

Beyond Survival: Clinical Competence, Professional Value and the Future of Chinese Medicine Education

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Abstract

Toby Daly's article in issue 141 of the *Journal of Chinese Medicine*, 'Chinese Medicine Education in Crisis: The Acupocalypse and the Path Forward', offers a timely and necessary account of the structural and financial pressures facing Chinese medicine education in the United States. This paper has been written in response to that article. It accepts Daly's financial diagnosis and call for structural redesign but argues that institutional survival is only half of the challenge. Beyond these financial and structural pressures lies a deeper crisis of clinical competence, educational quality and professional confidence – issues that must be addressed alongside structural reform. I propose a competency-value model of Chinese medicine education that combines leaner institutional structure with progressive clinical assessment, distributed but standardised apprenticeship, faculty development, professional-value training and transparent outcomes reporting. Such a model would give Chinese medicine education a path towards becoming not only more affordable, but also more clinically rigorous, professionally credible and publicly accountable.

Keywords

Chinese medicine education, acupuncture, clinical competence, professional value, competency-based education, faculty development

Daly's challenge



Since its publication in June 2026 in the *Journal of Chinese Medicine*, Toby Daly's article – 'Chinese Medicine Education in Crisis: The Acupocalypse and the Path Forward' – has prompted timely and vigorous discussion about the future of acupuncture and Chinese

medicine education in the United States. Daly clearly identifies the pressures confronting the field: declining enrolment, rising fees, unsustainable student debt, and the risk of losing eligibility for federal financial aid. These pressures are not merely prospective; several are already

reshaping the educational landscape. He is therefore right to argue that schools must become leaner and more adaptive – and more willing to reconsider inherited educational models.

Daly's proposal is especially valuable because it moves beyond diagnosis to offer a concrete model for reform: AI-first administration, reduced dependence on fixed-campus infrastructure and a distributed network for clinical training. Whether or not every element of the proposal is adopted, its central premise is sound. The profession needs more than an account of its difficulties; it needs workable models capable of reducing the institutional overhead that has made tuition increasingly untenable.

However, while Daly focuses his model on solving these structural and financial survival needs, we must recognise that institutional survival is not our only challenge. A school may keep its doors open and still fail in its central task. The deeper crisis facing Chinese medicine is educational and professional: an apparent erosion of clinical confidence and insufficient public recognition of its professional value. Schools do not exist simply to preserve themselves; they exist to form practitioners who can enter the clinic with skill, confidence and legitimacy. If graduates leave school underprepared for practice and enter a profession that is economically fragile and publicly uncertain of its worth, financial affordability and structural reform alone will not reverse the long decline.

Therefore, the present crisis must be understood in two interconnected dimensions. The first is institutional and financial, which Daly addresses through structural efficiency and reduced overheads. The second is clinical and educational, which requires a corresponding reform of professional training. Any durable model for the future must address both. At the centre of the educational challenge are two closely related priorities: clinical competence and professional value.

Clinical competency must come first

The purpose of professional education is not simply to deliver curriculum, accumulate hours and confer degrees. Its purpose is to form capable clinicians. That formation requires more than information. It requires the development of judgement, diagnostic clarity and technical precision, understanding of safety, communication skills

and the quiet confidence that comes only from meaningful preparation.

For too long, acupuncture education in the United States has been shaped primarily by licensure requirements. Board certification is necessary, but it marks only a threshold. It does not, by itself, guarantee sound clinical reasoning, accurate diagnosis or readiness for the realities of independent patient care. An acupuncture programme may satisfy accreditation standards, report respectable board pass rates, and still graduate students who do not

yet know how to meet a difficult patient with steadiness and skill.

This distinction is crucial. Written examinations are not the same as clinical competence. A student may memorise point functions, herbal categories and biomedical terminology and still

struggle to read a body, shape a treatment, or respond when the case begins to shift. Educational systems often drift towards what is easiest to measure. In acupuncture education, that too often means board performance. But what is easiest to measure is not always what matters most. What matters most is whether the graduate can practise well.

That is why the profession needs a more explicit commitment to competency-based education (CBE). Programmes should be judged not only by the hours they provide, but by the standard of practice their graduates can actually demonstrate. Stronger training would include repeated assessment throughout the programme: written examinations for foundational knowledge; oral examinations for clinical reasoning; practical assessments for technique and safety; objective structured clinical examinations (OSCEs); and final competency evaluations requiring students to demonstrate readiness for independent practice (Harden et al., 1975; Nyangeni et al., 2022). Objective structured clinical examinations are especially valuable because they place students in structured, real-time clinical scenarios where they must translate classroom knowledge into observation, judgement, communication and action under pressure.

While Daly rightly identifies that credential inflation has failed to guarantee clinical quality, his proposed model focuses almost exclusively on structural and technological survival. He leaves open the question of how a leaner school actually ensures clinical readiness. I argue that the answer cannot simply be fewer hours or cheaper tuition; it

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must be a fundamental pivot towards competency-based education. If schools are forced to become leaner, that reality makes competency standards more important, not less. Financial adaptation should not come at the cost of clinical seriousness. A leaner educational model will be credible only if it produces graduates whose practical ability is unmistakable.

The salary problem points to a deeper issue

The second issue is professional value. This must be defined carefully. Professional value means, first, the value of the profession to practitioners themselves: whether the work offers a viable, dignified and sustainable livelihood in return for the years and expense of training it requires. Second, it means the value of the profession to patients, communities and the wider healthcare environment: whether acupuncture and Chinese medicine are recognised as credible, effective, and worthwhile forms of care.

These two kinds of value cannot be separated. A profession cannot thrive if its practitioners cannot build stable lives within it. Nor can it thrive if the public, employers and other healthcare professionals remain uncertain about what it contributes. This is why the salary problem matters so deeply. Low compensation is not merely an unfortunate market outcome external to education; it is also a signal of how the profession's labour is perceived. Markets do not reward degrees in the abstract; they reward demonstrated and recognised value. Daly observes that newly licensed acupuncturists often enter the workforce at wages that compare poorly with those of occupations requiring less training. This disparity should prompt the profession to ask not only whether its practitioners are under-recognised, but also whether it has convincingly demonstrated the distinctive expertise they offer.

That question is uncomfortable, but it cannot be avoided. This is not an argument for reducing professional identity to economics. It is an argument for recognising that economic value is one visible expression of clinical and social value. If graduates are highly skilled, consistently effective and able to produce outcomes that patients and institutions can recognise, the profession's value becomes easier to defend. If they are not, its claims remain vulnerable, however sincerely they may be made.

Daly's model solves the debt-to-earnings crisis from

the supply side: by lowering tuition to \$15,000 a year, he makes a low graduate salary financially survivable. This is a vital structural intervention, but affordability alone is a defensive strategy. It will not restore a profession whose graduates continue to enter an under-rewarded labour market. If we accept low graduate earnings as an unalterable market reality, we miss a deeper signal: educational institutions have not yet demonstrated, consistently and publicly, outcomes that translate into stronger professional recognition. We must aim not just for cheaper education, but for education that actively elevates a practitioner's market value. Students are asked to invest years of graduate education and substantial debt. If the work awaiting them on the other side does not reflect that investment, declining enrolment is not mysterious. It is rational.

Educational weakness becomes professional weakness

The relationship between competency and value becomes clearer still when faculty culture and institutional life are brought into view. A profession that persistently under-rewards expertise risks losing it. If graduates enter a weak labour market, the effect does not end with them. Low professional salaries place downward pressure on teaching salaries as well. Schools then struggle to retain experienced clinicians, and the strongest faculty members leave for better-paid practice or other opportunities. In their place, institutions may come to rely more heavily on less experienced instructors or on teachers whose connection to contemporary clinical realities is limited.

The result may be a damaging feedback loop. Weak graduate earnings can contribute to poorly compensated

teaching positions; those positions may make it harder to retain experienced clinicians; the classroom can then become more theoretical and less connected to current practice; and the next generation may enter practice less prepared to earn trust and professional recognition. Salary,

faculty quality and educational decline should therefore be understood as interconnected rather than wholly separate problems.

This weakening of faculty expertise is compounded when institutions lose their connection to scholarship. A health profession's intellectual vitality depends on sustained engagement with research, critical inquiry and evolving

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clinical knowledge. When scholarship becomes peripheral, training risks hardening into habit, leaving students with two related deficits: insufficient clinical mastery and an educational culture that is less able to question, adapt and advance.

Together, these educational weaknesses help explain Daly's argument that declining enrolment may be more rational than mysterious. Prospective students are not merely responding to poor marketing; many are making a sober calculation about the cost and duration of education, uncertain professional outcomes and the salaries available to graduates. Their decision ultimately turns on a simple question: Is this path likely to provide a sustainable livelihood? Educational quality, professional opportunity and economic viability all appear uncertain, but the profession has yet to offer a sufficiently convincing answer.

A competency-value model

The next step is to pair institutional redesign with educational redesign. If the permanent-campus model is no longer financially sustainable, then the replacement cannot be judged only by whether it is cheaper but by whether it forms better clinicians and makes the value of Chinese medicine more visible to patients, employers and the wider healthcare system.

A practical path forward would be a competency-value model: a lean programme organised around demonstrated clinical ability, supervised practice, faculty development and measurable professional outcomes. Such a model would preserve Daly's emphasis on structural efficiency while adding a second requirement: the gains achieved through technical efficiency should strengthen clinical formation, not just to reduce operating costs.

1. Progressive competency gates: The curriculum should be built around progressive competency gates. Students advance not simply because they complete a term or accumulated hours, but because they demonstrate specific abilities: safe needling, accurate point location, coherent diagnosis and treatment planning, skilled patient communication and case management, and ethical clinical judgement. Written examinations would remain necessary, but they would be paired with oral case

examinations, practical technique assessments, objective structured clinical examinations and final readiness evaluations before independent practice.

2. Distributed but not diluted clinical training: Daly's distributed clinical network could preserve the benefits of apprenticeship while reducing institutional overhead, but it must not become an inconsistent collection of placements. The central school should serve as a quality-assurance hub, establishing shared standards for supervision, structured feedback, patient safety and clinical assessment across all sites. Standardised digital portfolios and case examinations could document students' progress and clinical reasoning. In this way, decentralised training can retain the value of local mentorship while ensuring consistent educational accountability.

3. Dedicated faculty development: Faculty development must become part of the model rather than an afterthought. If the profession wants excellent clinicians, it must also cultivate excellent teachers. Experienced practitioners should be trained and supported as clinical mentors, not merely hired as part-time instructors when institutional budgets allow. A leaner school should use its reduced overheads to protect the quality of teaching, supervision and scholarly engagement.

4. Direct training in professional value: Professional value should be taught directly. Students need more than clinical techniques; they need to know how to communicate outcomes, collaborate with other health professionals, educate patients, document care, understand practice economics and articulate what Chinese medicine contributes. These skills are not peripheral business concerns; they are part of how the profession earns trust and establishes value.

5. Public and transparent outcomes reporting: Finally, the model should call for schools to publish outcomes that matter. Schools can report directly on tuition, debt burden, board performance, supervised patient-care experience, employment pathways, and postgraduate mentorship. Measures such as graduate earnings, retention, patient-safety indicators and clinical competence assessment

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results will require shared definitions, regular reporting intervals, and, where feasible, independent verification. Transparency would help prospective students make informed decisions and would also require schools to remain accountable to the profession they claim to serve.

Beyond institutional survival

For all of the reasons detailed above, the profession does not simply need more graduates. It needs better formed ones. The central question is not how to preserve institutions at any cost, but how to design schools that produce clinicians of genuine calibre and help restore confidence in the profession's worth.

Daly is right to call for institutional innovation. Financial sustainability is indispensable, and schools must respond intelligently to demographic, technological and regulatory change. But innovation in structure is not enough. Chinese medicine education must also recommit itself to professional education through a concrete competency-value model that reduces unnecessary overheads while strengthening clinical assessment, mentorship, faculty quality and public accountability.

Chinese medicine education must aim at more than survival. It must unite financial sustainability with clinical excellence, and it must make professional value teachable, demonstrable and measurable. The question beneath the salary problem is whether the profession is producing graduates whose work is sufficiently distinctive and effective to command public trust and economic respect.

If these aims can be pursued together, the present crisis may yet become more than a struggle to keep schools alive. It may become an opportunity to build an educational model worthy of the medicine itself: lean enough to survive, serious enough to form excellent clinicians and transparent enough to earn the confidence of the next generation. 印

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