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SUBMISSION

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AMA submission on the updated professional capabilities for medical radiation practitioners

Introduction

The Australian Medical Association (AMA) supports a model of medical radiation practice where the medical practitioner — a clinical radiologist — is the leader of the multidisciplinary healthcare team. It is the clinical radiologist who provides professional supervision and oversight of all aspects of patient care.

The AMA's revised Diagnositc Imaging Position Statement (2025) underpins our position on the issues raised below. A copy of the revised position statement is also attached alongside this submission.

The distinction between performing a task, such as taking a history or imaging a patient, and the clinical reasoning behind why that task is necessary is crucial. The doctor develops a plan, while, medical radiation practitioners carry out the necessary imaging tasks. This collaborative approach ensures each task is performed with a clear understanding of its purpose, ultimately leading to better patient care. Therefore, safe, high-quality medical radiation practice involves all members of the medical imaging team working in collaboration. The AMA's position supports role delegation within scope but not task substitution.

The AMA values medical radiation practitioners as highly skilled members of the medical imaging team who have undergone extensive education and training. Medical radiation practitioners' technical expertise enables them to play an essential role in imaging with limited supervision and undertake significant responsibility to support the work of the clinical radiologist. The core focus of their role is image acquisition and presentation, assisting patients during imaging and procedures, and maintaining equipment. We acknowledge they have an important role in obtaining clinical information from the patient, for example, talking to patients about their medical history during the course of the interaction to perform the required scan.

The AMA does not support the extension of the role of a medical radiation practitioner to include tasks that require the comprehensive and broad scope of medical knowledge required to independently and safely care for patients. Medical radiation practitioners are not qualified to assess

requests or referrals, suggest alternative imaging, or to interpret and communicate findings without clinical input from radiologists. They do not undergo sufficient radiodiagnosis and medical training to the level expected of medical professionals, nor have the adequate background knowledge of pathology processes to the required depth that medical professionals possess.

The AMA notes some of the proposed revisions to the capabilities could be interpreted as a means to expand scope of practice into areas that require medical training and specialist expertise. Patient safety must always be the highest priority of all members of the healthcare team. As such, safeguards must be in place to ensure medical radiation practitioners operate under the leadership of a clinical radiologist, who is responsible for makingthe clinical decisions.

On occasions, there may be scenarios where medical radiation practitioners may need to communicate directly with non-radiologist referrers in the absence of a radiologist being available. For example, if a medical radiation practitioner detects a potential fracture during an X-ray conducted from a GP referral. Only in the rare instance that the clinical radiologist is offsite or unavailable to raise the concern, would it be appropriate for the medical radiation practitioner to contact the referrer first.

AMA comment on the draft professional capabilities

Costs

On page 11, the following statement appears to underplay the role clinical radiologists have in the patient medical imaging presentation: "There may be some costs for existing practitioners to update their skills and knowledge to meet the updated *Professional capabilities...*"

Lack of acknowledgement of the clincial radiologist

In the capabilities document, the term and role of a clinical radiologist is not mentioned, defined, or described at all. The AMA notes during intital feedback provided, there was one mention of "reporting medical specialist". However, this revised public draft capability document removes the term reporting medical specialist, and there is no mention or reference to a medical specialist/practitioner. The AMA also notes in our comments below, changes have not been made to this draft capability document from our previous submission.

It is an expectation that the capabilities document reflects terminology used in clinical practice and the use of the correct terminology when referring to the medical specialist. The AMA suggests using consistent terminology, such as **clinical radiologist** throughout the capabilities document. In addition, there must be greater emphasis on the role the clinical radiologist has in working and collaborating with medical radiation practitioners.

The responsibility for assessing requests, suggesting alternative imaging to referrers (if clinically appropriate), communicating results to referrers, and administering medicines must remain with the clinical radiologist or sub-specialists involved during the course of the patient's medical imaging encounter with the diagnostic imaging practice. Clinical radiologists possess complex clinical skills

requiring a comprehensive understanding of pathology and radiodiagnosis of a broad range of medical conditions, including of the spectrum of imaging findings. Therefore, extending a medical radiation practitioner's role into these areas puts the patient at risk. It is important for the medical radiation practitioner to understand this and for this to be emphasised in the capabilities.

Unexpected or urgent findings

The AMA fully supports escalating urgent or unexpected findings at the earliest point in time. However, the first point of escalation must always be to the clinical radiologist on duty, and only if they are unavailable, should the finding then be escalated to the referrer or to another relevant medical practitioner (for example, a radiation oncologist, nuclear medicine specialist, or other medical practitioner). This point must be made unambiguously in the capability document.

Key capability 1 (g), and 4 (d) suggests the practitioner should *"communicate this to relevant other practitioners"* and *"make recommendations to other practitioners".* Other pracitioners is a vague term and does not give weight to the important role the clinical radiologist or other specialists have in managing the patient during a procedure. The AMA recommends "other practitioner" be changed to **clinical radiologist** and **relevant medical practitioner** (to cover cases where medical radiation practitioners in the operating theatre are instructed to operate image mobile X-ray equipment under the direct supervision of orthopaedic surgeons, general surgeons, vascular surgeons, and urologists for their specific procedures).

The AMA notes the capabilities document mentions the need to "record urgent or unexpected findings and communicate in a timely manner" seven times. The AMA suggests adding the individual recipient of the information, i.e. the clinical radiologist (or the referring clinician). Again, the emphasis here is on whom the pracitioner communicates with.

Patient deterioration

The addition of "clarified expectations for recognising and responding to patient deterioration and strengthened requirements to include recognition and management of anaphylaxis" is a welcome change. The AMA acknoweldges the advice taken from our previous submissions. However, in recognising and responding to patient deterioration, the medical raditation practitioner must alert the clinical radiologist. There is no mention in the document of alerting the clinical radiologist if a patient deteriorates. Only if the radiologist is not immediately available should the emergency be communicated directly to the referring practitioner or appropriately delegated health professional who is responsible for the individual patient's care. The clinical radiologist is best placed to communicate with the referrer.

Role clarity within the team

There must be expectations and processes regarding the role of the whole team. Everyone has their own specific roles and these need to be clearly defined. To strengthen the aspirational nature of the proposed document, the AMA suggests including a flowchart of the responsibilities of the mutlidisciplinary team which emphaisises communication, as effective healthcare does not occur in silos.

Intervention during imaging

Another issue is the inclusion of the medical radiation practitioner performing fluoroscopy and angiography. Contrast administration (such as for CT and MRI studies) is determined by the practice after thorough discussion between the radiologists in terms of what is safe. The administration of contrast must be determined by the medical professional, namely by the supervising clinical radiologist.

There are several references in the capabilities document to tasks which require medical training, particularly related to the evaluation and/or interpretation of medical images that are outside the scope of medical radiation practice. CT and MRI examinations are inherently protocol-driven, based on the clinical information provided by the referrer. Medical radiation practitioners should only modify examination protocol in consultation with the radiologist.

Appendix A

Appendix A: draft updated professional capabilities for medical radiation practitioners is extremely scarce on the medical knowledge imaging practitioners are required to have. It details at length aspects such as being a culturally sensitive communicator and an ethical practitioner, but it lacks substance in terms of the medical and scientific knowledge. If a practitioner does not have the medical knowledge to assess, interpret and explain the findings, then it is not appropriate for medical radiation practitioners to have any remit in the medical aspects of the intervention. Imaging is a high-risk procedure. Patient findings must be detected at the earliest point in time, as catastrophic consequences may arise if they are undetected. The AMA reiterates the clinical radiologist is the only practitioner qualified to ensure this.

Under the key capabilities and enabling components section (from page 22 onwards), the AMA does not see any reference to descriptions of medical radiation practitioners applying medical knowledge to make interpretations about the images they generate.

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)

It is unclear as to the purpose of this draft statement. There is minimal reference to it in the capability statement. We would question the estimate provided regarding low-value care, as it is not referenced and likely draws on the American experience, which differs significantly from Australia's health system. It also puts medical radiation practitioners in a position where they may be working outside their scope of practice and effectively seeking to override the decision of a medical practitioner who has assessed the patient and determined that an investigation is appropriate and warranted. We recommend the statement should be removed entirely and efforts to deal with low-value care more appropriately addressed through education and information.

Example 4 on page 3 of attachment A appears to be designed to portray a doctor in a negative light: *"A MRP has just got off the phone with a difficult and demanding specialist practitioner who is insisting their requested imaging be performed. The specialist practitioner has also threatened to take his business elsewhere if the requested imaging is not performed."* This statement could be taken out of context or could introduce stereotypes about specialists being arrogant or domineering. It focuses solely on the negative actions of the specialist without offering balance (for example, stating the clinical reasoning or the patient advocacy behind the requested imaging.)

a. Is there any content that needs to be changed, removed or added to the Low value care statement?

The AMA is concerned with the statement: *"Where a medical radiation practitioner makes a decision to withhold or defer the provision of a health service, it must be reasonable in the circumstances, and they must ensure that the patient's health or safety is not put at risk."*

While the AMA acknowledges the National Law sets the standards for registration, accreditation and public safety, the lack of understanding about role delineation/delegation versus task substitution is a considerable issue. The AMA is concerned by the use of the term "reasonable" in the above sentence, as what is reasonable to a radiologist would be vastly different to what radiographers would consider reasonable.

b. Are there any potential negative or unintended affects that might arise?

The AMA draws attention to its position statement on the Doctors' Role in Stewardship of Healthcare Resources (2023). Stewardship requires doctors to balance their primary duty to protect and promote the healthcare interests of individual patients with their broader societal duty to use healthcare

resources responsibly and sustainably. In this context, doctors are the only practitioners trained to assess, diagnose, manage and make clinical decisions regarding the care of their patients.

The AMA agrees medical radiation practitioners should be aware of the impacts of low-value care and over scanning of patients. However, it is not in the scope of practice of medical radiation practitioners to make clinical decisions.

Evaluating the suitability of referred imaging examinations necessitates medical expertise and falls beyond the professional scope of medical radiation practitioners. Standard practice dictates medical radiation practitioners seek guidance from clinical radiologists when uncertain about the clinical appropriateness of an examination. Similarly, only clinical radiologists are qualified to offer advice on alternative imaging or treatment options to patients and healthcare team members and referrers. Medical radiation practitioners lack the necessary medical training to assess the appropriateness of an examination or suggest imaging alternatives.

Medical radiation practitioners do not receive training on assessing whether imaging is unnecessary or low value. They do not always receive a detailed patient history upon referral. The referenced document indicates medical radiation practitioners “must critically evaluate whether requested services are justified based on clinical indications, patient history”. The AMA is concerned by the use of the term “critically evaluate” for the reasons already mentioned. It is inappropriate to place the onus on the medical radiation practitioner to determine whether to conduct imaging.

The AMA asserts medical decisions should ultimately rest with the doctor, referrer, or specialist. Gatekeeping at the lowest level only leads to unnecessary time being wasted, when the decision to conduct imaging has already been made by the referrer. Questioning the referrer undermines their professional judgement.

Often in private practice, the practice is concerned with obtaining business from the patient, so they are more likely to complete scans. However, in the hospital setting, medical radiation practitioners may refuse to conduct the imaging. The referring clinician would then have the authority to override the refusal due to the initial need for the imaging. As such, the AMA questions the purpose of the low-value care statement within this capability document for medical radiation practitioners.

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