Organisation response to the Chinese Medicine Board of Australia public consultation on the proposed revised Guidelines on patient health records

Response from Federation of Chinese Medicine and Acupuncture

(Note: All responses have been reproduced as provided and have not been edited or otherwise altered.)

Question One: For the benefit of public safety and supporting the threshold requirement as part of the Professional capabilities for Chinese medicine practitioners and as part of the requirements under the shared Code of conduct, the Board is proposing that all patient health records should be made in English. This proposal aims to improve continuity of care for patients and support Chinese medicine practitioners to work effectively as part of the healthcare system, integrating Chinese medical practice into the broader healthcare environment.

Do you agree that making patient health records in English will help achieve these goals?

No
Please give a reason for your answer
1. Currently a small percentage (15%) of registered Chinese medicine practitioners with English conditional registration is allowed to keep patient records in their own languages. The proposal requests them to keep records in English is impractical and debatable. The proposal seems to violate the primary purpose of patient health record guidelines. Instead, this proposal unjust targets that cohort of practitioners whose English language skills are lower than their peers and forces them to keep patient's records beyond their language capacity. Consequently, it will unavoidably put them in a disadvantaged position in the profession and eventually being excluded out from the National Registration and Accreditation Scheme (NRAS). We do not believe that the guidelines for patient health record have been barriers for Chinese medicine practice to be integrated into the health system as of the 15 regulated health professions under NRAS, only four of them (Chinese Medicine Board, Chiropractic Board, Osteopathy Board and Podiatry Board) have guidelines for patient health record in place. No evidence has been provided that public safety has been compromised because of the absence of guidelines for patient health record in the other 11 regulated health professions. 2. This proposal for the cohort of Chinese medicine practitioners with English conditional registration places unreasonable demands, which could affect their personal health and wellbeing as well as their livelihoods. Section 303 (grandparenting clause) of the Health Practitioner Regulation National Law (National Law) granted the right to those Chinese medicine practitioners who had met other registration standards set by the Chinese Medicine Board of Australia (the Board) for registration where their English skills were less than their peers were subjected to impose a condition on their registration. This arrangement has allowed them to continue their health care to patients when the Chinese Medicine profession was included into NRAS in 2012. Section 303 of the National Law has protected their civil rights to make their livelihoods via continuity of practice. Unless an unprofessional conduct is confirmed, that cohort of the practitioners should be permitted to continue their practice and provide health care to the public. The present Guidelines: Patient Health Records issued by the Board permits them to keep the patients' records with their own languages and no evidence has shown that public safety has been compromised by patient health records kept in non-English languages since the present Guidelines published in August 2016. It is only one who has attempted to learn another language that appreciates the difficulty in trying to do so. It is already difficult to learn to speak another language to get by for daily activities. It is even more difficult to be sufficiently literate to be able to write as well as to acquire specific technical vocabulary for medical practice. The proposal for Chinese practitioners with English conditional registration to enter records in English is unreasonable. 3. This proposal for English health records may cause some to give up their practices as the proposal has unfairly targeted them. They may not able to abide by the proposal. The healthcare system would lose some very experienced and competent practitioners. Many of them have serviced the public for years. This would also impact on their patients. 4. The need for non English health records to be translated into English for the purpose of communication or in the event of emergencies at this stage is debatable. Every primary health care provider should be competent enough to make an initial assessment of a patient's condition independently. It is not a common practice that a primary health care provider, in particular a medical practitioner needs to access a patient's health record created by another health professional to make his/her medical diagnosis for the condition of that patient. Even if it is necessary, the only intervention that had been given to the patient which could be meaningful to a medical practitioner may be their interest in drug-herb interaction or potential adverse effect of Chinese herbs. This could be achieved by reviewing a label or a prescription of the intervention that the patient had. Requirements of labelling and prescription of Chinese herbal medicine practice have been well documented by the Guidelines of safe Chinese herbal medicine practice issued by the Board in September 2023. 5. The nomenclature of Chinese medicine diagnoses and syndromes are based on concepts and physiology different from other health care paradigms. The information in the translated documents would not be understandable to the treating medical practitioners. Terminology such as "Taiyang disease", "Kidney yang deficiency" or "External wind heat" would not make any sense to other health care providers. The Chinese herbal formula would also be of no used to medical practitioners. The patients would generally be able to provide the medical practitioners with their symptoms or signs that lead to the presenting medical episode(s).

Question Two: Do you consider a period of transitional arrangements an effective method of giving Chinese medicine practitioners with English language conditions on their registration time to adjust or alter their practice or put in place arrangements to ensure patient health records are made in English?

No
Please say why or why not
The expectation of Chinese medicine practitioners with English language conditions to make adjustments or alterations to their practices during a transition period is not a matter of time provided to make the changes. All the changes that are expected to be made are determined by the English language skill of the practitioners. A transition period would not be of use as it takes years to learn a new language, let alone essential technical vocabulary. Most Chinese medicine practitioners who keep records in their own languages would be in the "grandparenting" cohort under Section 303 of the National Law. This group of practitioners would be more senior or close to retirement in age. It would be very difficult for them to learn English proficiently within the transition period and for several years to come. Unfortunately, this proposal does not suggest what alterations or arrangements that could be made to ensure patient health records are completed in English after a 12 month transitional period. Due to privacy, it would not be ideal for practitioners to obtain assistance from individuals who are bilingual to translate the health records. If individuals were trusted, they may also be unfamiliar with medical vocabulary and mistakes could be made in the translations/interpretations. If a recognised medical interpreter were to be employed, the cost would be prohibitive to the Chinese medicine practitioners.

Question Three: Do you consider 12 months to be a suitable period of time for the transitional arrangements to be in place in order for Chinese medicine practitioners with English language conditions to prepare for making health records in English?

No
If No, what do you consider to be an appropriate length of time for transitional arrangements to be in place? Please give a reason for your answer.
How much time Chinese medicine practitioners are given to transition to be able to keep health records in English is a moot point as it is not known how long it would take practitioners to learn the language proficiently to be able to keep records in English. If it were feasible, the practitioners would have taken the initiative to learn English to a proficient level rather than be confronted with the current demand. The numbers of practitioners who keep records in their own languages are small. We suggest that we allow natural attrition and retirement from advancing age to play out. The admission of local graduates and overseas practitioners who are competent in English would further reduce the practitioners in question.

Question Four: Do you consider 24 hours to be a suitable window of time for Chinese medicine practitioners with English language conditions to have health records translated to English during the transitional period?

No
If No, what do you consider to be an appropriate length of time for health records to be translated?
It is, again, unreasonable for practitioners to translate health records into English within a 24 hour period. If these practitioners are capable of translating records into English, the practitioners will be capable of writing the initial record in English. If the practitioners are to depend on a dictionary to translate each word from the health records, the final product will not be coherent; not to mention the time taken and the stress put upon the practitioners. Practitioners' health and wellbeing are paramount for safe clinical practice. A person who speaks a second language without the literacy of that language is unable to translate adequately. Words from one language to another cannot be just translated or just interpreted. Translations of words from one language to another do not provide proper meanings of the patient/clinician encounters without adequate interpretations of the nuances of the original language. Proper translations and interpretations are specifically important as the Chinese language (for example) is very sophisticated. A character in the Chinese language has several meanings and the correct interpretation is very important to get it right. It is also required that the Chinese medicine practitioners have to verify the accuracy of the translated English records. This verification would be impossible for the practitioners as they would not have the level of English to read and understand the translation and the technical vocabulary used. To verify the accuracy of translations/interpretations, the documents have to be translated into the second language, and then back translated to the original language; to see how much the back translation resembles the original documents.

Question Five: Outside of the changing requirements regarding the language in which health records are made, are there any other implementation issues that the Board should be aware of?

Yes
If Yes or Maybe, please explain what other implementation issues the Board should be aware of.
We speculate that this consultation regarding Chinese medicine practitioners to transition to keeping health records in English is inadequate. In response to this consultation, it is those who are well versed in English to provide responses to this request. Those who are not English speaking practitioners depend on their English speaking colleagues to speak on their behalf. Those who reply on behalf of their colleagues are "not in their shoes" to fully appreciate the hurdles faced by those who do not complete health records in English. While Australian Health Practitioner Regulation Agency (Ahpra) is encouraging that the different health care professionals and their relevant Boards to encourage cultural safety, Ahpra could do the same in terms of encouraging communication among the different professions. The relevant Boards could develop strategies for communication. It would be beneficial for Ahpra to encourage every professional group to be informed of the practices of each health profession to be able to integrate, complement and to achieve better and safer health care for the patients. This improves the continuity of care for patients in the scheme of the whole health care system. It is only when every professional group understands the other health care professions and communicates with each other that translations becomes understandable, workable and useful to each other. Keeping health records in English would be of no use to anyone, without that basic communication and understanding. Since the different Boards recognise education programs that meet certain criteria where candidates could seek registration, the Boards could stipulate the need for each profession to be informed of other health professions during the candidates' undergraduate education.

Question Six: Is the wording and language of the proposed revised guidelines helpful, clear, relevant and workable?

Yes / No
If No, please explain why
We do not believe that it is workable without knowing the needs of the non-English speaking practitioners and to consult with them directly. It is also not workable without communication with and understanding of the different professions.

Question Seven: Is there any content that needs to be changed or deleted in the proposed revised guidelines?

Yes
If Yes, please explain what should be changed.
We prefer Option 1 for the status quo to continue. However, we believe that this requirement for Chinese medicine practitioners to transition to English health records is still premature. If the requirements of these practitioners are understood, the content in Option 2 document would change. We believe that any statement regarding transition or insistence to keep health records in English have to be deleted for now. This would be consistent with other Boards' guidelines for patient heath records which have no additional language requirement imposed. Furthermore, English language requirement has been well defined by the English language skills registration standards under Ahpra.

Question Eight: The Board may consider developing supporting materials should the proposed revised guidelines come into effect. Which of the following, if any, would you like to see the Board develop? You may select multiple options.

Health record templates
Health record templates to a certain extent Given the current situation, we prefer Option 1 for the status quo to stay.

Question Nine: Are there any potential negative or unintended impacts that the proposed revised guidelines may have for Aboriginal and Torres Strait Islander Peoples?

Yes
If Yes, please explain what they may be.
It is acknowledged that the Aboriginal and Torres Strait Islander Health Practice Board of Australia does not have guidelines for patient health record in place. In a worst case scenario, those practitioners who were excluded out of the NRAS because they were unable to keep patient records in English could provide their health care to public without protected tiles, i.e. dry needling or selling herbs. Public including the First Nations people could face a substantial high safety risk.

Question Ten: The Board's Statement of assessment against Ahpra's Procedures for development of registration standards, codes and guidelines, included at Attachment B, identifies potential regulatory impacts from this proposal that the Board will take into account when considering whether to implement the proposed revised guidelines. Are there any additional potential regulatory impacts that the Board should also take into account?

There will be regulatory impacts with regards to the Board attempting to implement procedures in Attachment B requiring English health records to be kept by Chinese medicine practitioners who record in non-English languages. It would present a challenge to implement the change. If practitioners are unable to make the change there could be potential investigations by the Board resulting in expenditure of time and cost. The expected change could lead to practitioners leaving the profession and shrinking the number of registrants. The profession would also lose some of the best practitioners.
This proposal places additional English requirement to those registered Chinese medicine practitioners who have been imposed with English conditional requirement is inadequate. It allegedly breakdowns the registration condition set by the Board itself. It also substantially overrides the English language skills standards set by the Board in 2015 (English language skills registration only applies for initial registration). No additional language requirement should be imposed on any current registrants who have been renewing their registration annually. We have been concerned that English requirement on this proposal could be deliberately or undeliberately used as a tool to exclude those current registered Chinese medicine practitioners who have been imposed with English conditional requirement from NRAS. The history of the notorious Dictation test in White Australia should never ever happen again.

Question Eleven: Do you have any comments on the Board's Statement addressing Patient and Consumer Health and Safety Impact, included as Attachment C?

No

Question Twelve: Do you have any other comments on the proposed revised guidelines?

Comments are stated in the above questions. We prefer Option 1 for the status quo to remain.