COUNCIL OF ACUPUNCTURE AND ORIENTAL MEDICINE ASSOCIATIONS

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August 18, 2003

Michael E. Alpert, Chairman
Little Hoover Commission
925 L Street, Suite 805
Sacramento, California 95814

Dear Chairman Alpert:

Thank you for the opportunity to represent my profession in this very important review.

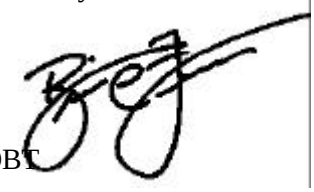
The practice of Oriental medicine can be dated back at least two millennia in China, Korea, Taiwan, and other Asian countries, where it is still practiced by doctors of Traditional Chinese Medicine and Doctors of Oriental Medicine. These doctors participate as integrated primary health care practitioners whom the public can visit to gain access to their health care systems. During the 1970s, China took local healers from the countryside and retrained them as "Barefoot Doctors" in order to provide their large population with access to basic health care services. Since that time, those practitioners have been systematically replaced by trained graduates of professional colleges of Traditional Chinese Medicine, where programs require five to six years to complete.

Since the 1970s, when President Nixon normalized relations with China, Asians have been emigrating to California and other parts of the United States, and have included highly trained practitioners who had aspirations of bringing their trades to this country. State after state adopted registration or licensing laws for the practice of acupuncture and Oriental medicine, initially as acupuncture-only practitioners who require a physician referral, and later, as primary health care practitioners who diagnose, prescribe, and treat. Treatments include a myriad of procedures and techniques whose origins can be traced to Asia and which have been finely tuned by centuries of experimentation and practice.

In the early 1990s, after obtaining relatively broad scopes of practice, and after being included in both private and public health insurance, the Licensed Acupuncturist profession and its affiliated stakeholders agreed that the acupuncture and Oriental medicine schools needed to improve upon our educational standards, and that we should work together to create and adopt a professional doctorate degree for entry into the profession. This new standard would be similar to the internationally-recognized educational standards of China, Korea, and Taiwan, as well as those of the United States, where other primary health care professions also require four or more years of specialized training.

Now, we are facing a challenging review of our profession, and hopeful that the outcome will be beneficial to both our profession and to our patients. As a representative of our profession, I have made the following comments on questions posed to us by the Little Hoover Commission.

Respectfully submitted,



Brian C Fennen, LAc, QME, OBT

Scope of Practice for Acupuncturists

Summary: The Acupuncture Licensure Act (Business and Professions Code, Sections 4925-4979) authorizes acupuncturists licensed by the Acupuncture Board to use acupuncture and other holistic procedures of oriental medicine to modify pain, treat disease, normalize physiological functions, and to promote, maintain, and restore health. The Act prohibits non-licensees from practicing acupuncture or from claiming to practice acupuncture, oriental medicine, or Chinese medicine. There have been a some problems and challenges caused by a lack of specific inclusion of the term "diagnose" in the Acupuncture Licensure Act, the arbitrary prohibition against performing disability determinations for injured workers, and by the misleading nature of the "Acupuncturist" title. SB 1951 requested that the Little Hoover Commission to "***review and make recommendations on the scope of practice for acupuncturists.***"

Recommendations

At this point in time, it would be beneficial to change the licensing title to include the words "**Oriental Medicine**." Oriental Medicine is the scope of practice that Licensed Acupuncturists in California practice, and the use of the "Acupuncturist" title continues to mislead the public. In some other states, the licensing title is "**Doctor of Oriental Medicine,**" which recognizes both responsibility and scope of practice. Many states, like California did in the past, continue to use the title "Acupuncturist" to describe practitioners who cannot diagnose, prescribe, or use modalities other than acupuncture and moxibustion.

The term "diagnose" should be added to the statutory scope of practice. Because the term is currently lacking, insurance companies frequently challenge reimbursement for evaluation and management services and referrals, diagnostic labs sometimes chose not to perform lab tests for patients of acupuncturists, and some schools avoid providing adequate clinical application of diagnostic procedures and responsibilities. The use of the title "Acupuncturist" continues to cause people to think of the profession as technicians, and not as diagnosticians.

The "disability determination" limitation should be removed from the Labor Code. Section 3209(e) of the Labor Code that has been interpreted to prevent Acupuncturists from performing "**disability evaluations**" for injured workers. While this law does not outright prohibit the performance of disability evaluations, and while disability evaluations performed by acupuncturists have been no less reliable that those performed by medical doctors or chiropractors, and while there is no such limitation outside of the Labor Code, employers' and their insurance carriers challenged and delayed cases on these grounds so many times, that the Industrial Medical Council decided to outright prohibit acupuncturists from performing disability evaluations as of January 2001.

The Labor Code requires acupuncturists, medical doctors, chiropractors, and others to perform the routine functions of a "treating physician," including diagnosing, treatment planning, determination of disability, and other responsibilities, yet this conflicting law prevents even those who have passed the

Industrial Medical Council's Qualified Medical Evaluator exam from performing disability evaluations within the Workers Compensation system. Since there is no such limitation outside of the Labor Code, there should be none within the Labor Code.

The profession has attempted to change this law through legislation, offering 300 hours of post-graduate training in addition to the passage of the Industrial Medical Council's QME exam as a pre-requisite. However, physicians who specialize in "industrial medicine" have opposed this change with claims that it would "expand the scope of practice for acupuncturists to include (competition for the performance of) disability evaluations."

Acupuncture point injection therapy should be added to the scope of practice. This procedure uses a limited pharmacy of analgesic drugs, sterile herbal, vitamin, and saline solutions to treat local pain. Point injection therapy is included in the scope of practice of at least five other states, two of which require additional certification. Similar certification should be an additional requirement in California. The New Mexico Acupuncture and Oriental Medicine Practice Act (Chapter 61, Article 14A, NMSA 1978) and its related board rules could be used as a model, as they set standards for training in this specific subject.

The Acupuncture Board should consider codifying some definitive scope of practice terms into their regulations, if there continue to be challenges from competing interests. At the very least, they should be allowed, and encouraged to include newer techniques of Oriental medicine, such as injection point therapy, and to set the standards for such minor expansions of the scope of practice.

For the benefit of persons not familiar with the practice of acupuncture and Oriental medicine, the following contains brief summaries of selected sections of the Acupuncture Licensure Act, followed by the actual language from the Business and Professions Code.

Legislative Intent

Section 4926 describes the Legislature's intent to regulate "acupuncturists" as a primary health care profession comprised of practitioners of the holistic arts and sciences of oriental medicine who strive to eliminate the causes of illness, and to establish an initial "framework"for such regulation through the regulation of the technique of "acupuncture."

4926. In its concern with the need to eliminate the fundamental causes of illness, not simply to remove symptoms, and with the need to treat the whole person, the Legislature intends to establish in this article, a framework for the practice of the art and science of oriental medicine through acupuncture.

The purpose of this article is to encourage the more effective utilization of the skills of acupuncturists by California citizens desiring a holistic approach to health and to remove the existing legal constraints which are an unnecessary hinderance to the more effective provision of health care services. Also, as it effects the public health, safety, and welfare, there is a necessity that individuals practicing acupuncture be subject to regulation and control as a primary health care profession.

Definitions

Section 4927 defines "acupuncturists" as those licensed under the provisions of the

Acupuncture Licensure Act, and defines acupuncture, electroacupuncture, moxibustion, and cupping as procedures used to modify pain, treat disease, and normalize physiological functions.

4927. As used in this chapter, unless the context otherwise requires:
(a) "Board" means the Acupuncture "Board".
(b) "Person" means any individual, organization, or corporate body, except that only individuals may be licensed under this chapter.
(c) "Acupuncturist" means an individual to whom a license has been issued to practice acupuncture pursuant to this chapter, which is in effect and is not suspended or revoked.
(d) "Acupuncture" means the stimulation of a certain point or points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain diseases or dysfunctions of the body and includes the techniques of electroacupuncture, cupping, and moxibustion.

Scope of Practice

Section 4937 specifically authorized acupuncturists to practice acupuncture and to prescribe and perform the various modalities of Oriental medicine, but does not prohibit others from doing so. Authorization to diagnose was interpreted to have been added when the physician referral was removed in 1979, and an acupuncturist's scope of practice was expanded to include modalities other than acupuncture.

"Diagnosis" is used as a standard practice by all primary health care practitioners for the determination of treatment options that are based upon commonly accepted standards of medical care and necessity, and as a common language use for describing a person's medical condition. People sometimes see an acupuncturist for general well being and health advice, but most visit acupuncturists to be treated for specific conditions, both acute and chronic. Acupuncturists make routine internationally-recognized diagnoses (ICD-9), and additionally attempt to categorize patients' symptoms into any number of traditional oriental disease patterns identified as affecting the functions of organs, the circulation of nutrients, and other classifications, in order to identify the best method of treatment, referral, and/or co-managed care.

"**Oriental massage**" is the generic term used to describe a wide variety of simple, complex, and combination techniques of manipulation that have evolved and been practiced as an art, science, and profession in China over the past three millennia. Oriental massage, more commonly known as "**Tui Na**," often combines manual therapy with passive and active movement and exercise. **"Acupressure"** is simply the digital or mechanical manipulation of acupuncture points without the use of needles, and was added to the scope of practice in 1985, in order to differentiate it from complex "oriental massage" techniques.

"**Exercise**" is usually thought to include formal **Taiji Chuan** movements and other strengthening and flexibility exercises derived from the practices of Wu Shu, Kung Fu and other oriental martial arts.

While most Taiji Chuan exercise includes attention to the breathe, another practice developed by Taoists and martial artists in China is called **"Qi Gong**," a form of exercise that emphasizes breathing and

mental focus on internal circulation. "**Breathing techniques**" was added to the scope of practice to represent Qi Gong. Generally speaking, Taiji Chuan can be thought of as a form of physical movement that pays attention to the breathe and body position, and QiGong can be thought of as mental and breathing exercise that directs attention inward, yet may include outward motion. It is sometimes difficult to tell the difference between the two forms of exercise.

"Heat," "cold," and "magnets" have traditionally been used as nature provided them in the form of fire, water and ice, and the mineral magnetite. In modern times, chemically-activated or microwavable hot packs, heat lamps, low level lasers, ultrasound, or diathermy, may be used instead, as these are far safer than the traditional methods of placing burning herbs, charcoal, or rocks directly on the skin. Magnets today are manufactured in many sizes.

"Diet," "nutrition," and "dietary supplements" are at the core of the philosophy and practice of Oriental medicine, as they are considered a first line of defense, prevention, and treatment of illness. Modern biochemical science and investigation has generally served to confirm and enhance the practice of dietary and nutritional therapy practiced by acupuncturists.

"Herbs, plant, animal, and mineral products" is meant to describe the traditional Chinese Herbal Medicine Pharmacopeia that was originally described as "poisoning" or "toxic" medicines, as they were most commonly used to poison and drive disease out of the body. The toxic side effects of their chemical constituents are part of the reason that pharmaceuticals are so heavily regulated today. Over time, Chinese herbal medicine came to use some of the same plant, animal, and mineral products as dietary therapy and the culinary arts, and has incorporated plants, animals, and minerals from around the world. Chinese herbal medicine is an advanced system that can take any substance, determine its effects, categorize it, and use it as a replacement, or addition to, certain traditional Asian "herbs."

Due to the heavy regulation of drugs, a clarification was made to exclude dangerous (i.e. "prescription") drugs and controlled substances, though this could prove problematic as more and more chemical constituents come to be identified and classified as controlled substances or dangerous drugs.

4937. An acupuncturist's license authorizes the holder thereof:

(a) To engage in the practice of acupuncture.

(b) To perform or prescribe the use of oriental massage, acupressure, breathing techniques, exercise, heat, cold, magnets, nutrition, diet, herbs, plant, animal, and mineral products, and dietary supplements to promote, maintain, and restore health. Nothing in this section prohibits any person who does not possess an acupuncturist's license or another license as a healing arts practitioner from performing, or prescribing the use of any modality listed in this subdivision.

(c) For purposes of this section, a "magnet" means a mineral or metal that produces a magnetic field without the application of an electric current.

(d) For purposes of this section, "plant, animal, and mineral products" means naturally occurring substances of plant, animal, or mineral origin, except that it does not include synthetic compounds, controlled substances or dangerous drugs as defined in

Sections 4021 and 4022, or a controlled substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

(e) For purposes of this section, "dietary supplement" has the same meaning as defined in subsection (ff) of Section 321 of Title 21 of the United States Code, except that dietary supplement does not include controlled substances or dangerous drugs as defined in Section 4021 or 4022, or a controlled substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

Unlicensed Practice of Acupuncture and Oriental Medicine

Section 4935 prohibits all persons not licensed under this chapter to practice acupuncture or to hold themselves out as practitioners or experts of acupuncture, oriental medicine, and Chinese medicine. Exceptions are limited to the practice of needle acupuncture by physicians, dentists, and podiatrists.

4935. (a) (1) It is a misdemeanor, punishable by a fine of not less than one hundred dollars ($100) and not more than two thousand five hundred dollars ($2,500), or by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, for any person who does not hold a current and valid license to practice acupuncture under this chapter or to hold himself or herself out as practicing or engaging in the practice of acupuncture.

(b) Notwithstanding any other provision of law, any person, other than a physician and surgeon, a dentist, or a podiatrist, who is not licensed under this article but is licensed under Division 2 (commencing with Section 500), who practices acupuncture involving the application of a needle to the human body, performs any acupuncture technique or method involving the application of a needle to the human body, or directs, manages, or supervises another person in performing acupuncture involving the application of a needle to the human body is guilty of a misdemeanor.

(c) A person holds himself or herself out as engaging in the practice of acupuncture by the use of any title or description of services incorporating the words "acupuncture," "acupuncturist," "certified acupuncturist," "licensed acupuncturist," "oriental medicine," or any combination of those words, phrases, or abbreviations of those words or phrases, or by representing that he or she is trained, experienced, or an expert in the field of acupuncture, oriental medicine, or Chinese medicine.

Workers Compensation "Physicians"

Section 3209.3 of the **Labor Code** includes acupuncturists within its definition of "physicians" since 1989, along with licensed physicians and surgeons, psychologists, optometrists, dentists, podiatrists, and chiropractors, as primary care providers for injured workers. The Industrial Medicine Council has not found any unique problems with acupuncturists' participation, aside from the disability determination limitation, which requires Acupuncturist QMEs to refer patients for a duplicate exam from another type of QME practitioner. Acupuncturists' role was expanded in 1998 to allow workers to "pre-designate" an acupuncturist, instead of a medical doctor or chiropractor, as their primary treating physician, in the event that they become injured on the job in the future.

Labor Code, Section 3209.3. *(a) "Physician" includes physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by*

California state law.

(b) "Psychologist" means a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology.

(c) When treatment or evaluation for an injury is provided by a psychologist, provision shall be made for appropriate medical collaboration when requested by the employer or the insurer.

(d) "Acupuncturist" means a person who holds an acupuncturist's certificate issued pursuant to Chapter 12 (commencing with Section 4925) of Division 2 of the Business and Professions Code.

(e) Nothing in this section shall be construed to authorize acupuncturists to determine disability for the purposes of Article 3 (commencing with Section 4650) of Chapter 2 of Part 2, or under Section 2708 of the Unemployment Insurance Code.

"Primary Health Care Profession"

The following definitions have been made by the State of California:

"*primary health care profession means that the licensed acupuncturist is a general or family practitioner who is the initial care provider*"

Legislative Counsel of California, Opinion #27622, Sept. 15, 1995

"*a profession which provides licensed health care services and is capable of being consulted in a first instance of injury or illness as compared with the healing arts professional who is a specialist and relies primarily upon referrals for patients*."

California Acupuncture Board, Legal Counsel Opinion, December, 1999

"*a first-contact healthcare professional who possesses the skills necessary to provide comprehensive and routine care (preventive, diagnostic, palliative, therapeutic, curative, counseling and rehabilitative) for individuals with common health problems and chronic illnesses that can be managed on an outpatient basis, and who can differentiate health conditions that are amenable to their management from those conditions that require referral or co-management*."

California Acupuncture Board, Regulatory Proposal, May 2000

25 Most Commonly Treated Conditions

(from the California Acupuncture Committee's 1996-97 Occupational Survey)

The broad variety of patients and kinds of conditions treated by acupuncturists in their practices serves to verify that acupuncturists practice as "primary health care professionals." This list of conditions that were most commonly treated by acupuncturists in California in 1996 demonstrates a wide spectrum of health conditions. The following twenty-five most commonly treated conditions comes from 115 conditions listed in the 1996-97 Occupational Survey. Some are combined from the original list, such as "arthritis, tendinitis, and joint pain," which were originally listed as separate items. Notably absent are treatments for cancer. This indicates that acupuncturists were fully aware that the law only allowed cancer to be treated by surgery, chemotherapy, and radiation, none of which fall within an acupuncturist's scope of practice. Acupuncturists, however, did frequently treat patients with cancer, often focusing on treating the side effects from the cancer treatments themselves.

- Anxiety & Depression
- Arthritis, Tendinitis, & Joint Pain
- Asthma & Allergies
- Auto Injuries
- Bladder and Kidney Infections
- Cardiac Palpitations (Irregular Heartbeat)
- Chronic Fatigue Syndrome
- Common Cold & Influenza
- Degenerative Disk Disorders
- Diet, Nutrition, & Weight Control
- Fibromyalgia
- Headaches & Migraines
- Hypertension (High Blood Pressure)
- Indigestion, Gas, Bloating, Constipation
- Insomnia
- Menopause Symptoms
- Musculoskeletal Pain
- Nausea
- Orthopedic Conditions
- Pain - other kinds
- PMS & Menstrual Irregularity
- Sports Injuries
- Tension / Stress Syndromes
- Tinnitus
- Work Injuries

History of Licensing Status

1975	"Certified" Acupuncturist	treatment by MD/DDS/DPM referral only (SB 86)
1979	Independent status	referral requirement removed (AB 1391)
1980	Primary Care status added	declared a primary health care profession (AB 3040)
1988	"Physician" status	Labor Code (Workers Compensation)
1998	Pre-designated Acupuncturist	Labor Code (Workers Compensation)

History of Scope of Practice

1975	Acupuncture (SB 86)
1980	Electroacupuncture, moxa, cupping, oriental massage, breathing techniques, exercise, nutrition, drugless substances and herbs (AB 3040)
1987	Acupressure (SB 1544)
2001	Heat, cold, magnets; plant, animal, and mineral substances (SB 341)

Educational Requirements for Acupuncturists

Summary: The Acupuncture Licensure Act requires that the Acupuncture Board establish curriculum standards for training programs in Acupuncture and Oriental Medicine, not to be less than 3000 hours, and that those standards go into effect on January 1, 2005. The 3000 hours are less than the 4000 hours recommended by experts in the field, less than the 3200 hours proposed by the Acupuncture Board in 2000, and more than the 2800 hours proposed by some schools which have a very different vision for the future of their students. Those schools have chosen to put their own interests ahead of the profession, students, and patients, and have promoted "optional" 1200-hour add-on (post-graduate) "doctoral" programs designed to produce educators and researchers to help the schools qualify for research grants and other sources of funding. Many schools quietly agree with the profession that there is a need for improvements in the entry-level training programs, but are afraid to speak up publicly for fear of losing their accreditation status. The real issue boils down to balancing the benefit from better educated entry-level practitioners with the higher costs and the potential "barrier to entry" that could be associated with higher standards. Better trained practitioners should be better prepared to step into a practice upon graduation and licensing, provide superior care to their patients, work seamlessly within the existing health care system, and survive in the highly competitive field of health care in California. There is no evidence that higher standards have caused any significant barrier to entry to this or any other health care profession, yet some school representatives have successfully used this argument to slow progress and advancement for the profession. Meanwhile, survey after survey of acupuncturists confirms the widespread dissatisfaction of the current provision of acupuncture and Oriental medicine education. While the pace of public grade school education is often matched to that of the slowest students, higher education need not follow such a model of equal opportunity. Higher education in the professions, by definition, seeks students who are self-motived, have superior learning skills, and are serious about the profession for which they are training. That is the direction in which our profession wants our schools to go. The schools, instead, are seeking to protect the weakest among their ranks. SB 1951 requests that the Little Hoover Commission *"**review and make recommendations on the educational requirements for acupuncturists**."*

Recommendations

Our profession recommends adopting a four-year, full-time, 4000-hour or equivalent, first professional doctorate level of training as entry into the profession. These program requirements must include sufficient training in basic sciences and clinical medicine, similar to the subject matter outlined in the Acupuncture Board's Regulatory proposal. While those standards may only require 3000 hours at this time, they already include most of the subject matter that a 4000 hour program should include. In fact, the curriculum standards that have been adopted by the **National Oriental Medicine Accreditation Agency (NOMAA)**, were developed with

full participation of the California licensed acupuncturist profession, as an extension and fulfilment of the Acupuncture Board's Competencies and Education Task Force proceedings, with California and other primary health care states foremost in mind.

We would recommend that a gradual transition process be considered that ultimately leads to a uniform licensure title and educational standard within ten years. While the ACAOM accredits "Masters" degrees, nobody uses the title "Master" in their practice. This is simply a mis-match that cannot go away soon enough. Patients most frequently address acupuncturists as "Doctor," as a sign of respect, and that should be the designated title.

Some schools have already been approved by the Bureau of Private Postsecondary and Vocational Education for 4000-hour doctorate programs. Some have been approved by the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) for post-graduate 1200-hour research and teaching doctoral degree programs. Unfortunately, these ACAOM-approved specialty programs are diverse and inconsistent with any single title, and were not designed to produce better entry-level practitioners. The resulting titles will likely result in confusion among the public and the profession, as the standardized degree title will not reflect the specialty training obtained. This is one of the latest in a long series of bizarre, controversial, and conflicting issues and situations that has resulted from the interference and influence of the Council of Colleges, which seeks to further its own interests over those of the students, the public, and our profession.

An entry-level doctorate standard would be on par with other primary health care professions in California and most importantly, with the Chinese "**Doctor of Traditional Chinese Medicine**" and Korean "**Doctor of Oriental Medicine**" professions that we wish to emulate. Those Asian programs are five or six years in length, including pre-medical subjects. Graduates from such programs are issued a bachelors or masters degree, but are licensed with the "doctor" title. In the United States, the degree granted for similar professional degrees (medicine, chiropractic, dentistry, etc.) is a professional "doctor" degree. Until a sufficient number of schools have accredited first professional doctorate programs, granting the title of "Doctor of Oriental Medicine" to the profession would be a workable solution.

The Council of Acupuncture and Oriental Medicine Associations and the profession has long supported a full 4000-hour training program standard. In 1993, the national organizations (AAAOM, CCAOM, NCCA, NASCAOM) formally agreed to recommend support for the development of a first professional doctorate program. Shortly thereafter, the Council of Colleges distanced themselves from the interests of the profession, and proceeded to found an alternative professional "alliance" organization to better serve their own interests and vision. That division has resulted in ten years of confusion among the public, students, profession, and government officials. Further adding to the confusion, the Council of Colleges has often presented themselves as an organization of the profession itself.

During 2001-2002, the California Acupuncture Board's Competencies and Education Task Force reviewed and adopted recommendations for curriculum to include between 3150 and 4050 hours, but sent the Board a final pared-down version of only

3000 hours, which was inserted into AB 1943. A vote was never allowed on 3150 hours, 4050 hours, or splitting the difference at 3600 hours. However, the NOMAA program looked particularly hard at the Task Force recommendations, and developed a 3600-hour curriculum for a Doctor of Oriental Medicine. After reviewing the NOMAA program requirements, including its prerequisites, **the Council endorsed NOMAA's 3600-hour curriculum**, as substantially meeting the 4000-hour standard set by the profession.

Primary Health Care Professions

Educational Comparison		Academic and Clinical Training			
Profession	**Admissions Requirements**	**Clinical Hours**	**Didactic Hours**	**Total Hours**	**Total years**
ACUPUNCTURE AND ORIENTAL MEDICINE					
CA Acupuncture School (2004)	2 years college	950	2,050	3,000	4 years
CA Acupuncture Tutorial	2 years college	2,250	1,548	3,798	3 years
ACAOM Masters	2 years college	660	1,515	2,025	3 years
NOMAA OMD	2 years college	1,500	2,100	3,600	4 years
Doctor of Traditional Chinese Medicine (Beijing, China)	High school diploma	2,240	2,573	4,813	5 years
Doctor of Traditional Chinese Medicine (Chendu, China)	High school diploma	1,920	2,806	4,726	5 years
Doctor of Oriental Medicine (Seoul, Korea)	High school diploma	2,000+	3,000+	5,000+	6 years
OTHER PRIMARY CARE PROFESSIONS					
Chiropractors	2-3 years college	1,400	3,000	4,400 - 5,000	4 years
Dentists	3-4 years college	2,000+	2,000	4,000 - 5,000	4 years
Naturopaths	2-3 years college	1,200	3,200	4,400 - 4,750	4 years
Optometrists	3 years college	2,000+	2,000+	4,200 - 4,700	4 years
Osteopaths	3 years college	3,000+	2,000	5,000 - 6,000	4 years
Physicians	3 years college	4,000+	2,000	6,000 - 7,000	4 years
Podiatrists	3 years college	2,000+	2,000+	4,000+	4 years
Psychologists	College degree	1,250+	2,750	4,000+	4 years

Acupuncturist Education and Competency Surveys

The following surveys of California licensed acupuncturists over the past six years give a clear and strong indication of weaknesses in acupuncturist education programs. Most acupuncturist training programs have expanded by about 500 hours over the past ten years. These surveys of the profession indicate a lack of hours of training in important subject areas. Students also complain, and schools freely admit, that quality is an issue of concern.

Occupational Analysis and Test Plan, California State Acupuncture Committee, May 1997. Based upon 254 respondents.

- 28% of acupuncturists felt "unprepared" to enter practice after training.
- 62% of acupuncturists indicated that additional pre-licensure clinic training would have better prepared them to be licensed acupuncturists.
- 52% of acupuncturists indicated that additional pre-licensure TCM training would have better prepared them to be licensed acupuncturists.
- 60% of acupuncturists indicated that additional pre-licensure western training would have better prepared them to be licensed acupuncturists.
- 45% of acupuncturists indicated that additional pre-licensure herb training would have better prepared them to be licensed acupuncturists.
- 48% of patients consider Acupuncturist to be their "primary care provider."

Survey Analysis, Acupuncture Board, April, 2000. Based upon 477 respondents.

- 34% of acupuncturists indicated that training did not prepare them to enter 1st year of practice.
- 58% of acupuncturists indicated that additional clinic hours are necessary to begin practice.
- 40% of acupuncturists indicated that additional TCM training would have better prepared them.
- 55% of acupuncturists indicated that additional western training would have better prepared them.
- 35% of acupuncturists indicated that additional herb training would have better prepared them.

California Acupuncture and Oriental Medicine Education Survey, California Health Institute, 2000. Based upon 667 respondents.

- 38.2% of Acupuncturists felt "unprepared" to enter practice after training.
- The average rating given to training in routine physical exam, medical reporting, and coordinating care with other health care professionals was "poor."

Acupuncture Practice: Analysis of Supplemental Demographic Data Questions in the Occupational Analysis, Office of Examination Resources, California Department of Consumer Affairs, January, 2002. Based upon 282 respondents.

- 35% of Acupuncturists felt "unprepared" to enter practice after training.

California Acupuncture Licensing Exam, January, 2002. Based upon 413 examinees.

- 37% of graduates failed licensing exam on first try.

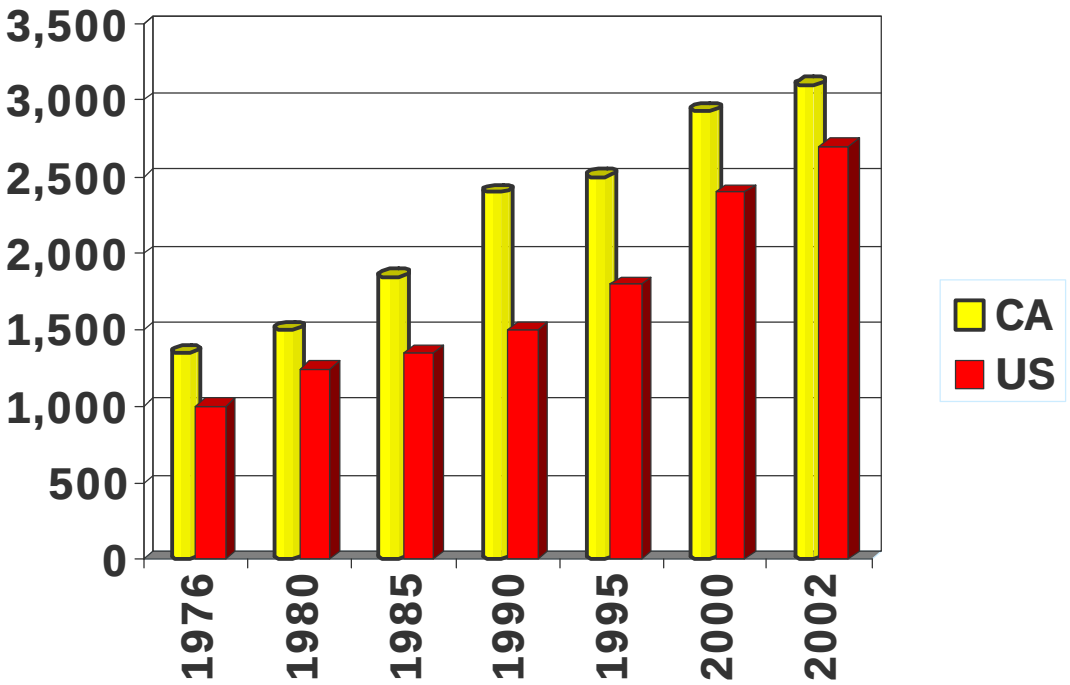
On-line Survey, *Acupuncture Today*, March, 2002. Based upon 280 respondents.

- 39% of respondents rate their acupuncture school as fair or poor.

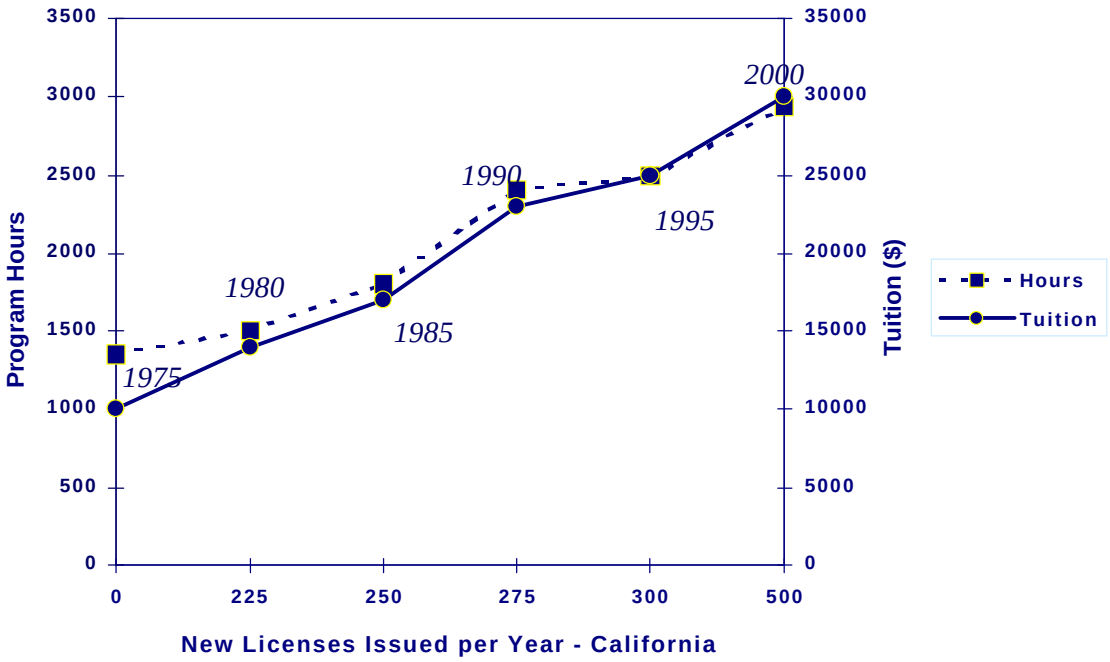
Competencies Task Force, Acupuncture Board, April, 2002. After five meetings with dozens of practitioners and schools representatives. Based upon 280 respondents.

- A range of 3,150 to 4,050 hours were recommended for entry level training.

Length of Acupuncturist Education 1976 -2002



Hours and Tuition vs New Licensees 1975 -2000



NCCAOM and California Examinations

Summary: The California Acupuncture Licensing Exam (CALE) has long been held as the "gold standard" among the profession. Historically, when it was easier for Asian-trained practitioners to take the exam, acupuncturists from Hong Kong and Taiwan would take the CALE, and prominently display their California exam as a the highest standard to be met. Apparently, the degrees and licenses did not always reflect legitimate training and qualifications in those regions. During the late 1980s, the CALE came under scrutiny, as it was discovered that an Acupuncture Committee member was selling examinations. This individual, who also served on the National Certification Commission for Acupuncture, was eventually sentenced to three years in prison. As a result of this "CALE sale" incident, the CALE was taken out of direct oversight of the Acupuncture Committee, and contracted to a third party. During the 1990s, the practical portion of the CALE came under criticism for the use of models whose skin or other conditions made it difficult to be objective in point location and diagnosis. Other problems, such as an individual's allergic reaction after tasting an herb during an exam, caused the clinical portion of the exam to be questioned. Finally, after the practical exam was improved and cleaned up, a clerical error by the exam contractor resulted in a mix-up in the issuance or denial of licenses to thirty-six examinees. The Legislature yanked the clinical portion of the exam, while failing to add program hours to make up for the difference. Meanwhile, the NCCAOM lost computerized exam results from one of its locations, and later lost an entire exam, resulting in a number of examinees being forced to retake their exams. The NCCAOM has previously bid to conduct the CALE, but had been underbid by other companies. The CALE is a fully integrated and comprehensive exam, based upon occupational surveys that determine what is practiced in the field in California. The NCCAOM has recently conducted a similar survey, and has decided to implement a new examination and certification scheme. SB 1951 requests that the Little Hoover Commission *"**evaluate the national examination, administered by the National Certification Commission for Acupuncture and Oriental Medicine, and make recommendations as to whether or not the national examination should be offered in California in lieu of, or as part of, the state examination**."*

Recommendations:

Conduct an independent evaluation of the examination and certification process of the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), and determine its credibility, reliability, and relevance to the California acupuncture profession, and compare those results with the California Acupuncture Licensing Exam (CALE). Since such an evaluation can only take place on the NCCAOM's existing examinations and certification process, **any further action on this issue must necessarily be postponed** until such time that the NCCAOM has implemented its new examination and certification scheme, and has not established a track record. Without objective data, it is impossible to make any recommendations,

other than to continue with the current situation. **The Acupuncture Board should be directed to continue monitoring the progress of the NCCAOM, as it implements its new certification scheme, and to consider revisiting the issue sometime in the future, when more facts are available.**

Determine why California students have such high pass rates on the NCCAOM exams. Included in directives of any independent evaluation, should be a determination as to exactly why the pass rate for California acupuncture students taking the NCCAOM exams, who traditionally take the NCCAOM exams at least one full year before graduation, has historically been ten percent and higher than the national examinee pass rate. The following is an example:

NCCAOM Exam Pass Rates

Acupuncture Exam - November 2001	
US Students	73%
CA Students	85%

The twelve percent difference would be even greater if the California scores were excluded from the national pass rate statistic.

The NCCAOM has historically demonstrated an unhealthy competitive agenda towards the California Acupuncture Licensing Exam, the California Acupuncture Board, and the California Licensed Acupuncturist profession. The NCCAOM consistently provides testimony that favors their chances of entering the lucrative California market without having to participate in a competitive bidding process.

For example, during public testimony, the NCCAOM nearly always claims never to have had an actionable complaint against any of their certified members ("*diplomates*"), touting this as an indicator of excellence. Yet, it seems more likely to be either an indicator of a lack of high expectations, or simply a lack of authority to enforce any laws. Public complaints are typically filed with the appropriate licensing authorities, or through malpractice claims, rather than through private organizations. Granting a private membership organization jurisdiction over a profession, via a licensing standard, raises serious issues of accountability.

An evaluation and recommendation as to whether the NCCAOM should be broken up into multiple components should be undertaken. The NCCAOM uniquely combines a professional membership organization, an examination agency, and a certifying agency into one. They have certified well over a thousand practitioners without any examination at all, simply through a credentialing process, and can attest only to the fact that many of those "diplomates" have continued to renew their membership. Because of this factor, consideration for the use of the NCCAOM certification should never be retroactive, and any consideration for use of their exam should be independent of their unique certification process.

The recent examination and certification scheme changes approved by the NCCAOM have taken place as the result of constructive criticism from the profession. While they currently have three entry-level exams – acupuncture, herbs, and massage – there are no states that independently license herbalists. From the very beginnings of their herbal exam, the NCCAOM was roundly criticized for offering an herb exam to those who had not first passed the acupuncture exam, resulting in essentially duplicate questions on principles and theory, and no licensed profession to enter. Additionally, they had no basic sciences or clinical medicine component, when, in fact, all acupuncturists are expected

to practice within the realm of the established system of modern scientific medicine and health care.

After it was noted that the NCCAOM was making progress in these regards, and was developing an "Oriental Medicine" exam, NCCAOM Executive Director, Christina Herlihy, wrote a protest letter to Senator Liz Figueroa, Chair of the California Joint Legislative Sunset Review Committee, dated April 30, 2002, claiming that "***the NCCAOM is NOT developing any additional examinations at this time...***"

Within a few months, however, the NCCAOM admitted that it was in the process of making the decision to take two existing exams and divide them into three exams, including an "Oriental Medicine" exam, and to add a fourth exam on an entirely new subject, thus creating at least two "additional examinations." They have announced plans to implement their new scheme by July 2004.

There is some concern as to whether they can implement this new program on time, given their previously aborted effort to implement computerized exams a few years ago after a severe set-back, and a reversal of a decision to implement new re-certification standards last year after re-thinking that decision.

Ms. Herlihy made another strange claim in her letter, stating: that "*The NCCAOM is not a "professional society".... It is ... a ... 501(c)(6) tax-exempt organization...*"

This seems to be contradicted by the Federal Tax Code, where the 501(c)(6) tax exemption status is specifically allowed for "business league" non-profit organizations, the classification under which most professional membership societies qualify. The NCCAOM has established membership requirements, have a code of ethics that members must abide by, requires membership fees and renewal, lobbies the federal and state governments on behalf of themselves and its members, and publishes a membership newsletter that explains and promotes its activities.

The NCCAOM's attitude towards the California Acupuncture Board and the California Acupuncture Licensing Exam became so negative and controversial that the Acupuncture Board addressed a letter to Ms. Herlihy, dated July 25, 2002, courteously pointing out that: "*Several misstatements were made in your letter regarding the Board's receptivity to NCCAOM and ill-founded judgmental comments were offered about the California licensing examination.*"

Lastly, there have been historical concerns about the high costs of the NCCAOM exams, as compared to the California Exam. The three NCCAOM exams could cost applicants over $2,000, while the CALE is $550. The NCCAOM has previously failed to competitively bid to develop the CALE. If the NCCAOM can lower the costs of its exams, succeed with its new examination and certification scheme, then it could go a long way in gaining the support from the profession, and in successfully bidding for the CALE, without the need for legislative intervention.

School Approval Process

Summary: Schools providing education in Acupuncture and Oriental Medicine are subject to laws regarding higher education, which vary from state to state. In California, such programs and schools must be approved by the Bureau of Private Postsecondary and Vocational Education (BPPVE) and the California Acupuncture Board (CAB). Additionally, schools that wish to gain access to Federally-guaranteed Title IV student loans and to Federal grants, must be "accredited" by a private agency that has been "recognized" by the US Department of Education. The Federal government was not granted any authority to oversee education in the United States, and the US Department of Education does not directly approve schools, but asserts indirect influence through the redistribution of Federal taxes to institutions which meet Federally-recognized "standards." The Secretary of the US Department of Education "recognizes" private accrediting organizations, such as the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) as legitimate authorities to "accredit" schools. While the California BPPVE strives to assure that schools are financially stable, the CAB focuses on curriculum and faculty. The BPPVE, ACAOM, and CAB all have on-site criteria which schools must meet. The BPPVE and CAB have coordinated their approval processes for some time. Since ACAOM and these state agencies have some duplicate requirements, they have also been developing a better working relationships. With the CAB adopting new curriculum standards, all schools will have to be reviewed. It was never envisioned by the Legislature that the CAB would be performing site visits outside of California. Given the complex nature and interrelationship between the profession, the schools, private organizations, and public agencies, there are some basic questions as to how to streamline the school approval process without granting a private organization the authority of law, or stifling competition and innovation. SB 1951 requests that the Little Hoover Commission *"**evaluate and make recommendations on the (school) approval process of the Accreditation Commission of Acupuncture and Oriental Medicine, the approval process of the Bureau for Private Postsecondary Education, and the board's approval process**."*

Recommendations:

Allow the Acupuncture Board to determine how best to approve schools of acupuncture and Oriental medicine, and whether to utilize outside sources for the purposes of approving schools in other states, particularly for site reviews. Evaluate the consistency of ACAOM's enforcement of its site review standards, and determine if it can be relied upon in the event that the CAB utilizes ACAOM's site review for out-of-state schools.

ACAOM has indicated that it is getting "tougher" on enforcement of its standards, meaning that they must have been lax in some instances in the past. Are changes to

enforcement standards a result of new interpretations, or a means of changing program standards without going through a process?

The profession has concerns about granting ACAOM too much authority, given their history of opposition to standards proposed by the profession itself. The Council has recently endorsed the curriculum standards developed by the National Oriental Medicine Accreditation Agency (NOMAA), and would like to see every effort made to allow them to become formally "recognized" by the US Department of Education as an accreditation agency for schools offering Doctor of Oriental Medicine programs.

ACAOM, as the sole gate-keeper to Federal funding for acupuncture schools at this time, exerts tremendous influence on those schools, and the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) exerts tremendous influence on ACAOM. These two organizations have shared facilities since the founding of ACAOM, and they frequently lobby government agencies and officials in a coordinated fashion, which has resulted in many states requiring ACAOM accreditation. In California, Florida, New Mexico, Nevada, Rhode Island, and elsewhere, the CCAOM and ACAOM have simultaneously taken sides in opposition to proposals made by the profession and/or regulatory boards, and have successfully blocked proposals to increase curriculum standards above those supported by the CCAOM and adopted by ACAOM.

During the CAB's regulatory proposal process for the 3200-hours curriculum in 2000, it was noted that over half of the schools had privately voiced support for the CAB proposal. Suddenly, they all changed their minds and refrained from commenting further. Some claimed that they felt pressured and were fearful of losing ACAOM accreditation, partly because ACAOM standards seemed to have been unevenly enforced, leaving schools to believe it was reserved for political reasons. In nearly all matters where the profession and the CCAOM have disagreed about educational standards, ACAOM has adopted the CCAOM's recommendations.

In 2002, at the specific request of the CCAOM, ACAOM adopted new accreditation standards for its Masters programs, even though neither CCAOM or ACAOM could provide any data or explanation that would substantiate such an increase. The Council and the profession supports a first professional doctorate degree program for entry level purposes, so it made no sense to support increased masters program standards beyond what they were. Professional input for that proposal, like those for the post-graduate doctoral program adopted in 2000, was largely ignored, in favor of the CCAOM's agenda and purposes.

In California, the CCAOM has hired a lobbyist specifically to represent its interests over those of the public, students, and the profession, and testified repeatedly against the profession in legislative hearings. According to their lobbyist, the CCAOM's strategy for 2003 includes the following recommendation:

"*Our consultations with Little Hoover Commissioners and staff should lead to an effective strategy using information resources to forward the interests of CCAOM and protect it against the agendas of practitioners and other stakeholders.*"

Those "other stakeholders" are the students and patients.

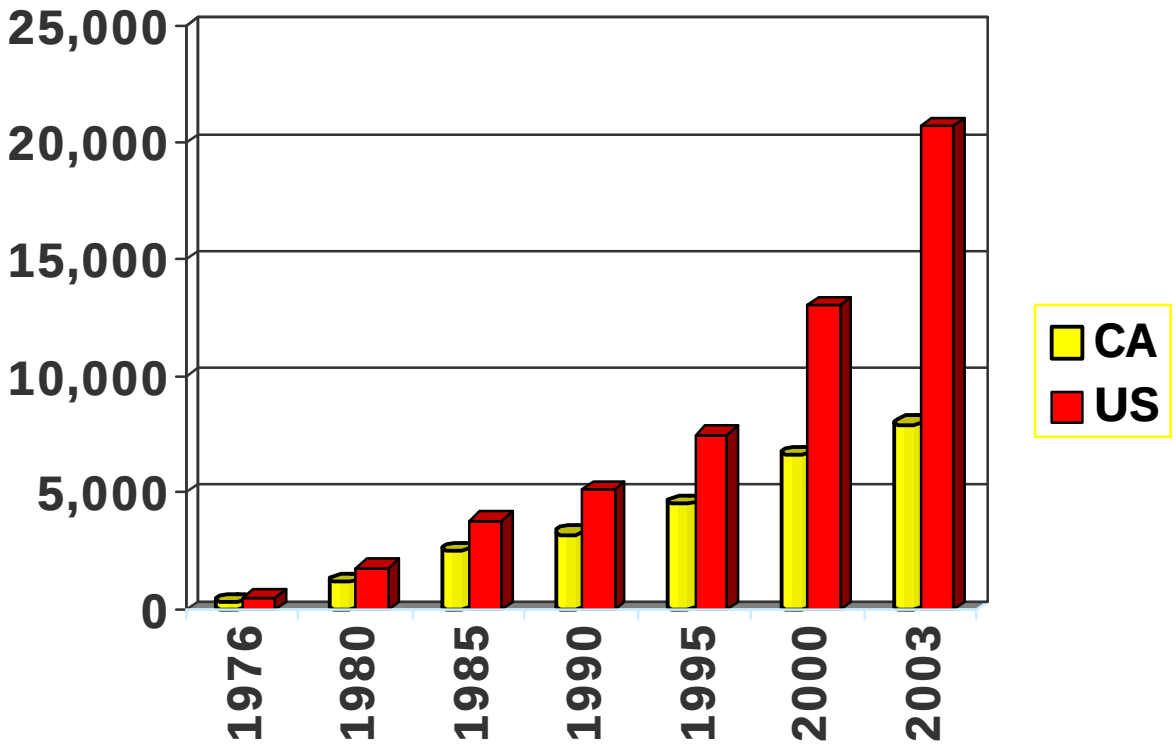
There is no doubt that using ACAOM accreditation as an approval requirement has been a benefit for smaller states which do not have the resources to independently review

schools. The unfortunate side of a government-endorsed private monopoly is that it can stifle competition and innovation. For example, when California schools applied for accreditation by ACAOM in the 1980s, they were forced to close down their advanced "Doctor of Oriental Medicine" programs, because they were not accredited, even though they were approved by two State agencies. This served to stifle progress and advances in the education of our profession in California.

During the past two years, a new accreditation agency, the National Oriental Medicine Accreditation Agency (NOMAA), has been working cooperatively with the California acupuncturist profession to develop accreditation standards for a "Doctor of Oriental Medicine," that conforms to the vision and recommendations made by the profession.

We would recommend that nothing be done to discourage or prevent the further evolution and development of the National Oriental Medicine Accreditation Agency, and its recognition by the US Department of Education.

Number of Acupuncturists Licensed in the US and California



Recommendation to Increase Curriculum above 3000 Hours

Summary: The profession has long recommended and supported a 4000-hour, first professional doctorate be the entry level for the profession, and continues to support this standard. The evidence has continued to mount in favor of this vision to raise entry-level educational standard to that of the first professional doctorate. With the development of such standards by the National Oriental Medicine Accreditation Agency, the profession feels comfortable endorsing their curriculum standards. AB 1943 requests that the Little Hoover Commission *"**make recommendations to increase curriculum hours for the licensure of acupuncturists in excess of 3,000 hours up to 4,000 hours to fully and effectively provide health services under their scope of practice."***

Recommendation:

A specific goal should be established for the Acupuncture Board to adopt curriculum standards of 3500-4000 hours by approximately the year 2010, and to do everything possible to encourage schools to offer first professional Doctor of Oriental Medicine degree programs by that time.

The Council believes that the National Oriental Medicine Accreditation Commission (NOMAA) Doctor of Oriental Medicine degree program will become a commonly accepted standard of training for our profession within ten years, if given a fair chance.

The arguments made for this case are contained in the earlier section on the review of educational standards.

Competencies of Current Licensed Acupuncturists

Summary: During the legislative process for AB 1943, some of the arguments made by the profession for increasing educational standards included concerns that the past and existing standards had left many practitioners without the skills necessary to survive in practice. Some of the schools (all of which exceeded the proposed new standards), opposed the legislation, asking that existing practitioners be forced to return to school for the education that they had failed to provide before. The profession offered to accept this, with hopes that such education could be provided at very low costs. However, the general rank and file of the profession were not willing to make such a sacrifice under such uncertain terms, and the bill was amended to refer the issue to the Little Hoover Commission. AB 1943 requests that the Little Hoover Commission ***"provide recommendations for reviewing the competence of (currently) licensed acupuncturists who are not subject to the 3,000 hour minimum curriculum requirement, and shall provide recommendations for training, testing, or continuing education that would be required for these individuals to meet the standards for continued licensure."***

Recommendations:

Change the title for the profession to "Doctor of Oriental Medicine," for all new licensees entering with 3000 hours of training, and allow existing practitioners to attain this new title based upon the number of years in practice, the number of hours taken during original training, additional post-graduate continuing education hours, teaching, writing, and other credentialing criteria. Options for challenging these criteria could include on-line competency exams in certain subject matter, or completion of a certification program.

This issue has been discussed at length, and it was determined that it is impractical and/or unfair to expect all licensees to return to school or to devote a substantial number of hours to re-education. Schools have been allowed to "creep" up the number of hours in their programs with little or no oversight, and determining how many hours a particular licensees graduated with and needed could be problematic. Many licensees have taken hundreds of hours of additional continuing education, and may not have a record of it. The scope of practice has gradually been expanded over a number of years.

A recent survey of a small group of professionals re-affirmed a proposal made by the Council a number of years ago, where credit could be given to licensees based upon how many years they have been in practice, allowing one hundred hours for every year in practice, and requiring up to one thousand hours equivalency from practice. Practitioners could then either wait for ten years, or obtain additional credits to shorten their wait. Within ten years of implementing such a transition, all licensees would be granted the title, "Doctor of Oriental Medicine," and "Licensed Acupuncturists" would no longer be used.

Priorities

2. Among these issues which is the highest priority for the members of your organization?

Summary: It is difficult to separate the issues, especially those of **education and scope of practice**. Our profession has been relatively successful in obtaining a reasonable scope of practice, primarily by obtaining it through the legislative process. However, we have reached a point where the arguments made by the California Medical Association, and other competing interests, against our profession, have been based upon the claim that our educational standards are insufficient. The lobbying efforts of some of our schools against our profession have only exacerbated the situation, as they have repeatedly embarrassed themselves and our profession by pronouncing that they have not been properly training their students. A recent letter from the California Medical Association to the California Acupuncture Board challenges the Board's proposal to require expanded educational standards, arguing that the scope of practice does not require further training. However, on scope of practice matters, such as in Workers Compensation, they have argued that acupuncturists are inadequately trained. Clearly, the common theme seems to be that they advocate against any form of legitimate competition for their members, whether through better training or expanded scope of practice. While this might be good for the physician profession as a whole, individual physicians generally do not have a problem with other expert health care professionals offering qualified opinions and recommendations that could serve the interests of their patients.

Our member organizations are quite clear that our priorities at this time are based upon a desire to survive and succeed. Ideally, what our profession needs, are:

1) a broad scope of practice that includes routine diagnosis, prescription, and delivery of Oriental medicine procedures,

2) first professional doctorate education,

3) continued access to the general public and injured workers

4) parity in health insurance coverage.

With other health care professions having already obtained doctorate degrees, including a proposal to license naturopathic doctors in California, and with physical therapists rising up to doctorate training, our profession must obtain this standard soon in order to continue to compete in a free market system, where publicly-recognized titles and credentials can mean the difference between success and failure. The standard has already been set in China and Korea, and we just need to emulate them as quickly as possible.

The Council of Acupuncture and Oriental Medicine Associations

3. Please provide the Commission information on your organization's membership, history, organizational structure, financing and goals for acupuncture in California.

Membership

Council of Acupuncture and Oriental Medicine Associations is an organization of professional Acupuncture and Oriental Medicine organizations, mostly representing California Licensed Acupuncturists. The nine current members of the Council include the Acupuncture Association of Rhode Island (AARI), the Associated Korean Acupuncture and Oriental Medicine Association of California (AKOMAC), the California Alliance of Acupuncture Medicine (CAAM), the California Acupuncture Medicine Association (CAMA), the California State Oriental Medicine Association (CSOMA), the Chinese Medicine and Acupuncture Association (CMAA), the Japanese Acupuncture Association of California (JAAC), the United California Practitioners of Chinese Medicine (UCPCM), and the Vietnamese Acupuncture and Oriental Medicine Associated Institutes (VAOMAI). Two other Korean organizations have expressed recent interest in joining. Active participating and affiliated organizations include the Acupuncture and Oriental Medicine National Coalition, the National Guild of Acupuncture and Oriental Medicine, the National Oriental Medicine Accreditation Agency, and more.

History

The Council of Acupuncture and Oriental Medicine Associations was originally formed in the 1980s to coordinate the activities and resources of a few professional Korean and Chinese acupuncturist organizations for the purposes of legislative advocacy. By 1992, Japanese, Vietnamese, and English language organizations had joined, giving the Council full representation of the state's ethnically diverse populations.

The Council and its member organizations have continuously sponsored legislation and commented on regulatory proposals affecting the practices of Licensed Acupuncturists. Legislation has included participation as physicians in Workers Compensation, expanded scope of practice, insurance coverage, incorporation, etc. The Council was the sponsor of Assemblywoman Judy Chu's AB 1943 of 2002, which improves educational standards for the profession, and which requested the Little Hoover Commission to review the matter further.

In recent years, the Council opened membership up to other states, after a pattern of interference in state licensing issues by CCAOM/ACAOM and their affiliated organizations became problematic for the profession nationwide. The Council has since become involved in supporting professional organizations and their legislation and regulation in a number of other states. The Council has also presented testimony before various departments of the Federal Government, in an attempt to fill a leadership vacuum at that level. The Council is the primary proponent and backer of HR 1477, the Federal MediCare Acupuncture Coverage Act, sponsored by Congressman Hinchey of New York and co-sponsored by over twenty

California congresspersons.

Organizational Structure

The Council of Acupuncture and Oriental Medicine Associations has been incorporated since 1995 as a California non-profit mutual benefit organization. The primary function of the Council is to present a unified voice of the profession to legislators and regulators, while member organizations stay focused on providing continuing education, newsletters, and other member benefits. The Council provides a neutral forum for discussion and consensus-making on the issues. In exchange for full decision-making participation, member organizations agree to support the Council's positions and activities.

The Council conducts business under the direction of a Board of Directors. Council member organizations seat one or two representative members on the Board of Directors, and this Board elects its own executive officers, which include a President, Vice President, Secretary, and Treasurer. Attempts are made to have diversity on the Executive Committee, and especially to rotate the president from association to association. Policy, budget, and other major business decisions are made at quarterly Board meetings, after allowing for thorough discussion and debate. Most decisions are made by consensus or unanimous vote. The Board appoints an Executive Director who is responsible for normal administrative functions, such as distributing information to member organizations, and filing lobbying reports with the Secretary of State. The President and Executive Director generally represent the organization in public venues.

The Council holds quarterly board meetings, which are open to all participants, and all known professional organizations in California are informed of meeting dates and are invited to send representatives. Organizations from other states have shown interest in the past few years, and two have joined the Council. Many organizations and institutions have sent representatives to Council meetings over the years.

Financing

Council member organizations are required to pay a membership fee that is used to cover office, travel, and meeting expenses. The Council has no paid staff, and all Council functions and activities are conducted by volunteers. Lobbyist contributions are based upon each organization's ability to pay. The financial contributions used for the lobbyist are separate from the membership fees, and some organizations chose to pay the lobbyist directly, rather than through the Council. The Council's annual budget, including lobbying fees, is normally less than $25,000.

Goals

The goals of the Council can be identified in some of the **formal positions** that it has taken:

1. The Council and its member organizations believe that the modalities of Traditional Oriental Medicine, including acupuncture, herbal medicine, Oriental massage, exercise, together form an integrated health care system which should be taught, tested and licensed as a unified whole.

2. The Council and its member organizations support a 4,000-hour professional doctorate as the entry level to the profession, and support efforts to raise the standards to that level.

3. The Council and its member organizations recognize ICD-9 diagnostic codes as the accepted standard for patient diagnosis, record-keeping and medical reports for all licensed health care professions.

4. The Council and its member organizations support the inclusion of Oriental Medicine services in treatment of work-related injuries.

5. The Council and its member organizations recognize that acupuncture needles are for use in the performance of acupuncture by acupuncturists who are registered, certified or licensed in any State, or other primary care providers whose training and scope of practice includes the practice of acupuncture.

6.The Council supports a public education program to convey that Licensed Acupuncturists are the only health care providers specifically required to be trained, examined for competency, and licensed to practice acupuncture and Oriental Medicine, including Chinese Herbal Medicine, and that no other health care profession has developed similar and adequate training standards to claim the title of "Acupuncturist," "Chinese Herbalist," or any other designation allowing themselves to be called a practitioner of Oriental Medicine. The Council recommends that members of the public seek guidance and treatment from a Licensed Acupuncturist, Doctor of Oriental Medicine, or other similarly qualified professional for acupuncture and Oriental Medicine services.

7. The Council is opposed to the used of endangered species in traditional Asian herbal medicines, and is in support of the Convention for the International Trade in Endangered Species of Flora and Fauna.

8. The Council is opposed to the use of Traditional Chinese Herbal Pharmacopeia in weight loss products when not used in accordance with the practice of Traditional Chinese Herbal Medicine.

Purpose

The purpose of the Council, as outlined in its **bylaws**, are as follows:

1. To serve as an official representative of, and spokesperson for Member organizations.
2. To support the interests of Affiliate organizations, when those interests do not conflict with those of Member organizations.
3. To preserve and advance the science, art, and practice of acupuncture and Oriental medicine as a distinct primary care healing art and profession.
4. To develop, maintain, promote, and disseminate standards for practice, scope, ethics, education, and peer review required for competence and excellence in the practice of acupuncture and oriental medicine.
5. To educate legislators, regulators, and the general public regarding the nature and scope of practice of acupuncture and Oriental medicine, and to advocate for laws and regulations that support and protect high professional standards.
6. To develop and promote events that further public awareness and inter-organizational professional relationships.
7. To serve as a forum for discussion and resolution of issues by leaders of acupuncture and Oriental medicine organizations.

Additionally, the Council has consistently supported the inclusion and integration of Oriental medicine and its practitioners into the health care delivery system in the United States.

Consumer Protection

4. What should the State's primary concern be in terms of protecting consumers of acupuncture services? Is the State adequately providing the protection and if not what else should be done?

The State of California's primary concerns with protecting consumers of acupuncture and Oriental medicine services should be to assure that providers of acupuncture services have proper levels of education, practice safely and effectively, and exhibit a level of professionalism consistent with the expectations of the public which is often under-educated about making healthy choices.

The State should assure that patients who seek the services of providers of acupuncture and Oriental medicine are gaining access to safe and effective services of the same high standards and expectations that Californians have come to expect from other primary health care providers.

The State should do everything possible to assure that acupuncture and Oriental medicine is practiced in a manner consistent with the State's general goals for public health, requiring that practitioners be highly skilled in their specialties, while having a thorough understanding of the diversity of services provided by other health care professionals.

The State should discourage experimentation with procedures that cannot be substantiated through historical precedent, scientific basis, or common practice.

The State should encourage further scientific investigation, including comparative clinical outcome studies, with the ultimate goal of providing only evidence-based medical services to the public.

The State should assure that the public can feel safe and comfortable in the hands of Oriental medicine practitioners, even when not familiar with the procedures of Oriental medicine. The public should be educated that acupuncturists are experts in acupuncture, herbal medicine, and other practices of oriental medicine, and should consult with acupuncturists in certain instances before taking herbs or dietary supplements.

The State should encourage the profession to promote high standards through the continued development of standards of care, ethical guidelines, peer review, and quality continuing education.

The Acupuncture Board should continue protecting consumers through enforcement of its standards and through educational materials provided to the profession and to the public. The Board should continue to maintain a good working relationship with the profession and continue to depend upon its expertise.

The State should encourage and assist the Acupuncture Board to move forward with actions that would benefit the public, even in the face of negative lobbying campaigns waged by vested interests against them. The current Board is comprised of individuals who seem fair and prepared to raise the level of expectation in the profession, and should continue working to improve quality of care to the public and to reduce enforcement cases through the establishment of higher

educational standards and other means.

The State should assure that everything is being done to assess the risks posed by the provision of acupuncture and Oriental medicine services to the public. Complaints and adverse events are limited to cases reported to the Board, and to hearsay from members of the profession. There are numerous other "enforcement" cases that are not reported, but are instead paid off by malpractice carriers.

In 2002, the the Department of Consumer Affairs, the Acupuncture Board, and the Council all concurred with the Joint Legislative Sunset Review Committee (JLSRC), recommendation that:

"Acupuncturists should be subject to professional reporting laws.

"*The Department (of Consumer Affairs) concurs with the JLSRC's recommendation. Like other health care professionals licensed in California, acupuncturists should be subject to professional reporting laws (Section 800 of the Business and Professions Code).*"

Unfortunately, the JLSRC proceedings became so heavily influenced by a negative smear campaign, that the Acupuncture Board's sunrise legislation, SB 1951, failed to even include the unanimously agreed upon reporting requirement.

The Council continues to recommend that acupuncturists be added to Section 800 of the Business and Professions Code.

Lastly, the State should encourage the profession and its schools to constantly upgrade and expand their training and skills and to keep apprised of, and to support, modern scientific advancements in health and medicine throughout the world. Licensees should be aware that there is a great need to "*eliminate the fundamental causes of illness,*" and that this is what inspired the California Legislature to license individuals practicing acupuncture and Oriental medicine.