Education, training and continuing professional development in medical acupuncture
– a contemporary overview

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Summary
Most medical and complementary medicine practitioners will have some awareness of the government-driven requirement to set and maintain explicit standards for education and professional development. For many doctors, revalidation has become a concern because they worry that it will raise the requirements for practice and increase bureaucratic documentation in support of the process. For those who have integrated complementary practices into their work within the National Health System, issues of registration and regulation add a further complication. The publication of the Department of Health consultation document on proposals for statutory regulation of herbal medicine and acupuncture in March 2004 raises issues of particular significance for medically qualified practitioners (such as ‘medical acupuncturists’), and other health professionals whose practice includes complementary skills. This paper focuses on the educational implications of these recent developments and offers an informed perspective that includes a reflection on how education and training (as initial training and as continuing professional development) can best meet the needs of acupuncture practitioners in this fast-changing environment.

Keywords
Education, training, continuing professional development, medical acupuncture.

Introduction
In this article, the aim is to introduce and stimulate an informed debate about the most appropriate way to engage, support and record professional development in medical acupuncture to meet the needs of appraisal, registration and revalidation for registered medical practitioners and other registered health professionals. This paper has been stimulated by the recent changes within the sphere of regulation of health professionals, and the drive towards regulation of the ‘acupuncture profession’ – whatever form is finally settled upon as most appropriate. On 2nd March 2004 the Department of Health published a consultation paper titled: Proposals for the statutory regulation of herbal medicine and acupuncture. These proposals may subtly alter the terrain; however, change is inevitable, and all relevant health professionals are advised to engage in the debate. A section of the BMAS discussion forum will be set up to facilitate this debate. The paper summarises some of the key issues associated with regulation and registration for those whose first qualification is in medicine or a related healthcare discipline. Whilst the focus of this discussion will be from the perspective of registered medical practitioners, it should be of interest to other practitioners whose work involves integrating different modes of practice within medicine and healthcare across regulatory boundaries. Education, training and professional development will continue to be of concern to the medical acupuncture community so we anticipate that brief articles will feature on an occasional basis in the pages of this journal.

Context, concepts and principles
The context for this paper is undeniably complex and it is likely that some issues, which deserve more detailed attention, are being simplified. The paper describes how changes in medical, sociological and educational perspective overlap and interweave to form a canvas of changes to professional education for medical practitioners in the 21st century.
this simplified picture anecdotal and temporal links are drawn between the different reasons and incentives for change, but these links do not infer any direct causal relationship between the different developments.

Two fundamental shifts have occurred in the practice and core knowledge of medicine during the last century, neither of which is based on the discovery of a new cure or a revolutionary insight. First, doctors are increasingly instructed to focus their attention on responding to individual patient needs, to help them maintain positive health and to deal with degenerative diseases. Even the global and pandemic challenge of HIV/AIDS seems, in the Western world at least, to have become a personal challenge for the patient engaged in choices about their own care, subject always to the limitations of funding and resources. So the primary shift is towards individual patient responsibility in a market-driven economic climate.

A second shift is more epistemological – concerned with the weight of medical knowledge itself. What is known and on the verge of being known across overlapping areas of medicine seems to expand at a rate such that very few professionals could claim to be fully aware of what is known within any single subject area. Even with the speed of information technology creating opportunities for tracking down research evidence, generalists will find it increasingly difficult to keep up to date. Ready access to medical knowledge can be a double-edged sword as web-based information can also raise patient expectations and nip at the heels of practitioners trying to maintain the currency of their knowledge. For example, patients may now ask their doctor for ‘keywords’ so that they can undertake their own internet research into proposed treatments. Managing patient expectations is thus a major challenge for health services and practitioners, while policy still dictates that the patient has a right to be engaged in informed choices about their treatment. Complementary Medicine (CM), in all its modes and forms, has offered models of health, healing and care that seemed to challenge western orthodox understandings, and it provides, for some patients at least, a wider range of choice than ever before. Along with this choice, doctors are struggling to work within, and explain to patients, a plethora of ways to understand and describe health and patient care. This change is likely to have impacted on the practice of every health professional, whether or not they are sympathetic to these complementary and apparently alternative approaches.

The growing public awareness of some examples of unprofessional practice has further eroded the unquestioned respect that professionals traditionally enjoyed and contributed to an expectation that professionals in general should adhere to explicit standards of competence and behaviour. For doctors – as well as for other professions – shifts in the hitherto authoritative status of their profession seem to have moved the ‘consumer’ from acting as a passive recipient to taking far more responsibility for decisions about their own care and the care of their relatives. In medicine and health care, the focus of governance and professional regulation has become patient safety, patient confidence and patient choice: regulatory structures aim to impose this change on practice and on training or continuing education, and appraisal provides the basis for checking that such structures are in place and working. For CM practitioners, the focus has, in similar ways, moved towards regulation in the interest of patient safety and informed choice. There is a strong emphasis on the standards of professional competence that, it is claimed,1 can be achieved through regulated provision of education and training, and a commitment to continual updating and reflection with what is termed ‘continuing professional development’ (CPD).

For years, many doctors and other healthcare professionals have engaged in their own continued learning, but now such professionals are expected to document evidence that they have participated in, and reflected on, this process: ‘lifelong learning’ as a requirement for professional practice across the health service. The principle underpinning this emphasis on CPD is that it helps ensure that practitioners:
- keep up to date with new facts and changing approaches to practice
- build stronger partnerships with patients and colleagues
- provide evidence of their fitness to practice in ways that counter potential accusations of malpractice.

Professional education and training need to take account of these changes.
Similar changes are reflected in the design and assessment of training for registered practitioners in complementary therapies and in the continued training and updating offered to graduate practitioners in all fields. In this context too, the principle of competent and self-regulated learning is more highly valued than factual knowledge or simple exposure to experience. The change from a knowledge-testing system to a competency-based process that is self-regulating and includes bureaucratic reporting structures is complex and is not yet fully developed. In the UK, for example, the systems are built around appraisal structures. These anticipate that practitioners will demonstrate to peers that they update their knowledge, reflect on their practice in the light of patient needs and expectations, and plan and record their learning, as a normal part of their working day. Clinical audit and governance structures are intended to frame that individual or personal process in an organisational context. Experience and the passage of time will only embed these emerging systems in practice with the support of integrative processes that help practitioners plan and report their learning with the most effective use of their time and energy.

### Education, training and development

The distinction between education and training may be quite subtle (see Box 2), and the term ‘professional development’ (CPD – Continuing Professional Development, or CPPD with the word Personal added for good measure) can encompass a range of learning activities and outcomes that might also be confused with training or education. In its 2001 report: Hidden Talents: Education, Training and Development for Healthcare Staff in NHS Trusts, the Audit Commission uses the term ‘education’ to refer to learning that leads to a formal qualification obtained from an academic institution such as a university. The terms ‘training’ and ‘development’ are used to refer to the complete spectrum of learning opportunities. Thus, CPD forms one component of education and training. Box 2 provides a slightly more helpful distinction, although the boundaries between the words continue to blur.

### Box 1  Regulation, registration and revalidation defined

#### Statutory regulation

Orthodox healthcare professionals are subject to regulation by the State (statutory regulation). The prime aim of this process is to protect patients and the public by ensuring that healthcare professionals meet agreed standards of practice and competence. (Many complementary therapies are self-regulating – this does not have the same basis in law but shares the same intentions.)

#### Registration

A statutory regulatory system involves the establishment of a register of practitioners who are qualified and competent to practise. Use of a specified title is then restricted to practitioners who are included on the register. Sanctions, such as suspension or removal from the register, can be applied to any practitioner whose fitness to practise is impaired.

#### Revalidation

This process means that doctors who want a licence to practise in the UK must demonstrate that they remain fit to practise. It will be introduced for all doctors from 2005. All doctors wishing to retain a licence to practise should have begun collecting evidence to support revalidation.

### Box 2  Education, training and development defined

#### Education

refers specifically to qualification-focused activities that develop key skills or knowledge and enable continuous professional development. It is however recognised that general aspects of education also contribute to the holistic development of individuals and organisations.

#### Training

refers to the processes which bring about a change in behaviour, for a definite purpose. The three main areas involved are skills, knowledge and attitudes.

#### Development

refers to an emphasis on the growth of the individual. It relates to acquiring and widening skills, knowledge and attitude through planned activities and experiences. Development has no fixed end point recognising that people have potential to continuously improve.
In considering each of these activities in turn, we show how the terms overlap and highlight where practical changes will impact on daily practice for health practitioners and educational practice for professional bodies such as the BMAS.

**Education for new doctors and practitioners**

As was suggested above, the knowledge that medical students absorb during their university study is no longer thought to be sufficient for a lifetime of professional practice. In undergraduate education, the expansion of medical sciences has led to an acceptance that graduating medical students can only be expected to possess a basic level of knowledge and competence, and that this should continue to develop over their career in response to new challenges. It is also accepted that interpersonal skills and the subtleties of professional judgement continue to develop over time through experience and through reflection on interactions with patients and colleagues.

But perhaps the changes have not been quite as drastic as we claim. We may wish to affirm a positive assumption that good practitioners have always undertaken continued learning – often building their expertise on the search for solutions to the problems that are brought to them in the course of daily practice. Problem based learning (PBL), increasingly popular in medical education, takes this model of good practice into the training of novice doctors, expecting them to learn the skills of good communication, good observation and good questioning before (or alongside) theoretical knowledge of the patient’s problem, and his or her symptoms. The approach claims to focus on the learning situation and the patient in order to contextualise knowledge and understanding in practice. Many claims are made about the benefits of PBL with regard to knowledge, understanding, thinking, communication, teamwork and satisfaction; however, the systematic reviews in this area are not unanimous in their support for this learning approach.\(^2\) The boundaries between education and training become blurred, as theoretical knowledge is tested in practice on the basis of observed competence against set standards. Notions of professional competence look for evidence of achievement and the ability to perform in practice, but the challenge is to measure appropriate vocational competences in valid and reliable ways.

The GMC education guidance for universities (The New Doctor, 1997) set out clear basic competence standards that required institutions to make objective assessment of a range of skills.\(^7\) By 2002, medical educationalists were identifying the limitations of teaching towards an assessment of simple clinical competence,\(^8\) and in 2003 a more complex list of educational outcomes incorporated the requirement to ensure a commitment to ongoing development (see Box 3).\(^11\)

Medical educationalists continue to be challenged by the fact that assessing this more complex learning is not easy or straightforward, but this is an issue for professional development across all sectors. The post-graduate stage of medical education during which new doctors are encouraged to choose and develop a career direction is becoming more closely regulated (or guided) through vocational or specialist training schemes to help a smooth transition from education and training through to an established routine that incorporates continuing or lifelong medical education (CPD or CME as it is sometimes known).

**Training for practitioners**

In the paragraphs above describing undergraduate education, it is clear that training and CPD processes

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**Box 3  Skills, attitudes and behaviour expected of new graduates**

- Be able to gain, assess, apply and integrate new knowledge and have the ability to adapt to changing circumstances throughout their professional life
- Be willing to take part in continuing professional development to make sure that they maintain high levels of clinical competence and knowledge
- Understand the principles of audit and the importance of using the results of audit to improve practice
- Be willing to respond constructively to the outcome of appraisal, performance review and assessment
(according to the definitions in Box 4) have become increasingly aligned with the basic educational qualification for new doctors. This fundamental change also impacts on the training and practice of doctors who are already qualified to practise and may have been trained under a quite different regime. Training for teachers and training for appraisal may help in changing attitudes and behaviours: for those who wish to add new medical techniques or update their skills, there are new procedures for identifying and evaluating that training which may parallel some of the outcomes-oriented educational practice (such as PBL) that is current in university courses. Although there are overlaps, this is where we draw our boundary between training (as discrete events in specified locations such as PG Centres) and CPD, which is likely to be work-based, unstructured and informal. So, what are the formal events that constitute training?

**Training to teach**

Experienced doctors often take on responsibilities for teaching new graduates and supervising their progression in a chosen field. These practitioners, who are likely to have qualified some years ago, may have experienced quite a different sort of first-level professional education: their role as supervisors and mentors for new graduates has to take on board the changing expectations of a rapidly changing system. This may challenge or unsettle some of their assumptions in ways that can impact on their medical practice, too, so those who undertake to teach new colleagues in the work-place must be trained to develop appropriate teaching skills in line with a new recognition of the complexities of work-place learning. They must also be trained to develop ways of managing change and incorporating new practical knowledge and techniques.

**Training for appraisal**

Appraisal has been in place for GPs since 2002 and seems now to be a routine part of NHS human resource strategy. It aims to both support and check updating: regular appraisal provides core evidence for revalidation and feeds into strategies for clinical governance and the detailed surveillance and management of practices. Doctors, by a process of peer appraisal, are now expected to produce evidence of their learning on an annual basis and to provide a set of identified and purposeful training needs in the form of a personal or professional development plan (PDP). Here, again, there are training needs associated with appraisal itself: it is not realistic to anticipate that practitioners will have the skills and behaviours of effective appraisal without some training and feedback on the process. Many organisations offer formal appraisal training for practitioners as one way to support the change in culture: the Royal College of Physicians has an online training tool that is accredited on the basis of self-testing.

**Training in new medical skills**

Programmes such as that offered by the BMAS supplement the skills of qualified practitioners and, potentially, add to the tools for use in daily practice in ways that may reduce prescribing and referral costs and increase patient satisfaction. Although intensive and demanding, such courses offer opportunities to reconsider some principles of medicine and to revisit fundamentals such as anatomy in the company of peers. Increasingly, such programmes are multidisciplinary, which allows for informal learning between, say, anaesthetists from pain clinics and general practitioners or physiotherapists. So there is real professional development value in such training events, although their feasibility may be challenged by changes to funding arrangements.

In the first two years of practice, local deaneries provide funding for such learning and, in the recent past, experienced practitioners have drawn on PGEA funding to enhance their knowledge and skills. With the demise of the ‘points’ system for training, resources and time for continued training in the form of events and courses seem to be at risk. So, while the rhetoric of updating and continuing professional development should underpin education and training for lifelong learning in practice, the means to support that training seems to be at risk.

BMAS has taken on board many of the changes to medical education, not least in the way it has opened its programmes to a range of registered practitioners. The balance of each course has also moved from a knowledge-focus
using lectures and presentations to incorporate more interactive, experiential processes that value the practice of medical acupuncture alongside the knowledge and understanding of its principles. Participants on BMAS foundation courses are encouraged to work with symptoms and patients in mind, using their theoretical knowledge to ensure safety and develop explanation.

**Continuing professional development and updating**

It is clear that the demands of training in the ‘soft’ skills of practice (appraisal, teaching and communication) will not sit comfortably with the many other demands on scarce ‘learning time’ that doctors are juggling: new drugs, new techniques, new referral procedures and new technologies make their claims alongside new organisational expectations including, in the case of GPs, the new contract. In this climate, continuing professional development and reflection on this practice may seem to be luxuries. These conflicting pressures on training time and resource clearly pose a potential threat to medical acupuncture and other integrative complementary techniques, despite their potential to enhance effectiveness in the longer term. It seems that CPD may become shorthand for the sort of learning that appears to have no cost: the third quote in Box 4 prioritises the informal (low-cost) learning over more formal (high-cost) training or lecture events.

**The position of the BMAS**

Our purpose, here, has been to summarise and reflect on these changing expectations of patients, funding bodies and of accrediting bodies. In the following sections, we ask how these new structures and principles can be integrated into initial education and continued development for medical acupuncturists (and other practitioners who integrate a range of approaches) without overwhelming the community with additional work, unnecessary bureaucracy or too many unsettling or radical changes.

**BMAS membership**

The British Medical Acupuncture Society now welcomes membership from registered healthcare practitioners (from an appropriate clinical background) across a far broader spectrum of practice than was the case before 2001. Nurses, physiotherapists, podiatrists, osteopaths, chiropractors etc, are now invited to join the programme at Foundation level and to progress through to the first level of accreditation. As the moves to register all complementary therapists begin to take effect, potential membership could be very wide indeed, and could even attract practitioners of Traditional Acupuncture who are currently unregulated, following their inevitable progress to statutory self-regulation. Although we expect membership to continue to be dominated by doctors, there is a noticeable increase in other practitioners joining BMAS courses and this presents an interesting challenge to the education arm of the Society in considering appropriate assessment at the various levels and in planning a framework for continuing professional development that will meet the appraisal needs of all members.

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**Box 4  Continuing professional development**

‘A process of lifelong learning for all individuals and teams which meets the needs of patients and delivers the health outcomes and healthcare priorities of the NHS and which enables professionals to expand and fulfil their potential.’


‘The planned acquisition of knowledge, experience and skills and the development of personal qualities for the execution of professional and scientific duties throughout one’s working life, encompassing where appropriate scientific, technical, clinical and more general matters.’


‘Continuing professional development can be provided in several ways, eg open learning, on-the-job coaching, mentoring, action learning, use of multimedia packages and conventional learning. There are individual preferences for different methods of learning, such as peer group or individual learning, learning at work, at home or in the lecture room. Considerable emphasis is now placed on delivering CPD as work-based learning and on the importance of learning in multidisciplinary teams.’


Future plans
The Foundation course has been a well received and successful course for almost two decades. In recent years it has been modified to incorporate contemporary educational techniques, as well as responding to progress in the scientific evaluation of acupuncture; however, the curriculum has remained largely unchanged. Feedback and audit suggest there is no necessity to modify this introductory training, despite the ubiquitous, negative and probably politically motivated rhetoric about doctors studying acupuncture on ‘weekend courses’. On the contrary, it is hoped that a flexible programme of training can be designed for individual participants to best meet their particular needs following on from the Foundation course.

The main educational developments are being planned to follow on from the Certificate of Basic Competence (the title here is likely to change), which is generally completed after the first three months of clinical practice. From this point the training of healthcare professionals who are already in practice needs to be tailored, in a self-directed manner, to their individual requirements. The intent is to produce a framework for continuing training and professional development structured around a personal internet-based (or initially paper-based) portfolio. For those who wish to progress to the diploma level, this portfolio will need to cover the main topics within an agreed curriculum of medical acupuncture, but study in individual topic areas can be documented in any one of a number of different ways. For example, a section on ‘acupuncture in paediatrics’ might take the form of a case report, an essay reviewing the clinical trial evidence, a comprehensive book review, or even a travel report of a visit to the Far East. Individual items will be assessed for ‘training points’ by peers undergoing the same process and by mentors. Quality and consistency can be maintained through peer review of staff (mentors’) portfolios as well as end-point review of the candidates.

It is hoped that when the internet-based links are in place, all this activity will neatly cross-reference to the CPD section that feeds the annual appraisal portfolio, or that for five yearly revalidation, or the equivalent for the relevant profession. The overall aim of these processes will be to adequately document training and development activities, in a quality assured manner, without the requirement for excessive or repetitive bureaucracy.

For those who wish to maintain a peripheral interest in medical acupuncture, CPD can be covered within their normal professional process of reappraisal; however, higher levels of interest, denoting a more specialist level of practice, would need to be maintained by a medical acupuncture specific element to the CPD portfolio. In a similar manner to the training process described above, this CPD requirement could be assessed on a peer review basis, with quality measures in place to ensure transparency and consistency within the process. The authors welcome your views, and hope that you will engage in the debate, which will be found on the BMAS discussion forum at: http://www.medical-acupuncture.co.uk/discus/index.html

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