AOM Comes of Age:

ACAOM Draft Doctoral Standards Compared to Current Entry Level Masters Standards

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Background:

For the past six years, the Accreditation Commission for Acupuncture & Oriental Medicine (ACAOM) has engaged in a comprehensive process to assess the likelihood that the AOM profession might eventually migrate to a first professional doctorate for entry into the profession. The process entailed several steps, with major input from all stakeholders:

- Winter 2002 survey regarding development of first professional doctoral standards, with respondents evenly divided on the issue;
- Establishment of Doctoral Task Force with representation from Council of Colleges of Acupuncture & Oriental Medicine, American Association of Oriental Medicine, Acupuncture & Oriental Medical Alliance, Federation of Acupuncture & Oriental Medicine Regulatory Agencies, and the World Federation of Chinese Medicine Societies;
- Three working meetings of Doctoral Task Force in March 2004, November 2004 and June 2005;
- Receipt of final consensus report from Doctoral Task Force: *Recommended Core Competencies for the First Professional Doctorate in AOM*;
- June 2005 posting on ACAOM web site of Task Force consensus report and Call for Comments at a series of public hearings during 2005-2006;
- From 2006-2007, ACAOM empowered a Doctoral Committee to draft standards for a first professional doctorate;
- Reconvened Doctoral Task Force to ensure input from all stakeholders, which met in Fall 2007;
- Accepted Task Force consensus on proposed first professional doctoral standards and followed its recommendation to release these proposed standards;
- Posted these draft standards on ACAOM web site with an on-line survey in September 2007;
- Held first public hearing on the proposed draft standards for a first professional doctorate in October 2007;
- Reached unanimous resolution to halt review of first professional doctoral standards, citing negative feedback from the educational and practitioner communities in February, 2008;

- Acknowledged that May 2008 CCAOM motions "to support the offering of first-professional doctoral education in Oriental medicine and in acupuncture with appropriate standards of accreditation", and a motion that requested "that ACAOM renew its review of the first-professional doctoral standards" provided "sufficient evidence of consensus among the AOM educational community";
- Stipulated that ACAOM would still require sufficient evidence of support from the practitioner community;
- Clarified that once AOM practitioner consensual support were received, ACAOM would reconvene the Doctoral Task Force to complete the draft accreditation standards, invite public comment, and consider at that time authorizing AOM colleges to pilot these standards by beginning to offer first professional doctoral programs.

At the same time, ACAOM determined that the competency and outcome-based draft standards for the first professional doctorate suggested the need to review current master's and post-graduate DAOM program standards. ACAOM established a Master's Task Force for this purpose and plans to establish a post-graduate DAOM Task Force as well, to ensure that all accreditation standards follow the same succinct, competency and outcome-based format as that of the draft first professional doctoral standards.

Comparison of Current Entry Level Masters and Draft First Professional Doctoral Standards:

A careful comparison of the current Master's degree entry level standards, which have stood the test of time for 21 years, and the draft first professional doctoral standards, which have been developed over the last 6 years with AOM community wide input, is very instructive. The first thing that becomes apparent in such a comparison is that the AOM professional content areas of expertise delineated in great detail in the master's standards are absent, and replaced by succinct references to Acupuncture and Oriental Medicine. Thus the draft first professional standards refer to formulating an Oriental medicine diagnosis "pursuant to AOM principles and theory" (draft standards, #4/c) with no further details, because the AOM educational community and AOM accreditation and in fact certification agencies have established over these past two decades what knowledge and competencies are entailed in the use of AOM principles and theory to inform the process of conducting an AOM intake, formulating a diagnostic assessment, developing an AOM treatment plan and executing an AOM treatment.

In the 6 year development of these draft first professional doctoral standards, it was determined that the AOM competencies had been well developed in the masters standards, and merely needed to be framed in competency and outcome-based terms.

AOM professional practice had thus come of age, and the masters AOM competencies were therefore determined to be adequate to a first professional doctoral level of practice. The only difference with respect to AOM competencies between the masters and doctoral standards is therefore one of competency-based language and expectations.

Biomedical Competencies—the Big Difference:

For two decades, critics of the entry level masters standards have argued for more rigorous biomedical knowledge and skills for entry level practice in North America. While this was reduced in many debates to the ability to perform biomedical differential diagnosis, the larger debate recognized that in those states where AOM practice arguably occupies a primary care status, it was logical to require stricter biomedical knowledge and skills sets to support a primary care scope of practice.

In the draft first professional doctoral standards, something much more rigorous and relevant to actual AOM practice is included in the definition of independent AOM practice competencies, namely the ability to:

- Engage in critical thinking that facilitates good judgment because it relies on criteria and evidence, is self-correcting and is sensitive to context;
- Apply critical thinking skills and exercise professional judgment to improve patient care;
- Make treatment choices from various alternatives;
- Identify information needs and locate sources of information to support clinical decision making to improve patient outcomes, commonly referred to as "information literacy".

This set of competencies frames the professional practice expectations in the first domain of the first professional doctoral standards, the PATIENT CARE DOMAIN, around the ability to practice critical thinking and exercise AOM professional judgment to solve clinical problems and provide patient care. This is consistent with all other doctoring health care professions, which may be proven by a simple google search of "critical thinking and professional judgment in health care". Reference to critical thinking and clinical decision making is absent from the current masters standards. In fact, research methods and information literacy are absent as well, creating a serious GAP in the current AOM entry level standards when compared to virtually all other health care professions.

The second major difference between the current masters entry level standards and the draft first professional doctoral standards is in the area of biomedical clinical sciences and biomedical diagnostic skills. Here, the ACAOM accreditation standards for

masters degree level programs merely lists content areas such as relevant basic sciences that are directed to attaining the biomedical clinical competencies; biomedical and clinical concepts and terms; human anatomy and physiology; pathology and the biomedical disease model; the nature of the biomedical clinical process including history taking, diagnosis, treatment and follow-up; the clinical relevance of laboratory and diagnostic tests and procedures as well as biomedical physical examination findings; infectious diseases, sterilization procedures, needle handling and disposal, and other issues relevant to blood borne and surface pathogens; biomedical pharmacology and potential herb/nutritional supplement and drug interactions and how to access this information (the only reference to accessing information in the masters standards that I could find); the basis and need for referral or consultation and the range of biomedical; referral resources and their modalities."

The only real outcome here is "referral or consultation", not AOM practice informed by this significant didactic biomedical education: biomedical education, devoid of outcomes that students would be able to demonstrate in clinic.

Under "diagnostic skills" in the masters standards, one finds very limited skills: "measuring and recording vital signs, ie., respiratory rate, pulse rate, temperature and blood pressure" and one competency-based outcome: "recognition of symptoms requiring referrals, including infectious disease".

And it is here, in addition to the addition of critical thinking and clinical decision making based on information and evidence, that the first professional doctoral standards represent an enormous shift in thinking about AOM entry level skills that takes classroom theory in biomedical clinical sciences and places this theory, this knowledge, in the context of clinical skills that AOM interns must be able to practice for improved patient care.

In the first professional doctoral standards, "diagnosis" is defined as "the process used to identify the disease entity and individualizing factors of disease, with five specific competencies, namely the ability to:

- Collect and organize relevant data to facilitate the development of a diagnosis;
- Access relevant resources such as research literature and clinical experience in arriving at a diagnosis;
- Formulate an Oriental medical diagnosis pursuant to AOM principles and theory;
- Identify and describe the biomedical pathophysiological process responsible for the patient's clinical presentation;
- Explain the subjective and objective findings that warrant consultation with and referral to other health care providers.

These diagnosis competencies identify a more advanced and higher level of clinical decision making informed by biomedical knowledge, and which require a search for appropriate information and evidence to support AOM care. This is consistent with other doctoring health care professions.

These competencies in diagnosis are further reinforced by case management competencies that are also glaringly absent from the current masters entry level standards such as the ability to:

- Demonstrate cultural competence;
- Formulate, communicate and record short, medium and long term treatment plans;
- Modify plans consistent with changes in the patient's condition;
- Assess patient outcomes;
- Collaborate with patients, care givers and other professionals and payors to determine appropriate care plans;
- Provide a report of findings and health care plan to the patient;
- Create reports and professional correspondence relevant to the care pf patients;
- Use information systems in case management (information literacy yet again).

Here, the independent AOM provider is expected to be able to perform at a doctoring level consistent once again with other doctoring level health care professions, by accessing information to inform development of treatment plans. This set of skills is critical for AOM providers working in mainstream and integrative multi-disciplinary settings, where plans of care must be developed and monitored to assess patient outcomes, based on evidence of improvement.

Finally, while the masters entry level standards delineate only a few very basic diagnostic skills that require minimal biomedical knowledge, the draft first professional doctoral standards state that independent AOM providers are "expected to be able to review, understand and communicate about diagnostic studies, demonstrating an ability to:

- Describe the relevant laws and regulations, including scope and practice, that may govern or limit conducting diagnostic studies;
- Explain the clinical indications, risks, and benefits for diagnostic procedures;
- Outline the principles and applications of equipment utilized for diagnostic imaging, laboratory and other relevant diagnostic tools;
- Assess diagnostic reports, including the range of values that distinguish normal from abnormal findings, as relevant to patient care and communicate with other health care providers;
- Incorporate findings from diagnostic studies with objective and subjective findings from the assessment of the patient;

- Communicate effectively with other health care providers regarding the results of diagnostic studies.

While some critics of the draft standards might wish the competence to order diagnostic tests were listed, nothing in these standards would preclude an AOM college in a state where AOM providers have primary care scope of practice and where they can order and even perform diagnostic tests from teaching students how to do this. The standards merely stipulate that an independent AOM provider practice within their legal scope of practice when "conducting diagnostic studies", which state laws would require as well.

In the new SYSTEMS-BASED MEDICINE DOMAIN, again totally absent from the current masters entry level standards, independent AOM providers will be expected to be able to:
communicate with other health care providers from a knowledge of these other disciplines, in language understandable to other health care providers; discuss biological and physiological theories of the mechanisms of AOM; articulate expected AOM clinical outcomes from a biomedical perspective; access relevant and appropriate information to educate health care colleagues (informatics and critical thinking again).

AOM Comes of Age:

Taken together, the increase in rigor and relevance of the biomedical knowledge of the disease process, and the integration of competencies in information literacy, which stem from biomedical quantitative and qualitative approaches to evidence, as this informs best AOM care represents a tremendous increased level of professional competence. This augmented set of competencies ands professional practice expectations places independent AOM practice on the same footing as all other doctoring health care professions.

Alongside medical doctors, osteopaths, chiropractors, naturopaths, and now doctors of physical therapy and doctors of occupational therapy, independent AOM doctors will be competent in all of the core competencies articulated by the quasi-governmental Institute of Medicine, for best 21st century health care. And they will occupy this doctoring position based on a mature AOM professional practice where AOM intake, diagnosis, treatment planning, treatment execution and assessment of outcomes is informed by biomedical knowledge and skills in diagnosis and assessment of diagnostic tests.

In this process, independent AOM practitioners will be able to gather, analyze and share evidence of its efficacy to a panel of peers from all other independent doctoring level health care professionals, in a mature way that determines when and where this

AOM care is appropriate, and even at times primary in the best care of 21st century citizens who seek, in rapidly increasing numbers, AOM care as a significant part of their treatment options.

Graduates of such first professional doctoring programs, as well as licensed AOM providers who come back to upgrade to the new doctoral degree level, will be positioned to occupy the position of primary AOM provider, alongside primary biomedical, chiropractic, naturopathic, physical and occupational therapy providers.