AUSTRALIAN ACUPUNCTURE
& CHINESE MEDICINE
ASSOCIATION LTD
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9 January 2012

Ms Debra Gillick
Executive Officer
Chinese Medicine Board of Australia
AHPRA
GPO Box 9958
MELBOURNE VIC 3001

Dear Ms Gillick

**Re: Proposed CMBA Codes and Guidelines**

Thank you for the opportunity to lodge a submission on the *Proposed CMBA Codes and Guidelines*.

**Advertising guidelines**

AACMA supports the inclusion of a Chinese medicine specific criterion in relation to the use of the titles Professor and Associate Professor, with the following comments.

In relation to use of the title Emeritus Professor, we think that a small explanation is required. Considering that there is poor understanding in some sectors of the profession about the appropriate use of the title Professor, an explanation is needed to prevent future inappropriate use of the title Emeritus Professor.

It is proposed that an additional statement along the lines of the following be included:

> The title Emeritus Professor is a title formally conferred by a university on a retired professor. The title Emeritus Professor cannot be adopted simply on the basis of retirement and cannot be self-conferred.

In relation to the use of the Visiting Professor title, it is recommended that this title cannot be used as a name prefix, but should be restricted to use as an affiliation only.

For example:

> John Smith
> Visiting Professor (ABC University)

NOT

Visiting Professor John Smith
ABC University

NOT

Professor John Smith
Visiting Professor (ABC University)

**Guidelines for mandatory notifications**

AACMA does not see the need for additional profession-specific guidance in the Guidelines for Mandatory Notifications.

**Code of conduct for registered health practitioners**

The proposed replacement section 3.3 (Effective Communication) is acceptable.

AACMA does not see the need for additional profession-specific guidance in the Draft Code of Conduct.

**Draft Guidelines for patient records**

AACMA is in broad agreement with the Draft Guidelines for patient records.

In relation to the language in which the records should be kept, there is a need to balance ease of access by third parties against the quality of recorded information if the practitioner is not sufficiently competent in the mandated language.

On the one hand, permitting records to be maintained in a language other than English, being is the native language of the practitioner, means that records are likely to be more thoroughly maintained with more accurate clinical information. On the other hand, practitioners are expected to have sufficient English language competence to enable records to be maintained in English, and maintaining records in English will facilitate authorised access by third parties to those records.

For the first three years of the NRAS 2012 professions, it is preferable that there be a statement in principle that, in general, records should be maintained in English. This will facilitate better record-keeping on the part of practitioners. After three years, practitioners will be expected to have improved English language competence which could support mandating the use of English for patient records.

However, the following information should be mandated to be in English to facilitate fast access in the event of an emergency:

- **key personal information** such as name, address, birth date – to facilitate correct identification of the patient

  This is not an unreasonable requirement. No matter what the person's name is in another language, they will have a name in English that is used for official purposes (drivers licence, Medicare card, passport, et cetera). Similarly, the person's address in Australia will always be in English.

- **key clinical information** such as presenting condition, adverse reactions and allergies

  This is necessary in the event that, having regard to the known history of the patient, the treatment may have the potential to result in an adverse reaction.

- **treatments provided**

  This is necessary as the treatment may need to be identified by a third party in the event of an adverse reaction.

  - Acupuncture treatments should include the alpha-numeric point name, using commonly-accepted systems of numbering points (for example SP 6); the practitioner would be at liberty to include other names, such as the Chinese character or the *pinyin* name of the point; off-channel points should be listed using commonly used short-form or long names for the points.
  - Chinese herbal medicine treatments should include the herb names in *pinyin* and the dosage in English (for example, *Danggui* 6g); the practitioner would be at liberty to include other names, such as the Chinese character and/or the pharmaceutical name.

Section 3, dot point 6, sub-point 8 states that a *Chinese medicine diagnosis* must be recorded. We recommend that this be changed to simply require a *diagnosis*. There may be other issues involved in the patient assessment that require the diagnosis to be broader that a Chinese medicine diagnosis.

Furthermore, the National Law implies the practice of Korean Oriental Medicine, Japanese Acupuncture and Kampo (Japanese herbal) medicine, and Vietnamese Traditional Medicine practices are within the scope of the CMBA registrable practices. This is evidenced by the term 'oriental medicine' being a protected title. This title (oriental medicine) is commonly used to collectively refer to practitioners of Japanese, Korean, Vietnamese other East Asian traditional medicines that evolved out of traditional Chinese medicine. This perspective is also supported by the CMBA practice of translating key information into Korean and Vietnamese as well as Chinese.

Please contact me at the AACMA national office if you wish to discuss or clarify the contents of this submission.

Yours faithfully

**Judy James**
**AACMA CEO**