Submission to the Medical Radiation Practice Board of Australia on the Composition of the Accreditation Committee.

Background:

I am Diagnostic Radiographer and my principal role is as a radiography academic. I have always had one desire and that is what is best for a profession I truly am proud to belong to and have spent over 30 years doing my best to produce quality radiographers. I am approaching the end of my working career and quite honestly am concerned about what the future holds for the Medical Radiation Profession. It sickens me to see that only those with vested interest are listened to and not what is best for the profession. It is irrelevant to me if a student needs a 4 year degree and no NPDP or 3 years and an NPDP or those clinicians who totally refuse to accept that the only way to get a chest x-ray right is to do a 1000 (yes they still exist)!

I have been a clinician heavily involved in student education and I have been an academic with clinical involvement preparing students to enter practice. I work in a tertiary sector that is totally driven by research outcomes and above all realise that Universities are not focused or interested in adopting clinically based education, anyone that thinks otherwise is delusional and out of touch with reality. The universities are not going to change but the professions do, as Physiotherapy, Medicine and a number of other Health Science disciplines have and flourished as a result.

I have been through periods of boom and bust, not enough radiographers to having too many as the loud voices are saying, despite the modelling that suggests the demand is still there but not today. One of the greatest problems that MRP has had is the ridiculous notion that we should produce only enough professionals to meet employment demand, be they outstanding or bordering on incompetent, and believe you me it is easy to get an incompetent radiographer up to the minimal CBA standards required. I personally believe only the best should get a job and the "also rans" seek alternative career pathways, all have degrees and a multitude of pathways available to them.

In this light I am offering my comments to your questions:

a) Do you agree with the proposed inclusion of at least one educationalist, at least one medical radiation academic, at least one medical radiation practitioner and at least one allied health sciences academic to the Committee?

My response to this is simple YES, however it must be one of each background. It must be recognised that there are 3 distinct yet closely aligned disciplines and EACH must be equally represented. I wonder what is meant by an allied health science academic as I consider myself as both. I teach into radiography, radiation therapy, nuclear medicine, physiotherapy, medicine, nursing, nurse practitioner, occupational therapy, speech pathology, oral health and general educational and IT skills courses. If you mean someone from another discipline then the answer is NO as they are represented at Board level, this is purely at the material development and delivery stage. I do however support a person with an educational (preferably clinically based programs and preferably not MRP) background to look at the educational aims, objectives, expectations and outcomes...practical not theoretical only (yes there is a huge difference)!

b) Do you think there should be additional sub-criteria for the selection of the above persons and if so what should they be?

Again the answer is YES and the sub-criteria is above all NONE must be from a position of vested interest, ie, a Chief, a manager, a Program Convenor or any other position where the interest of their position, career, job or institutional focus is a factor (generally the primary factor) in the decision making process. My personal opinion is that those who are widely known as being "their way or the highway" should be specifically excluded, you need open minded people not blinkered out of date mouth pieces, who basically would be clinically unsafe to practice in most cases. There is an absolute wealth of knowledge and experience out there that has no personal interest other than a desire to see their profession prosper and good graduates emerge from programs. You need individuals who want what is best for the profession, not what is best for themselves or what they believe and if the majority decision is against them then they start their own group! Looking at most positions offered (but I do acknowledge I was impressed with the approach adopted in the appointment of the Board, especially no academic and no biased outspoken inflexible individuals) the majority of these positions and committees are held by those with strong views and vested interests and the majority of ideally suited individuals do not even bother to apply. Until this approach changes we will continue to be in the same introverted loop.

c) Do you think a Board member should be on the Accreditation Committee?

Again yes BUT ex-officio, no voting rights. It is essential that the Board know what is going on and the Committee is aware that the Board will know what they are doing! This provides a balance and a more open approach to discussions. The Board member can inform the committee of the Board's feelings and the Committee can also inform the Board of its feelings. To work in isolation as appears to have occurred with the former Accreditation Committee approach results in this feeling of an "us and them mentality" which is totally counter-productive. Above all the committee should be there to implement the Board's decisions!

d) Do you think a community representative should be on the Accreditation Committee?

This again is a no brainer and the answer is absolutely NO. At this level you are looking at the technicalities of the delivery of quality education programs, the guidelines decided upon by the Board (who will ratify the Committee's decision) which has input from the community representatives. The line must be drawn when the decision for the role of the practitioner is designed by those best able to deliver this under the framework designed by the over-riding authority which is the Board that has community involvement.

e) How many members do you think the Committee should have?

As mentioned in Point a) EQUAL representation from each of the disciplines with both academic and clinical input with specialist input as required.