AAAOM
全美中醫公會
American Association of
Acupuncture & Oriental Medicine

REVIEW OF 2nd DRAFT STANDARDS FOR THE FIRST PROFESSIONAL DOCTORATE IN AOM

Accreditation Standards Manuals Reviewed:

1) **Medicine (MD):** Liaison Committee on Medical Education – Functionals and Structure of a Procedures – July 1, 2011 Medical School – May 2011
2) **Osteopathy (DO):** Commission on Osteopathic College Accreditation (COM) – Accreditation Standards and Procedures— July 1, 2011
3) **Chiropractic (DC):** Council on Chiropractic Education (CCE) – Principles, Processes & Requirements for Accreditation – January 2012
4) **Naturopathy (ND):** Council on Naturopathic Education (CNME) – Accreditation Standards – June 2009
5) **Physician Assistant (PA):** Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) – Accreditation Standards for Physician Assistant Education – October 2011
6) **Physical Therapy (PT):** Commission on Accreditation in Physical Therapy Education (CAPTE) – Accreditation Handbook – November 2011
7) **Audiology (AuD):** Council on Academic Accreditation (CAA) – Accreditation Manual – March 2012

SECTION 5: ADMISSIONS AND STUDENT SERVICES

5.2.D Language, programmatic:

Source: *(page 18) "English language competency must be demonstrated by all students seeking admission to the program. Specifically:*

a) For programs taught in English, competency may be demonstrated by scoring at least 500 on the Test of English as a Foreign Language (TOEFL) and by achieving at least the currently reported mean score on the Test of Spoken English (TSE).

b) For programs taught in languages other than English, competency may be demonstrated by scoring at least 450 on the Test of English as a Foreign Language (TOEFL) and by achieving at least the currently reported mean score on the Test of Spoken English (TSE)."

Issues:

1) It is not typical for medical education or examinations to be conducted in any language other than English.
2) The written TOEFL and TSE are no longer in use.
3) It is not typical for an accreditation standards document to include TOEFL iBT or TSE requirements.
4) The TOEFL iBT score threshold is unacceptably low and should be revisited.

Precedent analysis: There are no stated language or TOEFL iBT/TSE requirements set for medicine, osteopathy, chiropractic, naturopathic, or physician assistants. It is possible that this is because their programs are not offered in a language other than English. Each university sets its own TOEFL level for admitting international students to its program. The university with the largest international student body in the U.S. has set its TOEFL criterion score at 600.

Recommendation: ACAOM should investigate and establish standards for a level of English language proficiency for independent healthcare providers in the U.S. using an exam that is currently in use. Programs taught in any language other than English are not consistent with standards of practice in healthcare education. This raises serious concerns regarding public safety and consumer protection.

5.3.B Transfer Credits, institutional:

Source: *(page 19) "Credits accepted for transfer by the institution must have been earned at an institution of higher education accredited by an agency recognized by the U.S. Secretary of Education, or its international equivalent."*

Issues:

1) Regional accreditation is the highest cross-institutional standard.
2) "Institution of higher education" is undefined.

Precedent analysis: Having prerequisite coursework accredited by an agency that is recognized

by the U.S. Department of Education is done by DO/DC programs and is not mentioned for MD/ND/PA/PT/AuD programs but may be implied. There was no mention in the compared standards of a regional accreditation requirement.

1) MD: (page 17) No mention of accreditation given in reference to prerequisite coursework.
2) DO: (page 17) Coursework requirements must be from a college or university "accredited by an agency recognized by the United States Department of Education."
3) DC: (page 18) Coursework requirement must be from an "institution(s) accredited by an agency recognized by the U.S. Department of Education or an equivalent foreign agency."
4) ND: No stated requirement.
5) PA: No stated requirement.
6) PT: No stated requirement.
7) AuD: No stated requirement.

Recommendation: Recommended language change: Credits accepted for transfer or required as pre-entry requirements by the institution must have been earned at an institution of higher education accredited by a regionally accredited agency recognized by the U.S. Secretary of Education, or its international equivalent.

5.5 A & B Student services institutional (A-B) and programmatic (A-C):

Source: (page 19-20)
Institutional:

A. "Student services and activities must support the fulfillment of the institutional mission.
B. The institution must ensure that all students have access to a well-developed and effective program of orientation, counseling, academic advising, and career development."

Programmatic:

A. The program must develop and maintain program-specific student services and activities that support the accomplishment of the program's goals.
B. Program-specific services and activities must be organized to ensure that student needs are met and that the program's learning outcomes are achieved.
C. The program must ensure that all students enrolled in the program have access to program-specific services.

Issues:

1) Discussion of academic and health student services should be itemized in great detail.
2) Details regarding how the services are evaluated should also be included.

Precedent analysis: Standards are commonly and extensively itemized in clinical doctorate standards of other professions. For example, the LCME devotes two and a half pages, Section B with three headings and 12 standards, to this area.

1) MD: (page 18-21) Two and a half pages, three sections – Academic and Career Counseling, Financial Aid Counseling and Resources, and Health Services and Personal

Counseling – including 13 standards.

2) DO: (page 17-19) Student services covers half a page with two standards. Academic instruction covers two and a half pages with eight standards.
3) DC: (page 17-18) One and one fourth pages devoted to student support services, including ten standards.
4) ND: (pages 7-10) Three pages devoted to student services, with six sections – General Provisions, Admissions, Student Records, Financial Aid, Counseling, Official Publications and Online Resources – including 25 standards.
5) PA: (pages 20-36) Student standards intermixed with faculty and staff standards including dozens of student standards.
6) PT: (page B-20) Very brief description of student services.
7) AuD: (pages 4.1-4.5) One page of student services information with five standards.

Recommendation: This section should specifically list those student services that ACAOM believes should be provided to students consistent with the standards referenced above. A list of examples is insufficient, details are required.

SECTION 6: ASSESSMENT

This entire section should be more specific in describing standard approaches to program assessment commonly found in health professions training programs, i.e., self study, evaluation of specific program areas such as clinical training sites, summative evaluation of student performance, etc. The issue is not just quantity; it is specificity.[1]

6.4 Graduate Success, programmatic:

Source: *(page 22)*

A. The program must use systematic methods to track and evaluate the professional career development of its graduates.

B. Graduate career development data must be used to assess the extent to which the FPD program is achieving its goals and learning outcomes.

Issues:

1) Terms such as "career development" should be operationally defined.
2) Methods and criteria for tracking graduate success should be defined.
3) Graduate survey with specific information areas should be established.

Precedent analysis: It is apparent through review of the professional accreditation documents that data collection for "graduate success" is far more prescriptive. This approach provides the ability to use institutional contributions to assess the field overall. This data doesn't need to be collated specifically for the institution or its benefits.

1. MD: (p. 16) Mentions a variety of specific areas of data collection to be gathered from current and graduated students, including academic and professional statistics.
2. DO: (p. 22) Includes collection and publication of all student scores on the licensing exams, personal student assessment for motivation, assessment of clinical rotations and clerkships.
3. DC: (p. 11) No specifics – discusses a self-assessment of curricular effectiveness with no detail.[2]
4. ND: (pp. 18-19) In depth discussion over two pages of methods and details regarding individual and program assessment.
5. PA: (pp. 61-62) Specific definition of background, participants, ongoing assessment, analysis and reports.
6. PT: (pp. 57-68) Explicit discussion of self-assessment plans and review procedures.
7. AuD: (pp. 5.1-5.4) One page of detailed self-assessment plans with four standards.

Recommendation: Each program must complete a standard biennial graduate workforce survey. The raw data must be submitted to ACAOM. Survey must focus on [fill in focus areas, e.g., income, hours worked weekly, practice setting, reimbursements, fee range, total graduates in each year, matriculation info such as time to graduation, numbers of graduates who took a lic/cert exam and outcomes, etc.]. It is recommended that ACAOM be as prescriptive as possible. It is also recommended that ACAOM release the de-identified raw data for processing to the AAAOM in order to compile workforce data on the field.

6.4.E Licensure Pass Rate, programmatic:

Source: *(page 22) "The FPD program must maintain a state licensure exam pass rate of at least sixty percent (60%), according to published ACAOM policies."*

Issues:

1) The licensing pass rates for professions to which acupuncture is commonly compared are all above 85%.[3]

Precedent analysis: Based on the precedent analysis below, it is clear that the licensing pass rate is not set by the accreditation standards manual.

1) MD: (p.16) No pass rate requirement given. Rates are to be collected and distributed.
2) DO: (p. 34) Despite detailed self-assessment expectations, no rate requirement is given.
3) DC: (p. 10-11) Self-assessment goals without rate requirements.
4) ND: (p. 18) Discusses collection and distribution of graduation and testing data without stating rate requirement.
5) PA: (pp, 20-36) Student standards intermixed with faculty and staff standards including dozens of student standards.[4]
6) PT: (p. B-36) When averaged over 3 years, 80% or more of their graduates must pass the licensure exam.
7) AuD: (pp. 5.1-5.4) Discusses the compilation of data for testing, graduation and post-graduate work without stating minimum requirement.

Recommendation: Programs must provide annual outcomes data for (i) pass rates of graduates who take licensing exams, discriminating between first time and repeat takers; and (ii) total graduates in each year and total who sit for a licensing exam from that cohort within three years.[5] With regards to pass rates, ACAOM should set a standard that allows for progressively achieving a criterion level on par with other health professions; e.g. annually working towards 0.5 deviation – approximately the 67th percentile - above the mean within a two-year moving average until the criterion level of 85% is attained.

STANDARD 7: PROFESSIONAL COMPETENCIES

7.2 Patient care competencies, programmatic:

The competencies in this document are intended to be relevant to acupuncture practice in an integrative practice setting. If the LAc is to work in an integrative practice setting, i.e., alongside, in the company of, and communicating with mainstream providers, then it logically follows the foundational knowledge should include the basic components of all healthcare training programs. Naturopathy makes unequivocal linkages.[6,7]

The competencies as written in 1.1, among others, fails to do this and instead communicates that training will adhere strictly to Oriental medicine principles and practice. Subsequent statements claiming integration with biomedicine are effectively undermined by the precedent as stated here.

The Federation of State Boards of Physical Therapy developed a Standards of Competence document in 2006 that guides the standards for assessing competence. This Standards of Competence document is a model for the Competencies described in Section 7. However, it is not a Standards Guide for program accreditation. It provides a guide for describing the skills and knowledge, i.e., the "competencies," which a graduate of any PT training should possess to practice competently. The Accreditation Standards specifically describe the metrics and performance standards—criterion levels—used by the training programs to assess those competencies.[8] Naturopathic Medicine provides an example of how professional competencies are commonly determined.[9]

Sources: *(page 25) "The FPD program learning outcomes must address, and lead to the development of* [all Master's level competencies plus] *the following set of professional competencies to be attained through learning experiences included in the curriculum.* (Note: all Master's level competencies are required for the corresponding FPD AOM program. As Master's Standards/Criteria are revised, the Master's competencies in these Standards will be removed and incorporated by reference.)"

Issues:

1) It is atypical to find professional competencies in an accreditation standards manual.[10]
2) Professional competencies should be dynamic and do not fit within a relatively static accreditation standard.[11]
3) Only the overarching principles of competencies should be described in the standards manual, however, the standards manual can refers to how the program should interact with and assess the competencies.[12,13]
4) The participants and process in the defining of competencies needs to be more clearly defined.[14]
5) AOM and biomedical competencies[15] are conflated and not clearly defined throughout the competencies.[16]

Precedent analysis:

1) MD: No discussion of competencies within standards

a. Competencies/domains are defined by ACGME in their competency documents - http://www.acgme.org/acwebsite/RRC_280/280_corecomp.asp

2) DO: (p. 21) Core competencies discussed within standards document
   a. Linked to standards document - https://www.do-online.org/index.cfm?PageID=lcl_opticcp
   b. Competencies defined by AOA BOS in their competency document - http://www.osteopathic.org/inside-aoa/development/aoa-board-certification/Documents/bos-handbook.pdf

3) DC: (pp. 19-21) Meta-competencies discussed within standards document
   a. Competencies defined by CCE in their competency document

4) ND: No discussion of competencies within standards
   a. Competencies defined by AANMC in their competency document - http://www.naturopathic.org/Files/About_Naturopathic_Medicine/AANMC%20Competency%20Profile%203-31-08.pdf

5) PA: No discussion of competencies within standards
   a. Competencies defined by NCCPA in their competency document - http://www.nccpa.net/pdfs/Definition%20of%20PA%20Competencies%203.5%20for%20Publication.pdf

6) PT: No discussion of competencies within standards
   a. Competencies defined by FCBPT in their competency document - http://www.fsbpt.org/download/StandardsOf**Competence**2006_10.pdf
   b. Note: Physical Therapy is a health profession perhaps more akin to Acupuncture. Unlike PA or MD it does not necessarily include physician supervision or adherence to the physician approach to practice. The PT accreditation manual published by the CAPTE understands that competencies and standards are distinct qualities. Note the distinction between program and student competencies; a line that is blurred in the current ACAOM Standards. Also note that the term "competencies" only appears twice in the document.[17]

7) AuD: No discussion of competencies within standards
   a. Competencies defined by ASHA in their competency document - http://www.asha.org/Certification/2012-Audiology-Certification-Standards/

Recommendation: Professional competencies should be dynamic and should not be included in the relatively static accreditation standard. They should be reviewed and revised as needed every few years with the professional organization to ensure skills and knowledge ascribed to AOM mastery are updated. While the standards manual should not include the competencies, it should include the requirement that programs assess competencies acquisition using accepted methods in the assessment of training. Additionally, the participants and process in defining the competencies needs to be more clearly defined.

This section could be reworded to state: *"The FPD program standards address assessment of the Master's level competencies plus the additional set of competencies acquired through doctorate training."*

7.2.PCD1 Patient Care Domain #1: Foundational Knowledge (master's level)

Source: *"1.1 The learner must demonstrate the ability to acquire and utilize the knowledge of AOM basic principles, modes of diagnosis, and treatment strategies in the care of patients."*

Recommendations: This section could be reworded to state: "The program will describe assessment strategies and protocols for evaluating the methods by which foundational knowledge of AOM principles, modes of diagnosis, and treatment strategies in the care of patients are acquired."

7.2.PCD2 Patient Care Domain #2: Critical Thinking/Professional Judgment (master's level)

Source: *"2.1 C. Document and support AOM treatment choices.*

Issue: Item 2.C need not isolate treatment choices to AOM. For example, the first professional competency for a Naturopathic Doctor states "Integrate naturopathic philosophy, theory and principles with naturopathic medical knowledge in the care of patients and case management including the assessment, diagnostic and treatment phases."[18] There is no qualifier that assessment is limited to "naturopathic" assessment or that diagnostic and treatment must be "naturopathic."

Recommendation: This section could be reworded to state: "C. Document and support treatment choices."

7.2.PCD4 Patient Care Domain #4: Diagnosis. (master's level)

Source: *A. Collect and organize relevant information to facilitate the development of a diagnosis. B. Access relevant resources such as classical and modern literature, research literature, and clinical experience in arriving at a diagnosis.*

Recommendation: This section could be reworded to state: "A. Demonstrate information literacy, familiarity with evidence-based medicine, and the ability to access and utilize a wide range of appropriate information resources.[1]

Source: *D. Describe and apply the biomedical pathophysiological process responsible for the patient's clinical presentation.*

[1] The removal or future inclusion of "classical and modern literature" in this competency requires further discussion and exploration with the profession.

Recommendation: This section could be reworded to state: "demonstrate knowledge of biomedical pathophysiological process and clinical presentation in the context of formulating a working biomedical diagnosis."

Source: *E. Recognize the relevance of physical exam findings, laboratory, and diagnostic tests and procedures to an AOM diagnosis.*

Recommendation: This section could be reworded to state: "Describe and utilize" not "Recognize the relevance of."

Source: *F. Explain the subjective and objective findings that warrant consultation with or referral to other health care providers.*

Recommendation: This section could be reworded to state: "appropriate health care providers" not "other health care providers."

7.2.PCD5 Patient Care Domain #5: Case Management (master's level)

Issues: Thirteen (13) competencies describe skills and knowledge found in other health care professions without attempting to fit them into the AOM profession. It is unclear what criteria shape the variability. For example, item 5.D states "Collaborate with the patient to develop short, medium, and long term treatment plans." If the determining criterion for enforcing the AOM point of view is clinical treatment as it appears to be for other competencies then we would expect to see the AOM qualifier applied here something like "…develop AOM treatment plans." Hopefully, this example underscores the confusion created by the current use of the AOM qualifier in other competencies.

Recommendation: The standards can focus on common sites where competencies such as diagnostic or triage skills and knowledge are acquired, such as clinical settings. The program should provide for case management training in the classroom and clinical setting. The program should describe how Rounds and Grand Rounds are included in the training program and how participation and mastery of case presentation are assessed. Program methods will include a fixed number of case reports and speaking assignments.

7.2.PCD6 Patient Care Domain #6: AOM Treatment (master's level)

Recommendation: The standard should require a description of assessment methods for ensuring the acquisition of skills and knowledge in preparing a defensible treatment plan rooted in the best available evidence base.

7.2.PCD8 Patient Care Domain #8: Advanced Diagnostic Studies (doctoral level)

Issue: The focus on diagnostic studies, presumably imaging and labs, should be part of Master's level training.

Recommendation: These competencies should be considered for the master's level and the doctorate level competencies should be redesigned accordingly.

SYSTEMS-BASED MEDICINE COMPETENCIES

Source: *"AOM Practitioners must be able to deliver and coordinate care within healthcare systems, provide collaborative care such as found in team-based and multi-disciplinary health care settings, and engage other health care professionals regarding the appropriate use of AOM."*

When AOM is referenced it is in the context of educating other professionals who will not likely be aware of or comprehend AOM practice. This concern is commonly expressed defensively and with an instructive tone, e.g., *"...regarding the appropriate use of AOM,"* and this approach is not found in other accreditation or competencies documents.

7.2.SMD1 Systems-based Medicine Domain #1: Education and Communication (master's level)

Source: *A. Summarize the applicability of AOM to bio medically-defined diseases and syndromes.*

Issue: Suggests the learner should understand and describe AOM mechanisms of action in terms of medical conditions. Use of terms such as biomedicine and "Western" medicine are unique in their use by AOM when referring to modern medical approaches.

Recommendation: This section could be reworded to state: "demonstrate applicability" not "summarize the applicability."

Sources: *B. Communicate with other health care professionals in their own terms. E. Articulate expected clinical outcomes of AOM from a biomedical perspective.*

Issue: Reinforcement of an AOM silo, as though there are multiple communication languages in medicine - as though clinical outcomes differ by theoretical system.

Recommendation: This section could be reworded to state: "students demonstrate the ability to communicate effectively about clinical outcomes with health care professionals not trained in AOM."

Source: *D. Discuss AOM in terms of relevant scientific theories.*

Recommendation: This section could be reworded to state: "contemporary scientific theories"

7.2.SMD2 Systems-based Medicine Domain #2: Patient Care Systems (doctoral level)

At the doctorate level these competencies include integrative training and the ability to work collaboratively with mainstream professionals. The standards are thereby able to be stated neutral to AOM or biomed.

Issues: The five competencies describing the skills and knowledge relevant to cross-system comparisons are superficially articulated and not described at the doctorate level. An inherent issue is the absence of interdisciplinary training as a featured and universal component within AOM training programs. Without interdisciplinary training, the opportunity to apply interdisciplinary principles will never materialize and the competency cannot be mastered. More appropriate models exist, for example, ARC-PA Accreditation Standard B1.08 under Curriculum includes the annotation which describes specific salient knowledge (the competency).[19]

Recommendation: Certain interdisciplinary competencies should be considered for the master's level and the doctorate level competencies should be redesigned accordingly.

7.2.SMD3 Systems-based Medicine Domain #3: Collaborative Care (doctoral level)

Source:

B. Interact appropriately and skillfully with other members of the health care team and within that health care system.
D. Discuss, in the appropriate context, the patient's condition using vocabulary and concepts common to other members of the health care team.
E. Understand the terminology to appreciate the importance of supporting and participating in professional activities and organizations.

Issues: These competencies illustrate how the authors view their skills and knowledge as a language foreign to mainstream medicine.

Recommendation: These are doctoral level competencies. They should be stated in a separate competencies document as skills and knowledge required for working competently with other healthcare professionals who share a common language and approach to healthcare and medical management. This standards document will describe the importance and requirement to measure competencies acquisition.

7.3 Clinical Training, programmatic

Source: *(page 35) A. Definition: Internship is defined as clinical training that is completely controlled by the academic institution. Training is carried out by regular faculty, and the administration has immediate and complete access to the training environment. Faculty schedules as well as faculty replacement may be carried out by the administration, and the entire teaching environment is under faculty and*

administrative direction. Such training would preclude clinical training that is not within reasonable proximity to the academic institution or that does not provide for immediate, unannounced access by program administrators. All students qualified for clinical training are permitted to enter an internship.

Definition: Externship/clerkship is defined as clinical training that involves a secondary, rather than a direct relationship to the academic institution. Externship training may be carried out in private practices or clinics where a written agreement has been established with the academic institution for such training to be made available. Externships involve monitoring the training by less direct means than internship. Externships may or may not be carried out by regular faculty in private practice or clinical settings, and students may be selected by the practitioners supervising the externship. Externships usually involve individual students or a small number of students working at an existing acupuncture practice. The academic institution generally has less direct supervision of externship training, but may add or eliminate externship sites rather than replace faculty or administration.

G. The FPD program must incorporate two or more stages or levels of clinical training, which must be associated with clearly defined outcomes that describe the achievement of competency.

H. As part of its clinical training, the FPD program must provide opportunities for interns to engage in collaborative interactions with other medical providers in appropriate clinical settings.

Issues:

A. The words "Internship", "Externship", etc. inconsistent with the definitions being used by other healthcare professions.
B. Clinical training should be conducted in mainstream settings.

Precedent analysis: All other professions use the term "clerkship."

1. MD: (pp. 20-22) No usage of internship/externship or discussion of clinical training settings.
2. DO: (p. 22) No usage of internship/externship. There is discussion of clerkship training sites.
3. DC: (p.19) No usage of internship/externship. There is discussion of clerkship training sites.
4. ND: (pp.14-17) No usage of internship/externship. In depth discussion of clerkship training sites and their locations.
5. PA: (pp. 44-46) No usage of internship/externship. In depth discussion of clerkship training sites and their locations.
6. PT: No usage of internship/externship or discussion of clinical training settings.
7. AuD: (pp. 3.1-3.7B) No usage of internship/externship. Some discussion of clerkship training sites and their locations.

Recommendation: Any secondary site outside the primary academic setting should be referred to in a standardized fashion similar to other healthcare professions (ie. clerkship). Clinical training at secondary sites should be in mainstream settings.

---

[1] Two examples from the ARC-PA manual of what we would be prefer are located in section A3.14 and A3.15 (note: this is from a different section than assessment).

[2] Students ratings of program belong in program evaluation section and not grad success. Same for #4 and other items below.

[3] The pass rate on the licensing is a function of student preparation and/or exam quality. The two acupuncture licensing/certification exams show very good alpha coefficients. This suggests the "source of error" that contributes to low passing rates is the examinee which usually means poor education prior to and during training. A low pass rate is an indicator of poor training.

[4] The ARC-PA expects results of ongoing self-assessment to include critical *analysis* of student evaluations for each course and *rotation*, student evaluations of faculty, failure rates for each course and *rotation*, student *remediation*, student *attrition*, *preceptor* evaluations of students' preparedness for *rotations*, student exit and/or graduate evaluations of the program, the most recent five-year first time and aggregate graduate ARC-PA.

[5] This is an area where the importance of educational reform must take precedence to what other professions do. The underlying issue is educational quality. The ability of graduates to pass the licensing exams is the best measure of training quality. The profession needs to make a commitment to upgrade the quality of the under-performing educational institutions, specifically with consideration to this criterion as well as throughout all the criteria. A separate but compounding issue is the number of graduates of specific programs who do not sit for licensure, and therefore are not included in the reporting requirements.

[6] "Naturopathic medicine utilizes traditional and conventional medical sciences for the diagnosis, treatment and prevention of human disorders with an emphasis on the therapeutic use of natural methods and materials. Naturopathic doctors are united by a practice philosophy that centers around core principles developed through historical and modern methods of studying health and disease. These principles are the cornerstone of the naturopathic doctor's approach to the patient and their application provides for individualized care." AANMC PROFESSIONAL COMPETENCY PROFILE – AUGUST 2007 page 4

[7] Naturopathy Competency 2 states: "Develop, maintain and value a comprehensive knowledge base in naturopathic medicine." This is further delineated to describe "knowledge of the history and philosophy of naturopathic medicine; knowledge of biomedical and clinical arts and sciences essential to the practice of naturopathic medicine; knowledge of the theory and practice of therapeutics including but not limited to botanical medicine, homeopathic medicine, physical medicine, clinical nutrition, naturopathic counseling/health psychology, nature cure, traditional healing arts and pharmacology."

[8] Federation of State Boards of Physical Therapy. Alexandria, VA www.fsbpt.org PH: (703) 299-3100

[9] **Introduction to the Profile:** Naturopathic medicine is growing in stature, prevalence and acceptance throughout North America. The institutions and organizations associated with naturopathic medicine are becoming ore numerous, diverse and professional. This growing complexity has highlighted the need for an agreed-upon description of what a naturopathic doctor knows, believes and is trained to perform. In 2005 the Association of Accredited Naturopathic Medical Colleges (AANMC) Board established a structure for member institutions to work together in developing a competency profile that will clearly communicate the roles that a naturopathic doctor can perform, and that will underpin the development of common competency-based curriculum elements. The Council of Chief Academic and Clinic Officers (CCACO) was asked to lead the process of soliciting the views of leaders throughout the profession in building this profile. Valuable input was received from the American Association of Naturopathic Physicians (AANP), Canadian Association of Naturopathic Doctors (CAND), Council on Naturopathic Medical Education (CNME), North American Board of Naturopathic Examiners (NABNE) and members of the

Foundations of Naturopathic Medicine project. This work culminated in the Naturopathic Doctor Professional Competency Profile; a document that we hope will serve as a foundation for naturopathic medical licensure, education and practice. The profile is organized around five key roles - medical expert, manager, professional, health scholar and health advocate – that collectively define the essential abilities of a naturopathic doctor. Within each role is a brief description followed by broad statements of competency. The roles are not mutually exclusive; rather, they influence and overlap one another. - AANMC Professional Competency Profile – August 2007 page 4.

[10] The ARC-PA August 2010 document comparing competencies with standards clarifies the distinction by making the separate and complementary relationship explicit: "The Accreditation *Standards* for Physician Assistant Education are the requirements to which an accredited program is held accountable and provide the basis on which the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) will confer or deny program accreditation (August 2010 comparison document)." -Comparison of ARC-PA Accreditation Standards for Physician Assistant Education, 4th Edition (2010), To the Competencies for the Physician Assistant Profession (2005)

[11] "The *Standards* recognize the continuing evolution of the PA profession and practice and endorse experiential competency-based education as a fundamental tenet of PA education. (August 2010 comparison document)."

[12] The ARC-PA Accreditation Manual illustrates under Standard B1.09 "For each didactic and clinical course, the program *must* define and publish *instructional objectives* that guide student acquisition of required *competencies*." on page 14. Similar references and separation of domains are found in the LCM Accreditation manual.

[13] *Instructional objectives* stated in measurable terms allow assessment of student progress in developing the *competencies* required for entry into practice. They address learning expectations of students and the level of student performance required for success."

[14] Both Naturopathy and Physical Therapy provide useful examples about how such "Competencies" bodies are organized. The ACAOM PFD Task Force document identifies individuals but does not offer background information on what groups they represent which should argue how this assembly is qualified to represent the profession. While persons within the AOM profession may recognize several of the individuals we must keep in mind this is a public document. More information must be presented about why the work should be considered representative of the profession. The Naturopathic groups accomplished this in 251 words at the beginning of their Competencies document - AANMC Professional Competency Profile – August 2007 page 4.

[15] The term "Biomedical competencies" refers specifically to the use of basic biological science concepts and the medical sciences in managing patients.

[16] Medical knowledge includes an understanding of pathophysiology, patient presentation, differential diagnosis, patient management, surgical principles, health promotion and disease prevention. [fill in provider group – this competency is standard for most] must demonstrate core knowledge about established and evolving biomedical and clinical sciences and the application of this knowledge to patient care in their area of practice.

[17] "Expected student outcomes: Competencies that the program expects students to have achieved at completion of the program, as well as stated expectations for graduate success in relationship to graduation rates, licensure rates, and employment rates. Expected student outcomes are a subset of the expected outcomes of the program." - PT Evaluative Criteria (11/11) Accreditation Handbook, November 2011 B- x

[18] AANMC PROFESSIONAL COMPETENCY PROFILE – AUGUST 2007 p. 6

[19] B1.08: The curriculum must include instruction to prepare students to work collaboratively in interprofessional patient centered teams. ANNOTATION: Such instruction includes content on the roles and responsibilities of various health care professionals, emphasizing the team approach to patient centered care beyond the traditional

physician-PA team approach. It assists students in learning the principles of interprofessional practice and includes opportunities for students to apply these principles in interprofessional teams within the curriculum.