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Attention: Program Manager, Accreditation
Email: accreditation.unit@ahpra.gov.au

Program Manager, Accreditation,
AHPRA, GPO Box 9958,
Melbourne, 3001

Dear Program Manager,

RE: Feedback on draft 'Accreditation standards and accreditation process for Chinese medicine' document

Thank you for the opportunity to lodge a submission on the draft '*Accreditation standards and accreditation process for Chinese medicine*'. The School of Medical and Molecular Biosciences (MMB), Chinese Medicine Unit, has two program offerings in Chinese medicine to which the accreditation standards being proposed will apply. The two programs are:

- Bachelor of Health Science (Traditional Chinese medicine)
- Bachelor of Health Science (Traditional Chinese medicine) + International Studies

In considering our response, we are mindful of the need to ensure sufficient representation of both Chinese medicine specific outcome-focus items in the standards as well as the importance of these items also reflecting the outcomes necessary to operate as a health care professional. Our concern with the standards is to ensure that a health care professional role does not become a consequence of Chinese medicine practice alone, rather that the outcome-focus has an aim towards developing a health care professional who is also competent and safe to practice Chinese medicine and acupuncture, in keeping with the purpose of a national registration framework.

Furthermore, the development of a guidance document or range statements for the standards will assist in identifying to educators the scope of items which maybe considered against each of the standards and their outcomes. It is paramount that a diversity of views and range of items reflecting the contemporary practice of Chinese medicine and acupuncture are described. Our concern is that any guidance document does not become a means, or is used, to re-introduce a prescriptive model of learning, thereby negating the benefits of an outcome-focused approach outlined in the draft accreditation standards.

Consequently, we have an interest in ensuring the accreditation standards and process are clear, accurate and appropriate as noted in our response to the proposed standards. A response to each of the questions posed is noted below. Additional comments deriving from the questions are noted for some of the items in the standards where further clarification, queries or concerns we have noted for consideration.

Accreditation Standards

1. These standards are intended to be outcomes focused do you think that they achieve this?

Yes.

The outcome-focus approach taken is to be applauded and reflects contemporary thinking on teaching method and the role of the educator. The approach provides the necessary flexibility to design and deliver programs effectively in response to changing needs and circumstances of stakeholders. Specifically, we believe it provides the autonomy and flexibility to better enable the development of individual plans that meet the differing needs of students, individually or as a group, in different stages of learning throughout a program. It encourages diversity in learning and programs, innovates and embraces the expanding role of flexible learning and delivery with new technologies.

The approach additionally allows for the development of high critical appraisal skills and lifelong learning skills necessary in any healthcare environment, important learning outcomes which can be lost in prescriptive models of learning.

2. Are the criteria in the draft standards clear?

Generally, yes. We have identified several items where we have queries or potential concerns and have subsequently identified these below subsequent to Question 5.

3. The set of standards will be used to assess whether a program of study and the education provider provides students who complete that program with the knowledge, skills and professional attributes to practice the profession.

3.1 Is the set of standards adequate for this purpose?

Yes, we concur that the standards cover the necessary areas.

3.2 Are the relevant issues covered by the draft standards?

For the most part, yes. We do have some queries on aspects of the standards and have noted these below (see Question 5 and subsequent response).

3.3 Does any content need to be changed, deleted or added?

Yes, there should be consideration to amending or clarifying some of the items. We have noted our questions, feedback and concerns accordingly against each of the items with Question 5. There also needs to be further explanation for some of these, a few are ambiguous with interpretation and could be considered for revision before finalisation the standards.

3.4 Are any additional standards required?

Ultimately the standards should be looking at the outcomes graduates require in the role of a health care practitioner specialising in a Chinese medicine's scope of practice and knowledge. We believe these achieve the goal intended.

Our only concern are that the 'health practitioner' outcomes are not all made subsequent to the 'Chinese medicine framework' – some of these 'health care practitioner' outcomes should be independent of a 'framework' and would reside in every health care professional irrespective of the profession's title. Perhaps consider removing the qualifying statement 'Chinese medicine framework' for the outcome items expected of any health care provider.

4. What specific guidance relevant to the standards and criteria in Field 5 should be included in the guidance document to accompany the standards, particularly in relation to any content and/or skills you expect an education provider should include in their curriculum. ?

This should cover a scope of practice, a range of techniques and variations in those techniques utilising both classical Oriental/Chinese and biomedical approaches to reflect correctly the contemporary practice of Chinese medicine and acupuncture. There is concern were these to focus only on the classical practice of Chinese medicine and acupuncture and not reflect the diversity of contemporary practice. For example, principles of application using neurophysiological understandings (as in the application of acupuncture, in acupuncture induction and analgesia with childbirth), the wide use of granulated herbs (in addition to raw herbs), trigger point applications of acupuncture, these all constitute part of the contemporary Chinese medicine's practice scope being utilised in health care practice by Chinese medicine and acupuncture health care professionals.

Consideration should be given to a scope of practice, including techniques like laser, gua sha, cupping, bleeding techniques, electro/TENS, laser, heat therapies, rehabilitation etc should also be considered in range statements.

Perhaps a further follow-up survey needs to be undertaken of all stakeholders to determine better the current and future requirements of the profession and the knowledge and skills that need to be instilled in graduates for appropriate development of any guidance documents. This should include the professional associations, course advisory committees as well as the education providers.

5. Do you have any other comments on the draft standards?

Additional comments, clarifications and queries are noted for consideration below (*Additional Comments, Questions and Feedback*). This has been sorted and presented in order of Field, Standard and Outcome as it appears in the draft document and these are only noted where comments have been raised.

Additional Comments, Questions and Feedback

FIELD 1: Governance, management and resourcing

Point 1.5.6 (page 7)

Compares its performance on teaching, student learning outcomes and graduate outcomes for its Chinese medicine program with other education providers, and uses regular, valid and reliable feedback from internal and external stakeholders to improve its higher education operations.

UTS Response

This category appears to be composed of two distinct items – comparators with other programs and issues of stakeholder input. The two are not necessarily the same. We recommend consideration towards breaking these into two distinct categories (such as 1.5.6 and 1.5.7).

A considerable concern for this item is the accessing performance data from other education providers. Some information maybe available through jointly applied surveys such as the Australian Graduate Survey (AGS), however the extent of data being released for public consumption to other providers may not be able to fulfil the inferred needs of this outcome's category. It relies upon an assumption that providers will release sensitive data from one institution to another, and in some cases a competing provider, all targeting the same and limited potential student cohort. Barriers to the release of such information become pronounced where there are limits on the local market for potential new students (changes in socio-economic, consumer demand), constraint through macro-economic factors (economy, education legislation and policy) or have limited growth potential (population limits and graduate saturation). It places an unfair and inequitable constraint and reliance beyond the institutions own program, data collection and quality assurances practises: where there is a failure to release such information to 'competitors' this will in affect mean this criteria will not be met.

Additionally, the potential extent of the requested data being requested will raise further industrial, privacy and confidentiality concerns where it is being specifically linked to a subject and/or the performance of individuals. This leads to further questions on the purpose of the item. For example, what is the extent and details of such data to be used for inter-provider comparisons? Will the CMBA and the Accreditation Committee have powers to force other providers to release such information if it is not available or being refused release?

There also appears to be an assumption that VET sector, private colleges, higher education providers and universities all operate under a uniform model of operations and/or legislation – this is not the case. There are obviously degrees of cross-over in all their operations and each endeavours for specific quality assurances, but there are additional constraints placed upon each which means their operations are also different. In affect, the performance request noted in 1.5.6 for comparative data and analysis thus assumes 'oranges' are being compared with 'oranges', which is not the case. Further, it also assumes that the performance data available is comparable – unless there is a standardised requisite criteria for each of these data criterion to be collected, along with quality assurances for its independent collection and analysis, then this will not be the case.

As such, should there be greater consideration to performance comparisons within the institution, based instead on criterion referencing to provider's own historical performance outcomes, hence a system of review and improve to their own teaching, subjects and program outcomes, rather than a comparison of the provider against the performance of other providers?

Point 1.8.5 (page 9)

Ensures the volume, range and level of clinical education is adequate for effective delivery of the Chinese medicine program learning outcomes

UTS Response

Clinical education is of prime importance to any health education program. We have concerns that it is not only quantity that needs to be noted here but also the quality and appropriateness of such clinical education. For example, observation and sitting at a front desk in a clinic for 500 hours is not comparable to 500 hours of clinic where the student attends with patients or administers actual treatments (under supervision).

We additionally hold the view that experiential learning is of utmost importance in any quality program for the appropriate development of the necessary skills and knowledge in graduates if they are to operate as registered health care professionals, thereby addressing the potential risks of harm to patient health and safety given the scope of practice utilised in the profession. Consequently, item 1.8.5 does not provide a minimum standard if risks of harm are to be addressed, nor does it necessarily link the application of effective and appropriate health care provision. Consequently, we wonder if the accreditation committee can give consideration towards clarifying or developing a range statement to address:

- a requirement for participation in a range of clinical activities, and not just 'clinic'
- clinic that is undertaken over time, throughout a program, in line with the students progress through the program and their acquisition of skills and knowledge thereby reflecting a scaffolded learning approach
- where clinic is undertaken in a majority of stages in the program, (for example, commences no later than in the second year of a four year program, or no later than the beginning of the third year in a five year program), as repeated exposure overtime is also very important to the development of competent health care practitioners
- requirement for the collection of evidence from clinical environments that shows students participation and importantly, the application of skills and knowledge equivalent to their progress through the program. Participation alone in clinic is not adequate to demonstrate the learning outcomes being supposedly obtained and further evidence maybe required.

Point 1.8.9 (page 10)

Ensures each Chinese medicine student's clinical education includes experience providing culturally competent health care, and

UTS Response

Is it culturally 'competent' or is it culturally 'appropriate' and 'considerate'?

Is it referring to the need that any health care professional (whether Chinese medicine or not), needs to have an understanding of the diversity of cultural and societal understandings that can influence an individuals response and expectations of health and response to treatment provided? Hence the student can apply to different situations as the need arises as not every 'culturally competent' experience can be provided in any one program of learning. Therefore it seems more directed towards ensuring the skills and understandings are instilled in the student for application to any relevant situation when the need arises, at any point in time and not just during their enrolment in a program of learning.

Consideration to including the term 'diversity' perhaps in outcome description?

FIELD 2

Standard 3.1 Program design

Point 3.1.2 Part C: (page 11)

Ensure Chinese medicine students are safe and competent Chinese medicine practitioners prior to confirming their completion of the program.

UTS Response

Is there a mis-understanding in this item? We believe the role of AHPRA/CMBA is to ensure practitioners are competent and safe to practice - registration using the term 'Chinese medicine practitioner' requires more than an education degree as there are other requirements to become a 'registered Chinese medicine practitioner'. This statement is thus linking registration as only being related to the education component.

Perhaps it is about ensuring the student demonstrates/shows evidence of having the range and practice scope of skills and knowledge to practice Chinese medicine safely in the role of a practitioner - for until they are actually registered as such they're not Chinese medicine practitioners (in the protected 'title' sense), instead, they're simply potential graduates from a program of learning - thus the number of exit exams completed would not alter this fact. Would this be correct?

Point 3.1.8

The design of the Chinese medicine program includes an integrated, structured clinical education program that provides each student with experiences (including simulated learning and opportunities for inter-professional learning) across the scope of practice expected of entry level Chinese medicine practitioners.

UTS Response

Inter-professional learning – is this term meaning actual placement in multi-disciplinary clinics/practices or with a non-Chinese medicine practitioner for clinical experience or is it in relation to a knowledge of the practice of other professions and where there is a cross-over with Chinese medicine?

If the former and it means actual placement this will increase the costs to all programs with the oversight and time to organise placements for students – especially programs with large cohorts. Additionally, health care placements in many professions are becoming increasingly difficult to source as competition increases between institutions as cohort size also increase. I would expect other professions to select their own students over placement of Chinese medicine students who would not be from their profession.

Are there plans for resourcing/assistance to facilitate openings of public health facilities for Chinese medicine students to assist placements into other professional practices?

Standard 3.3 Admission criteria are appropriate

Point 3.3.2

The education provider ensures students enrolled in the Chinese medicine program are sufficiently competent in the English language to participate effectively in the program and achieve its expected learning outcomes, and sets English language entry requirements accordingly.

UTS Response

Should this also note that the program should also be delivered in English?

Standard 3.5 Assessment is effective and expected student learning outcomes are achieved

Point 3.5.4

Management and coordination of the Chinese medicine program, including assessment moderation procedures, ensure consistent and appropriate assessment.

UTS Response

Query the term 'moderation' – quality education employs criterion referencing where the student is assessed against a set of criteria not against other students.

This term may give rise also to supporting the idea of moderating marks and assessment results – this system has been progressively phased out of university system.

Is the term used in the sense of a facilitator/organiser?

Point 3.5.6

The academic standards intended to be achieved by students and the standards actually achieved by students in the Chinese medicine program are benchmarked against similar accredited programs offered by other education providers.

UTS Response

Our concern is as previously raised that there actually exists sufficient data for this to be done if specific performance outcomes are required to be benchmarked.

As noted, 'oranges' must also be compared to 'oranges' – it would be both statistically inaccurate and contravene demographical methods of population comparisons if degrees in one type of education provider were expected to be compared or benchmarked against a bachelor degree in a different education provider type – such a comparison would be inequitable and just simply wrong. Is it correct to assume Bachelor degrees and resourcing at universities is comparable to those from private providers? Each provider type have their strengths and weaknesses but it would be wrong to assume both have similar resourcing (as an example). Similar benchmarking one bachelor degree against another raises further issues – not all bachelors are the same.

Requesting this type of benchmarking and comparison will lead to a two tiered education system becoming apparent over time and will eventually compromise the diversity of education providers in the system, as is now seen with many of the other registered health care professions where many of the private providers that once provided programs are no longer extant and only university providers remain.

Standard 3.6 Program monitoring, review, updating and termination are appropriately managed

Point 3.6.1

Ensures the Chinese medicine program is systematically updated, through internal revision and external reviews, and that its coherence is maintained

UTS Response

By external reviews is this in relation to CMBA/Accreditation committee requirements? Can further detail/explanation be provided on this item?

FIELD 4 Qualification Attributes

Standard 4.2

Point 4.2.3 (page 14)

Identifies any part of the Chinese medicine program that has been delivered and/or assessed in a language other than English on the testamur and record of results

UTS Response

There appears to be a conflict in this statement 4.2.3 with other noted English requirements.

In general we agree to the statement however our understanding is that an accredited program in Chinese medicine in Australia must be undertaken in English if it is to be accredited and provide evidence of meeting the English proficiency requirements for registration by graduates from that program. By default then, no program should be providing teaching and learning in a language not in English and still receive accreditation.

Point 4.2.10 (page 15)

Ensures that if it issues a statement of attainment, it is identified with the words, 'A statement of attainment is issued when an individual has completed one or more accredited units'

UTS Response

The term 'statement of attainment' is specific VET sector terminology – has this been used appropriately here to reflect the diversity of all the different types of education providers or is it used generally to mean attainment/completion of specific subjects (that is, a university 'transcript')?

Point 4.2.11 (page 15)

Identifies in any statement of attainment or record of results whether any units have been delivered and/or assessed in a language other than English on the statement of attainment

UTS Response

Again, we query this non-English notation and the actual requirements of programs to be delivered in English if graduates are to meet the English requirements for registration.

Query the term 'statement of attainment' as a 'noun' to VET sector statement or as a 'descriptor' of any type of 'transcript'?

FIELD 5: Professional capabilities of Chinese medicine program graduates

Standard 5.1 Professional and ethical conduct

Point 5.1.10 (page 16)

Practise in a culturally safe, culturally sensitive and inclusive manner.

UTS response

Safety should transcend requirements of culture. In effect this statement reads that if a practice is considered safe in one culture but not in another, yet is being used in the culture where it is considered safe, therefore it is safe even though another culture may deem it not safe?

It is a very confusing statement – perhaps further develop or clarify?

Standard 5.2 Professional communication and collaboration

Point 5.2.5 (page 16)

Communicate effectively in English with Emergency Services if required,

UTS Response

Perhaps this should state communicate 'competently' in English?

Standard 5.3 Reflective practice and professional writing

Overall, should there be a specification to include 'English' in these items?

Standard 5.4 Quality and risk management

Point 5.4.3

Identify when emergency care is required and perform safely common emergency and life support procedures, including caring for the unconscious patient and performing cardiopulmonary resuscitation to an accepted standard

UTS Response

We're assuming this is referring to First Aid requirements. Is there a chance however that a program may provide this but bypass the First Aid competencies? Is it necessary to specifically state First Aid here?

Standard 5.5 Chinese medicine practice

Point 5.5.5

Demonstrate knowledge of the biomedical sciences of cell biology, microbiology, anatomy, physiology, pathology, pharmacology, the physical sciences including biomechanics, and the behavioural sciences including psychology, sociology and public health as they relate to the practice of Chinese medicine within the Australian health care context.

UTS Response

Some of these items should be delivered independent of, or broadened beyond, the 'Chinese medicine' qualifier. For example, any health professional needs understanding of public health and not necessarily how it relates to Chinese medicine – it is a basic understanding of being a health professional. Should some of these items being moved into a separate point (ie, 5.5.6) rather than lumping them together with a 'Chinese medicine' qualifier? Palliative care should be included as it is an increasingly important area where Chinese medicine is being utilised.

Standard 5.7 Chinese herbal medicine practice

Point 5.7.2

Acquire specific knowledge and theories of the interaction between herbal and pharmaceutical medicines to enable the safe application of Chinese herbal medicine skills

UTS Response

Should this be expanded to include the skills to locate this knowledge as well – especially as new cross-interactions are documented? Should there be information also on how to submit

a report of cross-interactions to the relevant authorities as this is an area that potentially has a degree of underreporting by Chinese medicine practitioners according to some reports in the literature.

Point 5.7.13

Clearly and correctly explain usage and administration of prescribed Chinese herbal medicines, and label the herbal medicines for dispensing where relevant to practice.

UTS Response

We wonder if guidelines need to be developed by the CMBA for this to ensure a standardised application for the entire profession and every education provider?

Standard 5.8 Chinese herbal dispensing practice

Point 5.8.4

Demonstrate the ability to read and write common terms used in Chinese medicine practice

UTS Response

Is this to reference herbal names or is it for all aspects of diagnosis in Chinese medicine. Additionally, is this in reference to characters (simple or complicated), pin yin, English, botanical naming systems?