ORIGINAl RESEARCH

The contested space: The impact of competency-based education and accreditation on dietetic practice in Australia

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Abstract

Aim: Competency-based Education (CBE) has underpinned the education of dietitians in Australia since the first Competency Standards (CS) were published; however, little is known about how CBE has influenced dietetic practice. The aim of this paper is to explore how a CBE framework and the CS have influenced dietetic practice in Australia since 1990.

Methods: A qualitative investigation explored concepts of dietetic practice. Data analysed were original interviews previously undertaken with recent graduate dietitians during 1991 (n = 26), 1998 (n = 23) and 2007 (n = 19) and seven guided discussions with dietitians and employers (n = 28) conducted in 2014 to identify themes. The DAA Competency Standards and Accreditation Manuals/Standards since 1990 were also analysed to triangulate the interview data and to investigate how the CS were interpreted.

Results and Conclusions: Themes identified from interviews included: (i) communicating for better care, (ii) scientific enquiry for effective practice, (iii) critical thinking and evidence-based practice and (iv) professionalism, which remained core to dietetic practice over time, but leadership, advocacy, business management and entrepreneurial skills have emerged more strongly as the scope of practice has diversified. The landscape in which dietitians’ practice showed increasing complexity and clear boundaries separating professional roles were disappearing. The 2015 CS and the 2017 Accreditation Standards highlighted that competency remains a shifting construct and that professional behaviours change depending on economic and political reasons in the play of power. Accreditation policy and current standards have successfully maintained a standard of dietetic practice across a diverse country but have the potential to constrain innovation.

Key words: accreditation, competency standards, competency-based education, dietetics, professional competence, qualitative evaluation.

Introduction

Competency-based education (CBE) has underpinned the education of dietitians in Australia since the publication of the first Competency Standards (CS)1,2; however, little is known about how CBE has influenced dietetic practice. The apprenticeship nature of dietetic education prior to 1993 was time-dependent; if a student did the practice required, it was assumed they were competent. This is in direct contrast to the CBE approach introduced after 1993, where students were required to demonstrate competence before successfully completing the degree. CBE is outcome-focused, requiring the measurement of adequate performance in the workplace. CBE is defined as education for a prospective or actual role in society and focuses on demonstrated performance, de-emphasising time-based education and providing portability between practice contexts. It gained greater focus with the rise of behaviourist theories in the 1960s and 1970s,3 and the development of CS or frameworks for use by different professional groups is one outcome of CBE. In 1989, the Australian Government embarked on a reform process for recognising overseas trained professionals and, less obviously, reform of professions, making them more prepared for future globalisation.4 Dietetics was one of the first professions to develop CS,5 and Australia was one of the first countries to have published CS for dietitians.1

CBE, however, remained controversial. Criticism was widespread in universities, partly because CBE had arisen in vocational education.6 It was argued that competencies
were reductionist and ignored the high level of knowledge required for professional practice. Alternatively, without assessment of individual performance in the workplace, aspects of professionalism and context-specific complexity were difficult to assert by purely testing knowledge. Skills acquisition has been described as a complex interplay of knowledge, skills and attitudes and does not necessarily progress along a linear trajectory. Hodges argues that competency is not a fixed entity; it changes over time and contexts. It may also be designed for one purpose but used for another. Despite these limitations, CS and CBE contexts. It may also be designed for one purpose but restrict innovation. The accrediting bodies, the professional community and educators need to have a shared understanding of CS, but this can be challenging, especially if the accrediting body holds power over the credentialing process.11 The accrediting body protects the profession from well-meaning but often misguided views about education but may also inadvertently restrict innovation.11 The accrediting bodies, the professional community and educators need to have a shared understanding of CS, but this can be challenging, especially if the accrediting body holds power over the credentialing process.11

The aim of this research was to explore how a CBE framework influenced CS and their application and how this influenced dietetic practice in Australia since 1990.

**Methods**

A qualitative investigation was used to explore concepts of dietetic practice. Data analysed included all interviews that were previously undertaken with recent graduate dietitians during 1991 (n = 26), 1998 (n = 23) and 2007 (n = 19) and guided discussions (n = 7) conducted in 2014 with a variety of experienced and recent graduate dietitians and employers. These interviews and discussions were conducted as part of the development (1991) or review (1998, 2007, 2015) of the DAA CS. The methodology and ethics for the collection of the interview data have been previously published in 1993, 1998, 2007, 2015,13 but broadly, the methods used a mixture of functional analysis techniques and critical incident reflections to define the major work roles, key tasks and activities of the profession.

Table 1 describes the demographics and methodology used in each of the studies.

Three experienced qualitative researchers, two of whom have had a significant stake in CS development and publication (SA, CP), re-analysed the original transcribed interviews with a view of constructing a narrative of how practice has changed over time and exploring the discourse of how competence was constructed. Only one researcher was previously involved in all the analyses. The third researcher had not been involved in any of the initial analyses, CS development or review and provided an independent view. Three transcripts from different time points were analysed by all three researchers to identify broad concepts emerging from the data, which were then independently summarised and discussed, and a coding framework describing broad themes was constructed. These discussions also supported researcher reflexivity in that individual interpretation was critically reviewed with peers and additional interpretations explored. The consistency of coding of these transcripts allowed the remaining transcripts to be allocated proportionately for analysis using the framework. Thematic analysis for data saturation was applied. Themes were viewed within time frames and across the time frames (longitudinally) for all data collected using the coding framework. Quotes were used to illustrate each of the themes.

In addition, a content analysis of the DAA CS documents (1993, 2009, 2015) was conducted by the first author to

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**Table 1** Demographic information of dietitians interviewed, 1991–2014

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<tbody>
<tr>
<td>No. of participants (n)</td>
<td>26</td>
<td>23</td>
<td>19</td>
<td>28</td>
<td>20 experienced, 8 recent graduate (focus groups)</td>
</tr>
<tr>
<td>Years of practice (median &amp; range)</td>
<td>0.25–1</td>
<td>0.5–1.5</td>
<td>0.75–2</td>
<td>67 (Delphi)</td>
<td></td>
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<tr>
<td>Sampling method</td>
<td>Purposive Critical incident interview</td>
<td>Purposive Description of core activities</td>
<td>Purposive Critical incident interview; Description of core activities</td>
<td>Review existing competency standards; Validate revised competency standards</td>
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<td>Type of data collection</td>
<td>Purposive Critical incident interview</td>
<td>Purposive Description of core activities</td>
<td>Purposive Critical incident interview; Description of core activities</td>
<td>Review existing competency standards; Validate revised competency standards</td>
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<tr>
<td>Purpose of study</td>
<td>Validate original competency standards</td>
<td>Review existing competency standards</td>
<td>Review existing competency standards</td>
<td>Validate revised competency standards</td>
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<tr>
<td>Focus group</td>
<td>Experienced 6–34</td>
<td>Recent graduate &lt;1</td>
<td>Delphi 4–40</td>
<td>Iterative, multiple methods</td>
<td>Guided discussion, Delphi questionnaire</td>
</tr>
<tr>
<td>Recent graduate &amp; employers</td>
<td>67 (Delphi)</td>
<td>28</td>
<td>20 experienced, 8 recent graduate (focus groups)</td>
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verify if the interview data identified themes over the same time period as the interviews. Accreditation Manuals/Standards documents were also analysed to assist in the interpretation of and to triangulate the interview data and investigate how the CS were interpreted in curriculum design and practice placement as part of accreditation. This involved initial familiarisation with the content, followed by verification of themes identified in the interviews with these sets of documents. Particular attention was paid to themes identified in the interviews that were not reflected in either the CS or the Accreditation Manuals/Standards. The findings were used to assist interpretation of thematic analysis of the interview data and are therefore reported in the discussion.

Results

Themes identified from interviews are followed by themes identified from the CS documents. A summary of the units or domains of practice in the National Competency Standards for Entry Level Dietitians is shown in Table 2. In 2015, the words 'Entry Level' were removed from the title. Wording from Accreditation Manual/Standards was used to highlight themes from the interviews and how the interpretation of the accreditation process may have influenced the interpretation of the CS over time.

Four core themes emerged from the interviews: (i) communicating for better care, (ii) scientific enquiry for effective practice, (iii) critical thinking and evidence-based practice and (iv) professionalism. However, the contexts in which dietitians were working changed dramatically between 1991 and 2017 (Figure 1). New themes of leadership, advocacy, entrepreneurship and business management became more prominent from 1998 but were ultimately grouped under professionalism in 2015 (Table 3).

Communicating for better care, as part of the therapeutic relationship, remained a central dietetic role. The communication skills of dietitians, however, evolved from educating patients (1991) to negotiating in partnership not only with patients/clients but with other stakeholders. The emergence of a social model rather than a medical model of health was evident, with more sophisticated methods of client engagement occurring.

‘Empowering a resident or client that we’re seeing, or whether it is empowering the food service staff to adjust to new systems to essentially impact all residents, it’s really the same thing’. (Focus group 4, 2014)

The CS reflected the change in emphasis of this communication theme from ‘Interprets and translates nutrition information’ (1993) to ‘Collaborates broadly with clients and stakeholders’ in 2015.

Scientific enquiry and problem-solving skills for effective practice, using the nutrition care process, were central to dietetic practice over time. The key skills of assessing nutrition needs, planning and providing a nutrition intervention and evaluating outcomes were evident across all time points. As practice became more complex, this

Figure 1  Emerging roles at each stage of the Competency Standards development and review.
approach extended to quality assurance, accessing funding and program planning.

‘I also need to be able to write proposals, whether that be program proposals or fee proposals to various bodies, …, and that’s part of ongoing funding, …, and tender-writing, and things like that’ (Tape 3, New graduate(NG), 2007)

The CS reflect a shift in scientific enquiry from a data manager who ‘Collects, organises and assesses data relating to the nutritional status of individuals and groups’ to a broad, outcome-focused practitioner with influence who ‘Positively influences the health of individuals, groups and/or populations to influence positive outcomes’.

Critical thinking and evidence-based practice became more dominant over time. The advent of computerised information in the mid 1990s and access to databases for quality assurance purposes, food analyses, online professional journals and other information contributed to this. Interviewees in the 1990s expressed their frustration at not being able to access the correct information, whereas this had changed by 2007, where not finding the correct information would have been considered incompetent.

‘…lack of consultation would be incompetent. Not also using accurate nutrition information, so not looking at the literature or current guidelines to guide your nutrition messages’. (CI5, NG, 2007)

Research enquiry in the CS of 1993 reflected the limited resources for practice-based research ‘Demonstrates basic skills in research and evaluation’, which changed significantly by 2015 to ‘Applies critical thinking and integrates evidence into practice’.

Professionalism was a core theme throughout. Professional practice and personal development were listed as part

| Table 2 | Main domains or units of competency, 1993–2015 |
|---|---|---|---|---|
| Demonstrates knowledge sufficient to ensure safe practice | Underlying knowledge | Underlying knowledge | |
| Interprets and translates scientific knowledge and principles related to nutrition into practical information | Interpretation of nutritional information into lay language | Nutrition Communication | Collaborates with clients and stakeholders |
| Collects, organises and assesses data relating to the health and nutritional status of individuals and groups | Collection, analysis & assessment of nutrition & health data | Collection, analysis & assessment of nutrition & health data | |
| Manages nutrition care for individuals | Individual case management | Individual case management | Positively influences the health of individuals, groups and/or populations to achieve nutrition outcomes |
| Manages components of programs that deal with nutrition issues in the community as part of a health-care team | Population health | Community and Public Health Nutrition and Advocacy for Food Supply | |
| Influences and contributes to activities promoting a safe and nutritious food supply | Influencing food supply | Food Service Management | |
| Demonstrates basic skills in research and evaluation | Scientific approach | Research & Evaluation | Applies critical thinking and integrates evidence into practice |
| Demonstrates an organised, professional and ethical approach to work | Professionalism within organisation | Management & Organisation | Practices professionally |
| | | Professionalism and Leadership | |

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of the Core Competency Areas in 1991\(^5\); however, the concept of professionalism has changed. The emergence of cultural competency and the formalisation of continuing professional development and mentoring were evident from 1998.

The emphasis on the professionalism-type competencies need to be greater … It should focus less on things that dietitians do, to actually function in a practice environment’ (FG4, 2014).

This theme was also reflected in all versions of the CS, changing from ‘Demonstrates an organized, professional and ethical approach to work’\(^4\) to ‘Practices professionally.’\(^2\)

Table 3 Themes from Interviews

<table>
<thead>
<tr>
<th>Themes</th>
<th>Domains of Competency</th>
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<tr>
<td><strong>Communication for better care</strong></td>
<td>Interprets and translates scientific knowledge and principles related to nutrition into practical information</td>
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<tr>
<td>Manages nutrition care for individuals</td>
<td>Individual case management</td>
</tr>
<tr>
<td>Manages components of programs that deal with nutrition issues in the community as part of a health-care team</td>
<td>Population health</td>
</tr>
<tr>
<td>Influences and contributes to activities promoting a safe and nutritious food supply</td>
<td>Influencing food supply</td>
</tr>
<tr>
<td><strong>Scientific enquiry for effective practice</strong></td>
<td>Collects, organises and assesses data relating to the health and nutritional status of individuals and groups</td>
</tr>
<tr>
<td><strong>Critical thinking and evidence-based practice</strong></td>
<td>Demonstrates basic skills in research and evaluation</td>
</tr>
<tr>
<td><strong>Professionalism -Leadership and advocacy</strong></td>
<td>Demonstrates an organized, professional and ethical approach to work</td>
</tr>
<tr>
<td><strong>Entrepreneurship and business management</strong></td>
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</table>

Other themes that emerged more strongly over time and are listed below were eventually grouped under professionalism in 2015 (Table 3).

**Leadership and advocacy** has become more evident. Dietitians in 1991 saw their role in acute care as advocating for their professional status. In 1998, dietitians advocating for the patient emerged more strongly as a key task. In 2007, it was clear that a more systems-based approach was taken. In 2015, there was a return to a focus on where the profession sits amid a plethora of competing demands in the workplace. The emergence of access to online information by members of the community, together with conflict over which work roles were valued within the profession, posed a risk to professional credibility. Dietitians were no
longer seen as the first point of contact for nutrition information.

‘We’re not really seen as the experts all the time, because there’s all this online stuff … no one wants to listen to me, because they’ve read something online that they think is more credible.’ (Focus Group 2, NG, 2014)

In contrast, this was also viewed as an opportunity to move away from traditional patient care to other roles in the community, including the online community and other settings in which dietitians had not been traditionally employed. This was occurring as early as 1998.

‘I also do web development as well, so I’ve got a website up and running… Just general communications, making sure, you know, advertising gets out… trying to reach people’ (Tape 17, NG, 1998)

The need for CS to keep up with these social changes was reported to be essential.

The 2009 CS16 include the added words around advocacy in the domain, ‘Demonstrates professional, organised and ethical approach… advocating for excellence in nutrition and dietetics’; however, in 2015, this is assumed in the body or elements of the CS, with words such as ‘positively influences’, ‘builds capacity’ and ‘actively promotes, under ‘Collaborates with clients and stakeholders’.2

Entrepreneurship and business management emerged as more dietitians graduated, and traditional employment avenues decreased. The scope of dietetic practice has expanded from being largely in acute care, hospital-based community dietetics or small private practice in 1991, with emerging health promotion roles in 1998, including employment in government public health organisations, non-government organisations, food industry and research. From 1998, graduates still reported having mainly individual client care within their working portfolio, but the data showed there was scope to broaden this using marketing and other entrepreneurial skills.

‘… while we don’t make a profit, we do actually have to run at cost price..., so sometimes we can get funding from third parties, for example, the Outback Division. Other times, places like AMS, so, Aboriginal Medical Services, pay for our time or, … other things. So it all sort of needs to be negotiated, which can sometimes be quite frustrating’ (Tape 3, NG, 2007).

The 2009 CS16 included a separate domain on business and management skills reflecting this theme; however, it was subsumed into mainstream practice and incorporated into the ‘Practices professionally’ domain in 2015.2

The emergence of multidisciplinary teams initially provided a clearer role for the dietitian as part of an allied health discipline. However, as scope of practice changed for all health disciplines, this also provided challenges.

‘I think the job market is changing, …there’s been a lot of cuts and they’re not employing more dietitians, so we have to branch out into other work areas… we’re working more broadly than in just that clinical area now’. (Focus Group 1, NG, 2014)

Frustrations were voiced across all data points about the way the practice placement program was organised, with a lack of understanding about the connection between placement experience and employability. There was also frustration expressed about the over-reliance on the acute hospital setting experience.

‘I was being pushed into a clinical area when I didn’t really want to go into a clinical area… They wouldn’t let me have a placement in private practice, even though I lined it all up and I suppose I always had problems with that’ (Tape 22, NG, 1998).

The Accreditation documents prescribe placement requirements and have done so since inception. Despite a competency framework suggesting that competence is not time-dependent, the requirement for 100 days of placement practice was retained through all versions and in keeping with international standards.18 How these days are allocated was linked to the earlier versions of the CS, which clearly stated three domains of practice, individual medical nutrition therapy, food service management and community/public health nutrition. With the change in emphasis of the current CS,2 these domains were given less emphasis in the current Accreditation Standards.10

‘The University must ensure the dietetics education program includes a Professional Placement Program, the duration of which must be a minimum of 100 equivalent working days’ (Standard 5, p.10).

All Accreditation Manuals included a section on Core Fields of Study up to 2015. These were based on the CS up to 2015, which included a unit or domain ‘Demonstrates knowledge sufficient to ensure safe practice’ (Table 2). Increasing details of how to assess competence via range variables and evidence were included in 200619 but were removed in 2011 and published as a separate document for assessment purposes.19 Subsequently, the concept was absorbed into the 2015 CS.2

The earliest Accreditation Manual7 recognised the need for universities to retain their independence to innovate curriculum as practice evolved.

‘The nature of many jobs in public and private industries is undergoing change … a trend to flexibility and versatility underlies this change. … It is desirable that the profession develops … with a common core of training and a broad common vocational purpose’ (Section 2, p.1).7

Accreditation Manuals continued to include a section on the philosophy of education for dietitians acknowledging the changes in the health-care environment; however, in the now renamed Accreditation Standards,10 this has been replaced with a governance section, heralding a more
regulatory approach. A series of standards must now be met, which detail:

‘the minimum requirements that Universities need to demonstrate to gain accreditation for their Dietetics education program(s) and that Universities must continue to meet to maintain their accreditation’ (Introduction p.4, 2017). 10

The 2014 interviews and focus groups asked participants to comment on the purpose and work roles of dietitians and whether they had issues with the current CS.

‘I think the real standout of being a dietitian is having that scientific background. It gives you that grounding to understand the role of food in health’. (FG 2, 2014)

The requirement for dietitians to have prerequisite bioscience training appears in all accreditation documents. In the 201710 Standards, the specific timing and volume of chemistry, biochemistry, biology and physiology within the undergraduate curriculum is required.

‘Dietetics is the application of science in nutrition and dietetic practice, and its study is based on Human Biosciences and Food and Nutrition Science, taught within an evidence-based paradigm’. (Standard 4, p9)

The application of medical nutrition therapy to individuals is a key feature in differentiating dietetics from nutrition. The 2011 Accreditation Manual,9 in spelling out the key purpose of the profession of dietetics, also defines the difference between a dietitian and nutritionist.

‘The key difference between a dietitian and a nutritionist is that, in addition to or as part of their qualification in human nutrition, a dietitian has undertaken a course of study that has included substantial theory and supervised and assessed professional practice in medical nutrition therapy (individual case management) and food service management in addition to assessed and supervised professional practice in community and public health nutrition’ (Section 1, p. 3).

While this statement no longer forms part of the Accreditation Standards, it is clearly stated in the preamble to the 2015 CS.2 The discussion weaves together these two sets of data.

**Discussion**

The present study aimed to explore how a CS and CBE framework has transformed dietetic practice and culture in Australia from 1990 and what factors have influenced their interpretation. It found that (i) communicating for better care, (ii) scientific enquiry for effective practice, (iii) critical thinking and evidence-based practice and (iv) professionalism remained core to dietetic practice over time, but leadership, advocacy, business management and entrepreneurial skills have emerged more strongly as the scope of practice has diversified. The theme of professionalism, leadership and safe practice became much more dominant, in line with generic competencies across the health domain.20 The terminology of the CS suggests a greater sophistication and diversity of practice as time progressed (see Table 2). Throughout this time, however, generalist practice with stated domains in individual client care, food service management and program planning in community and public health was evident across all versions up till 2015. These domains were removed in the latest CS, which assumes that this generalist practice and preparatory education can be integrated and is reflected in the 2017 Accreditation Standards.10

The distinction between credentialing, competency and capabilities, where qualifications define the scope of practice of an allied health practitioner (credentialing), whereas the knowledge and skills required to perform in the workplace (competency) will reflect that particular workplace context, has been clearly articulated.21 Credentialing requires a minimum standard of practice, and in the past, the DAA CS have been used in this way for accreditation. Greater understanding of the dynamic nature of practice has meant that the words ‘entry level’ have been removed from the 2015 CS, indicating that the CS are not minimum standards but reflect a continuum of practice.13 Nonetheless, Accreditation Standards continue to influence how competency is interpreted and assessed in curricula.

National registration of health professionals in Australia has embodied a flexible but quality and safety focus, reflecting the increasing complexity of health practice and workforce requirements.22 There has been a liberal approach to health profession education and little government regulation of entry points to professional programs. Universities must negotiate practice placements with brokers affiliated with health service providers, often at a cost. Demand-driven policy in universities has allowed large intakes of students who continue to have an interest in nutrition and dietetics. Nutrition and dietetics academics have struggled to provide the practice placements a CBE approach might dictate because the full cost of this is not covered by the university fees. How CS were applied in curriculum and the power held by DAA’s Australian Dietetic Council (ADC) to withhold accreditation status and thus entry into the professional association increased as dietetic education programs proliferated.

The earliest versions of the Accreditation Manual did not specify resources required to conduct programs nor did it specify how placements would be conducted or assessed but rather held a view, perhaps naïve in retrospect, that academic independence was paramount.

Course directors of dietetic programs up until the 1990s were medical nutritionists or biochemists rather than academic dietitians. The expansion of the profession and the proliferation of dietetic programs saw the emergence of dietitian educators with higher qualifications in control of the curriculum and with increasing expertise in clinical education research and CBE. Despite this, the curriculum remained committed to the evidence-based medical model and its underlying scientific paradigm. The rules most clearly articulated in the Accreditation
documents revolve around the science required to practice as a dietitian and the number of days of practice placement.

Power describes how dietsitans using the medical model have little real influence relatively and thus promoted a positivist, reductionist model of medical nutrition knowledge. This sets them up as the nutrition experts against the embodied knowledge of patients and clients. Clinging to knowledge informed by the rationalist medical model and scientific paradigm may therefore have unexpected negative consequences.

Professional identity remained a key theme, described by participants in 2014 as the emergence of online ‘fake’ practitioners. They expressed their frustration that as the experts in nutrition, they were not being given the same credence as nutritionists with limited training. On the other hand, they commented that acute care clinicians were rated more highly within the profession, a type of professional hierarchy that was unhelpful when there was so much work to be done in the wider community. There are opportunities for the profession to look more broadly at the links between nutrition science and dietetics, embracing some of the ideas suggested recently in Great Britain, where the two professions join in partnership. Leadership and advocacy continue to be strong themes in Australian dietetic practice and have now been clearly articulated between proficient and advanced practice.

The landscape in which dietitians practice showed increasing complexity, and clear boundaries separating professional roles were disappearing. Despite this, the data supported the notion that dietitians are scientists who understand the role of food in health and use evidence to provide food as a medical nutrition therapy. This understanding and evidence is increasingly applied to policy. What appeared to be missing was a focus on other forms of evidence to better understand how individuals view nutrition and food in a world of ready access to the internet for consumers and social media to spread unscientific information.

The 2015 CS and the 2017 Accreditation Standards highlighted that competency remains a shifting construct and that professional behaviours change depending on economic and political reasons in the play of power. In publishing the current Accreditation Standards and evidence guide, the ADC, as the dietetic profession’s accrediting body, has responded to the 2015 CS, removing some barriers such as the domains of practice placement but not the time required for placement, which a true CBE approach would suggest. Other conditions of accreditation, such as the underpinning bio-science requirements, remain as a safeguard to the modern definition of dietetics and in keeping with international standards. Current limits on courses via the Accreditation Standards may also reflect political pressure in gaining health professional registration. These limits may constrain innovations educators wish to introduce, with an eye on future changes in the health workforce.

Lukes describes power as three dimensional: those who have the authority to make the rules; the rules that subordinates choose to follow; and contestable power, which is where those following the rules contest their viability. He suggests that having power means being able to resist it as well as use it. Thus, the three-way dialogue between the profession, educators and accrediting bodies potentially becomes a contested space. Hodges suggests that competency will always be affected by different and dominant discourses, but the centrality of context and the importance of multidimensional thinking remain essential in understanding its interpretation.

A profession’s role is to reflect practice but also envision how that practice may evolve. Educators then need to translate that vision into needed competencies via an educational plan. The accreditors’ roles are to uphold, to the profession and its stakeholders, what is needed in quality preparation. The challenge is for the accrediting body to promote not just quality assurance but, more importantly, quality improvement. This can only occur when there is a true partnership and dialogue that includes all three stakeholders.

The strengths of this research include the triangulation of data from interviews and documents of the CS with Accreditation Manuals/Standards over a 25-year time period. It provides insight into how emphasis may change when a CBE framework is applied in practice. Limitations may include the authors’ previous experience with the data and analysis, which may have introduced some bias. Every attempt was made to acknowledge this through researcher reflexivity. Further research involving the application of CS to curriculum and accreditation processes and how these manifest to improve the quality of the profession and ensure client and community safety is recommended.

Our research has identified different issues influencing dietetic practice in Australia. The influence of CBE has promoted an outcome learner focus from 1993 onwards, and the research behind each review of the CS has provided rich data to describe changes in the working and professional lives of dietitians over that time period. CBE continues to influence curriculum and particularly assessment and accreditation policy. Dietetics, although a small profession, has continued to remain dynamic despite restrictions in public sector employment, contributing to the profession growing and remaining sustainable. Accreditation policy and current standards have successfully maintained a standard of dietetic practice across a diverse country but have the potential to constrain innovation. The CS provide a framework for the interpretation of practice, and the rigorous review of CS over time using methodology to provide a voice for practicing dietitians is recommended. Further exploration of the culture of the profession into the future as the role becomes more diverse and less medicalised is warranted.

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Conflict of interest

The authors have no conflicts of interest to declare.

Authorship

Susan Ash collected and analysed the data and wrote the manuscript. Claire Palermo and Danielle Gallegos analysed the data and participated in writing and revising the manuscript.

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