



Submission on the National Registration and Accreditation Scheme Partially Regulated Occupations

The Australian Medical Council Limited (AMC) welcomes the opportunity to make a submission to the Practitioner Regulation Subcommittee on the inclusion of partially regulated professions in the national registration and accreditation scheme.

The AMC is keenly interested in issues related to the development and implementation of the national registration and accreditation scheme as they relate to the AMC's remit in standard setting and accreditation. While this submission is framed in the context of the AHMAC criteria for assessing the need for statutory regulation of unregulated health occupations, the AMC has limited its comments to those criteria which most directly relate to its core functions, experience and expertise:

- Criterion 2 – do the activities of the occupation pose a significant risk of harm to the health and safety of the public?
- Criterion 3 – do existing regulatory or other mechanisms fail to address health and safety issues?

Given the charter of the AMC in relation to standards of basic and specialist medical education, the AMC has focussed this submission on the following partially regulated occupations:

- Chinese medicine practitioners
- Aboriginal and Torres Strait Islander health workers.

1 AMC STRUCTURE AND FUNCTION

The Australian Medical Council Limited (AMC) is an independent national standards and assessment body for medical education and training. It is not part of the Australian government.

The purpose of the AMC is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community. Over time, the AMC has adapted its policies and processes to maintain a high level of quality.

2 AMC CORE ACTIVITIES AND EXPERTISE

The key functions of the AMC are:

- since 1985, setting standards for medical education and training, assessing medical courses against these standards, and accrediting courses that meet AMC standards

- since 1986, setting assessments of the knowledge, skills and attributes of overseas trained medical practitioners who wish to practice in Australia and administering the related assessment processes
- since 1992, advising Health Ministers on matters pertaining to the registration of medical practitioners and the maintenance of professional standards in the medical profession
- since 1985, with the medical registration authorities in the Australian states and territories, developing nationally consistent approaches to medical registration, and nationally consistent policies on standards for registration
- since 2000, setting standards for specialist education and training, assessing specialist medical colleges against these standards
- since 2002, setting standards for the recognition of new medical specialties in Australia, assessing proposals to recognise new medical specialties and advising the Minister for Health on the strength of the case for recognition.

The AMC also, through its Joint Medical Board Advisory Committee (JMBAC), advises medical boards in Australia on uniform approaches to the registration of medical practitioners and, at their request, researches approaches to streamline interactions between boards.

The AMC has experience in setting standards for a regulated profession in which the profession is linked to registration. Through its activity in standards setting and working with medical registration authorities since 1985, the AMC has been involved with education and training that is geared towards producing safe and competent medical practitioners. The role of the AMC in this area is to ensure safety and competency of practitioners not only for today, but for the changing health services in the future.

Issues identified by regulation authorities are able to be used by the AMC to inform education and training standards. The AMC has used the link between regulation, education and training to collaborate with Australian medical schools to develop policies on practitioners with blood borne viruses and practitioners with impairment to name two examples.

3 PARTIALLY REGULATED PROFESSIONS

3.1 Practitioners of Chinese medicine

The AMC recognises that complementary and alternative medicine is a broad term which encompasses a number of therapies, including Chinese medicine (which is also described as Traditional Chinese Medicine [TCM]). The World Health Organisation has adopted the following definition:

Complementary and alternative medicine (CAM) refers to a broad set of health care practices that are not part of a country's own tradition and not integrated into the dominant health care system. Other terms sometimes used to describe these health care practices include 'natural medicine', 'non-conventional medicine' and 'holistic medicine'.¹

¹ World Health Organization. Guidelines on developing consumer information on proper use of traditional, complementary and alternative medicine. WHO, 2004. <http://www.who.int> (accessed on 18 September 2008). p. XIII.

The current regulatory framework in Victoria limits its definition of Chinese medicine to three modalities of practice, namely Chinese herbal medicine, acupuncture and Chinese herbal dispensing. This may prove to be a useful approach for the national regulation of the practice of Chinese medicine in order to limit the scope of regulation to those most common practices with the strongest evidence base of providing benefits to patients with minimal risk.

The AMC believes the inconsistent application of standards on education and practice could also affect the health and safety of the general public. Patients are at risk when practitioners do not know or understand how complementary and alternative medicine treatments interact with other health treatments or conventional drug therapies. Patients are also at risk when they do not seek medical attention for serious conditions or do not disclose to their doctor that they have been or are receiving treatment from a practitioner of Chinese medicine.

The AMC understands that the health risks associated with the practice of Chinese medicine are related, but not limited, to:

- knowing the limits of one's own knowledge and practice
- knowing when to refer a patient to a medical practitioner
- understanding drug interactions
- standards of ethical practice and codes of conduct
- the need to protect consumers from misleading claims on the quality or outcomes of treatment
- standards of hygiene and the risk of infection
- the need for consumers to be able to make informed choices by identifying suitably trained and qualified practitioners of Chinese medicine
- the need to ensure that overseas trained practitioners of Chinese medicine are safe and competent to practice in Australia.

Self-regulation has led to the development of guidelines for practice, education and continuing professional development, such as those published by the Chinese Medicine Registration Board of Victoria (CMRBV). The CMRBV Guidelines take into account aspects of minimum levels of quality, requirements for course approval teams, and timeframe for the approval of courses. Although these guidelines are largely consistent with the principles of accreditation, Chinese medicine practitioners come from a variety of training backgrounds and there appears to be no consistent approach in how education standards are developed or assessed, or how training and fitness to practise are assessed.

It is the view of the AMC that practitioners of Chinese medicine, irrespective of whether they had trained overseas or in Australia, should be assessed as safe and fit to practise according to a consistent standard. Those standards should clearly define the knowledge, skills and professional attributes expected at the end of training and in broad terms and how that training should be delivered. Education providers should be accredited to those standards. Similarly, there should be consistent application of standards which should apply to practice and continuing professional development. Doctors who choose to include modalities of Chinese medicine in their daily practice are bound by their professional obligations to maintain good standards of medical practice and ensure good patient care. The AMC considers that defining the evidence for the effectiveness of complementary or alternative practices and remedies by Doctors, should they decide to use these practices and remedies in their treatment of patients, requires careful consideration.

In December 2004, the New South Wales Medical Board published a policy on Complementary Health Care² which relates to the issue of medical practitioners offering complementary health care as distinct from complementary health practitioners who do not hold registration. The New South Wales Medical Board states within this policy that medical practitioners who offer complementary health care are accountable to the NSW Medical Board for the full range of conventional and complementary health services that they provide.

The AMC expects that medical graduates should have knowledge and understanding of systems of provision of health care in a cultural diverse society. This includes knowledge of their advantages and limitations, the principles of efficient and equitable allocation and use of finite resources and recognition of local and national needs in health care and service delivery. Medical graduates should have the ability to counsel patients sensitively and effectively, and to provide information in a manner that ensures patients and families can be fully informed when consenting to any procedure.

Given the popularity of complementary and alternative medicine practices, the AMC believes it is equally important that medical graduates have an understanding of what complementary and alternative medicine encompasses and the requisite skills to deal with this issue in practice, in particular in communicating relevant information to their patients. With the increase in popularity of complementary and alternative medicine, doctors should take steps to be informed of the demonstrated benefits and take steps to minimise risks.

Medical schools have a role to play in addressing these issues in their curricula. The AMC's standards for basic medical education are relevant to understanding the needs that complementary and alternative medicine seeks to meet. In its Accreditation Guidelines for Medical Schools, the AMC does not prescribe either the specific topics that should be included in medical curricula or how they should be delivered. Instead, the Guidelines provide generic goals and objectives, within which each medical school is required to define its own more specific goals and objectives and to devise an appropriate curriculum to meet them.

The AMC objectives for undergraduate medical education provide a basis for a balanced evaluation of the efficacy and consequences of such practices. Medical schools should provide specific opportunities for students to gain some insight into the types of complementary and alternative medical practices and remedies most widely used. Medical schools are encouraged to devise teaching and learning strategies that examine the interface between conventional and complementary and alternative medicine, and an understanding of the evidence base for such practice.

The present Guidelines focus on the knowledge, understanding, skills and attitudes that are required for the practice of medicine. The AMC Guidelines for the Assessment and Accreditation of Medical Schools describe the overall goal of basic medical education as follows:

“The goal of medical education is to develop junior doctors who possess attributes that will ensure that they are competent to practise safely and effectively as interns in Australia or New Zealand, and that they have an

² This policy can be accessed at <http://www.nswmb.org.au/index.pl?page=58>

appropriate foundation for lifelong learning and for further training in any branch of medicine.”

Where the Guidelines do not refer directly to complementary and alternative therapies, virtually all the objectives, by specifying desirable attributes of medical practice, provide indirect commentary of complementary and alternative therapies.

The AMC Accreditation Standards for medical schools does refer to complementary practices in the explanatory notes for Standards 3 - The Medical Curriculum. The specific Standard 3.2 - Curriculum Structure, Composition and Duration, states:

The medical school has developed descriptions of the content, extent and sequencing of the curriculum that guide staff and students on the level of knowledge and understanding, skills and attitudes expected at each stage of the course.

Standard 3.2 lists the coverage that courses should provide and while complimentary practices do not feature in the list, the explanatory notes related to one of the items on the list (scientific method, inquiry skills, critical appraisal and evidence-based medicine) makes reference to this therapy option from the point of view of evidence based medicine. The note states:

Scientific method and evaluation of evidence are fundamental to many aspects of modern medicine. The curriculum should include instruction in the principles of evidence-based practice and should foster critical thinking and analytical problem-solving by students. There are a variety of ways in which these aims may be achieved, including clinical problem-solving tasks, problem-based tutorials and exercises in evidence-based practice, as well as research projects and assignments. It is suggested that schools use a number of these approaches throughout the medical course.

Medical schools are encouraged to devise teaching and learning strategies that examine the interface between orthodox and complementary practices, in a context of evidence-based practice. Contemporary doctors must be aware that many patients are interested in, and choose to use, a range of therapies, and that some of these therapies will not be supported by evidence. Graduates must be aware of the existence and range of such therapies, why some patients use them, and how these might affect other types of treatment that patients are receiving. It is recommended that medical schools provide specific opportunities for students to examine the types of complementary practices and remedies most widely used.

During 1997 and 1998, the AMC established a working party of its Accreditation Committee to consider issues surrounding complementary and alternative medicine that were relevant to the AMC in the exercise of its responsibilities for standards of basic medical education in Australia and New Zealand.

The working party of the Accreditation Committee developed a position statement titled ‘*Undergraduate Medical Education and Unorthodox Medical Practice*’, which was endorsed by the AMC Council on 21 July 2000. This paper can be accessed through the AMC web site at:

<http://www.amc.org.au/index.php/accreditation-aamp-recognition-mainmenu-188/medical-schools-mainmenu-194/publications-mainmenu-135.html>.

The AMC Accreditation Committee working party, in developing the position statement, collected information on approaches of other standards bodies dealing with medical education outside of Australia.

In December 1999, the working party also circulated a draft discussion paper to a range of stakeholder bodies, including the medical schools, medical boards, health consumer groups and specialist medical colleges for comment. Thirty responses were received, and these comments were considered by the June 2000 meeting of the Accreditation Committee, which made additional revisions to the position paper in response.

As a result of consultation with medical schools, the working party's enquiries indicated that there was consensus in Australian and overseas medical schools that medical graduates should have an understanding of what unorthodox (also referred to as complementary/alternative) medicine encompasses and some skills to deal with this issue in practice.

From its survey of the Australian and New Zealand medical schools, the working party noted that all the medical schools give some attention to issues relating to complementary or alternative medicine and that more than half of the schools surveyed prior to 2000 planned to expand their course offerings in this area in recognition that, in around 2000, about half the population of Australia was anticipated to use these practices at some stage in their lives. It was also noted that medical practitioners were also increasingly using complementary or alternative therapies³.

The position paper also stated that some needs that are provided through complementary and alternative medicine, such as the wish for remedies for conditions that are irremediable cannot ever be met by medicine alone, whilst noting that remedies generated by particular cultural beliefs could also never be fully replaced by conventional medical practice.

Development of safety standards for complementary and alternative forms of clinical practice is challenging. Safety standards in this area are not always based on researched scientific paradigms that allow development of rational standards. The belief systems of practitioners and their clients can often be faith based. Composition of therapeutic materials may be variable and uncertain, and the addition of "western" medicines such as glucocorticoids and nonsteroidal analgesic agents is not unknown.

The AMC believes that registration of complementary and alternative practices implies, in the public view, therapeutic validity and jurisdictional responsibility in terms of patient safety.

The AMC believes that regulatory boards for complementary and alternative clinical practices must include members with high clinical and scientific knowledge and credibility from outside the practice groups together with high level consumer representation.

³ This statement included reference made to the fact that Since acupuncture was introduced as an item eligible for Medicare payments in 1984, claims had risen by 50% in 12 years (in the year 1996/7 representing a reimbursement of \$17.7million by 15% of general practitioners).

3.2 Aboriginal and Torres Strait Island health workers

Research has shown that the Indigenous population in Australia has a 17 year gap in life expectancy in comparison to non-Indigenous Australians. This gap is directly attributable to the social and economic determinants of health. Concerted action in education and health is needed to produce a workforce that is qualified, competent and culturally appropriate to meet the needs of Indigenous people. Research has also shown that access to Aboriginal and Torres Strait Island health workers is not only culturally appropriate but is also central to improving the health outcomes of Indigenous people.

In the AMC's view, Aboriginal and Torres Strait Island health workers need to be multi-skilled as they work in complex and diverse environments, and are called upon to deliver a range of specialised health care and health-related services, including:

- assistance in the management of chronic diseases
- assistance in the management of substance abuse
- child protection
- maternal, perinatal and postnatal health
- counselling.

The development and application of consistent standards would assist in clarifying a nationally consistent understanding of the role of Aboriginal and Torres Strait Islander health workers and assist in providing support to health workers for ongoing training and professional development. Those standards should clearly define the knowledge, skills and professional attributes expected at the end of training and in broad terms, how that training should be delivered. Education providers should be accredited to those standards. Similarly, there should be consistent application of standards which should apply to practice and continuing professional development.

The AMC is committed to contributing to an improvement in the health outcomes of Indigenous people. Australia has special responsibilities to Aboriginal and Torres Strait Islanders, and New Zealand to Maori. In collaboration with the Australian Indigenous Doctors Association, the AMC works to ensure that these responsibilities are reflected throughout the medical education process. Since 2005, the AMC has engaged Indigenous doctors and educators in a range of AMC activities, including reviews of accreditation standards, membership of AMC teams, invitations to attend AMC examination item writing workshops, and the development of the code of professional conduct. The AMC has also given presentations and contributed to publications on the new Indigenous health standards. The AMC recently conducted an Indigenous Health Assessor Training workshop, which was targeted to Indigenous doctors and medical educators who had indicated an interest in participating in the AMC accreditation process.

The AMC believes that Aboriginal and Torres Strait Island health workers are an asset in the health workforce. Generally, they improve access to health care services, enhance the capacity of a team to provide culturally safe and appropriate care and as a result, help to reduce health inequities for Indigenous communities. In geographically isolated areas, Aboriginal and Torres Strait Island health workers often work alone and in extended roles. To be an effective community health workforce, their training should equip them with the knowledge, skills and attributes to deliver safe and quality health care to the community. The AMC believes that Aboriginal and Torres Strait Island health workers have a significant role to play in the health workforce and that health and safety issues in this particular area would be best addressed through a consistent standards framework which is linked to appropriate accreditation standards.

4. Conclusion

Since the inception of a legal framework to regulate the practice of medicine in 1837, the key principle of formal regulation has been protection of the community by prescribing those practitioners who are legally qualified to provide medical services. The process of 'registration' is intended to provide an assurance to the public that legally qualified practitioners have the requisite knowledge, skills and professional attitudes for safe and effective practice within the Australian community.

The proposed National Registration and Accreditation Scheme (NRAS) will provide a mechanism to ensure consistent application of regulatory standards across all jurisdictions for those health occupations that are encompassed by the Scheme. Through the accreditation arm of the scheme, it will also provide an opportunity to ensure education and training standards can be applied consistently in all jurisdictions [the experience with the AMC accreditation processes for undergraduate (medical school) and specialist medical education in Australia confirms that accreditation is a powerful driver of ongoing quality improvement].

In the case of both Chinese Medicine Practitioners and Aboriginal and Torres Strait Island Health Workers, formal regulation through the proposed National Registration and Accreditation Scheme would appear to warrant consideration. In the former case, consideration is warranted because of the risk potential to health and safety of the community in general, and in the latter case, consideration is warranted because of the importance of the occupation to the health and wellbeing of a significant and disadvantaged group within the Australian community.

Canberra
3 October 2008