New Zealand Medical Radiation Technologists Board
Te Poari Ringa Hangarau Iraruke

MRTB scope of practice consultation summary

August 2026

Practising medical radiation technology practitioners and relevant stakeholders were invited to provide feedback to the consultation via an online survey. The survey ran from 12 November 2025 to 28 January 2026 with 81 medical radiation technology practitioners and 8 stakeholders providing feedback. Feedback considered was received via a survey (SurveyMonkey) and email.

A summary of the feedback provided to each of the consultation proposals is given below. Where the question relates to a specific scope, feedback is provided to show the responses from all respondents and from those who are registered in the scope. Numbers in the graphs refer to the number of respondents who answered each of the questions.

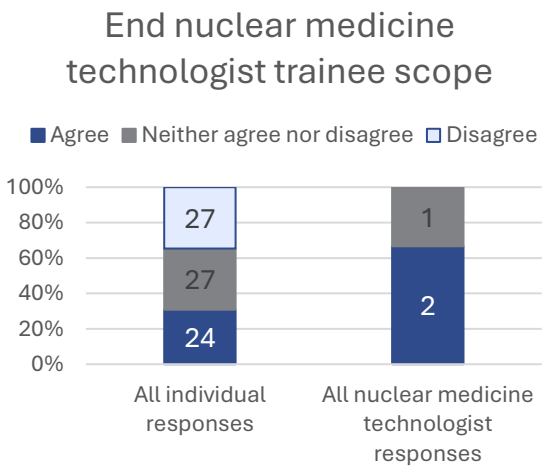
Ending trainee scopes

"Do you agree with the proposal to end the trainee scopes?"

Individual responses

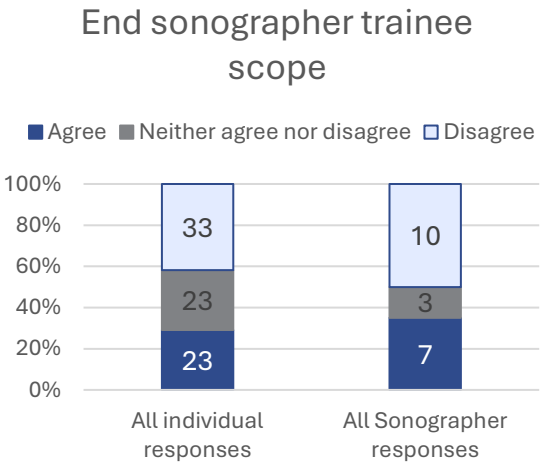
There were mixed responses to the proposal to end trainee scopes. Those who agreed with the proposal reasoned that:

- Trainee scopes are not supported by the Health Practitioners Competence Assurance Act 2003.
- Trainees are already sufficiently monitored by education providers and supervised by clinical supervisors, and this aligns with many other regulated professions.
- There are no standards to hold trainees to as they are not yet qualified.



- Trainee scopes may provide a false sense to the public that because they are registered, they are qualified professionals.

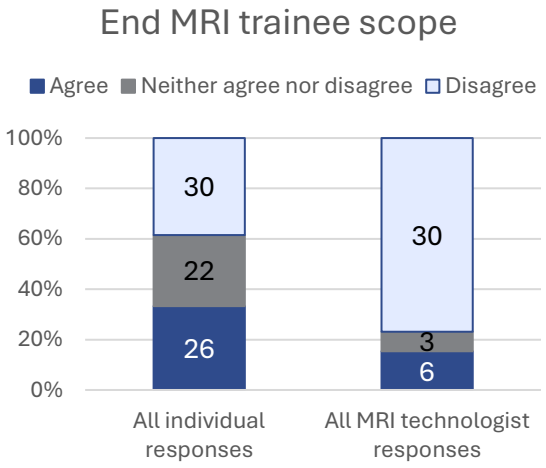
> The reasoning behind the removal of the scopes trainee scopes of practice is sound. Further, the trainee scopes should not have been part of the MRTB regulation as they sit outside the Act, similar to the undergraduate students who are not regulated by the MRTB.



A couple of respondents agreed with the proposal provided the MRTB still require education institutions to keep a record of student numbers for workforce planning. A number of respondents agreed with removing the trainee scopes for those already registered with the MRTB in another scope. While they expressed concern about those who would not be regulated in another scope or in another profession while undertaking their training.

> While I support streamlining the scopes of practice, I am concerned that removing the 'Trainee' scopes could reduce transparency for patients and the public. I recommend that the Board implement clear title protections or a provisional registration system to ensure trainees remain easily identifiable and accountable during supervised practice.

Those who disagreed with the proposal reasoned that:



- Removing trainee scopes could reduce transparency for practitioners and the public, putting patient safety at risk.
- It is helpful to have a clear and regulated distinction between those "in training" and those qualified.
- New Zealand produces a high standard of medical imaging professionals with our current model. Changes to this model risk lowering the standard.
- Trainee scopes provide protection for the person in training as overall responsibility sits with the supervisor. It is not clear where the responsibility sits if there are no trainee scopes.

- It is not clear who a member of the public would contact if they had concerns about the care they have received.
- Trainees are paid healthcare workers and therefore must be regulated to ensure accountability and professional standards.
- Education institutions may not uphold current requirements if they are not monitored by the MRTB and that trainees may not be sufficiently supervised.
- How would members of the public or employers identify those in training to ensure practitioners are not pressured to practise outside their competence level

> These trainee staff members are paid clinical workers and must maintain a registration with a governing body to provide accountability as a health care worker. Using the example of MIT students is not a direct reflection as they are not paid employees. If the proposal to remove the trainee scope is adopted then as an employer I must make sure that all trainees hold a registration with a governing body before employing them as a trainee therefore I must only look to MITs or registered health practitioners as a pathway to U/S or MRI.

There was particular concern about the removal of the trainee scope for magnetic resonance imaging technologists due to the uniquely high-risk imaging environment and specialised skills.

> The existing trainee scope ensures that MRI technologists spend substantial, structured hours developing advanced safety knowledge — including static field hazards, gradient and RF risks, implant safety, emergency procedures, and complex patient screening — under appropriate supervision and governance.

> The proposal also creates substantial role ambiguity. The distinction between a qualified diagnostic radiographer and an MRI technologist in training is already poorly understood by management unfamiliar with MRI role delineation. Removing the trainee scope will further blur these lines, increasing the risk that individuals without appropriate MRI-specific training are expected to perform complex or high-risk tasks.

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Organisation responses

Majority of organisations support the proposal to end trainee scopes with only one organisation expressing opposition to the proposal. Organisations that supported the proposal requested certain conditions to be met if the proposal were to go ahead. Their feedback is provided below.

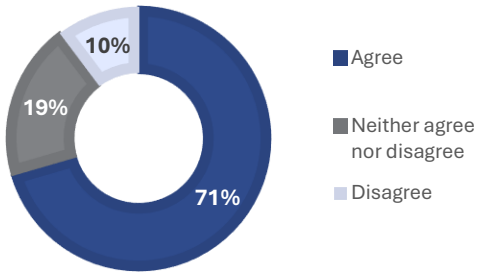
Supports the proposal on the condition that the legal liability for students sits with education providers, and/or the employer/supervisor
Support the development of a transition plan to ensure those registered are appropriately managed and the responsibility of each party is clearly defined.
Clarification on whether the MRTB would continue to keep a register of students, if the trainee scope is ended, as we believe this is vital for workforce planning purposes. This includes recording the number of students studying and graduating, by course, per year, as well as a range of geographic and socio-demographic variables.
Regulation of trainees does not fall under the jurisdiction of the HPCA Act.
Any impact of this change on the employability of trainees and the gaps in accreditation standards will need to be reviewed and revised to align with this change.
Consistent with current practice for undergraduate MIT and RT students who fall under the responsibility of their education providers and supervising practitioners.
Education institutions are equipped to manage training quality and ensure that supervision is delivered to a standard that protects both trainees and the public

The organisation that opposed the proposal provided the following feedback.

The Trainee scope recognises the vocational nature of training in these modalities and the progressive acquisition of advanced competencies. It also clearly communicates to other health professionals and employers that trainees are on the pathway to becoming fully qualified in that scope and ensures they are only allocated clinical activities aligned with their training programme and competence progression.
Whilst supervision levels and policies are determined by the training provider, registration in the Trainee scope adds a much-needed layer of oversight by the regulator; tasked under the Health Practitioners Competence Assurance Act (HPCAA) to protect public health and safety. This provides a level of public assurance that external, independent mechanisms are in place to protect safety.
As the regulator the MRTB is best positioned to collect information on the number of Trainees in each scope, annually. This has clear workforce planning implications in being able to quickly identify and resolve workforce issues and direct national planning efforts.1 The removal of the Trainee scope will likely impair workforce planning.
Several other professions regulated under the HPCAA implement similar intermediary scopes such as Dietitians (provisional), Pharmacists (intern), and Psychologists (intern and trainee). This is also the case in Australia where trainees in approved courses must be automatically registered by the training provider with the Medical Radiation Practice Board of Australia as a ‘student’ for the duration of their clinical training.

Endorsements

"Do you agree with the use of endorsements to show to the public which practitioners have qualifications and skills?"



Individual responses

Respondents who agreed with the proposal reasoned that additional education should be appropriately recognised. Endorsements will also provide more transparency around practitioner qualifications and competence.

> Endorsements are appropriate for the recognition of additional qualifications and skills. This will also allow the enhancement of service delivery where they may be limited practitioners in a specific practice area.

One respondent asked for better clarification of sonographers to recognise those working in cardiac, general, vascular and obstetrics.

Some respondents reasoned that the public would not understand endorsements and do not review practitioner qualifications before seeking care.

> I don't think the public would understand however I do believe employers would use this as a tool to ensure scope of practice is valid and not in breach of their registration conditions.

Organisation responses

All organisations expressed support for the proposal. The following feedback was provided.

Suggested wording update: "Medical imaging and radiation therapists with a qualification approved by the Board may be endorsed to practise in specific expanded areas. The Board maintains a list of approved qualifications and criteria for endorsement."
We believe it is appropriate for MRTB to extend the current use of endorsements for the PET-CT program, to other applicable areas in line with the following: ○ Endorsements offer a clear and consistent mechanism to formally acknowledge a practitioner's advanced, accredited training beyond the core scope of practice.

○ They also offer a structured pathway for practitioners seeking to develop advanced capabilities while maintaining a clear baseline scope of practice for all registrants. ○ The application of endorsements should be carefully limited to well-defined areas supported by accredited postgraduate education or equivalent formal training that has been approved by the Board. ○ Endorsements should not become a requirement for routine practice within a practitioner's existing scope—particularly in generalist areas—where additional credentialling may unnecessarily restrict workforce flexibility. We encourage the Board to ensure that the introduction of endorsements strikes an appropriate balance between recognising professional expertise and supporting the practical realities of workforce capacity and service delivery. ○ Using endorsements and recording them on the public register benefit and protect the public by providing employers, other practitioners, and the public with clear, accessible information about a practitioner's qualifications and competence. This transparency helps ensure patients receive safe, high-quality care from appropriately trained professionals
Will expand the ability for the practitioners to extend their roles and endorsements are the best approach
Endorsements should also allow non-MITs to practice in specific limited areas e.g. researchers performing brain CT scans.
Official recognition by the MRTB will help ensure clarity and transparency for employers, making it easier to verify a practitioner's competence when considering new hires or allocating extended responsibilities.
Endorsements also provide a structured and credible way to acknowledge specialised training without altering the core scope itself.
The term "endorsement" appropriately conveys that the practitioner has achieved something additional and specific beyond their initial qualification, while maintaining consistency across different modalities.
The introduction of endorsements is particularly important as services evolve and practitioners increasingly take on extended roles.
We note the importance of ensuring that endorsements complement, rather than complicate, the development of advanced practice roles. Clarification may be required to ensure that endorsements do not inadvertently become a workaround for advanced practice pathways currently under development. Clear and accurate wording within the framework will be essential to avoid confusion and ensure alignment with long term workforce planning.

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Scopes of practice and qualification pathways

Overall, there was large support from the organisations who provided feedback on the proposed changes to the scopes of practice and qualification pathways.

> We support the Board's intent to modernise and clearly define scopes of practice across medical imaging and radiation therapy in alignment with the HPCA Act, evolving clinical practice, and contemporary education pathways. The clear articulation of the five scopes strengthens role clarity, professional accountability, and public safety.

This support was accompanied by some suggested improvements/changes to strengthen the proposals. One organisation suggested clarifying in the "Qualifications prescribed for registration" section that non-accredited qualifications would also need to meet competence requirements set by the Board to qualify for registration. They also suggested clarifying who ultimately is held responsible for the patient, should there be an adverse event, who takes accountability for the care of the patient.

Other scope specific feedback is provided in the specific scope sections below. The majority of concerns raised were around the Sonographer scope of practice definition.

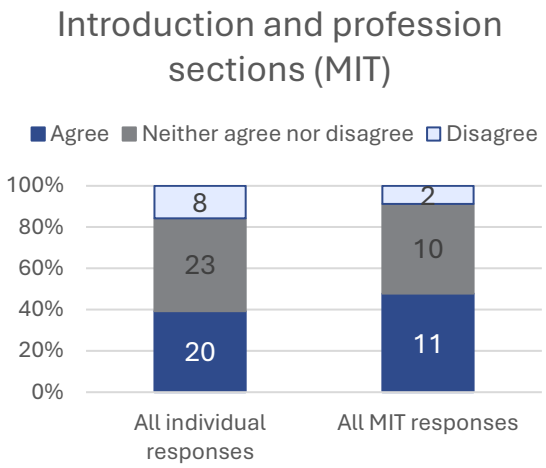
There was mixed feedback from individuals on the proposed changes to the scopes of practice and qualification pathways. Scope specific feedback is provided in the specific scope sections below. One respondent suggested adding competency in administration of contrast media and other relevant pharmaceuticals for all scopes of practice.

Medical Imaging Technologist

Individual responses

Respondents that agreed with the revised Medical Imaging Technologist scope of practice had the following recommendations.

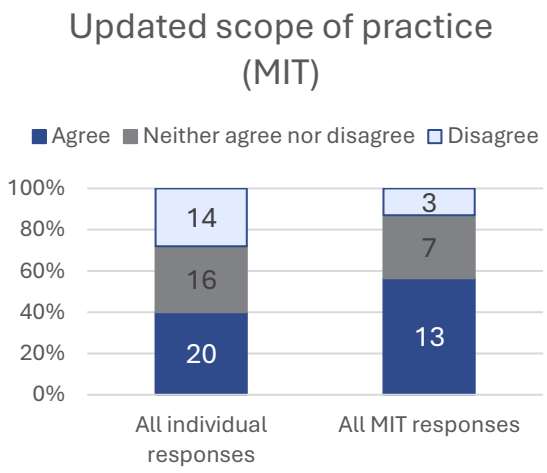
- Competencies around informed consent, infection prevention and control, basic patient health assessment and emergency response should be included
- Supportive patient care is not explicit enough
- Should include fluoroscopy



> These changes reflect the reality of modern clinical practice

Respondents who neither agreed nor disagreed with the proposed MIT scope had the following recommendations:

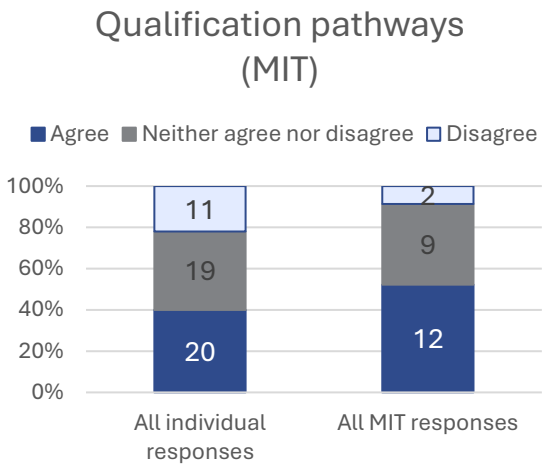
- Maintain strong links to Health and Disability Services Consumers' Rights
- How will the board determine evidence of CT competency obtained elsewhere?
- would be nice for mammographers to have a recognition for being involved in biopsies as not all staff are competent in this
- propose an amendment to this text: "Medical imaging practitioners may, in accordance with clinical and workplace guidelines, extend the examination..." by adding the words "may extend OR LIMIT the scope of the examination".



Respondents who disagreed with the proposed updates had the following concerns and recommendations:

- All post graduate qualifications should remain separate from general MIT
- Reference to the practices of medical imaging and radiation therapy excludes the other regulated scopes that do not use radiation
- Nuclear medicine technologists are referred to in the 'profession of medical radiation technology' section but the section only classifies MIT and RT practitioners. This appears inconsistent with no mention of MRI or Sonographers.

- Puts patient safety at risk
- Current qualification pathways are adequate
- Remove the word ‘outcome’ in the sentence: "Such-and-such practitioners are responsible for the facilitation of the procedure, outcome..." as this could be understood to be the final diagnostic report.
- there is no specific definition of what 'appropriate education' means
- Seems to limit rather than expand the scope of practice
- for conveying the results to other health and medical practitioners. Specifically disagree with this statement, we do not convey findings and nor should we.



> Seem to want to be limiting what an MIT can do, rather than expanding our scope of practice. You seem to want to take out image evaluation which is a massive part of our role and it should be recognised properly. Adding in fluoroscopy which is a basic imaging skill seems pedantic.

Organisation responses

Majority of organisations expressed support for the proposed changes to the Medical Imaging Technologist scope of practice and qualification pathways. Some organisations provided suggested improvements/changes. These are outlined below.

Suggest the following addition to indicate that MITs are responsible for the imaging or treatment session they are overseeing at the time, rather than for the entire treatment of the patient: “Medical imaging technologists are responsible for the facilitation of the procedure and outcome of the diagnostic image evaluation. <u>They have clinical and organisational responsibility for the examination and/or treatment being undertaken</u>.”
The use of the term image evaluation is ambiguous, does it mean image interpretation, or it means something else.
The last paragraph uses the words “with appropriate education”, this could be revised with the use of “with appropriate education and clinical competence” as the latter as important for current practice.
Clarification required: This statement is a misfit and either needs to be reworded or deleted – “With appropriate education, medical imaging technologists may also practise within the areas of computed tomography (CT), mammography, fluoroscopy and interventional radiography” – these areas are part of the scope of practice for MITs and do not need to be listed separately unless there is a specific reason for that.
Further clarification is needed regarding how the MRTB assesses overseas trained MITs, as current processes do not consistently reflect the diversity of international training pathways

and levels of experience. In particular, the treatment of Australian registrants appears to lack the fluidity intended under the Trans-Tasman Mutual Recognition Act (TTMRA).
We understand angiography is still utilised across some districts and question why this is being removed from the MIT scope of practice. However, the addition of fluoroscopy and interventional radiology within this scope are improvements, as this recognises practitioners will have undertaken specific training to ensure they are safe, competent, and experienced in carrying out these procedures.

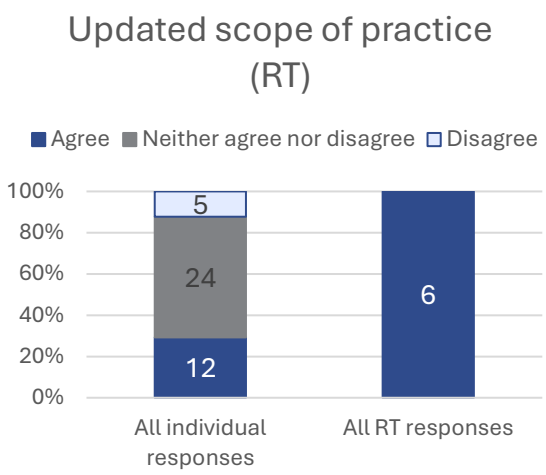
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Radiation Therapist

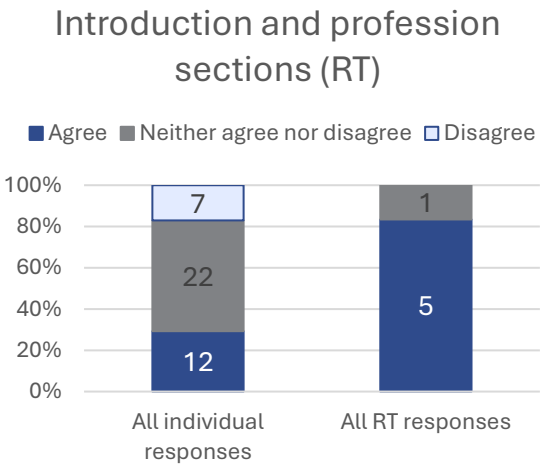
Individual responses

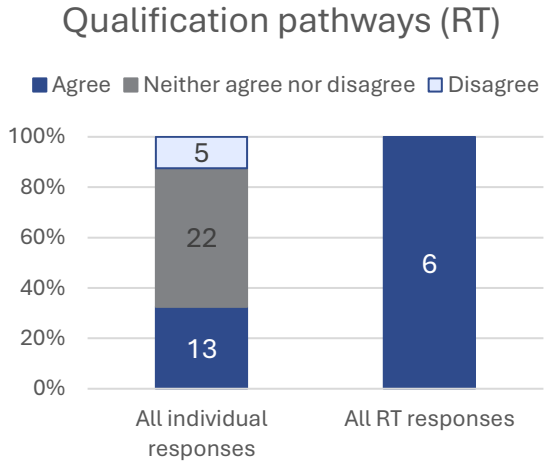
Only two respondents provided specific feedback to the proposed radiation therapist scope of practice.

> CT scope being included is now a requirement. I hope to see NM and PET-CT combined with employers and practitioners working across both. If a MIT wants to cross to NM then it should only be the NM physics and Clincal application papers.



> Radiation therapists could be able to do CT and mammography; I trust that this aspect will be catered for through endorsements.





Organisation responses

Majority of organisations expressed support for the proposed changes to the Radiation Therapist (RT) scope of practice and qualification pathways or did not explicitly provide feedback on the RT scope. A couple of suggested improvements/changes were provided.

- In the "Scopes of practice" section for radiation therapists (RTs), we suggest the following additions:
    - "Radiation therapists are responsible for the planning, delivery and care of patients and their whānau throughout the course of their radiation treatment as part of a multidisciplinary team which would usually comprise of a Radiation Oncologist (RO), an RO Medical Physicist, and specialist nursing staff."
    - "Radiation therapists create and evaluate images for the localisation, planning and delivery of radiation treatment according to the prescription of an appropriate authorised prescriber (in most cases this will be an RO).

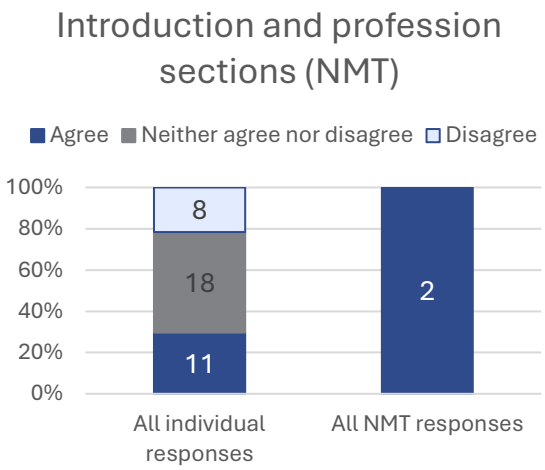
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Nuclear Medicine Technologist

Individual responses

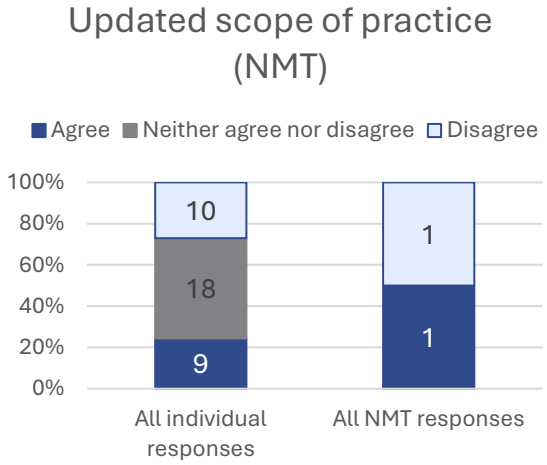
Respondents who agreed specifically stated the need for undergraduate training in nuclear medicine.

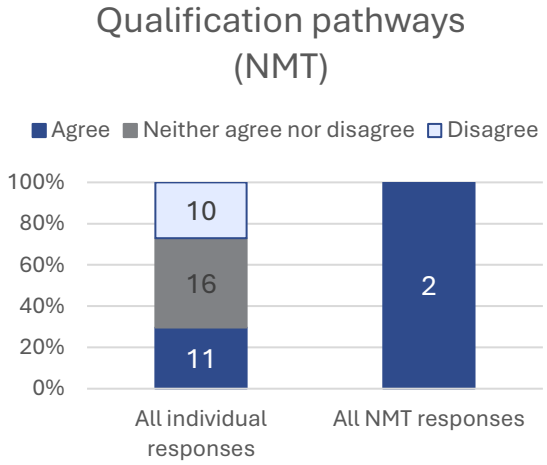
> I support the development of undergraduate pathways for MRI, CT, and Nuclear Medicine in the future. This could help address workforce shortages and provide earlier entry into specialist modalities



One piece of feedback was received from a respondent who disagreed.

> Delivery of Theranostics is very broad and to say that NMT's can deliver Theranostics is not quite correct. The wording should be under the prescription and guidance of a NM Specialist. Theranostics can also include synthesis of the Radiopharmaceuticals in the Hot Lab. I believe as this is usually performed by a Radiopharmacist overseas that the board should think of this as an extension of practice for NMT's





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Organisation responses

Most organisations expressed support for the proposed changes to the Nuclear Medicine Technologist scope of practice and qualification pathways. While there was overall support, some suggested changes were provided to strengthen the proposal. These are provided below.

We refer to the statement about the NMT being responsible for the outcome of the examination and interpret this as providing results. We believe this may be an advanced practice scope for the standard NMT. Although they are to identify urgent findings, we believe the results should be conveyed by a consultant.
Theranostics is part of delivering therapeutic radiopharmaceuticals to treat various medical conditions already mentioned in paragraph 2. To avoid duplication of mentioning Theranostics in the last paragraph, paragraph 2 can be reworded as follows “Nuclear medicine technologists are responsible for preparing and administering diagnostic and therapeutic radiopharmaceuticals, performing imaging procedures, and quantifying results to assess organ and molecular function. Nuclear medicine technologists may also be involved in the delivery of theranostic treatments, in collaboration with a wider clinical team, delivering integrated diagnostic imaging and targeted radionuclide therapy to enable personalised patient care”.
Regarding theranostics, it is unnecessary to reference this as a stand alone section. The description of NMT practice already encompasses the preparation, administration, and delivery of both diagnostic and therapeutic radiopharmaceuticals. Theranostics falls naturally within this definition, as it involves the administration of therapeutic radiopharmaceuticals for targeted treatment. Including it separately creates redundancy and may introduce confusion about whether theranostics is considered an extension of practice, when it is already covered by the broader description.
NMT have undergraduate education pathways that already exist in Australia.
There is concern that introduction of an NM and MRI undergraduate program may have an unintended impact on smaller departments that require dual scopes to ensure that there are enough.

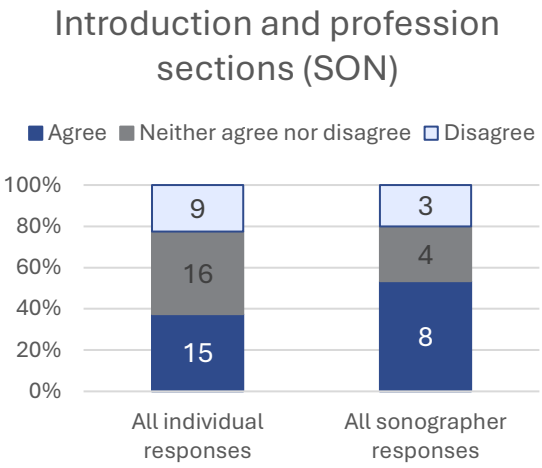
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Sonographer

Individual responses

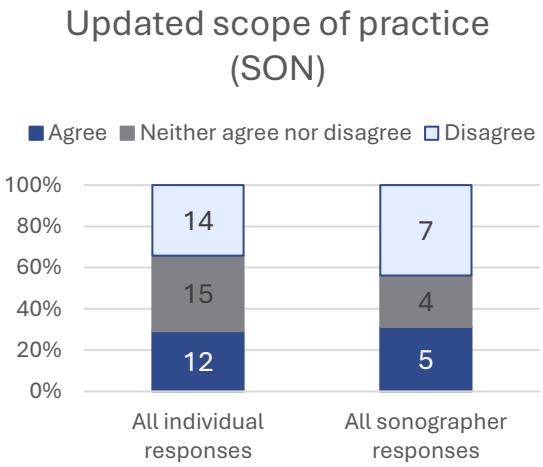
Respondents that agreed with the proposed Sonographer scope had the following recommendations:

- Ensure term 'reporting sonographer' is included
- Addition of "Sonographers may administer contrast media and other relevant pharmaceuticals in accordance with their level of competence, workplace policies and procedures"
- Addition of "Sonographers may convey the results of the scan to the patient in accordance with their level of competence, workplace policies and procedures"
- We should have direct undergraduate pathways to practise in New Zealand



> This is alignment with sonographer-based reporting which will soon become normal practice

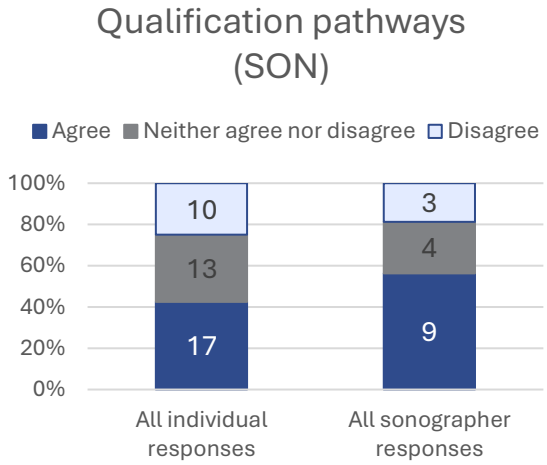
Majority of respondents who neither agreed nor disagreed commented that sonography is not their scope of practice and hence they cannot comment. One respondent commented that sonography does not have a radiation component and hence the profession name of medical radiation technology is not suitable.



Respondents that disagreed with the proposed Sonographer scope had the following recommendations:

- Would like to see Sonographer mentioned separately in the profession section
- Inclusion of sonographer reporting within the scope of practice
- Include patient centred discussion
- The scope currently reads: They must be able to recognise and interrogate normal and abnormal anatomy. This should be changed to: They must be able to recognise and interrogate normal and abnormal anatomy, functionality and physiology.
- Include obstetric and gynaecological sonographer

- The Radiologist reporting the exam should be responsible for the conveying of results not the sonographer
- Allowing undergraduate qualifications for registration has the potential to endanger patients and lower the New Zealand standard



> for conveying the results to other health and medical practitioners- we should not be responsible for conveying results. This amounts to being a reporting sonographer which we are not. If this does happen it is years away and needs way more consultation!

> I do not support moving Sonography to an undergraduate structure. Sonography requires a high level of autonomous decision-making, complex diagnostic interpretation, and extensive clinical reasoning. A postgraduate training model remains the safest and most robust pathway and should be retained.

Organisation responses

Majority of organisations supported the proposed changes to the Sonographer scope of practice and qualifications. However, there were some concerns raised around sonographer responsibilities and reporting, definitions and wording within the scope, and disciplines and titles. The feedback and suggested changes are outlined below.

In terms of sonographers being responsible for the outcome, we recognise that this is included in the current scope for sonographers, and now also in the scope for all modalities except radiation therapists; however, we would like to seek clarification on the intended 'outcome' that sonographers are responsible for. The diagnostic outcome can be confounded for many reasons outside a sonographer's control, due to the limitations of ultrasound from a physics perspective. For example, image quality and diagnostic outcomes can be influenced by patient-specific factors, such as undertaking exams on patients that are obese, have limited mobility, or have not followed preparation instructions appropriately. These factors have the potential to impact ultrasound more than other modalities. Where a sonographer is aware that the outcome has been confounded by these or other factors, a sonographer should highlight this in their report.
There are significant concerns about sonographers being held responsible for conveying the results to other health and medical practitioners. The way in which results are conveyed can differ significantly by practice / employer and by the IT system in place. Many practices do not allow their sonographers to convey results to referrers and other health professionals, and only allow radiologists to do so. In terms of IT systems, sonographers will submit reports but

don't necessarily routinely check that reports are actioned unless it relates to an urgent case requiring immediate attention.
Seek clarification on how the appropriate physics knowledge is to be measured, to enable a sonographer to demonstrate they have 'a high level of understanding of the physics of ultrasound instrumentation, ultrasound bioeffects, anatomy and physiology.'
While we agree with the second sentence 'They must be able to recognise and interrogate normal and abnormal anatomy,' we also note that there are wide variations on what is considered 'normal' anatomy, which can come down to an individual sonographer's experience
Recommends that the prescribed disciplines and titles are reviewed and updated to reflect contemporary areas of practice, in particular, to include obstetrics and gynaecological sonography.
The titles that Sonographers can use in accordance with their area of education and competence mentioned on this section include cardiac sonographer, echocardiographer, and echocardiographic sonographer. However, these titles could have the same meaning and therefore this might be tautology.
Agree in principle however, it reads in parts that sonography is part of medical radiation technology and of course radiation is not part of the sonographer scope.
We feel the proposed scope wording "diagnostic interpretation of ultrasound findings and conveying the results" is ambiguous and does not clearly communicate that sonographers in Aotearoa New Zealand are authorised to produce diagnostic reports within their recognised scope. While services may still choose to have a radiologist sign-off as a local governance decision, the scope itself should explicitly acknowledge that independent reporting by appropriately credentialed sonographers is valid practice. We suggest the wording below would better reflect this: *Sonographers are responsible for performing ultrasound examinations, facilitating the procedure and outcome, and producing and communicating diagnostic reports based on their interpretation of ultrasound findings. Sonographers are authorised to report within their recognised scope of practice and must convey clinically relevant results to appropriate health and medical practitioners.* *Sonographers must demonstrate a high level of understanding of ultrasound physics, instrumentation, bioeffects, anatomy, and physiology. They must be able to recognise, interrogate, and interpret both normal and abnormal findings.*
The distinction between general, vascular, and cardiac disciplines also needs strengthening. Vascular and cardiac sonography represent separate qualifications and credentialling, and the scope must recognise this distinction (and its implications) by specifying that practitioners must not work outside their credentialled discipline. We suggest the wording is refined as below: *Sonographers may practise in a variety of disciplines including general, cardiac, and vascular ultrasound. A sonographer must only practise within the discipline(s) for which they are appropriately educated, trained, and credentialled. A general sonographer is not permitted to independently practise in vascular or cardiac ultrasound without the relevant recognised qualification and scope endorsement.* *Sonographers may use the following professional titles in accordance with their education, competence, and recognised scope of practice: sonographer, general sonographer, vascular sonographer, cardiac sonographer, echocardiographer, or echocardiographic sonographer.*

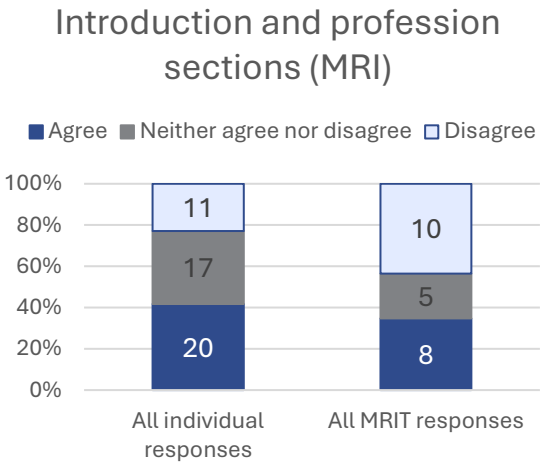
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Magnetic resonance imaging (MRI) technologist

Individual responses

Respondents who agreed with the proposed MRI scope stated that it is important to provide opportunities for career growth and to address workforce shortages.

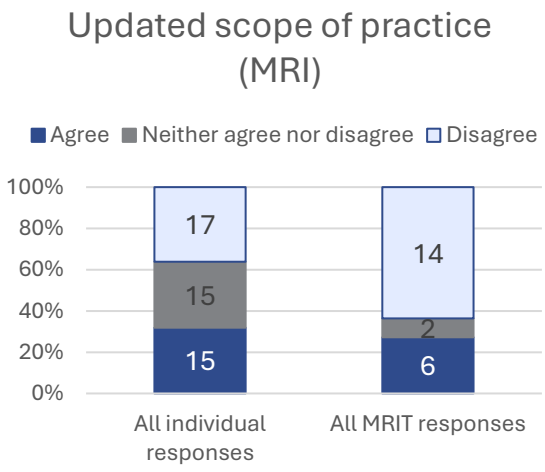
> Reads really well and is quite clearly stating the responsibilities and knowledge requirements for an MRI tech.



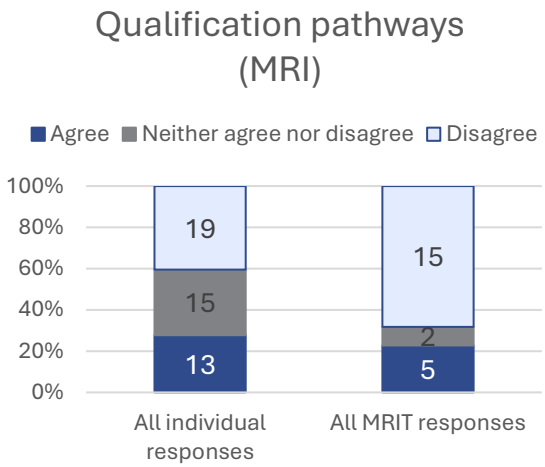
> Care needs to be taken to define the differing NCEA levels of education. While we should be able to assume graduates will have the same level of didactic knowledge and clinical competency, there will have to be subtle differences somewhat muddying the waters when ensuring competence. There needs to be a delineation between under grad (honours), post grad certificate, and post grad diploma levels of qualification.

Some respondents who neither agreed nor disagreed were concerned with the removal of trainee scopes – this is addressed in the 'ending trainee scopes' section above. Other respondents provided the following feedback.

- Remove requirement for post graduate study
- Competency in administration of contrast media and other relevant pharmaceuticals is not an activity which is specific to MRI Technologists. This should be taken out of the MRI scope and added on page 2: The profession of Medical Radiation Technology
- NZ MITs are trained with very little exposure to MRI in comparison to overseas which will make our MITs unemployable internationally in the near future



- All applicants applying for MRI scope should be required to do one year post graduate study focused on physics and safety and clinical competency
- The MRTB has over-restrictive requirements affecting the workforce and wait times
- MRI should not be a separate scope of practice
- Insufficient detail has been provided to form an opinion



For respondents that disagreed with the proposed MRI scope, there was strong opposition to introducing an undergraduate pathway to registration. There is a concern that an undergraduate qualification is insufficient in preparing a practitioner for the high-risk imaging environment of MRI and this will put patient safety and New Zealand standards at risk.

> Needs to be kept as post graduate course. The delivery of a post graduate course is more research, investigative, critical thinking and critiquing of written resources based. This delivery is important as qualified techs use the same techniques in assessing and investigating the safety of implants and foreign bodies and preforming MRI scans safely.

Other feedback received included:

- The language within "MRI technologists may administer contrast media and other relevant pharmaceuticals in accordance with their level of competence" is far too broad, specifically the phrase "other relevant pharmaceuticals". It fails to mention standing orders and fails further specify which pharmaceuticals and their purpose.
- It is not clear why MRI is a separate scope of practice in NZ
- Introduction of an undergraduate degree would erode ability to collectively bargain with Te Whatu Ora and would be a significant driver to lower wages
- Undermines the postgraduate study of those currently practising

Organisation responses

Organisations supported the proposed changes to the MRI scope of practice and qualifications. Additional feedback is provided below.

- Largely support the accompanying responsibility to “advocate for the protection of the public and staff” within this environment. Reasonably we expect this responsibility extends to maintaining a current knowledge of the modality (through CPD), undertaking

appropriate health and safety procedures, safely guiding patients and their whānau through the process, and advocating for safe staffing requirements.

  - we question whether the wording could be interpreted to mean that this responsibility extends further. For instance, does it empower MRI technologists to cease work entirely if institutional risks remain addressed? More importantly, we feel the inclusion of this wording has the potential to blur the line between an individual practitioner's professional responsibility and the employer's primary duty of care obligation. This blurring could leave an individual practitioner more open to Health and Disability Commissioner cases when the onus for providing a safe working environment – including adequate and well-maintained equipment, sufficient staffing, and proactive risk management – ultimately falls on those charged with management of the radiology service.
    - We recommend this statement is refined with appropriate caveats that clearly delineate an individual practitioner's "responsibility".

- There is concern that introduction of an NM and MRI undergraduate program may have an unintended impact on smaller departments that require dual scopes to ensure that there are enough e.g. MRI staff to cover one scanner with sick leave and annual leave etc without having too many staff that can only work in MRI.

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Other feedback

Individual responses

A number of individuals asked for further clarification in some areas. These questions are included below.

Endorsements should include CT and mammography within the MIT scope
How will restrictions be implemented in the future?
What are the advantages to removing the trainee scopes?
How you will separate the differing NCEA level of MRI education and clinical competence pathways.
Not enough detail on how the new proposal would work, ie how many hours of study / clinical. Are there clinical assessments?
The document uses the words "with appropriate education" in a select few parts of the document. This is inconsistent because all practice within any scope requires appropriate education. It might be useful to just insert a statement in the introduction to state that all areas of scope practice require practitioners to have appropriate training applicable to a specific scope of practice.
Will the removals of trainee scopes accelerate undergraduate training programmer?
I encourage the Board to ensure the updated scopes continue to clearly articulate the complexity and skill level of MIT practice, including advanced hybrid imaging such as EOS, fluoroscopy, and interventional procedures.

> I appreciate the Board's work in modernising the scopes and providing clarity on remote practice. The proposed changes reflect the realities of contemporary imaging practice and support a safe, future-oriented workforce.

Organisation responses

Further feedback was provided from a couple of organisations. This feedback related to the Board's name no longer being fit for purpose due to specialisations that do not use radiation technology. And the inconsistent reference to scopes of practice in the document.

> This heading and probably the Board's name as well, are not fit for purpose because medical imaging is inclusive of specialisations that do not use radiation technology e.g. Ultrasound and Magnetic Resonance Imaging.

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> The document in some place refers to medical imaging technologists (MITs), radiation therapists (RTs) and nuclear medicine technologists (NMTs) while in some it only classifies the practitioners to MITs, RTs only. This is inconsistent and may be perceived as meaning that the nuclear medicine technologists are different from MITs. If this is true, it would require that the other medical imaging technologists specialisation have their practitioners listed according to their specialisation e.g. sonographers.