaging or radiation therapy or ultrasound). The pathway must ensure the practitioner's practical expertise is assessed based on demonstrable competencies. It would be our view that while the concept of a plan for the consideration of the MRPBA is highly desirable, it would be further benefitted by the requirement for some clear expectation of independent assessment of practical skill and expertise. This may include OSCE style assessments that have evidence based success in clinical professions. We see this as an omission in the current standard.

In respect to the 3 years as a trigger, current AIR policy is generally 5 years though this is under review at present. The AIR would be interested in further discussion with the MRPBA on this topic.

**5.3 Whether or not a practitioner should be required to undertake a minimum number of practice hours to maintain their recency of practice.**

This requirement while highly desirable is going to be a significant burden administratively and from the practitioner's point of view frequently unachievable. We would base this comment upon the expectation that those who do take a break from practice may not necessarily be in a position to undertake a minimum number of practice hours given the variety of reasons behind absence from practice. We would recommend that the MRPBA focus on the maintenance of CPD and the mechanisms for return to practice in preference to this approach. We note that the Standard does not in fact touch upon this.

**6. Grandparenting and general registration eligibility registration standard**

The provisions under this aspect are we note 'broad'. Of all the items contained within this consultation document this is the area which potentially is of the greatest concern to the AIR. This is in recognition of the fact that there have been two States (New South Wales and South Australia) which have not had registration of practitioners' previously. We are aware that there are practitioners currently who do not meet the AIR professional accreditation standards working in one of those States, though they do apparently hold 'use' licenses.

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The National Law (S 303) sets out the 'grandparenting' provisions for individuals who do not hold an approved qualification to be qualified to apply for registration to the profession. These individuals may apply for registration until 1 July 2015, if they meet the requirements of section 303 of the National Law and the criteria outlined in this standard.

The intent of the grandparenting provisions is to recognise qualifications, training, further study and clinical experience that are not 'approved qualifications' but are considered by the Board to be adequate for the purposes of practising the profession. The AIR is concerned that this is an area which might again attract the interest of the Ministerial Council given the potential implications for the workforce.

The MRPBA is seeking advice about;

**6.1 Methods to assess a practitioner's experience to determine their eligibility for general registration.**

The AIR notes and recommends to the MRPBA for their further consideration that there have been previous 'grandfathering' arrangements established by some of the State Medical Radiations Practice Registration Boards which will offer useful mechanisms for consideration in process terms. The AIR has a process established around the Institute Validated Statement of Accreditation which rests upon well publicised standards and expectations facing those who might wish to be recognised by the AIR. It is open to the MRPBA to set a lesser standard of expectation for professional practice but that is not a path the AIR would wish to follow. It is important however that the MRPBA does develop a method to assess not just the experience but also satisfy themselves that the relevant knowledge and learning is appropriate for the individual practicing in the profession.

The standard is expected to provide clarity and certainty to practitioners who may not otherwise be eligible to apply for general registration because they do not hold an approved qualification. The intent is to ensure that practitioners who are legitimately practising the profession (particularly in those jurisdictions that do not currently require registration) are not unjustly disadvantaged because they are not registrants or do not hold a current qualification. This is an argument which contains the sentiment of expediency and support for lesser standards in a specific case of need and must be handled by the MRPBA on a case specific basis. As already indicated the AIR will continue with our present standards of entry into membership.

**6.2 The amount of emphasis that should be placed on a practitioner's CPD to determine their eligibility for general registration.**

The AIR has previously argued that the CPD requirement should be a set figure. We would return to that argument with the expectation that any practitioner should be expected as a

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minimum to meet certain defined standards of continuing learning. The emphasis should remain an unchanging constant across the profession.

#### **6.3 General eligibility for registration.**

The AIR has noted an error in the Schedule 1 of courses leading to registration. It does not include RMIT Certificate holders who were around in the late 1960's. Students were then offered the additional subjects to go to the Associate Diploma and some did not take up that offer and are still practicing in Victoria. We would strongly recommend this inclusion to the schedule. The AIR also notes that Central Queensland University is listed and would remind the MRPBA that this is a course currently only in the early stages of accreditation.

#### **Conclusion**

The AIR welcomes the opportunity to make submission and hopes that the key principles of this submission, rigorous standards transparently applied offer some assistance to the MRPBA in their deliberations. We would return to the fundamental difference between a Registration Board tasked with ensuring the safety of the public through the setting of essential standards of practice; and the Professional Association encouraging world's best practice across diagnostic imaging and radiation therapy for all our members.

#### **Notes:**

- 1. The AIR has endorsed and facilitated the career path for medical imaging technologists in ultrasound.*
- 2. NATA requirement conflict/reinforcement. Accreditation standards consider the provision of medical imaging services across all imaging modalities. Specific standards address qualifications and CPD, acknowledging specialist professional streams.*

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<sup>i</sup> Madden, C A & Mitchell, V A (1993) *Professions, standards and competence: a survey of continuing education for the professions*. University of Bristol, Department for Continuing Education

<sup>ii</sup> Gear, J, McIntosh, A & Squires, G (1994) *Informal learning in the professions* University of Hull, Department of Adult Education