AACMA
AUSTRALIAN ACUPUNCTURE & CHINESE MEDICINE ASSOCIATION LTD
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AHPRA Accreditation Unit
Accreditation.unit@ahpra.gov.au

Dear CMBA and AHPRA Accreditation Unit

Re: Submission on Accreditation Standard and Process for Chinese Medicine

Thank you for providing the opportunity to lodge a submission on the draft Accreditation Standard and Accreditation Process for Chinese Medicine.

The Australian Acupuncture and Chinese Medicine Association Ltd (AACMA) is the peak national professional body of qualified and registered practitioners of acupuncture and Chinese herbal medicine and represents more than 2100 members.

AACMA has set the benchmarks in Chinese medicine education and practice for more than 30 years and has been the primary professional driver of improvements in Chinese medicine educational standards and program delivery in the pre-registration environment.

We see our organisation continuing as a major stakeholder in accreditation standards and processes for Australian Chinese medicine education programs, if simply because graduates of board–approved programs are the members and practitioners of the future.

Overall, the documents are well-written and well-presented.

We are aware that the standards are intentionally outcomes-based. Outcomes are important drivers of standards. However, they are not the complete picture and the standards are lacking in four fundamental areas about which clear and unambiguous standards must be set – minimum content requirements, program duration, supervised clinical practice, and program delivery modes.

A key to achieving the stated outcomes in actual course delivery, as opposed to a matrix of finely tuned written statements, is paying attention to these four key issues.

Program and course content

Chinese medicine is based on a well-developed and coherent body of knowledge that underpins its practice. Nevertheless, there is not universal agreement about what that body of knowledge should be, with debates ranging from issues such as the essential

importance of the classics and fundamental theories to arguments that only the 'scientific' and mechanistic basis of Chinese medicine should be considered.

A shallow or narrow rendering of the extensive body of knowledge that underpins effective practice will narrow the mind of the practitioner and limit his/her capacity as a Chinese medicine clinician.

We are aware that there are general references to Chinese medicine theory in the standard, but details on what that comprises are largely absent. At the same time, we understand that it is not the purpose of the standard to give education providers with a pro forma course structure without putting in the work needed to construct a program that meets course objectives.

The danger of the approach taken by the Accreditation Committee in the draft standard is that course content will be over-simplified and the focus narrowed to fit in with the pragmatic preferences of the education provider and the pre-ordained space allocated in the timetable, as opposed to what is the best outcome for the profession and the students.

Therefore, there needs to be further consideration about how to deal with this issue of minimum content to ensure that programs have sufficient depth and breadth to equip the graduates for competent contemporary practice and effective Chinese medicine problem solving.

Program duration

Similarly, although reference is made to a minimum qualification standard, there is no reference to a minimum standard for full-time course duration (or part-time equivalence) for primary qualifying Chinese medicine programs.

Duration is an important factor in developing a good understanding of the Chinese medicine paradigm and the related cognitive, practical and clinical skills. Programs should be at least four years full-time duration for one modality, and at least five years for two or more modalities.

Supervised clinical practice

Furthermore, no reference is made to minimum hours for supervised clinical practice, a key element in developing safe and competent practitioners. There should be at least 500 hours (preferably more) of supervised clinical practice for a single modality and 800 hours for a dual or triple modality program.

There also need to be quality markers developed to ensure students have exposure to different clinical supervisors and patient presentations during their studies. Students exposed to only one or two supervisors and a narrow range of patient presentations will not be adequately prepared for the rigours and diversity of independent practice.

Therefore, the issue of minimum standards for supervised clinical practice needs to be addressed in the standard.

Course delivery modes

Reference to delivery modes is also missing. We know that the prevailing trend in education is for flexible delivery modes. However, adherence to this should not override the most important issue – that face-to-face interactive learning is a key part of developing professional attributes as well as an understanding of TCM paradigm and practice. For example, on-line learning is a great adjunct to face-to-face learning, but is not a substitute for quality face-to-face interactive learning in a classroom.

Therefore, programs should offer substantial face-to-face delivery with live interactive tutorial and practical components.

By failing to incorporate minimum standards for these four fundamental criteria, the standard fails to address issues that directly drive the quality of program delivery.

We have decades of experience in dealing with a range of higher education providers and we have noted one consistent theme when outcomes versus duration/content is under discussion. When we are told by education providers that we should not be focusing on such pedestrian issues as duration or content but instead should focus on the outcomes and leave the delivery to the education provider, it is usually a prelude to stripping down the course content, converting the program to on-line delivery and/or shortening the duration.

It is rare that the outcomes focus results in more face-to-face content or more contact hours, but is always argued as the reason for reducing content, face-to-face access and duration, with little or no evidence to support how it results in better outcomes for students and graduates.

Chinese medicine as primary healthcare practice

Finally, Chinese medicine is still an emerging profession and the nature of practice will evolve considerably over the next decade.

It is expected that the role of the Chinese medicine practitioner as the primary healthcare provider will increase. Practitioners therefore need to be educated to adapt to changes in the nature of practice and not limit their thinking to the Chinese medicine tools of trade; rather they need to be open-minded to the integration of other clinical skills/tools to assist with holistic Chinese medicine patient care.

Please contact me at the AACMA national office on [redacted] if you wish to discuss or clarify the issues raised in this submission.

Yours faithfully

Judy James
AACMA CEO