



State of California

LITTLE HOOVER COMMISSION

September 30, 2004

The Honorable Arnold Schwarzenegger
Governor of California

The Honorable John L. Burton
President pro Tempore of the Senate
and members of the Senate

The Honorable Fabian Núñez
Speaker of the Assembly
and members of the Assembly

The Honorable Dick Ackerman
Senate Minority Leader

The Honorable Kevin McCarthy
Assembly Minority Leader

Dear Governor Schwarzenegger and Members of the Legislature:

In 2002, the Commission was asked by the Governor and Legislature to assess some long-standing and contentious issues regarding the State's regulation of the acupuncture profession. Specifically SB 1951 and AB 1943 requested that the Commission review the scope of practice and educational requirements for acupuncturists, the process for accrediting acupuncture schools and for examining licensees.

In conducting this review, the Commission sought out detailed and technical analysis – from experts at the University of California, California State University and RAND – to help sort through the conflicting claims that have frustrated the policy-making process. The Commission heard hours of public testimony, and engaged in even more hours of less formal public discussions. The Commission solicited and reviewed written comments from any individual and organization that desired their view to be considered, and it reviewed volumes of scientific and other treatises on acupuncture and Oriental medicine.

The Commission, as an independent and bipartisan panel, also explored the underlying tensions that have contributed to the persistent debates and probed the broader public interest aspects that are embedded in the specific regulatory issues that were before the Commission.

Through this process, the Commission developed an appreciation for the profession and for acupuncture and traditional Oriental medicine. It also developed and assembled a substantial body of technical analysis that could be used by regulators and lawmakers to resolve the precise issues that were before the Commission, as well as other challenges.

One source of confusion emanates from the Legislature's declared intent to regulate acupuncture as a primary health care profession without specifying in statute the full authority or limits of acupuncturists to diagnose and treat patients. This ambiguity – along with the legal opinions crafted to resolve confusion over the scope of practice – raise the potential for conflict between practitioners of traditional Oriental therapies and modern Western medical doctors. And when the two paradigms conflict – rather than complement – the opportunity for patient harm increases and the potential for patient benefit decreases. The Commission recommended specific ways to amend the scope of practice to resolve this issue.

Regarding educational requirements, the increased standards that will go into effect on January 1, 2005 appear to provide adequate time to teach the knowledge, skills and abilities needed for entry-level practitioners to perform this clarified scope of practice. The Commission, however, recommended ways to make sure that this training provides the information necessary to protect the public.

The Commission concluded that the Accreditation Commission of Acupuncture and Oriental Medicine should be relied upon to validate the quality of acupuncture training schools. The Commission, however, concluded that the State should continue to use its own examination as the regulatory threshold to practice in California, rather than rely on the national exam.

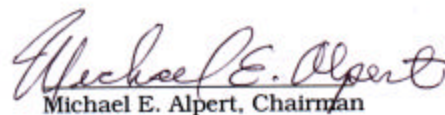
The Commission also identified additional opportunities for the State's consumer protection agencies, including the Acupuncture Board, to safeguard patients against practices or products that can threaten their safety and the public health – perhaps more importantly, measures to control infections. These safeguards begin with the qualifications of board members, and by making sure that vacancies on the Acupuncture Board – which currently number six out of nine seats – are expeditiously filled.

California's fundamental policy toward alternative health care has been to provide patients with the freedom to choose. That path confers onto regulators the primary responsibilities of making sure that practitioners meet minimum standards, and that consumers have the information needed to make informed choices. Disclosure statements and other consumer education materials should provide patients with information regarding treatment efficacy and safe practices.

An important underlying tension is the trend toward blending traditional Oriental Medicine with Western biomedicine. While both healing paradigms can benefit the public, those benefits will be jeopardized if the two regulatory schemes are not kept separate and distinct. The Commission's recommendations would clarify the role for acupuncturists and – if enacted immediately – would prevent greater confusion and even potential harm to consumers in the future.

The Commission sincerely appreciates the willingness on the part of state regulators, acupuncturists and other health professionals to inform its process. The Commission also appreciates the straightforward analysis provided by researchers at the University of California, San Francisco, California State University, Sacramento and elsewhere who contributed to its understanding of the issues. But as always, the conclusions and recommendations are the Commission's own.

Sincerely,



Michael E. Alpert, Chairman

Regulation of Acupuncture

A Complementary Therapy Framework

September 2004

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Executive Summary

As a destination for dream seekers, California has inherited the treasures of cultures Occidental and Oriental. Predictably, government is occasionally required to arbitrate, even regulate, how some traditions and practices are used in the public interest.

Such is the case of acupuncture and Oriental medicine, a healing art with ancient roots and modern branches. In 30 years, the State has evolved a full-scale professional regulatory scheme that licenses more than one in four acupuncturists in the United States.

This practice has flourished in the Golden State in part because of Asian immigration and influence in California. Increasingly though, Californians from all cultural perspectives have sought holistic approaches to maintaining health and have turned to traditional healers to complement or as an alternative to Western medicine.

Throughout this evolution, acupuncturists have sought to define and expand their authority, their role in the health care system, and their standing among health care professionals. These ambitions, however, have at times conflicted with the purpose of state regulation and created controversies that have been difficult for policy-makers to resolve. In two measures, SB 1951 and AB 1943, the Governor and the Legislature asked the Commission to review the scope of practice and the educational requirements for acupuncturists. The Commission also was asked to compare the State's procedure for approving acupuncture schools and administering the licensing examination with the national organizations that accomplish those tasks for other state regulators.

In examining these issues, the Commission identified three underlying tensions or conflicts that make it difficult to assess and reconcile the demands of the profession with the role of state government:

1. The nexus between traditional Oriental and Western medicine is poorly defined. The two paradigms are based on different understandings of how the body works and how it is healed. While allowing acupuncturists to practice independent of Western medical doctors, the State has not defined when and how the two systems should work together. In turn, some acupuncturists are advocating

for authority to make Western diagnoses using Western diagnostic tools.

2. The profession has sought to elevate its standing through the regulatory process. While educational requirements were recently raised, the profession asserts that still higher minimum standards are needed to achieve “parity” with Western primary health care providers. The purpose of the government’s educational requirements, however, is clear and limited to preparing entry-level practitioners to perform their scope of practice. They are not intended to serve as a measure of professional status or to favor one sector of the profession over another.
3. Acupuncturists and the Acupuncture Board are concerned that relying on national standards and procedures will hold back the profession in California. Some professional acupuncture associations in the state have strongly resisted efforts to create a national framework for accreditation and examination, which has become the norm in Western medicine. While California acupuncturists are among the nation’s leaders in the profession, the national organizations and experts in other states have much to offer the profession as it continues to mature.

Identifying these tensions is important to understanding the controversies, and hopefully providing a clear path for government regulators and the profession. Policy-makers must remember that the regulatory structure exists for the sole purpose of protecting the public. Licensure is not intended to advance the profession or ensure the economic prosperity of a segment of practitioners. Other health professionals can and do use other mechanisms – most of them private – for encouraging excellence among practitioners or integrating health care services.

To protect consumers, the State must regulate acupuncturists and other professionals by appropriately applying the following tools:

- ***A clear scope of practice.*** For the most part, the scope of practice for acupuncturists clearly focuses professionals on some of the traditional Oriental healing methods. Controversy, however, has arisen over their authority to diagnose patients and their role as primary care practitioners. In those aspects, clear statutory language is needed to affirm that consumers have direct access to acupuncturists who can diagnose patients using traditional Oriental techniques and should coordinate treatment and refer patients to Western doctors when appropriate.

- ❑ **Minimum educational requirements.** Educational requirements should be based solely on providing the skills, knowledge and abilities necessary for entry-level professionals to safely perform the existing scope of practice. The recently enacted educational standards were designed to accomplish this task, but regulators need to ensure that existing practitioners also are equally well-trained. In addition, the national accrediting agency is well positioned to play a larger role in helping California regulators ensure that acupuncture schools are providing quality education.
- ❑ **Quality examination.** The State needs a rigorous, accurate, fair and secure means of examining candidates for licensure. While the national examining agency has considerable potential to help the State test new professionals, the California examination is currently the stronger tool and should continue to be used.
- ❑ **Informed consumer choice.** Given a policy predicated on consumer choice, public education is necessary to help patients make informed choices. Toward that end, the State can provide consumers with unembellished research information about the documented efficacy of various treatments, as well as information about the preparation, complaints and enforcement activity associated with individual providers.

To assess these issues identified in the legislation, the Commission conducted public hearings, empanelled an advisory committee of stakeholders, solicited written comments, and consulted with experts around the country.

Because some of the issues required technical analysis, the Commission contracted with experts from the University of California, San Francisco; California State University, Sacramento; and, the RAND Corp. These experts assessed legal aspects of the scope of practice, the details of the educational standards and the accreditation process, and scrutinized the examination instruments used by the Acupuncture Board and the National Certification Commission for Acupuncture and Oriental Medicine. This analysis-based

Acupuncture Efficacy

According to the National Institutes of Health, "Acupuncture is based on the premise that there are patterns of energy flow (Qi) through the body that are essential for health. Disruptions of this flow are believed to be responsible for disease. Acupuncture may correct imbalances of flow at identifiable points close to the skin... The most studied mechanism of stimulation of acupuncture points uses penetration of the skin by thin, solid, metallic needles, which are manipulated manually or by electrical stimulation... Despite considerable efforts to understand the anatomy and physiology of the 'acupuncture points,' the definition and characterization of these points remain controversial."

The National Institutes of Health continues to research the potential for acupuncture. The following summarizes their findings to date: "Promising results have emerged, for example, showing efficacy of acupuncture in adult postoperative and chemotherapy nausea and vomiting and in postoperative dental pain. There are other situations, such as addiction, stroke rehabilitation, headache, menstrual cramps, tennis elbow, carpal tunnel syndrome, and asthma, in which acupuncture may be useful as an adjunct treatment or an acceptable alternative or be included in a comprehensive management program."

Source: US National Institutes of Health Consensus Conference proceedings JAMA 1998;280: 1518-1524.

testimony augmented the positions and perspectives offered in the public process. These separate reports also contain a wealth of detailed information and analysis that should assist regulators, policy-makers and the professionals in ways that go beyond the Commission's charge.

As requested, the Commission made recommendations on each of the issues identified in the legislation. In the course of the study, the Commission also identified other issues related to public safety that it believed were important enough to bring to the attention of policy-makers and the public.

The Commission greatly appreciates the time and expertise that so many people provided in the course of this study. But as always, the Commission's conclusions are its own.

Finding 1: While the legal scope of practice clearly defines the modalities that acupuncturists can use, the statute is silent on issues that are important in defining their role as health care providers.

To establish a sound regulatory scheme, policy-makers must clearly define the practice that the State intends to regulate. This legal "scope of practice" is the foundation on which health care regulation is built. The scope determines the minimal educational requirements that will be necessary for a practitioner to enter the field. The scope of practice defines the breadth of the licensure examination. And the scope of practice provides boundaries that are then enforced by regulators.

The statute clearly defines the treatments that acupuncturists may use. The Business and Professions Code is fundamentally a list of modalities and services provided to patients by traditional practitioners in China, Korea, Japan, and now around the world. The statute, however, is silent on many other facets – such as the authority to diagnose patients or limitations on the conditions practitioners may treat – that are detailed in the practice acts for other health care professions.

In 1979, the Legislature eliminated the statutory requirement that medical doctors refer patients to acupuncturists. And the following year, the Legislature in "intent language" referred to acupuncture as a "primary health care profession."

Subsequently, acupuncture – as defined in legal opinions by attorneys for the Acupuncture Board and as practiced in California communities – has incorporated the diagnosis of patients. And while traditional Oriental diagnosis exclusively relied on external physical cues, acupuncturists have been allowed by legal opinions to order blood tests, X-rays, MRIs and other advanced tests that have been developed to

diagnose ailments as they are defined and understood in the Western medical paradigm.

As a result, there is some confusion between the statute and the legal opinions about the role of acupuncturists in the health care system, as well as how that role may be defined in the future.

Professional acupuncture associations say this modernization trend is an essential and natural development of the profession that mirrors the evolution of medical practice in China and other Asian nations.¹ But California, as with other states, already has a means for regulating Western medical practice – supported by separate educational, professional and licensure institutions. And, in fact, many California practitioners have obtained dual licensure.

This murky legal framework – coupled with the trend toward blending Eastern and Western Medicine – complicates efforts to regulate acupuncture, has the potential to confuse the public about the capacity of acupuncturists, and could potentially compromise public health.

Recommendation 1: The Governor and the Legislature should clarify in statute the role of acupuncturists in the health care system. Specifically the statute should:

- ❑ ***Keep licensure focused on traditional Oriental medicine.*** Consistent with existing “intent language” and legal opinions, the statute should clarify that licensure is for the practice of traditional Oriental medicine as an alternative and a complement to Western medicine. Practitioners interested in mastering both Eastern and Western methods should continue to seek licensure under both systems.
- ❑ ***Define primary care practitioner.*** The statute should make it clear that acupuncturists are primary care practitioners within the context of traditional Oriental medicine, and are responsible for referring patients to primary care practitioners in the Western medical system when appropriate. The law should make it clear that the definition does not impose requirements on health care providers regulated by the Knox-Keene Act.
- ❑ ***Authorize and define traditional Oriental diagnosis.*** The scope of practice should include an explicit authorization to conduct traditional Oriental diagnosis. Practitioners who are already licensed and choose to perform biomedical tests in making any diagnosis should be required to complete specific continuing education requirements and take a supplemental examination.

- ❑ **Require disclosure of critical information.** Patients should receive information on the benefits of coordinating care with MDs and accurate information on the efficacy of traditional therapies. They should receive safety precautions, for example, about single-use disposable needles, alcohol preparation of skin, herb-drug interactions and the potential for herbal contamination. Practitioners should be required to report malpractice settlements.
- ❑ **Allow for acupuncture-only licensure.** To ensure public access to acupuncture services – for instance, to promising addiction therapy – a separate category of licensure should be created for professionals who provide only acupuncture, and not the array of traditional Oriental therapies. A reduced educational curriculum and examination would have to be developed and implemented.

Finding 2: The new 3,000-hour educational requirement is adequate to prepare entry-level practitioners and to protect the public safety.

A primary goal of educational requirements is to provide some assurance that professionals have the knowledge, skills and abilities necessary to safely practice the profession. And the standard for professional licensing is to ensure that incoming licensees can perform the legally authorized scope of practice as entry-level practitioners.²

Effective January 1, 2005, new students in acupuncture schools will need to complete 3,000 hours in training before they will be able to take the licensure examination. That new standard represents a 28 percent increase over the current 2,348-hour requirement.

The higher educational standard was not prompted by a new increase in the scope of practice. Rather, it was justified in part as a belated increase in training warranted by the 1980 legislative change to allow for direct access to acupuncturists. While there is little evidence that patients were endangered by the previous educational requirements, proponents argued the increase in training was critical to patient safety.

The new requirement – and the desire to further raise the standard to 4,000 hours – also is presented as part of a long-term goal of some professional associations to raise the preparation and standing of acupuncturists to the equivalence of Western medical doctors.

The Department of Consumer Affairs asserts that increases in license requirements should be directly related to the scope of a particular profession as defined in law, necessary to ensure the safety of consumers, and should not inappropriately restrict access to practice.³

By those standards, there is no evidence to support the need to further increase the educational requirements. But there is evidence, documented by the UCSF analysis and supported by other testimony, that implementing the new requirements will be difficult for some schools, and may result in fewer schools generating fewer students eligible to take the California exam.

Recommendation 2: The number of educational hours should not be increased, and should be focused on traditional Oriental healing practices within a modern framework for patient safety. Specifically, the Acupuncture Board should implement the following policies:

- ❑ ***Educate within scope.*** The State's required courses for licensed acupuncturists within schools of traditional Oriental medicine should only be for subject matter needed to competently and safely practice the legal scope of practice.
- ❑ ***Devote adequate curriculum to patient safety, including coordination.*** Once the new curriculum has been implemented, an independent evaluation should be conducted to ensure that concerns about minimum training needs have been met. Special attention should be given to patient safety training, including:
 - ✓ Up-to-date infection control practices that meet the standards of the National Institutes of Health, such as exclusive use of single-use needles.
 - ✓ Improving coordination with Western medicine, including recognizing "red flag" conditions, and knowing when and how to refer to and work with physicians.
- ❑ ***Teach within area of expertise.*** Courses in physiology, chemistry, biology and other sciences should be taken at colleges and universities that are accredited to grant degrees in those areas. The board also should separately consider requiring successful completion of basic science courses as a prerequisite to educational training in traditional Oriental medicine.

Finding 3: The steadily increasing educational requirements for new entrants into the acupuncture profession potentially creates different levels of competency, and could confuse or mislead the public regarding the knowledge, skills and ability of those previously licensed.

Acupuncture Board regulations require practitioners to take 30 hours of continuing education every two years.⁴ However, when the new 3,000-hour standard goes into effect, many practicing acupuncturists will have been licensed with only 1,350 hours of training, and were licensed prior

to the time that acupuncturists could practice independently of M.D.s and were allowed to make diagnoses. In addition, many of the approximately 900 acupuncturists who were initially licensed in the mid-1970s, who were "grandfathered" into licensure with no examination and undefined education requirements, will be practicing under the same scope of practice, presumably with even less formalized training.

Many of the professional organizations that advocated for higher educational standards have asserted that existing practitioners have gained, through experience or continuing education, the knowledge that will now be required before licensure. But in many professions, there is persistent concern that continuing educational regimes do not ensure that practitioners actually learn the latest knowledge, skills and abilities needed to practice safely and competently.

The University of California identified several options to address the unevenness in the education levels among practicing professionals, among them: "catch up" programs to enable practitioners to gain required competencies; test-out options that enable practitioners to demonstrate knowledge or skills in required competency areas; and, grace periods for completing a schedule of supplemental education or examinations. UCSF researchers also suggested the option of implementing differential levels of titling in licensing to reflect formal educational and career experiences.

From a public safety perspective, it is difficult to accept that new students should receive additional training on issues directed at improving patient safety without requiring current licensees to receive at least some of that training in a meaningful way. It is incumbent upon regulators to ensure that patient safety material is incorporated into the clinical practices of long-standing practitioners as well.

Recommendation 3: The Governor and the Legislature should reallocate – and consider increasing the number of – continuing education hours required of currently licensed practitioners as a mechanism to update patient safety requirements. The law should:

- ❑ ***Specify courses.*** The Acupuncture Board should identify the coursework necessary to keep practitioners current on "red flag" conditions, emergency procedures, emerging infectious diseases that require referral, exclusive use of single-use disposable needles, other patient safety issues, such as cancer treatment, and how to communicate effectively with Western practitioners.
- ❑ ***Require examination.*** The State should require testing for material related to patient safety.

Finding 4: The examination of candidates for licensure is a critical quality control measure for assuring competency of providers and is an essential mechanism for ensuring that evolving public policy goals are met.

California's regulator has had difficulties with the acupuncture examination, including documented fraud and criminal charges during the 1980s that spawned security improvements that require continuous refinement. In debating improvements to the examination, policy-makers also have considered replacing the California test with the examination offered by the National Certification Commission for Acupuncture and Oriental Medicine.

Most other California health professionals are licensed based on a national examination. However, the acupuncture profession is still relatively new in its evolution within the United States and the profession in California has evolved somewhat differently than it has developed nationally. Just as different nations take different regulatory approaches to acupuncture, herbs and other modalities of traditional Oriental medicine, so do different states. As the profession evolves in America, a national examination may become the norm.

However, at this juncture, the independent psychometric analysis of the two examinations determined that while both the California and national examinations are statistically sound and meet all other measures of quality, the California examination was somewhat more robust. In addition, by controlling its own examination, California can directly control the evolution of policies and priorities. California has been able to achieve this goal even though the exam is administered by a private firm under contract.

The California examination does need to be refined to ensure that critical knowledge is tested and passed. Further, when the practical component of the examination was canceled in 1999, regulators lost the means to ensure that candidates possess the physical skills necessary for safe practice. Finally, ongoing concerns regarding exam security plague all professional examinations, requiring sophisticated and continuous vigilance.

Recommendation 4: The California Acupuncture Board should continue to control its examination to ensure that the State's policy goals are met. Among the policy goals that the State should ensure:

- ❑ ***Demonstrate knowledge of critical components of safe practice.***
"Must-pass" modules should be required for areas of particular concern, including herb-drug interactions, exclusive use of single-use disposable needles, additional infection control measures,

understanding of emerging infectious diseases, "red flag" conditions, first aid procedures, and knowing when and how to refer to physicians.

- ❑ **Competitive examination administration.** The board should continue to contract out for the secure administration of the California-designed and controlled examination.
- ❑ **Develop strategy for implementing internship.** This time-tested strategy for proving the practical skills necessary to be successful in many health professions should replace the discontinued practical portion of the examination.

Finding 5: The process used by the Accreditation Commission of Acupuncture and Oriental Medicine appears to be superior to the school approval process used by the Acupuncture Board and could be used by the State to ensure the quality of education for potential licensees.

Prior to taking the California licensing exam, potential licensees must graduate from a school approved by the Acupuncture Board. In addition, schools also must be approved by California's Bureau of Private Postsecondary and Vocational Education, or similar bureaus in other states, which guard against diploma mills and fraudulent business practices.

Most schools also seek accreditation from the organization that has been deputized by the U.S. Department of Education to ensure the quality of education required to qualify for federal financial aid. In the case of acupuncture, that organization is the Accreditation Commission of Acupuncture and Oriental Medicine (ACAOM). The other 39 states and the District of Columbia that license acupuncturists rely on ACAOM accreditation to ensure the quality of acupuncture schools. Students must graduate from an ACAOM-approved school as a condition of licensure in those states. Only California has its own school approval process.

ACAOM is the only accrediting organization that federal officials have approved for accrediting acupuncture programs and state regulatory agencies are not eligible to be deputized by the federal government as accrediting bodies.

Nearly all of the schools that are accredited by the Acupuncture Board also are accredited by ACAOM. ACAOM's process appears to be more rigorous and appears to put more focus on improving the quality of education over time. And – unlike the Acupuncture Board – ACAOM has

an established process for reviewing accredited schools to ensure they are continuing to meet standards.

While ACAOM's curriculum requirements are different than California's, other regulatory boards have relied on national organizations to establish quality and then develop a means for assuring that state-specific curriculum standards are met.

By relying on the federally authorized accrediting body, ACAOM, to assess individual schools, California's regulators would have more time and resources to spend on enforcement, clinic audits, continuous competency improvement of licensees and refining the California examination.

Recommendation 5: California should rely on ACAOM to accredit acupuncture schools, and other institutions for accreditation that are recognized by the Secretary of Education, while developing a mechanism to ensure that state-specific curriculum standards are met. To achieve that goal, policy-makers have two options:

- ❑ ***Contract with ACAOM.*** California could establish a memorandum of understanding with ACAOM to certify that California-specific requirements have been met by individual schools and ensure that aggregated information is publicly available.
- ❑ ***Require schools to document.*** California could require that schools document that they have met any California-specific legal requirements that exceed national accrediting standards. California uses this model for schools of podiatry.

Finding 6: The California Acupuncture Board has missed significant opportunities to protect the public, particularly in the areas of consumer information and herb-related safety.

Many of the specific issues that the Governor and the Legislature asked the Commission to review have festered because the Acupuncture Board too frequently acted as a venue for promoting rather than regulating the profession. As a result, the board has missed opportunities to protect the public by providing accurate and complete information about the therapies that licensees can provide. The board also has not adequately incorporated emerging scientific evidence into board policies, regulations and public communications.

One critical example is the board's presentation of the scientific evidence regarding the efficacy of acupuncture. The National Institutes of Health found that acupuncture needle therapy is effective for "postoperative and

chemotherapy nausea and vomiting and postoperative dental pain." However, the Acupuncture Board's Web site, fact sheet and consumer brochure implies efficacy for a broader range of ailments. Moreover, those materials do not provide cautionary information to consumers about the limits of what may be expected from traditional Oriental medicine, the need to coordinate with MDs, or how to go about selecting a qualified practitioner.

Also, the NIH in 1997 recommended shifting to the use of single-use needles by acupuncturists instead of following the older practice of sterilizing equipment between uses. This is in part due to the evolution of AIDS and antibiotic-resistant bacteria that can be life-threatening. FDA requires that acupuncture needles be labeled as single use only. However, in California, regulators have not required exclusive use of single-use needles and the law has not been updated to incorporate this fundamental public safety measure.

Much greater attention also needs to be placed on the portion of the scope of practice related to prescribing herbs. These substances are not regulated for purity, potency or effectiveness by the federal Food and Drug Administration nor California authorities. This issue extends beyond the purview of California regulators, and beyond the regulation of this profession. However, since California includes herbs in the scope of practice for acupuncturists, regulators are obligated to take the actions that are within their purview to protect the public.

Herb-drug interactions pose an increasing risk to the public that was not present when ancient herbal practices were developed. Further, in California, herbs from around the globe are used, posing further risk of herb combinations that were unknown in ancient Asian practice, but can result from the intermingling of healing practices.

Recommendation 6: The Governor and the Legislature, through the Sunset Review Process or other mechanisms, should ensure that the California Acupuncture Board becomes a strong advocate for consumers. Among the steps that should be taken:

- ***The board needs to develop a patient safety strategy.*** This strategy should ensure that federal recommendations for improving patient safety – for instance, the exclusive use of single-use needles – are quickly adopted in policies, examinations and written materials such as the consumer brochure. The California regulator could be required to submit, as a regular part of their sunset review, or annual report, what their compliance is with federal recommendations along with new research findings from the NIH. The board should study malpractice trends and publish the results. California regulators

also should bolster efforts to work with individual practitioners and clinics to ensure ongoing compliance with evolving consumer protection laws.

- ***Develop consumer protections for herb products.*** California should empanel legal and scientific experts to explore herb-drug interactions, herb purity and potency, accurate labeling, and reporting of adverse effects. The panel should identify regulatory and other policy steps the State could take to protect consumers.

- ***Restructure the regulator to benefit consumers.*** If policy-makers believe a board is desirable, the majority of the members should not have an economic interest in acupuncture. They should include consumers as well as experts in infection control and research methodology. And the regulator should develop standing advisory panels that are more representative of the various cultures throughout the world that are integrating traditional Oriental medicine into health care and regulatory schemes.

Introduction

Two bills passed by the Legislature and signed by the Governor in 2002 requested that the Little Hoover Commission assess and make recommendations on six issues concerning the regulation of acupuncture in California. The measures grew in part out of the Legislature's sunset review of the Acupuncture Board, which identified but did not resolve some issues of concern to policy-makers. The legislation also reflected an ongoing effort by some professional associations to raise minimum educational requirements for incoming professionals.

To explore these issues, the Commission augmented its standard public, bipartisan and independent review of state policies with technical analysis conducted by experts in the regulation of health professionals and licensure examination.

The Commission held two public hearings to gather testimony from experts and allow stakeholders to explain their perspectives. A list of the witnesses is contained in Appendix A. A subcommittee of the Commission conducted three advisory committee meetings to give stakeholders additional opportunities to explore the issues with Commissioners. All members of the advisory committee also were sent questionnaires, providing the opportunity to submit written responses to the issues raised by the legislation and by Commissioners. A list of advisory committee members is contained in Appendix B.

The Legislative Request

SB 1951 (Figueroa 2002) requested the Commission conduct a comprehensive analysis of the following:

1. Review and make recommendations on the scope of practice for acupuncturists.
2. Review and make recommendations on the education requirements for acupuncturists.
3. 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.
4. Evaluate and make recommendations on the approval process of the Accreditation Commission of Acupuncture and Oriental Medicine, the approval process of the Bureau for Private Post Secondary Education and the board's approval process.

AB 1943 (Chu 2002) raised educational requirements for acupuncturists to 3,000 hours and asked the Commission to review the following:

1. Increasing 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.
2. Reviewing the competence of licensed acupuncturists who are not subject to the 3,000-hour minimum curriculum requirement, and [the] training, testing or continuing education that would be required for these individuals to meet the standards for continued licensure.

To fully assess the technical aspects of the issues, the Commission contracted with the Center for the Health Professions at the University of California, San Francisco to systematically analyze the scope of practice, education requirements and accreditation processes for the acupuncture profession. The executive summaries of those reports are in Appendices C, D, and F and the full report is available on the Commission's Web site: www.lhc.ca.gov.

The Commission also contracted with psychometricians - experts in testing and measurement - from California State University, Sacramento and the RAND Corporation to analyze the California examination, as well as the exam used by the National Certification Commission for Acupuncture and Oriental Medicine. The executive summary of their report is contained in Appendix E, and the full report is available on the Commission's Web site.

Background

Acupuncture originated in China over 2,000 years ago and has been used in Japan for 1,500 years.⁵ It was first described in Chinese literature in approximately 100 B.C. in *The Inner Classic of the Yellow Emperor*.⁶ Over time and with trade, the use of acupuncture spread throughout Asia, into Europe and beyond. By the 1600s acupuncture was discussed in European medical literature.⁷

Different countries and regions evolved different approaches to the use of acupuncture. For example, the Chinese evolved the use of electro-acupuncture, whereas the Japanese are known for a gentle approach that relies on hair-thin needles.⁸ The many forms are prized by the populations that rely upon them, and have been refined over the generations by the master practitioners teaching in a given region.⁹

Europeans have developed their own theories and styles and have worked to explain acupuncture in Western scientific terms – despite differing philosophical underpinnings.¹⁰ According to the National Institutes of Health, "competing theoretical orientations (e.g. Chinese, Japanese, French) currently exist that might predict divergent therapeutic approaches (i.e., the use of different acupuncture points). Research projects should be designed to assess the relative merit of these

Defining Acupuncture

According to the National Institutes of Health: "Acupuncture is based on the premise that there are patterns of energy flow (Qi) through the body that are essential for health. Disruptions of this flow are believed to be responsible for disease. Acupuncture may correct imbalances of flow at identifiable points close to the skin. The most studied mechanism of stimulation of acupuncture points uses penetration of the skin by thin, solid, metallic needles, which are manipulated manually or by electrical stimulation. The U.S. Food and Drug Administration regulates them... under...single-use standards of sterility... Despite considerable efforts to understand the anatomy and physiology of the 'acupuncture points,' the definition and characterization of these points remain controversial." The National Institutes of Health continues to research the potential for acupuncture. Their findings are summarized on page 5.

California law defines acupuncture as: "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."

(The Scope of Practice Finding contains a full description of therapies authorized in the California Acupuncture Scope of Practice.)

Source: US National Institutes of Health Consensus Conference proceedings JAMA 1998;280: 1518-1524; California Business and Professions Code 4927 (d).

divergent approaches and to compare these systems."¹¹ As of 2003, NIH was spending over \$200 million annually in assessing alternative medicine treatments.¹²

Acupuncture in the United States

In the United States, acupuncture had been used primarily by Asian immigrants until President Nixon traveled to China and re-established diplomatic ties in 1972.¹³ Since that time, acupuncture has gained increasing acceptance with the public and the complementary medicine clinics of academic medical centers. In 2004, the National Center for Health Statistics at the U.S. Centers For Disease Control reported that 1.1 percent of the U.S. public had used acupuncture in the previous 12 months and that 4 percent had used it at some time.¹⁴

Following President Nixon's visit to China, the U.S. Food and Drug Administration (FDA) began investigational regulation of acupuncture needles. In 1974, Nevada became the first state to issue licenses to non-physician practitioners of acupuncture and the following year Hawaii established the first board of acupuncture.¹⁵

In the mid-1980s, the National Commission for Certification of Acupuncturists was founded with the mission of promoting national standards for safe and competent practice.¹⁶ Soon afterward, the American Academy of Medical Acupuncture was established to train and certify physicians in acupuncture.

In 1988, the U.S. Department of Education approved the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) as the authorized accrediting body for schools of acupuncture.

Due to the public's growing interest and use of complementary medicine, the National Institutes of Health (NIH) opened the Office of Alternative Medicine Research in 1993. The same year, interest was further fueled when The New England Journal of Medicine published a study indicating that one-third of surveyed Americans had tried some form of alternative medicine, including acupuncture, and that \$10 billion was being spent annually on such therapies.¹⁷ Because the acupuncture scope of practice also includes the use of herbs and dietary supplements, it is notable that in 1994 the United States passed the controversial Dietary Supplement Health and Education Act, establishing "that dietary supplements are to be regulated like foods instead of drugs, meaning that they are to be considered safe unless proved otherwise and are not required to be clinically tested before they reach the market."¹⁸

In 1996, the Food and Drug Administration reclassified acupuncture needles as regulated class II (unproven) medical devices for "general acupuncture use" by licensed, registered or certified practitioners. This decision came with the stipulation that manufacturers label needles for single use only and conform to requirements of prescription devices.¹⁹

In 1997 NIH embarked on a major review of all research results on acupuncture and at the end of the year issued an expert consensus statement. It found: "Promising results have emerged, for example, showing efficacy of acupuncture in adult post-operative and chemotherapy nausea and vomiting and in post-operative dental pain. There are other situations, such as stroke rehabilitation, headache, menstrual cramps, tennis elbow, fibromyalgia, myofascial pain, osteoarthritis, low back pain, carpal tunnel syndrome, and asthma where acupuncture may be useful as an adjunct treatment or an acceptable alternative or be included in a comprehensive management program."²⁰

Promising results have emerged, for example, showing efficacy of acupuncture in adult postoperative and chemotherapy nausea and vomiting and in postoperative dental pain.

National Institutes of Health, 1997

In 1999, New Hampshire implemented one of the most rigorous education requirements in the nation for acupuncture. Applicants for licensure in New Hampshire must possess a baccalaureate, be a registered nurse or have a physician's assistant degree, in addition to graduation from an accredited acupuncture program. It also made business, management and insurance courses ineligible for continuing education credits.

The following year, President Clinton named four acupuncturists to a 20-member White House Commission on Complementary and Alternative Medicine Policy, including two from California.²¹

As of 2003, more than 100 medical centers nationally had added complementary medicine clinics, many of which include acupuncture. They include the University of California medical centers, Cedars-Sinai and Stanford University.²² And a preliminary release of a UCLA study indicates that by 2003, a majority of both practitioners and patients in California were Caucasian women.²³

Healers and Licensing

One of two California acupuncturists on the White House Commission on Complementary and Alternative Medicine Policy, Qigong Grandmaster Effie Poy Yew Chow, cautions against overemphasizing formal licensure instead of nurturing the qualities necessary for healing:

"A license does not a healer make. Besides implicit technical skills and knowledge there must be heart, love, compassion, touch, laughter, and whole-ness of body, mind, and spirit. It is also the Qi-presence and the intention."

Effie Poy Yew Chow, Ph.D., R.N., L.Ac (CA), DiplAc (NCCAOM) is president of the East West Academy of Healing Arts in San Francisco, which specializes in teaching Qigong energy healing. She also travels extensively to work with patients in need.

Legalization, Licensure and Education in California

- 1972** AB 1500 (Duffy) authorized "an unlicensed practitioner to practice acupuncture under the direct supervision of a licensed physician if conducted in an approved medical school for the sole purpose of scientific investigation."²⁴
- 1975** SB 86 (Moscone-Song) authorized certification of acupuncturists. The measure also required a prior diagnosis and referral from a licensed physician and surgeon, dentist, podiatrist or chiropractor and required that at the completion of treatment, the acupuncturist was to report to the referring provider "the nature and effect of treatment." Certifications were authorized to be granted to applicants without taking an examination if they could demonstrate they had five years of experience (three if at an approved medical school program). Alternatively, candidates could qualify if they passed a Board of Medical Examiners-approved examination and either completed an approved course or had two years of experience.²⁵ SB 86 created the governor-appointed Acupuncture Advisory Committee under the jurisdiction of the Board of Medical Examiner's Allied Health Division, comprised of seven acupuncturists, two of whom also were physicians. And it defined acupuncture as "the stimulation of a certain point or points 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."
- 1976** California became the eighth state to authorize the practice of acupuncture when it began issuing certificates to practice.²⁶
- 1978** SB 1106 (Song) added four public members to the acupuncture advisory committee, required development of a tutorial or apprenticeship program for persons seeking certification as an acupuncturist, and established that the board could develop continuing education requirements. From 1976 to 1978 it is estimated that 900 acupuncturists were "grandfathered" into the system without taking an examination.²⁷
- 1979** AB 1391 (Torres) removed the Business and Professions Code section that required diagnosis by, and referral from, a physician, dentist, or chiropractor. It also deleted the report to the referring provider stating the patient's progress and outcome of acupuncture treatment.²⁸

AB 3040 (Knox) replaced the Acupuncture Advisory Committee with Acupuncture Examining Committee, added a seven-year acupuncture experience requirement for teachers supervising apprentices, and expanded the scope of practice to include electroacupuncture, cupping, moxibustion, Oriental massage, breathing techniques, exercise, nutrition, and drugless substances and herbs as dietary supplements.²⁹ AB 3040 also stated in intent language that "There is a necessity that individuals practicing acupuncture be subject to regulation and control as a primary care profession," but the measure did not define the term or include it in the code section that defines what an acupuncturist can do. In 1980 the UCLA School of Medicine also started teaching acupuncture in its continuing education program.

1980

The UCLA Center for East-West Medicine was founded as part of the medical school's Collaborative Center for Integrative Medicine. Acupuncture was among the complementary, alternative, and integrative therapies included in the program.

1993

SB 1980 and SB 1981 (Greene) removed the Acupuncture Committee from Medical Board jurisdiction, renamed it the California Acupuncture Board, and reduced membership of the board from 11 to nine members.

1998

The World Health Organization recommended a 2,500-hour training program for acupuncturists and the Acupuncture Board convened a Competency Task Force "to develop the details and rationale for the increase" in education hours.³⁰ The board implemented "life-scan" fingerprinted-background checks for licensees and the clinical portion of the board's examination was eliminated through trailer bill language.³¹

1999

The Department of Consumer Affairs, Office of Exam Resources, completed the most recent occupational analysis, documenting the treatment and practices of California acupuncturists.

2001

AB 1943 (Chu) implemented the Acupuncture Board's Competency Task Force recommendation to raise the entry level education requirement from 2,348 to 3,000 hours. SB 1951 (Figueroa) and AB 1943 (Chu) requested that the Little Hoover Commission review the scope of practice, as well as specific issues regarding education, accreditation and examination policy.

2002

Context for Policy-making in California

In the course of its study, the Commission identified a number of contextual issues important to formulating policies related to acupuncture.

- 1. Patient safety.** Government's first concern is patient safety, the bedrock for answering the legislative questions. Herb-drug interactions, infection control, Western diagnosis and coordination with other health practitioners emerged as patient safety concerns. For example, the scientific safety guidelines from the Centers for Disease Control and National Institutes of Health offer the State a baseline for policy-making, but federal recommendations for single-use disposable needles have not been adopted in California.³²
- 2. Limited record of complaints.** The number of complaints recorded by malpractice insurers and the Acupuncture Board is small. Absent evidence of a pattern of significant consumer problems in California, questions were raised about the purpose of increasing education requirements or other changes to examination, school accreditation, or scope of practice. The majority of enforcement cases pursued by the board involve unprofessional conduct, ethical issues, practice management issues and sexual misconduct.³³
- 3. Alternative medicine is in demand.** Consumer demand has pressed Western medical practitioners and insurers toward accepting acupuncture as a complementary addition to the health system. This in turn has pressed the field of acupuncture to adopt some of the standards of Western medical and insurance practices.
- 4. Minimum competency for acupuncture license is Eastern, not Western training.** Californians seeking acupuncture can choose among practitioners who have different types of training, including those only trained in ancient Eastern teachings. California-licensed acupuncturists (LAc) must demonstrate knowledge of specific traditional Asian healing practices. Practitioners who wish to also practice Western medicine can obtain dual-licensure, such as nurse-acupuncturists (RN-LAc), chiropractor-acupuncturists (DC-LAc) and medical doctor acupuncturists (MD-LAc). In contrast, the scope of practice of Western medical doctors is so broad that MDs are not required to hold separate licenses to practice acupuncture. While not legally required to be trained in acupuncture to perform it, professional norms and malpractice concerns are incentives for MDs to seek training. Dentists and podiatrists are the only other California licensees who are permitted to perform acupuncture without holding an acupuncture license. However, the use of acupuncture must be within their scope of practice and they must

undergo acupuncture training that is approved by their respective licensing boards.

5. Cultural perspective and different basic belief system. In California, there has been an effort to fit the traditional belief system that underlies acupuncture into a Western scientific framework. This creates pressure to incorporate into traditional acupuncture education Western scientific training in microbiology, chemistry, physiology, virology, etc. The practice of acupuncture that has been passed down from generation to generation has been based on beliefs about energy fields, spiritual factors, and connectivity between Yin, Yang and Chi.³⁴ The stated goal and philosophy of acupuncture is enhancing health through balancing energy. In contrast, Western medicine is based on physical science and focuses on repair and prevention of disease and injury.³⁵

6. Within acupuncture, wide spectrum of beliefs and practices.

Even experts in acupuncture disagree about how acupuncture works and whether it can be explained in scientific terms.³⁶ There also is disagreement about appropriate points for needle placement, how deeply the needles should be placed and how many needles are needed.³⁷ Some of this disagreement is attributed to different countries and different schools evolving different practices over thousands of years of trial and error. A fundamental disagreement in the acupuncture community is whether there is an underlying spiritual basis to this traditional healing, and whether it should not be melded into a Western scientific model.³⁸ How one answers that question influences whether traditional teaching and practice should be required to incorporate Western science.

Techniques Should Be Evaluated

"Competing theoretical orientations (e.g. Chinese, Japanese, French) currently exist that might predict divergent therapeutic approaches (i.e., the use of different acupuncture points). Research projects should be designed to assess the relative merit of these divergent approaches and to compare these systems with treatment programs using fixed acupuncture points."

Source: National Institute of Health. November 3-5, 1997. "Consensus Statements: 107. Acupuncture." Washington D.C. Web site accessed July 2004. http://consensus.nih.gov/cons/107/107_statement.htm

7. Preserving traditional healing methods. There are age-old and emerging diseases for which Western science has yet to find clear answers or effective antidotes. As a case in point, antibiotic-resistant bacteria is heightening interest in other approaches to battling infections. Thus, treatments such as herbal therapy and acupuncture have gained attention and heightened scientific scrutiny. Efforts to collect reliable evidence of efficacy and needle placement are ongoing.

Conditions vs. Modalities of Treatment

Acupuncture is defined in law in terms of authorized modalities of treatment (e.g., needle therapy, herbal and nutrition therapy, etc.). However, the scientific evidence is evolving around which diseases or conditions can be successfully treated with particular modalities. In particular, NIH has found that acupuncture needle therapy is effective for "postoperative and chemotherapy nausea and vomiting and postoperative dental pain." Multiple promising studies are underway. For instance, Stanford University's psychiatry department has conducted a pilot study indicating that for women suffering from depression during pregnancy, acupuncture may hold promise as a safe treatment option.³⁹

Prior to clinical research, thousands of years of positive patient experiences with acupuncture kept this traditional medicine alive. Research is beginning to reveal a scientific explanation of how acupuncture may work. High technology, such as functional magnetic resonance imaging, is helping scientists to understand the physiological mechanisms that may help to refine the use of acupuncture.⁴⁰ But even if it is not ever fully understood in modern medical terms, consumers want direct access. Many skeptics have become convinced of the merits

Valuing Ancient Wisdom in an Integrative Model

Dr. Andrew Weil, a graduate of Harvard Medical School who is internationally recognized for researching therapies from different cultures, recommended the State consider the following:

- Traditional wisdom and healing practices have been lost in the haste to learn about and use Western medicine's techniques. If a patient receiving acupuncture is also being treated by an MD – either before, concurrently or after the acupuncture treatments – acupuncturists do not need to also learn Western medicine.
- Collaboration between practitioners of acupuncture and physicians should be encouraged. Patients wanting acupuncture should notify their physicians of their interest and have their physician assess their complaints. Otherwise, they should be required to sign a release, stating that they have declined to see a physician. In any case, patients should be required to sign an informed consent that gives indications for the effectiveness of acupuncture treatment.
- Regulatory powers should be used to encourage the development of Integrative Medicine. Two mechanisms by which collaboration could be encouraged: by making insurance reimbursement for acupuncture contingent on physician assessment of the complaint, and by making practitioner liability contingent on collaboration with physicians.
- The term "Doctor of Oriental Medicine" can confuse the public and further increase separation of the practice of acupuncture from that of conventional medicine by reducing incentives to collaborate. Dr. Weil envisions a future with integrative medical facilities where acupuncturists and physicians work under the same roofs, as is often the practice in Asia.
- His representative, Elad Schiff, MD, also suggested that a model developed by an Israeli task force may be useful in California. It recommended that within the first eight visits to an acupuncturist, or within a month of starting treatment with an acupuncturist, the patient also see a Western medical doctor to ensure no serious underlying causes will be missed.

Source: Andrew Weil, MD, Chair, Integrative Medicine Program, University of Arizona Medical School, telephone interview and letter to the Commission, 2003.

of acupuncture after experiencing improvement when nothing else would help. And through the course of history, acupuncture performed by individuals with even informal training has proven to help patients.

NIH standards of evidence are strict. For acupuncture, this level of evidence only indicates its use for limited types of pain, nausea and vomiting. The World Health Organization (WHO) lists more conditions that acupuncture may be useful for than does NIH. WHO states that acupuncture is used on more than 40 conditions, but it does not state acupuncture is efficacious or advisable relative to other healing options for all of those conditions. According to the Harvard Center for Complementary Medicine, the NIH list of conditions reflects the current state of reliable research, indicating that the World Health Organization's list is not based on research methodology that is acceptable in the United States.⁴¹

Cancer Treatment

One important example of where policy-makers have distinguished between modalities of treatment and appropriate conditions to be treated is cancer. However, during advisory committee meetings it was brought to the Commission's attention that there was some confusion among practitioners and the Acupuncture Board about the appropriateness of cancer patients receiving acupuncture.

State law limits the specific treatment modalities that can be used to treat cancer and does not authorize acupuncture. However, the attorney for the Acupuncture Board and Department of Consumer Affairs reviewed the issue at the request of the Commission. In his opinion, he concluded that while acupuncturists are not authorized to treat patients for cancer, they can treat patients for the side-effects of cancer treatment. The opinion stated:

An acupuncturist is not permitted to diagnose, treat, alleviate or cure cancer. However, we believe that the use of acupuncture and Asian medicine treatments by acupuncturists for patients diagnosed with cancer is permitted if it is intended to relieve the side effects of or protect the body from the damaging effects of the therapies used to treat cancer and if it does not counteract the efficacy of or otherwise interfere with the treatments prescribed for the patient by a physician or other person licensed to treat or alleviate cancer as specified in Health and Safety Code 109290.⁴²

A Kaiser acupuncturist explained that while acupuncture would not be expected to heal cancer, it may be an appropriate complementary therapy pursued simultaneously with Western therapy. The general confusion of the advisory committee on the topic indicates that

clarification is needed among practicing acupuncturists and may be suitable material to include on examinations. It also raises the possibility that ill patients may not be receiving consistent information at a vulnerable point in their lives.

From Terminal Cancer Patient to Vibrant Healer

In 1995, Evan Ross was told he had a cancerous brain tumor and that he was going to die. Ross had previously battled cancer at age two and lost an eye in that episode. Twenty-two years later, he was living in Los Angeles, following his dream of working in the music industry when his doctor told him he had cancer again – a tumor the size of a lemon in the right frontal lobe of his brain. He underwent 10 hours of surgery at the University of California, San Francisco, but doctors could only remove half of the tumor. His family was told that it was unlikely that the surgery and subsequent cancer treatment would save his life.

As he continued to fight the cancer, Ross underwent chemotherapy and other standard cancer treatments. He also went on a macrobiotic diet and meditated twice daily. He tried acupuncture, took nutritional supplements, practiced Qigong and was treated with Ayurvedic herbs. He saw a shaman and consulted with a Jewish mystic.

The illness was a spiritual journey for him and as he reflected on his disease, he wondered why he had remained cancer-free for two decades. "The way I was living my life – mentally and spiritually – I was in a state of chaos," Ross said in a recent interview. "What is cancer but a state of chaos?"

Today, Ross has been cancer-free for eight years and works as a licensed acupuncturist and practitioner of Oriental medicine at Cedars-Sinai Medical Center in Los Angeles where he has worked since 2001. He holds a degree in Oriental medicine from Emperor's College, an accredited college of traditional Chinese medicine in Santa Monica.

Ross works closely with teams of doctors at Cedars-Sinai. He has staff privileges, can provide acupuncture treatment to hospitalized patients and works as part of the medical team. He sees about 80 patients a week, many of them cancer patients. As a licensed acupuncturist, he has a fairly unique relationship with the hospital. According to a 2003 survey conducted by the American Hospital Association, 17 percent of hospitals offer complementary and alternative medicine.

Ross is quick to point out that he does not practice alternative medicine. He always calls it complementary. "There is a danger in thinking of it as alternative medicine, because it implies one kind of medicine or the other. Both types of medicine have to be used together," he adds. Ross is still careful to send patients for conventional therapies, rather than trying to do everything himself.

Source: Hilary E. MacGregor, July 26, 2004, "His Path From Patient to Healer," [Los Angeles Times](#).

Shaping Policy with Evidence: Efficacy, Competency & Consumer Experience

Historically, health professions have carved out scopes of practice and related policy primarily by political means. But advanced research and modern technology now offer policy-makers the means to consider efficacy and patient preference when formalizing what professionals can or cannot do.

For many professions, scopes of practices were solidified long before the evidence base could provide guidance about what should be excluded or included in a profession's practice. In a relative vacuum of information, anecdotal evidence and customary practices are given more weight. But over the last decade, the strength of the research for evidence-based medical practices has grown geometrically. As this body of information becomes more robust and comprehensive, it can be given greater weight by policy-makers deciding on scopes of practice, education and related regulations. The Pew Health Professions Commission pointed out in 1995 that competency of practitioners to perform specific functions is a more reasonable approach to determining scope. This transition can be facilitated with research studies on patient outcomes.

The significant body of research that has been amassed will continue to develop and be refined about treatment efficacy across the spectrum of health professions, as well as provider competency. The National Institutes of Health and other federal research efforts have invested billions of dollars to determine which treatments hold up under the glare of scientific scrutiny. And California's largest professional association recommends that "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 World Health Organization's Traditional Medicine Strategy 2002-2005 also has endorsed this concept, as follows: "If traditional and complementary medicine is to be promoted as a source of health care, efforts to promote its rational use, and identification of the safest and most effective therapies will be crucial."

The impact of efficacy research has been enhanced by efforts to involve patients in decision-making. Dr. Jack Wennberg's Informed Patient Decision-Making Project provided a wake-up call to policy-makers nationally by showing that given the hard facts, patients often make decisions contrary to expensive and traditional standards of practice. Researchers found that patients often prefer watchful waiting instead of surgery when provided the realistic statistical odds of improvement.

Patient outcome data also can be used to shape regulatory and health system environments in ways that enable patients to have freedom of choice based on reliable information. Recent efforts to make the results of all clinical trials become public information is an important step. As clear research becomes available, regulatory policies have an obligation to respond. Specifically, if precise and uncontroversial evidence indicates treatments are harmful or unhelpful, the public has a right to expect such essential scientific information to be applied in clinical practices to protect patients.

Evolving information on efficacy may help to ensure that:

- Health professionals do not provide care that is proven to be ineffective or harmful.
- Providers stay up-to-date as the scientific research identifies how to improve the care they provide.
- Regulators overseeing health professionals rely on available scientific evidence. For instance, as research becomes clear about the efficacy of treatments, the scope of practice could evolve accordingly. This standard should apply across all health professions. Where strong and uncontroversial evidence indicates harm or ineffectiveness, those activities would not be licensed by the State.
- Information about what works is made publicly available. Patients should be given information about the known risks and benefits of the variety of treatment options available to them. If comparative information is available on quality of care and patient outcomes among providers, treatments and facilities, that information can improve the patient experience, and ultimately, quality of life.

Source: LHC; Interview with Paul Shekelle, MD, Director, RAND's Center for Evidence Based Medicine; various journal articles by Jack Wennberg, MD, health policy literature review; National Council Against Health Fraud; Brian Fennan, Executive Director, Council of Acupuncture and Oriental Medicine Associations, August 28, 2003, testimony to the Commission.

Scope of Practice

In SB 1951, the Legislature asked the Commission to:

"Review and make recommendations on the scope of practice for acupuncturists."

Finding 1: While the legal scope of practice clearly defines the modalities that acupuncturists can use, the statute is silent on issues that are important in defining their role as health care providers.

The legal scope of practice is the foundation on which health care regulation is built. The scope determines the minimal educational requirements that will be necessary for a practitioner to enter the field. The scope of practice defines the breadth of the licensure examination. And the scope of practice provides boundaries that are necessary to enforce the limits imposed by regulation.

Generally speaking, the boundaries established by a scope of practice also are lines of demarcation in the battles between various professionals, with licensees often trying to expand their own authority or limit the authority of a potential competitor. While these debates are usually voiced in terms of public benefit or public safety, an economic interest is at stake in virtually every polemic involving scope of practice.

Additional Research

The Center for the Health Professions at the University of California, San Francisco, prepared a detailed factual analysis of the scope of practice. The center identified elements of the scope that are clear and elements that are unclear, including diagnosis, use of Western diagnostic tests and limitations and definitions of essential terms.

The center also compared California's acupuncture practice act to the practice act for other health professions in California, as well as the practice act for acupuncture in other states. The center reviewed the occupational analysis and compared it to the practice act. And experts at the center analyzed some options for policy-makers to consider.

The executive summary of that analysis is in Appendix C. The full report is available on the Commission's Web site.

Authorized Modalities

Beyond the use of needles, acupuncture scope of practice includes performing or prescribing the following to promote, maintain, and restore health (Business & Professions Code 4937):

- Oriental massage and acupressure
- Breathing techniques and exercise
- Heat and cold
- Magnets
- Nutrition and diet
- Herbs*, plant, animal and mineral products and dietary supplements

California law defines acupuncture as "The stimulation of a certain point of points on or near the surface of the body by 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. (Business & Professions Code 4927)

*According to the Council of Acupuncture and Oriental Medicine Association, prescription of herbs as dietary supplements may include substances like deer horn, dried anteater scales, etc. but most are the roots, stems, leaves, seeds or flowers of plants.

In recent legislative proposals, as well as the review of the Acupuncture Board by the Joint Legislative Sunset Review Committee, policy-makers have been confronted with issues that ultimately related to the scope of practice for licensed acupuncturists. Debates over the limits of the legal scope of practice have made these issues difficult to resolve. And that confusion or disagreement was the basis for requesting the Commission to "review and make recommendations on the scope of practice."

In terms of treatments, the legal scope of practice is quite clear. However the legal evolution of the role of acupuncturists in the health care system, as well as how that role may be defined in the future, appears to be one of the most significant sources of tension.

The scope of practice for acupuncturists, contained in the Business and Professions Code, is fundamentally a list of modalities and services provided to

patients by traditional practitioners in China, Korea, Japan, and now around the world. The modalities are listed in the box.

In addition to the statute, the Acupuncture Board has adopted Standards of Practice in regulation, which further define the practice of acupuncture in California. And the Department of Consumer Affairs has issued a series of legal opinions, often in response to specific questions, that attempt to clarify what acupuncturists can and cannot legally do. The Acupuncture Board also has adopted "for reference" a document prepared by a professional association describing "standards of practice" for California acupuncturists. That document varies in some instances from state statute and regulation.⁴³

Many practitioners – such as podiatrists, optometrists and dentists – are limited to treating specific parts of the body. Acupuncturists are not limited in this way. Other practitioners – such as physical therapists – are limited in the assessments and therapies they can provide. Still others must practice under the supervision or referral of a physician.

The Move to Direct Access

When acupuncturists were first licensed in California in 1975, they could only see patients who had been diagnosed and referred by physicians.

In 1979, lawmakers were concerned that physicians were not referring patients, and so eliminated the referral requirement, allowing patients to have direct access to acupuncturists. The following year, the Legislature created a committee separate from the Board of Medical Quality Assurance to license acupuncturists and it added to the list of modalities that could be used by acupuncturists, including the use of herbs. The Legislature also added the following “intent” language:

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 hindrance to the most effective provision of health care services. Also, as it affects 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.⁴⁴

The profession and the Acupuncture Board rely heavily on this intent language to define the role of acupuncturists as responsible for a patient’s overall health care and for coordinating specialty care within the modern scientific medical system.⁴⁵ That view has significant repercussions on the other aspects of the State’s regulatory scheme, especially educational requirements for new licensees.

The intent language was added by AB 3040 (Knox). A review of committee analyses and other legislative documents suggests that legislative deliberations focused on the bill’s provisions to establish a separate examining committee and to expand the list of modalities. Scant attention in the analysis was given to the words “primary care” or the implications of the intent language in the bill. The Department of Consumer Affairs’s annual report for 1980 summarizes the changes made by the bill, but does not mention acupuncture becoming a “primary care profession.”⁴⁶

There are at least two concerns about relying on this language for fundamental policy decisions, one legal and the other practical.

The legal issue concerns the status of intent language. Legislative Counsel advises that “intent” language does not have the same weight as “substantive” language. Intent language is most often used by the courts to resolve disputes within the law itself. And given that the substantive portions of the practice act are clear, counsel concluded that the intent language does not broaden an acupuncturist’s scope of practice.⁴⁷ This legal opinion from the Legislative Counsel is included in Appendix G.

Secondly, the term “primary care” has many meanings. In more recent legislation – concerning naturopathic doctors, for example – the Legislature defined how the term was used in the context of that practice act. The term is predominantly used in a managed care model for physicians who are authorized to manage a patient’s comprehensive health care, including referrals to specialists. A more limited use of the term is to describe practitioners that patients can directly access for a specialty or complementary treatment.

Defining Primary Care

The University of California, Center for the Health Professions compiled definitions of the term primary care provider (or practitioner or profession), among them:

- Independent practitioner; a practitioner who may see patients without the need for a referral or prior diagnosis;
- “First contact” health care practitioner; an independent practitioner but likely with the responsibility or expectation that ordering of tests and referrals to other practitioners or specialists will be made as indicated (may or may not be associated with managed care or reimbursement policies);
- “Gatekeeper” practitioner who determines if a patient needs to see another practitioner, and if so, which type (most commonly used in managed care settings);
- As distinguished from a specialist; in this meaning, primary care is basic or general health care and may be considered comprehensive when the provider takes responsibility for overall coordination of the care of the patient’s health care problems (most commonly used in profession of medicine; using this definition, the medical policy discussions around primary care have centered on an articulation of types of MDs authorized in managed care as primary care practitioners (family practice, general practice, internal medicine, pediatrics and sometimes obstetrics and gynecology) in contrast to specialists (all others);
- Provider of treatment of routine injuries and illnesses and focuses on preventive care;
- Health care provider who assumes responsibility and accountability for the continuity of all health care of a patient (generally a physician but increasingly provided by others such as nurse practitioners and physician assistants);
- The Institute of Medicine defines primary care as “the provision of integrated accessible health care by clinicians that are accountable for addressing a large majority of personal health care needs, developing sustained partnerships with patients, and practicing in the context of family and community.”

Former Governor Edmund G. Brown Jr. testified that the goal of the 1980 legislation was to ensure that consumers could choose to see practitioners of traditional Oriental therapies without a doctor's prescription.

However, attorneys for the Acupuncture Board have relied on the intent language to craft legal opinions enabling acupuncturists to diagnose patients using modern technologies and the board has used the intent language to support broader educational requirements including more Western medical training, particularly as it relates to diagnosis.⁴⁸

The Debate Over Diagnosis

The ambiguity in the law emerges as a controversy in regard to the authority of acupuncturists to diagnose patients. Unlike the practice act for other health care professions, the acupuncture statute does not explicitly authorize the diagnosis of patients.

However, in a series of legal opinions and memoranda, the Department of Consumer Affairs has concluded that in removing the physician referral requirement the Legislature implicitly gave acupuncturists the authority to diagnose patients before treating them.⁴⁹

In early opinions, the department's attorneys concluded that acupuncturists could diagnose patients, but were limited to a traditional Oriental diagnosis. And in fact, the distinction between Eastern and Western diagnosis buttressed the case of implicit diagnostic authority. For example, a 1986 letter from the department concluded: "We are informed that a diagnosis in Oriental medicine is undertaken in a manner different from Western medicine. It would be illogical to conclude that an acupuncturist may treat a patient and then hold that an acupuncturist may not make a diagnosis before he or she undertakes such treatment."⁵⁰

In the most recent and comprehensive legal opinion issued in 1993, the department did not distinguish between Eastern and Western diagnosis. However the author of that opinion in public discussions has qualified the authority to diagnose "within the scope of practice." And the written opinion also states that practitioners are limited to only those modalities in the statute – "rather than the full range of procedures and treatments traditionally associated with Oriental medicine."⁵¹

Regulators periodically assess what practitioners are actually doing as a way of assessing the alignment between the regulatory scheme – including scope of practice – and reality in the marketplace. The Department of Consumer Affairs conducted an occupational analysis for

acupuncture in 2001 that documented close alignment between the legal practice and the actual practice. The potential exception is diagnosis, which acupuncturists consider critical to their practice but which is not explicitly authorized in statute.⁵² According to the board, the occupational analysis also revealed that “Western science diagnosis” was one of the “content practice areas” that had increased since the previous analysis.⁵³

Still, confusion, or at least uncertainty, persists. During the Sunset Review Process, the Acupuncture Board and a number of professional associations requested that diagnostic authority be explicitly added to the statute. But, according to the board, the Joint Legislative Sunset Review Committee believed that adding diagnosis authority to the statute would constitute an expansion in the scope of practice.

And Which Diagnosis?

In order to affirm whether acupuncturists can diagnose patients, policy-makers are confronted with the next issue: Are acupuncturists limited to traditional Oriental medicine, or an evolving blend of traditional Oriental medicine and modern biomedicine? While some in the profession want to stay focused on traditional practices (those included in the statute), other advocates are pushing for both a modern interpretation of how acupuncture affects the body, as well as access to modern technologies that were developed as part of the biomedical model.

The intent language in statute refers to an “art and science” that is a more holistic approach to health, but the language does not comprehensively define Oriental medicine. And as a result, policy-makers have had trouble assessing incremental proposals to change the practice act. For example, when the profession and the Acupuncture Board asked that acupuncturists be given the title of “Doctor of Oriental Medicine,” the Joint Legislative Sunset Review Committee pointed out that Oriental medicine is not defined in the law. (In addition, as referenced above, legal opinion 93-11 states that acupuncturists are not authorized to perform the full range of Oriental medicine.)

The board requires that students in acupuncture schools be trained in traditional Oriental medicine, including “the theory and practice of traditional diagnostic and therapeutic procedures.” It also requires that within their clinical training, students be trained in “diagnosis and evaluation – the application of Eastern and Western diagnosis procedures in evaluating patients.”⁵⁴

In regulations proposed to implement the new 3,000 hours of minimum training, the board more specifically described the education and

training in Oriental diagnosis that students must receive. But the proposed regulations also would add significant education in Western or biomedical subjects – and diagnostic techniques, in particular.

One justification for including Western concepts is to prepare practitioners – as primary care providers – to interact with specialists in Western medicine. But it is unclear where to draw the line and at least some professional organizations suggest there should be no line at all. For example, the Standards of Care, prepared by the Council of Acupuncture and Oriental Medicine Associations, which was adopted as a reference document by the board, states: “Oriental Medicine, by its nature and definition involves an individualized approach to patient management. It does include the assessment of syndromes within the theoretical constructs of Traditional Chinese Medicine as well as the diagnosis of biomedical syndromes common to modern biomedical systems.”⁵⁵

In addition, some of those advocating for greater Western training also are seeking the title of “doctor” and access to insurance reimbursements – making it difficult to sort out economic aspirations from medical issues.

This tension is subtle, but is perhaps the most significant issue facing the profession, policy-makers and the public. A former member of the Acupuncture Board, and chair of the board’s Task Force on Competencies and Outcomes, said in recent debates that the department’s legal counsel has concluded that “the primary care status refers only to the ability of an acupuncturist to treat a patient without having them first see a Western practitioner. They are not given, within their scope, the responsibility to diagnose and treat disease from a Western medical framework. This remains a contentious issue.”⁵⁶

The initial goal of policy-makers was to allow Californians, particularly immigrants, direct access to traditional healers, either because that is what they are accustomed to, or because they are dissatisfied with the results of modern Western medicine. Former Governor Brown testified that the essential policy decision was to provide the personal freedom to choose a healer.

But that liberty gives rise to a second concern: that in choosing one form of medicine over another, patients may not be fully aware of the potential or limitations of each. This lack of understanding could have significant consequences in the form of a missed diagnosis, ineffective treatment, or potential side effects. This is especially important given that the scope of practice does not define or limit the ailments that acupuncturists can treat. Traditional Oriental healers used these modalities to treat nearly

all ailments, and the board's written material implies that treatment is efficacious for ailments when scientific studies have proven otherwise.

The original safeguard to the public was the requirement for a physician referral. Given the fundamental differences between the two healing practices, it is understandable why policy-makers believed that physicians as gatekeepers would be an “unnecessary hindrance” for those seeking traditional Oriental medicine. But under the new scheme of “direct access,” policy-makers did not ensure that the public received the formal notification that would allow them to make informed choices and protect themselves.

Other countries such as Germany require written risk information to be provided to patients along with signed consent releases.⁵⁷ This is a common way to balance consumer freedom and protection. In addition, the following spectrum of integration displays some models for providing patients with the full range of care from practitioners competently practicing within their scopes.⁵⁸

<i>Spectrum of Integration</i>			
Shoulder to Shoulder	Interactive	Consultative	Prescriptive
Joint clinical team practice with Western-trained practitioners	Shared clinical verbal and written reports/consultations between MDs and LAc's MDs continue case management	Requires MD physical in first month of treatment (or 8 visits) for clearance	Requires MD visit prior to any treatment
Frequent in Asia	Weil - U. Arizona Integrative Medicine	Israeli Task Force	Kaptchuk - Harvard Medical Model

This spectrum also reveals alternatives to expanding the acupuncture scope of practice relative to Western diagnosis, testing and procedures.

As it relates to acupuncture, concerns about consumer understanding are escalated if acupuncturists are authorized to order modern laboratory tests. The concern is not the tests themselves, but the ability of acupuncturists to use the information to make a diagnosis – Eastern or Western – as well as the patient’s perception that the diagnosis would be the same as if an MD had reviewed the same test results.

Traditional Oriental medicine exclusively relied on external physical cues such as the brightness of eyes, skin and tongue coloration, and ultra-refined pulse-taking to determine diagnoses such as blocked chi.

The statutory scope of practice does not explicitly authorize the use of modern tests. However, attorneys for the Department of Consumer Affairs have opined that some modern tests are permitted, including blood tests and X-rays, while other tests are not. (The analysis by the Center for Health Professions details the legal arguments.)

Professional associations rationalize this trend as an essential and natural development of the practice that mirrors the evolution of medical practice in China and other Asian nations. However, California, as with other states, already has a means for regulating Western medical practice – supported by separate educational, professional and licensure institutions. This blending of Eastern and Western medicine complicates regulatory efforts and has the potential to confuse the public about the preparation and training associated with state-licensed acupuncturists.

Acupuncture Stands Out

Among the research into traditional Oriental therapies, acupuncture needle therapy is showing some of the most promising results. The National Institutes of Health has found that acupuncture can relieve certain types of pain, nausea and vomiting.

Acupuncture also appears to enhance treatment for drug and alcohol addiction. According to an expert committee convened by the federal Center for Substance Abuse Treatment, auricular (ear) acupuncture can be effective as part of a comprehensive treatment program. The center noted that acupuncture is being used in approximately 25 percent of U.S. drug courts and in almost 700 substance abuse treatment facilities nationwide.

However, the focus of the profession and regulators has been to prepare practitioners to provide the full range of treatments and serve as “primary care providers.” Toward that end, the Legislature in 2002 significantly raised the educational requirements for entry-level practitioners to 3,000 hours and the Acupuncture Board would like to raise the standard to 4,000 hours to provide more training on the use of herbs, diagnosis and communicating with the Western medical health care system.

From a public policy perspective, higher educational standards can deter people from entering the profession, reducing public availability of services and raising costs. These consequences are sometimes endured if there is a countervailing concern about the quality of care.

In this case, while the higher standards may be warranted for someone preparing to offer the full range of traditional Oriental therapies, the extra training may be unnecessary for a person wanting to practice only acupuncture. Given the effectiveness analysis, policy-makers should consider ways to ensure quality and access to the services that consumers need and want.

Other states recognize acupuncture in its own right, separate from other modalities of traditional practices, such as herbs. An acupuncture-only license would authorize a more narrow scope of practice for those who received less training and passed an acupuncture-only exam, without diminishing the scope of practice for those fully trained in traditional Oriental therapies.

Sources: CSAT Draft Treatment Improvement Protocol (TIP) on Guidelines for the Incorporation of Acupuncture into substance abuse treatment; Alan Trachtenberg, former Planning Chairman, NIH Consensus Conference on Acupuncture and Project Officer, testimony and interviews, 2003. CSAT TIP on Guidelines for the Incorporation of Acupuncture into Addiction Treatment.

From a practice standpoint, acupuncture and Oriental medicine might be best realized as an alternative or complement Western medicine if the two systems coordinate care to patients. There are several models – some of them regulatory, others based on profession-developed best practices – to formalize this cooperation. But under those models, licensure regulation is still predicated on a clear scope of practice that is faithful – and limited to – the basis of the healing tradition or science.

Unraveling the Confusion

Policy-makers will find it difficult to address one of these issues without addressing all of them. And without squarely dealing with the fundamental questions, the tensions will not be eased and the public will be denied the benefits that clarity will bring. To unravel the confusion, policy-makers will need to do the following:

Clarify the role of acupuncturists in the health care system. The law should clarify that patients have direct access to acupuncturists. The statute also could go beyond a list of modalities to include disease-specific guidelines or limitations, such as those that apply to cancer. The statute also could establish the requirement for referral to MDs or other primary care providers in the biomedical health care system when appropriate. The statute should define essential terminology, such as primary care provider. And commensurate with the freedom to choose healers, the statute should provide for notifications on the limitations of traditional Oriental medicine.

Determine the “medicine” that regulation will cover. The statute should clearly define the medicine that licensees are authorized to practice. The position advocated by many acupuncturists to modernize and westernize traditional Oriental medicine will likely lead to a greater collision – rather than cooperation – among the professions. And ironically, to the extent that patients are seeking an alternative to Western medicine, that trend may not satisfy what patients seek. But the foremost factor of policy-makers must be patient safety. And the public will not be protected by a regulatory scheme premised on a hybrid of Western and Eastern practices that bypasses the training and licensure structures already in place for modern scientific medicine.

Specify diagnosis within scope. There is little doubt that policy-makers intended acupuncturists to diagnose patients before treating them. But the tensions over what that diagnosis will involve – traditional Oriental or Western biomedical – have frustrated efforts to make this needed clarification in the law. Unless the first two issues are resolved, it will be difficult, and perhaps even inappropriate, to explicitly authorize diagnosis.

Summary

The existing scope of practice is both precise and insufficient. To provide an adequate framework, lawmakers will need to go beyond listing some traditional Oriental modalities to define in statute what is meant by traditional Oriental medicine.

The policy choice to give patients direct access to acupuncturists was clear, but the statutory intent to regulate acupuncturists as a “primary care health care profession” is not. The term has many potential meanings. While some people may turn to acupuncturists first for everything that ails them (one potential meaning), it is difficult to see how practitioners of an alternative healing paradigm can be responsible for coordinating care with biomedical specialists (another potential meaning).

Finally, while the direct access policy provided choice, it did not provide for informed choice. And unless the government wants to regulate a healing profession based on proven efficacy, it will need to take steps to make sure that patients understand the potential limitations as well as the benefits of a particular therapy.

Recommendation 1: The Governor and the Legislature should clarify in statute the role of acupuncturists in the health care system. Specifically the statute should:

- ❑ ***Keep licensure focused on traditional Oriental medicine.*** Consistent with existing “intent language” and legal opinions, the statute should clarify that licensure is for the practice of traditional Oriental medicine as an alternative and a complement to Western medicine. Practitioners interested in mastering both Eastern and Western methods should continue to seek licensure under both systems.
- ❑ ***Define primary care practitioner.*** The statute should make it clear that acupuncturists are primary care practitioners within the context of traditional Oriental medicine, and are responsible for referring patients to primary care practitioners in the conventional medical system when appropriate. The law should make it clear that the definition does not impose requirements on health care providers regulated by the Knox-Keene Act.
- ❑ ***Authorize and define traditional Oriental diagnosis.*** The scope of practice should include an explicit authorization to conduct traditional Oriental diagnosis. Practitioners who are already licensed and choose to perform biomedical tests in making any diagnosis

should be required to complete specific continuing education requirements and take a supplemental examination.

- **Require disclosure of critical information.** Patients should receive information on the benefits of coordinating care with MDs and accurate information on the efficacy of traditional therapies. They should receive safety precautions, for example, about single-use disposable needles, alcohol preparation of skin, herb-drug interactions and the potential for herbal contamination. Practitioners should be required to report malpractice settlements.

- **Allow for acupuncture-only licensure.** To ensure public access to acupuncture services – for instance, to promising addiction therapy – a separate category of licensure should be created for professionals who provide only acupuncture, and not the array of traditional Oriental therapies. A reduced educational curriculum and examination would have to be developed and implemented.

Education

In SB 1951, the Legislature asked the Commission to:

"Review and make recommendations on the education requirements for acupuncturists."

In AB 1943, the Legislature asked the Commission to:

"Review increasing 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."

Finding 2: The new 3,000-hour educational requirement is adequate to prepare entry-level practitioners and to protect the public safety.

Requiring specific education and other training is one way that government regulators can establish minimum competencies among entry-level professionals. A primary goal of educational requirements is to provide some assurance that new entrants to a profession have the knowledge, skills and abilities necessary to safely practice.

According to the Center for the Health Professions at the University of California, education and training hours should be based on the "legitimate length of time necessary to learn the respective knowledge bases and skills."⁵⁹ And the standard for professional licensing is to ensure that incoming licensees can perform the legally authorized scope of practice as entry-level practitioners.⁶⁰

Additional Research

The Center for the Health Professions at the University of California, San Francisco, conducted a review and prepared a detailed analysis of the current curriculum of Acupuncture Board-approved acupuncture and Oriental medicine educational programs. The center also reviewed responses to a survey of Acupuncture Board-approved institutions relating to educational issues.

The center also analyzed possible implications of the increase to 3,000 hours, including the impact on schools, the Acupuncture Board, students, the marketplace, the public and current practitioners.

The executive summary of that analysis is in Appendix D. The full report is available on the Commission's Web site.

In this way, educational requirements link the legal scope of practice and the licensure examination. These three regulatory tools need to be aligned to prepare practitioners so a minimum threshold of public safety is satisfied.

Given this baseline, policy-makers should increase educational requirements if existing standards are inadequate to support minimum competencies for the existing scope of practice, or if the scope of practice is expanded or changed.

An overarching guidepost for this and other regulatory decisions is fairness.⁶¹ That standard is grounded in the 14th Amendment to the U.S. Constitution and has been applied by the courts to the regulation of professionals. Specifically:

In the context of professional licensure, the due process clause imposes three essential requirements: specificity, rationality, and fairness. Specificity means that the standards used by a licensing board in its decision to grant, deny, suspend, renew, or revoke a license must be clear and intelligible in order to be constitutionally acceptable. In order to be rational, the standards must be reasonably related to the professional practice, and the ultimate goal of protecting the public welfare. Fairness, although more difficult to define, concerns the composition of the licensing board, the procedures it uses, and how and when a decision by the board can be appealed to a higher authority.⁶²

Finally, as it relates to the education of acupuncturists, the primary goal of competency in acupuncture needs to be augmented by the ability to communicate and coordinate care with the fundamentally different Western health care system. Just as this nexus is contentious in discussions regarding the scope of practice, this intersection is contentious in policies regarding educational standards.

A Steady Increase in Educational Requirements

Between 1976 and 1978, when acupuncturists were first certified in California, approximately 900 practitioners with between two to five years of experience were “grandfathered” into licensure.⁶³ Those with five years of experience (or three years if affiliated with approved medical school programs) were “grandfathered-in” without education or examination requirements. Those who could prove two years of experience were still required to take an examination, but did not need to present proof of education.⁶⁴ From 1976 to 1984, board regulations required new practitioners who did not have two to five years of experience to have 1,350 hours of training.

In 1985, six years after the legislative decision to allow patients to have direct access to acupuncturists, the board increased the education hours from 1,350 to 2,348 hours, a 74 percent increase.

Over the last several years, the acupuncture profession and the Acupuncture Board have advocated for further increasing the educational requirements. Those efforts included an attempt to raise the educational requirement to 3,200 hours through the regulatory process, which was rejected by officials at the Department of Consumer Affairs.

In a statement to the Commission, the former director of the Department of Consumer Affairs said:

There is often an initial impulse to assume that more education, more training hours, improve the performance of licensed professionals. But our job at the Department of Consumer Affairs was to ensure that proposed increases in license requirements were directly related to the scope of the profession as defined in law; and equally important - objectively warranted in order to ensure the safety of consumers, and not designed to, or have the effect of, inappropriately restricting access to practice. The proposed acupuncture regulations to increase education requirements did not meet any of these tests.⁶⁵

The board subsequently formed a Competencies and Outcomes Task Force, which identified a range of hours needed to teach necessary elements, and ultimately recommended 3,000 hours in training. Legislation was passed in 2002 - AB 1943 (Chu) - which raised the standard to 3,000 hours, a 28 percent increase, effective January 1, 2005. Still, the board and the profession have advocated for even higher minimum educational standards of 4,000 hours.

The 3,000-hour standard was not prompted by a new increase in the scope of practice. Rather, the argument for increasing education levels is based substantially on the 1979 change in law enabling consumers to be treated by acupuncturists without having been diagnosed and referred by medical doctors.

California's Education Timeline

1972-1975. No training specified.

1975. SB 86 (Song-Moscone) established that candidates satisfactorily complete "a course in acupuncture which shall be approved by the board," and pass a board-administered examination, or, prove that "he has performed acupuncture for at least five years," or three years in a specified program.

1975. The Acupuncture Board adopted regulations requiring 1,350 hours of acupuncture education as a prerequisite to the acupuncture examination.

1978. Tutorial apprenticeship program established.

1985. The minimum educational requirements were raised to 2,348 hours by board regulations.

1999. World Health Organization recommended 2,500 hours of training for non-medical acupuncturists (2,000 hours for acupuncture, 500 hours of Western science, no herbs.)

2005. The 3,000-hour requirement (including 450 hours for herbs) will go into effect.

Sources: SB 86. Chapter 267, Statutes of 1975; Acupuncture Board Strategic Plan, Sunset Review Materials and Competency Task Force; Legislative analyses, legislation, World Health Organization 1999 *Guidelines on basic training and safety in acupuncture.*

The board's proposed regulations reflect the recommendations of the task force. Some of the requirements appear to respond to patient safety concerns associated with direct access. For example, the proposed regulations would add 40 hours in public health, including eight hours of first-aid and cardiopulmonary resuscitation from the American Heart Association, American Red Cross, or other board-approved organization.

But the board also includes 350 hours of "basic sciences" to be taught at an acupuncture school approved by the board. The subjects include biology, chemistry, physics, biophysics, psychology and counseling skills, anatomy, physiology and pathology.

In addition, the new regulations would add 240 hours of "clinical medicine, patient assessment and diagnosis," which would include the International Classification of Diseases (ICD), which is used in Western medicine. This new section would require students to learn "procedures for ordering diagnostic imaging, radiological, and laboratory tests and incorporating the resulting data and results."⁶⁶

As described in the scope of practice discussion, attorneys for the Department of Consumer Affairs have long asserted that acupuncturists do not have the authority to provide Western diagnosis, and the Legislature declined to even add the word diagnosis to the scope of practice. So at the least, the new curriculum will substantially increase minimum training requirements in areas of practice where the legal authority to provide that service is unclear.⁶⁷

According to a UCSF analysis, the acupuncture curriculum is far more detailed and prescriptive than the educational requirements for other health professions. The regulations also would incorporate a task force recommendation that students be taught the practice of "bleeding," which is not listed in the approved scope of practice.⁶⁸

Acupuncture Board Task Force on Competencies and Outcomes

That task force was comprised of 20 members appointed by the board, each of whom either represented one of the schools or was a licensed acupuncturist. They deliberated for six months and in April 2002 recommended increasing education hours to 3,000 for new entrants. The task force recommended the hours include 2,050 classroom instruction and 950 hours of clinical practice. Their recommendations for classroom hours follow:

Clinical medicine: patient assessment and diagnosis	240
Practice management	
45	
Case management	90
Professional development	30
Public health	40
OM Principles, Theories and treatment	1,255
Basic Sciences	350
(Biology, physics, physiology, anatomy, pathology, etc.)	

The Acupuncture Board, in the proposed regulations, makes the following arguments for raising the standard to 3,000 hours:⁶⁹

1. "California Business and Professions Code Section 4926 states that individuals practicing acupuncture be subject to regulation and control as a primary health care profession.... The board's main objective is to require an adequate level of education, which is more consistent with standard health care, providing the applicant with the knowledge, skills and abilities to perform as a primary health care professional. A licensed acupuncturist is a first-contact health care professional who possesses the skill 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." The board cites a 1997 analysis by the Senate Office of Research stating that acupuncture education is not comparable to other health professionals in the workers' compensation system.
2. "All primary health care providers, medical doctors, doctors of osteopathic, doctors of chiropractic, doctors of podiatry, and naturopathic doctors have a core medical curriculum leading to a basic medical understanding. All medical practitioners should have an overview of the strengths and weaknesses of other modalities in order to know when to refer and who best to communicate to those providers."
3. The World Health Organization in 1999 recommended 2,000 hours of acupuncture training. This is in addition to the WHO recommendation of 500 hours of "Modern Western Medicine Theory and Clinical" training to provide acupuncturists with the "ability to decide whether a patient may safely and suitably be treated with acupuncture, or should be referred to a health professional or facility."⁷⁰ Unlike California, the World Health Organization does not include herbs in acupuncture practice.
4. In 1996, the board surveyed 1,000 practitioners with less than six years of experience. The board's assessment of the results was that the majority felt they needed more education in herbs, and many felt they needed more education in all areas of practice. Also, a variety of surveys have been conducted that indicate graduating students feel unprepared, particularly in communicating with Western medical professionals and in business aspects of solo practice.⁷¹

Typically, efforts to increase educational standards also would be supported by evidence that the existing standards are inadequate to ensure patient safety. However there is no evidence that the standards set in 1985 are jeopardizing patient safety.

Arguments For Going Beyond 3,000 Hours

In raising the educational standard to 3,000 hours, the Legislature also opened the door to an even higher standard by asking the Commission to assess the need for 4,000 hours for acupuncturists to “fully and effectively provide health services under their scope of practice.”

Some proponents argue that an even greater increase in training is necessitated by patient safety issues, including lack of knowledge of “red flag” medical conditions, first-aid and CPR, herb-drug interactions and communicating with Western providers.⁷²

But the persistent argument for raising the standards to 4,000 hours is based more on the comparison with biomedical practitioners than what is needed to safely practice acupuncture. The Acupuncture Board told the Commission: “The board’s goal is to ensure an acupuncturist possesses a level of education that is consistent with levels of education for other primary health care professions in the United States.”⁷³

However, the goal of parity in terms of educational standards assumes that the skills, knowledge and abilities of being a medical doctor require the same “hours” of education as the skills, knowledge and abilities of being a chiropractor, a podiatrist or an acupuncturist. As established earlier, education requirements are one tool to prepare practitioners to serve at an entry-level capacity within their own scope of practice. The purpose of educational standards, from a regulatory standpoint, should not be to enhance professional standing.

A former deputy director of the Department of Consumer Affairs and former executive officer of the Acupuncture Committee told the Commission: “State regulation and a rise in educational hours should be mandated only when there is a need to protect consumers.”⁷⁴

Still, some professional organizations assert that educational standards should be raised as a way to elevate the profession’s standing in the health care world. For example, the president of the Council of Acupuncture and Oriental Medicine Associations wrote: “The professionals in the field of Chinese medicine proposed AB 1943 to increase the education level to 4,000 hours and a doctoral entry level of Oriental medicine. It is hoped that the professional level of acupuncturists can be elevated through the establishment of doctoral

degree education which will meet the public demand, to confirm the primary care provider status, so that we can apply our skills in gaining acceptance by the insurance industry and serve the people of California."⁷⁵

California Association Leaders on Education

Association of Korean Oriental Medicine and Acupuncture of California (Yong Sup Lee, L.Ac, President). "The current [2,348] curriculum hours of training are not adequate. A majority of graduates from acupuncture schools indicate that they are not adequately trained to perform as primary health professionals, that they do not have enough knowledge and skills to take good care of patients, and that they are not confident in their abilities to treat basic problems... It is important to increase curriculum hours, but it is more important that the hours of training requirements be fully accomplished...recommend increasing curriculum hours up to about 4,100 hours. 3,000 hours are far shorter than foreign countries' curriculum in Korea and China."

California State Oriental Medical Association (Howard Kong, BA, L.Ac., President, CSOMA). "Education and training to allow acupuncturists to coordinate health care with other health care professions may be insufficient. ...The current curriculum and training requirements for California licensed acupuncturists has been adequate for new entrants. ...People have started to rely on acupuncture and Oriental medicine for more basic, primary care.... Rather than simply changing the number of hours to qualify a curriculum, to augment the system with competency-based program... to require specific competencies for any specific topic...practical...[clinical skills] should be tested in schools. ...There is no single topic that could not be taught within the 3,000 hour scheme... Any level of education could be provided within a fix[ed] amount of time: good/sufficient education or bad/insufficient education."

Council of Acupuncture and Oriental Medicine Association (Brian Fennen, B.S., L.Ac., Executive Director) "The current 2,348 hours of curriculum are totally inadequate, as evidenced by numerous task forces comprised of experts. The 3,000 hour curriculum that the Acupuncture Board has proposed will be a great improvement because it contains more specific subject matter. However, it still should include more clinical hours. ...The state should not allow licensed individuals to practice independently unless they assure that they are adequately prepared to compete and survive in the open market in their profession. ... Require basic sciences as a prerequisite. Many students enter school without adequate knowledge of biology, chemistry, anatomy and physiology. Teaching students point location before they have completed one year of anatomy simply slows the entire class down. Without basic biology, chemistry, biochemistry, and physiology, students learning pharmacology and herbal medicine are hindered. Without knowledge of neuroanatomy and physiology, students cannot be expected to understand the mechanisms of acupuncture. Without a thorough respect for basic science, many students enter school with the impression that acupuncture and Oriental medicine is simply some kind of imaginary "energetic" medicine that will never be explained. ... Hours [should] be increased to 3,500 – 4,000 hours. This is the commonly recognized standard of education expected of all primary health care professions in this country, as well as for Doctors of Oriental Medicine in China and Korea."

National Guild for Acupuncture and Oriental Medicine (Deke Kendall, Ph.D., L.Ac., Director of Education and Research) "Increasing the training to 3,000 hours is a step in the right direction and this should already be considered an O.M.D. level of training... Increasing the training to 3,000 hours is a major improvement in the right direction. These hours do provide an opportunity to assure that training could be consistent with the type of patients and presenting conditions that new graduates are most likely to encounter when they first start their practice."

Source: Written questionnaire responses submitted to the Little Hoover Commission, 2003.

In responding to a questionnaire from the Commission, a number of professional advocates expressed that the 3,000-hour requirement would resolve many of the preparation-related concerns. Still, they advocated for higher requirements.⁷⁶

Some professionals seeking to use the title “doctor” said the additional hours would justify that privilege. Others suggested a need to increase hours to create programs equivalent to education in China. A University of Arizona analysis of the Chinese traditional medicine programs, however, states that the average number of education hours for traditional-Oriental-medicine-only is 1,775 didactic and 1,008 supervised clinical hours, totaling 2,783.⁷⁷ The education and regulation in other countries is discussed more fully later in this section.

In addition to the parity goal, acupuncturists assert that new practitioners are not prepared to run businesses and some have suggested those skills should be included in an expanded curriculum. While those skills may be desirable for those intending to practice independently, they are not related to the health and safety of patients and so should not be required by regulation.

Finally, the board stated: “The profession of acupuncture and Oriental medicine must be able to adapt its educational standards to the ever-changing dynamics of science and technology applicable to the practice.” But this standard also is difficult and likely inappropriate for preparing practitioners to practice a healing art that is not based in Western science.

Arguments Against Increasing Hours

As explained previously, the purpose of education is to ensure minimum competence. Raising educational standards – beyond what is required for public safety – can discourage or delay new entrants into the marketplace, resulting in higher fees and lower access for consumers. When regulations unnecessarily limit competition, the options available to consumers are diminished.

An expert from the National Institutes of Health testified that there is no evidence indicating a need to raise education hours. He also stated that by doing so, consumer access could be unnecessarily restricted, particularly to promising addiction therapy.⁷⁸

According to the Pew Health Professions Commission, the “ostensible goal of professional regulation – to establish standards that protect consumers from incompetent practitioners – is eclipsed by the tacit goal

of protecting the professions' economic prerogatives. This dichotomy of goals has created serious shortcomings that include limited public accountability, [and] support for practice monopolies that limit access to care."⁷⁹

Specific to the acupuncture debate, some acupuncture schools have resisted the higher standards, asserting that the additional burden would unnecessarily discourage students. UCSF research also indicates that some acupuncture schools are operating on thin margins – and may not be able to stay in business if enrollments decline, even if students pay higher fees to cover the additional courses.

Implementation Concerns

The increase in minimum educational standards – as well as the Acupuncture Board's implementation of those standards – raises a number of concerns that the board, officials with the Department of Consumer Affairs, or lawmakers may need to address.

- ***Schools might not have expertise.*** Most accredited colleges have not been required to teach human physiology and other courses grounded in Western science. Expanding into this area will present challenges to those schools and particular efforts need to be taken to ensure that quality teaching takes place.
- ***Too much focus on Western medicine.*** In its proposed regulatory package, the board states: "All primary health care providers, medical doctors, doctors of osteopathic, doctors of chiropractic, doctors of podiatry, and naturopathic doctors have a core medical curriculum leading to basic medical understanding. All medical practitioners should have an overview of the strength and weaknesses of other modalities in order to know when to refer and how best to communicate to those other providers."⁸⁰ The basis for emphasizing Western science appears to be the 1980 intent language describing the need to regulate acupuncture as a primary care profession. But some stakeholders are concerned that too much of the expanded training is in Western medicine. They believe practitioners who want to remain faithful to traditional Oriental practices should not be required to adopt the modern Western paradigm.
- ***Transferability of credits.*** Because acupuncture schools do not provide degree programs in Western medicine, courses in those subjects taken at acupuncture schools may not be accepted at colleges that do grant degrees in those subjects. This is an important factor if acupuncturists are interested in becoming dually trained and

if the public is to benefit from complementary treatments that are coordinated with the biomedical health system.

- **Implementation may be uneven.** The UCSF analysis indicates that the method for counting credit hours is not standardized among the schools. As a result, counting hours is a crude measure that needs refinement.
- **Availability of skilled and learned professors.** A shortage of master teachers outside of Asia may impact the quality of education in acupuncture and traditional Oriental medical in California. This shortage also bears negatively on the consideration of some schools and professionals in their desire to develop doctorate programs.

In addition to the above concerns, UCSF's analysis states that the time frame for schools to implement the increase in specific required course work "is extremely ambitious."⁸¹

Implementation Opportunities

While there are fervent efforts to increase the hours associated with preparation, there are other avenues for increasing preparation that may better serve students, patients and the public interest.

Require prerequisite degrees. California could do as other states and adopt prerequisite standards to ensure that students have a grounding in Western health sciences. New Hampshire, for example, requires applicants for licensure to have either a bachelor's degree, nursing degree, or physician's assistant's license, in addition to completion of their acupuncture coursework.

Similarly, officials at San Francisco State University have recommended that acupuncture students be required to have a bachelor's degree in certain sciences.⁸² SFSU has developed a health sciences pre-professional curriculum to prepare students to enter osteopathy, naturopathy, physical therapy, and other health professional training programs. Requiring scientific prerequisites for everyone entering the health professions could ensure that practitioners understand and can discuss human physiology, biology and chemistry.

Acupuncture schools accredited by ACAOM already require incoming students to have an associate of arts degree. And since 28 of the 31 acupuncture schools accredited by the Acupuncture Board are also accredited by ACAOM, that standard is in place for most students who will take the California licensing exam. However, the ACAOM

requirement is not based on California's recent emphasis on increasing the Western medical training of future acupuncturists.

Encourage dual degrees. The study of multiple healing arts would be facilitated by requiring that basic science classes be taken as prerequisites at institutions that are accredited to grant degrees in those topics.⁸³ This could serve both the practitioner and the patient by enabling professionals to seek additional training as new technologies emerge and consumer preferences change.

Rely on standardized entrance exams. Some concerns have been raised about the ability of students to learn the curriculum required at acupuncture schools. If regulators develop evidence supporting this concern, they could explore using examinations relied upon by other master degree programs. Such examinations include the Graduate Record Examination for the study of scientific topics, or an exam similar to the Medical School Aptitude Test.

Perspectives from Other Health Professions and Nations

Some stakeholders argued that California should raise its educational standards to match those in Asian schools. However, in Asia there are multiple paths for studying acupuncture, including tutorial, vocational, college and university training.⁸⁴

The education of acupuncturists and traditional practitioners in Asia is not significantly incorporated into the training in modern medical schools. Acupuncture in Asia is taught primarily in schools devoted to traditional practices. In addition, some modern medical schools have sections exploring the scientific application of acupuncture.⁸⁵

In many Asian hospitals, acupuncturists work side by side with MDs, providing intern opportunities for new acupuncturists in team settings.⁸⁶ A minority of practitioners study both traditional and biomedical approaches to healing to the degree of becoming proficient practitioners of both.⁸⁷

In China, according to a professor and party official at Beijing University of Traditional Chinese Medicine, there are multiple paths and levels of study in acupuncture institutes and traditional programs, and the Chinese government has moved toward requiring licensure and establishing research programs in modern medical schools to learn more about acupuncture's efficacy.⁸⁸ In Japan, acupuncture is taught in

vocational schools, colleges and universities and passing a national entry examination is required prior to practice.⁸⁹

In Japan, China, Australia, England and British Columbia, acupuncture and herbs are sometimes taught together and sometimes separately. Japan, Australia, England and British Columbia recognize acupuncturists and herbalists as different professions with separate licensure or recognition.⁹⁰ China's licensure and education is not uniform in the cities and rural areas, where traditional practices are more prevalent and not as regulated.⁹¹ England and British Columbia also recognize practitioners of traditional Oriental medicine as a higher level of training that includes acupuncture, herbs, and other traditional therapies. In Australia, acupuncture and herbs are often practiced in separate clinics.⁹² Australia has an educational structure that has a bachelor's degree as the first professional degree, and master's degrees can be obtained subsequently.⁹³ In Cuba, MD degrees are required as pre-requisites for the study of acupuncture.⁹⁴ And The World Health Organization recommends entry-level training for acupuncture that does not include herbs.⁹⁵

The Commission did not conduct an exhaustive comparison between California's regulatory approach and the scheme used in other countries. In its cursory review, it did see some interesting attempts to integrate traditional and biomedical health care. But the Commission did not find any reason to suggest that California policy-makers should fundamentally rethink the current standards of setting educational requirements to meet the current scope of practice focused on traditional Oriental medicine. And it did not find any educational model that fused traditional and Western medicine into a single practice.

Summary

Until the new standards are implemented, and the performance of students assessed, there is no way of determining whether an increase in hours above the 3,000-hour standard is necessary – particularly if the scope of practice is focused on traditional Oriental medicine. But there are steps that can be taken to make sure that existing requirements are better preparing practitioners.

Recommendation 2: The number of educational hours should not be increased, and should be focused on traditional Oriental healing practices within a modern framework for patient safety. Specifically, the Acupuncture Board should implement the following policies:

- ***Educate within scope.*** The State's required courses for licensed acupuncturists within schools of traditional Oriental medicine should

only be for subject matter needed to competently and safely practice the legal scope of practice.

- **Devote adequate curriculum to patient safety, including coordination.** Once the new curriculum has been implemented, an independent evaluation should be conducted to ensure that concerns about minimum training needs have been met. Special attention should be given to patient safety training, including:
 - ▼ Up-to-date infection control practices that meet the standards of the National Institutes of Health, such as exclusive use of single-use needles.
 - ▼ Improving coordination with Western medicine, including recognizing "red flag" conditions, and knowing when and how to refer to and work with physicians.

- **Teach within area of expertise.** Courses in physiology, chemistry, biology and other sciences should be taken at colleges and universities that are accredited to grant degrees in those areas. The board also should separately consider requiring successful completion of basic science courses as a prerequisite to educational training in traditional Oriental medicine.

Continuing Education

In AB 1943, the Legislature asked the Commission to:

"Review the competence of licensed acupuncturists who are not subject to the 3,000-hour minimum curriculum requirement, and training, testing or continuing education that would be required for these individuals to meet the standards for continued licensure."

Finding 3: The steadily increasing educational requirements for new entrants into the acupuncture profession potentially creates different levels of competency, and could confuse or mislead the public regarding the knowledge, skills and ability of those previously licensed.

In 1985 and again in 2002, the minimum educational requirements imposed on applicants for licensure were increased substantially.

When the first California licenses were issued in 1976, acupuncturists who could document five years of practice were "grandfathered" into licensure with no education or examination requirements. Acupuncturists who had practiced three years at an approved medical school program were similarly "grandfathered." Professionals who had practiced for two years or who had completed an acupuncture course were allowed to take an examination and be licensed.

Between 1976 and 1985, new licensees were required to have 1,350 hours of training. Since 1985, new licensees have been required to take 2,350 hours of training. And as of January 1, 2005, new entrants into acupuncture schools will be required to take 3,000 hours of schooling.

It is estimated that from 1976-1979, some 900 acupuncturists were licensed under the initial provisions.⁹⁶ The Acupuncture Board

Additional Research

The Center for the Health Professions at the University of California, San Francisco, provided the Commission with options to consider for licensed acupuncturists who are not subject to the 3,000-hour minimum curriculum requirement.

The executive summary of that analysis is in Appendix D. The full report is available on the Commission's Web site.

estimates that 320 "grandfathered" licensees are still practicing in California. Overall, 6,428 acupuncturists are currently licensed and living in California, but the Acupuncture Board does not know how many were licensed with 1,350 hours versus 2,350 hours of training.⁹⁷

The hours distinction is a surrogate for a substantial variation in the formalized training that professionals have received. Most of that additional education has been justified by expansions in the scope of practice. When the new standard goes into effect, many practitioners will have been licensed with only 1,350 hours of training, and were licensed prior to the time that acupuncturists could practice independently of MDs and were allowed to make diagnoses. Those 320 practitioners who were licensed from 1976-1979 will be practicing under the same scope of practice, and presumably some of them have even less formalized training.

Many of the professional organizations assert that existing practitioners have gained, through experience and continuing education, the knowledge that will now be required before licensure. As a result, they assert that existing practitioners should not be required to complete additional training or pass additional exams.

Acupuncture Board regulations require practitioners to take 30 hours of continuing education every two years.⁹⁸ Acupuncturists must provide "certificates of completion" of approved course work as a condition of renewing their licenses every two years. Similarly, the board issues two-year approvals to continuing education providers who meet the board's requirements and pay a \$150 fee. As of August 2004, the board estimates that there are 180 approved providers in California teaching some 450 approved continuing education courses meeting the following criteria:

*The content of CE courses must be relevant to the practice of acupuncture and be related to the knowledge and/or technical skills required to practice acupuncture, or be related to direct and/or indirect patient care. Courses in acupuncture-practice management or medical ethics are also acceptable.*⁹⁹

Raising the Standards for All

Most health professions have tried to raise the standards for both new entrants, as well as seasoned professionals. The University of California identified several options:

- **Additional coursework.** Recommending or requiring educational programs to develop and implement “catch up” programs to enable practitioners to gain required competencies.
- **Testing.** Using test-out options to enable practitioners to demonstrate knowledge or skills in required competency areas for the purposes of acquiring updated training and credentials.
- **Grace periods.** Establishing a feasible schedule upon which supplemental education or examinations can be completed considering the professional responsibilities and workload of practitioners.
- **Different titles.** Defining and implementing differential levels of titling or categories of licensure (or add-on) certification that reflect the various formal educational or career experiences of all professionals within a specific jurisdiction (new and current licensees) and that indicate to the public the specific set of requirements that one or another practitioner has met.

The university also identified two options that do not require existing licensees to increase their knowledge or demonstrate adequate knowledge, skills and abilities. The first is to grandfather licensees, assuming that continuing education or experiences have provided the knowledge that was missing in the previous educational scheme.

A second option is patient notification. For example, practitioners could be required to inform patients of the training they have received, including continuing education, and how it compares to the evolution of standards. In addition to disclosure, this policy would allow patients to make judgments of their own, based on preference for experience versus formal training.

Concerns About Continuing Education

There are persistent concerns that continuing education in many fields is ineffective, and there is no assurance that practitioners acquire specific skills. This is especially relevant for the California acupuncture profession, given that the push to increase educational requirements has been officially predicated on concerns that acupuncturists are unprepared to treat patients as independent practitioners.

The Department of Consumer Affairs does not have strong rules for ensuring the quality of continuing education that could be applied for all professional boards. Among the concerns across the professions are:

- ✓ **No examination.** Regulators do not typically test to ensure that critical new information is understood by professionals who are renewing their licenses, only initial licensees.
- ✓ **Open-ended curriculum.** Coursework is not targeted on information that is necessary to protect patients.
- ✓ **Inadequate audits.** Course content is not sufficiently audited.

Many professions and specialties have used private certifications for ensuring continued and improving competency, such as board certifications for various medical doctor specialty areas such as internal and occupational medicine.¹⁰⁰

Regardless, state regulators have an obligation to ensure that the continuing education programs that they have in place ensure safe practices are followed by all licenses.

Beyond Minimum Competency

In their quest to raise the standing of acupuncture, the profession may want to look beyond the entry-level requirements that are the basis of government regulation.

Because regulatory licensing requirements are viewed as minimal, hospitals, insurers and medical peers often require specialty board certification, not just licensure, as a proxy for quality to ensure that professionals meet continuing education standards that are higher than the State's.

For example, the American Board of Internal Medicine, a private organization, does not require specific course hours of continuing education. Instead, to become "Board Certified in Internal Medicine," the board requires proctored, in-person, two-day examinations, with re-examination of specific modules every 10 years on a variety of topics. This is in addition to periodic computer-based testing of specific knowledge areas. Board certification also includes periodic surveys of patients and peers.

Over time, the acupuncture profession may be better served by a uniformly accepted private system that goes beyond minimum competencies of entry-level practitioners as licensing is intended to provide.

Source: American Board of Internal Medicine.
www.abim.org. Web site accessed September 7, 2004.

The Acupuncture Board maintains that existing requirements for continuing education are adequate to ensure that current licensees have the knowledge, skills and abilities that will soon be incorporated in the higher educational standards.

From a public safety perspective, it is difficult to accept that new students should receive additional training on issues directed at improving patient safety without requiring current licensees to receive at least some of that training in a meaningful way. It is incumbent upon regulators to ensure that patient safety material is incorporated into the clinical practices of long-standing practitioners as well.

Some practitioners suggested a formula of applying years of experience as a factor in calculating additional continuing education requirements. However, new information that impacts patient safety will not be obtained through experience alone, particularly since so many acupuncturists are self-employed. Instead, continuing education requirements can be focused on the patient safety material that demonstrates the needed knowledge, skills and abilities.

Cancer treatment confusion. As discussed in the Background, the treatment of cancer patients is a perfect example of the need to use continuing education hours for the purpose of ensuring the incorporation of critical patient care information into practice. Cancer treatment is an area that could be clarified through a combination of patient disclosure information and well-designed continuing competency improvement education.

Summary

Given the dramatic rise in educational standards, policy-makers and the Acupuncture Board cannot assume that the experience of practitioners alone is protecting the public. The State has reasonable options for ensuring that all practitioners are developing the knowledge skills and abilities that are necessary to protect patients.

Recommendation 3: The Governor and the Legislature should reallocate – and consider increasing the number of – continuing education hours required of currently licensed practitioners as a mechanism to update patient safety requirements. The law should:

- **Specify courses.** The Acupuncture Board should identify the coursework necessary to keep practitioners current on "red flag" conditions, emergency procedures, emerging infectious diseases that require referral, exclusive use of single-use disposable needles, other patient safety issues, such as cancer treatment, and how to communicate effectively with Western practitioners.
- **Require examination.** The State should require testing for material related to patient safety.

Examination

In SB 1951, the Legislature asked the Commission to:

"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."

Finding 4: The examination of candidates for licensure is a critical quality control measure for assuring competency of providers and is an essential mechanism for ensuring that evolving public policy goals are met.

California's regulator has had difficulties with the acupuncture examination, including documented fraud and criminal charges during the 1980s that spawned security improvements. Efforts to improve the examination also have included consideration of replacing California's licensure test with the examination offered by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). However, the California profession has resisted this change over concerns that the NCCAOM test was inadequate. The Acupuncture Board also asserts that it is important for the State to maintain control of the test.

International and American Examination in Context

Most other California health professionals are licensed based on a national examination. However, the acupuncture profession is still

Additional Research

Psychometric consultants from the Department of Psychology at California State University, Sacramento and RAND conducted a comprehensive review and psychometric analysis of the California and the National Certification Commission for Acupuncture and Oriental Medicine exams. This includes statistical analysis and review of the underlying documentation, such as job analyses. The analysis also included a review of the examination procedures to measure compliance with the highest professional standards.

The executive summary of that analysis is in Appendix E. The full report is available on the Commission's Web site.

relatively new in its evolution within the United States and the profession in California has evolved somewhat differently than it has developed nationally. Just as different nations take different regulatory approaches to acupuncture, herbs and other modalities of traditional Oriental medicine, so do different states.

One significant difference among states and nations is whether acupuncture and herbs are regulated as separate skills and professions. That basic decision is one factor that drives the breadth and depth of an examination.

The National Certification Commission on Acupuncture and Oriental Medicine uses a modular approach to accommodate the varying strategies of states and to enable professionals to take the acupuncture examination only, or the modules of herbs and massage. This approach has led to at least 17 states accepting the NCCAOM for licensure. As the profession evolves in America, a national examination may become the norm.

In China, Japan, Australia, England and Canada, it appears that acupuncture and herbs are recognized as independent specialties that are frequently, but not always, practiced together and examined and regulated as such. In America, some states require knowledge of Western science and practices as prerequisites to entering the acupuncture profession, while others see acupuncture and traditional Oriental medicine as alternative and complementary, but not inclusive of Western ideas. For states like New Hampshire, which requires a degree in nursing or science prior to entering the acupuncture profession, the examination goals do not include testing Western knowledge, but the traditional Oriental practices.

Policy Considerations

Whether California should continue to have a unique examination has been a contentious issue. Among the concerns:

Profession-wide standards. Many professionals advocate for establishing one standard examination used nationwide, which like other health professions, allows for reciprocity within the United States. But some California acupuncture associations, especially those advocating for blending the practices of Western and Eastern medicine, are opposed to national standards and testing. To the degree that the NCCAOM exam does not test Western science and practices, the California professional organizations are concerned that it does not comport with the direction that they are attempting to move the profession.

Certification vs. Licensing. Some have stated that using the NCCAOM examination would be a lower standard because it is a certification, not a licensing examination. While licensing examinations test minimum skills, knowledge and abilities, certification examinations are often used by professions to indicate advanced specialized knowledge, skills and abilities. The independent analysis pointed out that many respected professions, such as Certified Public Accountants, have adopted this approach. Within professions, building expertise can be indicated by receiving advanced certificates of achievement on specific topic areas.

Modularity. NCCAOM's modular approach to examination of acupuncture, herbs and body work, accommodates variation among state regulations but is objectionable to those in California who believe these modalities should not be practiced separately. They assert that the modular approach is inconsistent with the idea that practitioners should be comprehensive providers. However, NCCAOM is instituting an additional examination of traditional Oriental medicine that may allay those concerns. In addition, the independent analysis notes that the national examination for medicine uses a phased, modular approach, and that "must-pass" modules are particularly useful for matters of health, safety and ethics.

Costs. The fees for taking the NCCAOM examinations are higher than for taking the California examination. It is estimated that 50 percent of California practitioners voluntarily take both examinations to have the option to practice nationally. Some have questioned why the modules of the national examination cost approximately \$2,000, while the California exam fee is significantly less, at \$550. Whether the California fees cover the full cost of the examination, or whether the lower cost of the California examination is subsidized by detracting from funds available for other board activities, such as enforcement, should be determined. If there is a subsidy, the California fee should be raised.

Test Analysis

For this study, a comprehensive review and psychometric analysis of the state and the NCCAOM examinations was conducted by consultants from California State University, Sacramento and RAND. The analysis found that both tests meet professional psychometric standards. However, the California examination was determined to be more rigorous than the NCCAOM examination. The analysis also found that the test items on the California examination are on average more difficult than the NCCAOM examination. Further, California's underlying documentation – upon which examinations are built – was stronger. The chart on the following page provides a comparison of the two exams.¹⁰¹

Evaluation Summary of the State and National Examination Programs

Portion of Examination Process		California	NCCAOM
Occupational Analysis	Form expert panels	Consistent with professional standards	Consistent with professional standards
	Identifying tasks	Consistent with professional standards	Consistent with professional standards
	Identify knowledge elements underlying the tasks	Consistent with professional standards	Not explicitly documented
	Organizing the job content	Consistent with professional standards	Consistent with professional standards
	Sampling respondents for job survey	Consistent with professional standards	Consistent with professional standards
	Statistical analysis of important job components	Acceptable but less than best practice	Consistent with professional standards
	Reliability of the job analysis questionnaire	Rater reliability: not computed	
Internal consistency: very high for tasks; very high for knowledge elements			Internal consistency: very high for tasks (no knowledge elements were on the survey)
Developing the exam	Weighting of the content areas	Consistent with professional standards	Consistent with professional standards
	Crafting items	Consistent with professional standards	Not documented
Administering the exam		Consistent with professional standards	Consistent with professional standards
Quality assessment	Test reliability	Consistent with professional standards	Consistent with professional standards
	Item difficulty levels	Moderate	Relatively easy
	Point-biserial correlations	Consistent with professional standards	Consistent with professional standards
	Comparability of language versions	Seems likely	Not documented
Pass point setting	Process used	Consistent with professional standards	Consistent with professional standards
	Passing rate	Around 55%	75%+ except for lower Korean pass rate
	Maintaining same minimal competency standards	Yes	Not documented
Source: Lawrence S. Meyers, Ph.D., Department of Psychology, California State University, Sacramento. June 21, 2004. "The Acupuncture Regulation Project: Evaluations and Comparison of California's License Examination and NCCAOM's Certification Examinations. Report to the Commission.			

Among the issues analyzed were the following:

Meeting standards of exam development and security. One concern raised in the course of the study, and allayed by the consultant's analysis, was that only the national examination has met external quality review standards and the California exam has not. This is of particular importance because of long-standing concerns that both examinations

are subject to corruption.¹⁰² To determine whether an examination meets professional standards, externally validated criteria and constant refinements to examination security are needed. California's examination is developed by the State's Office of Examination Resources within the Department of Consumer Affairs using what are nationally recognized as the highest professional standards. Similarly, the NCCAOM examination has maintained accreditation by the National Organization for Competency Assurance as meeting nationally-recognized high standards for validity, reliability and other factors.¹⁰³ Both exams were found to meet high standards of security, but it was noted that this issue is one that requires constant vigilance for all professions because incentives for corruption are high.

Examination difficulty. Some California professionals raised the concern that the NCCAOM examination is easier. This has been confirmed by the independent consultant, who found higher passing rates and easier questions on the national exam. However, the goal of the examination is to test for competency to practice safely, not to exclude competent practitioners. So the question of relative difficulty of examinations is not the central issue, but rather whether an examination has sufficient rigor to demonstrate minimum competency for safe practice. Notably, other states that use the NCCAOM examination are not known to be experiencing safety problems at a greater rate than California.

Good Tests, But Room For Improvement

In summary, the psychometrical and statistical comparison of the two examinations concluded the following:

Based on all of the documentation made available for this project, one cannot help but conclude that, despite some weaknesses or documentation failures here and there, both testing programs conscientiously strive toward excellence and have in fact produced very good products. The two testing programs have each captured a weighted composite of the tasks performed in professional practice, have generated items of high quality, and have determined passing criteria in accord with accepted practice.

Nonetheless, the documentation that was provided does allow this writer to distinguish somewhat between these two testing programs. For example, it was possible to determine that a comparable level of minimal competency was maintained between the two California exams administered in 2003. It also appears that there is no substantive difference in either the test statistics or the passing rate of the English, Mandarin, and Korean language groups on the California tests. These are no minor accomplishments and speak extremely well

for the quality of OER's testing program. Not enough information was supplied by the national group to perform a similar analysis on their tests.

Refinement Approaches

While both examinations meet professional standards, policy-makers may wish to consider the following opportunities for improvement:

Require essential safety knowledge. It is possible to establish must-pass components of the examination to ensure that applicants for licensure demonstrate proficiency in each of the areas that are deemed to be essential for public safety. The box below provides further details on the consultant's conclusions regarding a modular approach for testing critical knowledge.

"Must Pass" Exam Components

"As the California licensing exam is currently structured, candidates must achieve a particular score on the test to be considered as minimally competent and therefore eligible to receive a license to practice acupuncture. It is therefore possible for candidates to lack knowledge in certain areas, such as the regulations governing the public health and safety, and still pass the exam if they demonstrate considerable knowledge on the other topics. Thus, they may theoretically do quite poorly on, for example, health and safety questions but still be presented with a license to practice by the state.

Other professions in which their practitioners engage in either physical or emotional interaction with their patients appear to have structured their license examination process somewhat differently. These professions seem to have decided that candidates on their license examinations must demonstrate minimal competency in multiple domains rather than just achieving an overall high score before they can acquire a license. The following are just a few examples.

To become a licensed physician, medical candidates must separately pass a Step 1 exam covering biology and chemistry, a Step 2 CK exam covering clinical knowledge, and a Step 2 CS exam covering clinical skills. Only then are they eligible to take a Step 3 clinical application exam.

To become a licensed dentist, dental candidates must separately pass Part I and Part II of the national boards, then take a clinical examination, and then pass both a written California Dental Law exam and a written test in ethics.

To become a licensed psychologist, psychology candidates must first pass the Examination for Professional Practice in Psychology and must then pass the California Jurisprudence and Professional Ethics Examination.

To become a licensed marriage and family therapist, psychology and counseling candidates must first pass a written examination covering a general knowledge of psychology and psychopathology and then pass a written clinical vignette examination.

Regardless of which testing program California ultimately endorses, it is probably worthwhile to consider the possibility of structuring the acupuncture licensing process in a tiered manner akin to other licensing programs already in effect in California. That is, not only might candidates be required to demonstrate knowledge of the content domains of the discipline of acupuncture and Oriental medicine, they might also be asked to demonstrate minimum levels of knowledge regarding public health and safety, as well as ethical issues, before the state is prepared to offer them a license to practice."

Source: Lawrence S. Meyers, Ph.D., Department of Psychology, California State University, Sacramento. June 21, 2004. "The Acupuncture Regulation Project: Evaluations and Comparison of California's License Examination and NCCAOM's Certification Examinations. Report to the Commission. pp 79-80.

Ensure balance. Acupuncture has evolved differently in different regions where it is practiced. As the NIH points out, comparative studies have thus far not proven that one style of practice, or one region's approach, is superior to another. It is important that the exam tests the underlying knowledge, skills and abilities required to safely practice acupuncture and traditional Oriental medicine without discriminating against one country's style as opposed to another.

Prove physical skill. The State has not replaced the discontinued component of the examination that required applicants to demonstrate needling practices. While it is essential for licensees to master the fine dexterity required in needling, agreement about how to prove that skill has been one of the most controversial elements of the examination.

Develop internships. An alternative approach to proving physical skill would be to require a post-graduation, pre-examination clinical internship.¹⁰⁴ The board's efforts to do so have failed, but should be pursued by developing a strategy with complementary medical clinics, drug treatment programs, Kaiser and other large health care systems.¹⁰⁵ Experts recommend the following requirements for such internships:

- ✓ Pre-requisite for taking the licensure examination.
- ✓ Conducted in practical and hands-on clinical settings away from school.
- ✓ Supervised by licensed practitioners with specific hours of supervised practice that follow careful bookkeeping.
- ✓ Designed with rotations that may include pain, addiction, and complementary therapy clinics of academic medical centers, as well as jails and prisons.
- ✓ Modeled after other successful professional internship programs, for instance, the Board of Behavioral Sciences internship for marriage and family therapists.

Summary

In choosing between the two examinations, policy-makers should consider the soundness of the testing instruments and whether they were appropriately developed from a valid occupational analysis. The tests also must be statistically valid and securely administered.

In this case, both examinations were found by independent statistical and psychometric analysis to be sound. However, California's more extensive technical documentation of the underlying exam factors was determined to be superior.

Further, examinations must demonstrate that they adequately test for minimum levels of competency for safe practice. In this case, both examinations could benefit from improvements, for instance, through the use of must-pass questions and modules.

Specific to acupuncture, a practical way of demonstrating physical competency must be found. Tests for practical, hands-on point location and sterile needle practice could be re-examined. As of now, due to difficulties in agreement of appropriate locations and complexity of administration, neither exam includes a hands-on component.

Over and above each of these considerations, California must reserve the ability to shape the instrument according to California's policy goals. At this time, only the California exam meets this criteria.

Recommendation 4: The California Acupuncture Board should continue to control its examination to ensure that the State's policy goals are met. Among the policy goals that the State should ensure:

- ❑ ***Demonstrate knowledge of critical components of safe practice.*** "Must-pass" modules should be required for areas of particular concern, including herb-drug interactions, exclusive use of single-use disposable needles, additional infection control measures, understanding of emerging infectious diseases, "red flag" conditions, first aid procedures and knowing when and how to refer to physicians.
- ❑ ***Competitive examination administration.*** The board should continue to contract out for the secure administration of the California-designed and controlled examination.
- ❑ ***Develop strategy for implementing internship.*** This time-tested strategy for proving the practical skills necessary to be successful in many health professions should replace the discontinued practical portion of the examination.

School Accreditation Practices

In SB 1951, the Legislature asked the Commission to:

"Evaluate and make recommendations on the approval process of the Accreditation Commission of Acupuncture and Oriental Medicine, the approval process of the Bureau of Private Postsecondary and Vocational Education and the board's approval process."

Finding 5: The process used by the Accreditation Commission of Acupuncture and Oriental Medicine appears to be superior to the school approval process used by the Acupuncture Board and could be used by the State to ensure the quality of education for potential licensees.

Prior to taking the California licensing exam, potential licensees must graduate from a school approved by the Acupuncture Board. In addition, schools also must be approved by California's Bureau of Private Postsecondary and Vocational Education, or similar bureaus in other states, which guard against diploma mills and fraudulent business practices.¹⁰⁶

In addition, most schools seek accreditation from an organization that has been deputized by the U.S. Department of Education to ensure the quality of education so their students can qualify for federal financial aid. In the case of acupuncture, the federal government has designated the Accreditation Commission of Acupuncture and Oriental Medicine (ACAOM) to accredit schools as eligible for their students to receive federal student loans.¹⁰⁷

Additional Research

The Center for the Health Professions at the University of California, San Francisco, analyzed the approval and accreditation processes for California acupuncture training programs and the accreditation and approval of educational programs in comparable professions. Additionally, the center provided the Commission results and findings from a survey of California Acupuncture Board-approved institutions for acupuncture and Oriental medicine on approval and accreditation.

The executive summary of that analysis is in Appendix F. The full report is available on the Commission's Web site.

The other 39 states and the District of Columbia that license acupuncture rely on ACAOM accreditation to ensure the quality of acupuncture schools. Students must graduate from an ACAOM-approved school prior to taking the licensure exam in those states. Only California has its own approval process.

Because California is a large market, many students in other states want to be eligible for the California exam, which encourages schools in other states to seek California's approval. From a practical standpoint, though, nearly all California-based and California-approved schools also are accredited by ACAOM so their students are eligible for financial aid.

Reviewing and approving schools is a substantial and episodic burden on the Acupuncture Board and information received in the course of the Commission's review indicates that the State's process is not as rigorous as the process used by ACAOM.

Nevertheless, members of the Acupuncture Board and the profession assert that it is important for California to perform this function, largely as a way to preserve discretion over educational and other standards that are central to the profession's efforts to raise the standing of the acupuncture in the marketplace. However, some on the board have expressed an interest in relying on ACAOM for approving out-of-state schools.¹⁰⁸

The Value of Accreditation

School approval procedures provide multiple values to students and the general public. One primary goal is to make sure that students receive a quality education in the subject matter that regulators deem necessary for entry level professionals. Similarly, the approval process protects students by making sure that they receive a solid education from a credible institution.

The federal government requires accreditation as a way to safeguard the federal investment in student aid. The U.S. Department of Education follows a stringent process for approving private accrediting bodies, deputizing them to perform the function as a benefit to the public. Some 73 organizations are deputized to accredit 51 types of higher education programs.¹⁰⁹ These organizations also must periodically demonstrate that specific standards are being upheld to remain federally recognized accrediting bodies. State agencies cannot act as federally deputized accrediting bodies.¹¹⁰

The California Acupuncture Board requires board approval of schools before they will allow graduates to sit for the California exam.

Acupuncture schools must apply to the board and undergo California board scrutiny for their students to practice in California. This creates a potential barrier for students who graduated from out-of-state schools that have not paid the California Acupuncture Board to review their programs.

The Business and Professions Code requires the board to "establish standards for the approval of schools and colleges."¹¹¹ However, the statute does not specify that the board must conduct the process, leaving the possibility to accept the accreditation by ACAOM, even under existing law, in lieu of a state-run process.

State law also requires private postsecondary institutions in California that are not accredited by a federally approved regional agency – such as the Western Association of Schools and Colleges – to be approved by the State's Bureau of Private Postsecondary and Vocational Education. Approval from the bureau indicates that an educational institution meets minimum standards for education quality and business practices. The bureau's rules also provide some transparency in terms of a school's finances and governance, as well as information on complaints.

Comparing ACAOM and California's Approvals

Through a survey of school administrators and other research, UC's Center for the Health Professions identified similarities and differences between California's review process and that used by ACAOM. Both agencies express similar philosophies, use similar procedures and look for similar factors when visiting programs. In the past, they have even coordinated their school visits.

Both agencies are increasing their educational requirements. And most of the schools approved by the Acupuncture Board also are approved by ACAOM (28 of 31). Among the differences:

Prerequisites. ACAOM-accredited programs must require that students complete 60 semester hours (two years) of college coursework before entering the acupuncture school. The California Acupuncture Board has no similar requirement.

Renewal requirement. ACAOM also accredits programs for a limited time period – one to five years, depending on the quality and stability of the program. The Acupuncture Board's approval does not expire. However, if problems come to the attention of the board, it can, and has, pulled approvals. ACAOM's periodic review of schools is a more rigorous monitoring process that assesses whether programs, once approved,

continue to meet standards. Three California schools approved by the Acupuncture Board have not met or have lost ACAOM accreditation.¹¹²

Transparency. ACAOM's guidelines, procedures, practices, history, accounting, reporting and decision-making were judged by the researchers to be more detailed and publicly available.

Focus. The approval process used by the board is focused on ensuring that schools meet the State's minimum requirements. ACAOM's process is more focused on continuous improvement of programs that meet minimum requirements.

Accreditation and Effort to Increase Professional Standing

A number of professionals, along with the Acupuncture Board, were adamant that ACAOM should not be used by the State as part of the school approval process. While various reasons were offered, the greatest concern appeared to be controlling the school approval process as part of the effort to raise the professional standing and economic viability of the profession.

Some stakeholders assert that ACAOM has resisted efforts to raise educational standards and to establish the doctoral degree as the entry level for acupuncture professionals.

The Council of Acupuncture and Oriental Medicine Associations testified that "when California schools applied for accreditation from ACAOM in the 1980s they were forced to close down their doctoral programs because they were not accredited even though they had been approved by California state agencies. This served to stifle progress."

ACAOM is only authorized to accredit programs up to the master's degree level. In 2005 the U.S. Department of Education will review that authority and at that time, ACAOM may apply to expand its authority to accredit doctorate programs. However, the Department of Education's process for approving doctoral level accrediting programs is stringent.

Those advocating for doctorate entry-level degrees are supporting the development of a new accrediting organization, the National Oriental Medicine Accreditation Agency. The organization states on its Web site that it intends to apply to the federal government for accreditation authority. The organization indicates that its intention is to accredit schools for doctoral degrees, and it would require the teaching of the Western system of medical diagnosis (ICD 9 codes). This organization also would like to restrict entry into the profession to those who have doctoral degrees.

According to the federal authorities, becoming deputized is a multi-year process for most new organizations. Before the Department of Education will deputize an accrediting agency to approve doctoral programs the schools must meet specific criteria. So far, the federal government has not been satisfied that those criteria have been met. As of July 2004, the National Oriental Medicine Accreditation Agency had not applied for federal approval, department officials said.

Some members of the California profession – along with the Council of Colleges of Acupuncture and Oriental Medicine – do support national standards. The Council also points out that since the colleges must retain ACAOM approval to meet federal financial aid requirements for students, requiring an additional California layer of bureaucratic approval is unnecessarily costly both in terms of time and fees.

California's new policy is to require 3,000 hours of education for licensure, for a master's degree. Neither ACAOM nor the Acupuncture Board approves schools based on their capacity to provide doctoral-level education. So whether either agency could or would like to assess and approve doctoral programs should not be the basis of determining which agency can best serve the public interest as currently defined in policy.

Sources: Testimony and questionnaire responses submitted to the Commission, 2003. John Barth, United States Department of Education, interview and written communications, June 2004. Web Sites www.ed.gov, <http://www.nomaa.org/>, accessed July 2004.

Education Standards. As of July 2004, ACAOM requires schools to have a minimum of 2,625 hours for its Oriental medicine accreditation, which includes both acupuncture and herbs.¹¹³ California's current requirement is 2,348 hours, but effective January 1, 2005, California's standard will increase to 3,000 hours. California's curriculum requirements also are more specific than ACAOM's.

While some respondents indicated that ACAOM's standards were geared to the "lowest common denominator," there is other evidence that ACAOM's standards are more rigorous. ACAOM, for instance, has denied and also terminated the accreditation of schools that the California Acupuncture Board continued to approve.¹¹⁴

Respondents provided numerous positive comments about the staff at both the Acupuncture Board and the Bureau of Private Postsecondary and Vocational Education. However, UCSF researchers also were told repeatedly that California's staff seemed to be overburdened and did not have adequate resources to perform their required duties.¹¹⁵

Questions for Policy-makers

While there is clearly animosity between some members of the California profession and ACAOM, the question for policy-makers is how to best ensure that schools are providing a quality education to students who will sit for the acupuncture exam.

Which Process Best Ensures Quality?

Nothing in the analysis conducted by the Center for the Health Professions or information provided to the Commission through its public process documented inadequacies in either the California or the ACAOM process that would diminish public safety. The Acupuncture Board's failure to periodically review approved colleges is perhaps the greatest concern in this regard.

Still the major differences between the approval procedures identified by the Center for the Health Professions indicate that the ACAOM process provided a more rigorous basis for establishing baseline quality. ACAOM's focus on continuously improving and continued monitoring can provide particular value to California consumers – both students and their future patients.

The Acupuncture Board has acknowledged this weakness in its strategic plan. But resources, rather than recognition of the problem, appear to be the limiting factor.

At the same time, most of the issues raised in the public process were not related to minimum standards – the purpose of state regulation – but aspirations among some practitioners to raise the overall standing of the profession.

By relying on ACAOM to assess individual schools, California’s regulators would have more time and resources to spend on enforcement, clinic audits, continuous competency improvement of licensees and refining the California examination.

Can California Rely on ACAOM and Control Standards?

California has – and should – maintain control over its educational standards for the sole purpose of ensuring adequate minimum competency for entry-level practitioners.

Some stakeholders oppose involvement by organizations that are active throughout the United States, preferring to evolve the California profession independent of national and international trends. But as others suggest, the Acupuncture Board could have ACAOM accredit schools and still reserve final approval for the board.¹¹⁶

Five of the nine schools that responded to the UC survey said that the approval process should involve a combination of ACAOM and Acupuncture Board evaluation.

Other regulatory boards have relied on national organizations to ensure the quality of individual programs and then develop a means for ensuring that state-specific curriculum standards are met. In the case of podiatry, national accreditation is used as a basis for approval, and then schools must document their compliance with California policies that exceed national standards.¹¹⁷

Should Costs Matter?

In UC’s survey, the greatest criticism of the approval process pertained to the fees charged by ACAOM. And UC calculated that a school could spend 10 times as much on fees to ACAOM over a 10-year period than it would pay to the Acupuncture Board.

From a public policy perspective, the cost to schools should only be a significant consideration if fees resulted in significantly higher tuition, which might result in fewer new entrants into the marketplace.

But from a practical standpoint, even schools in California choose to be approved by the board and accredited by ACAOM, because of the benefits to students and the schools. The costs to schools would not be increased if the State were to rely more on ACAOM, and in fact the total expenses should decrease because presumably California's fees could be reduced to reflect the board's significantly lower expenditures.

Conversely, even California's modest fees could prevent qualified candidates from taking the examination in California. While many out-of-state schools have opted to be California-approved, some have not, ostensibly because of the added cost. And their graduates have complained that California discriminates against them by not allowing them to take the examination. Presumably, if the examination is functioning adequately, passage should indicate that the potential licensee has the knowledge, skills and abilities for safe practice in California. The California Bar Examination uses this strategy for licensure.

Summary

The efforts to raise educational standards even higher have spilled over into the policy debate over how to best assess the quality of education that schools provide. The best information available indicates that ACAOM's process is sound, and in some ways better than the review provided by the California Acupuncture Board. California can make use of this capacity without sacrificing control over curriculum standards or other aspects that ensure adequate preparation.

Recommendation 5: California should rely on ACAOM to accredit acupuncture schools, and other institutions for accreditation that are recognized by the Secretary of Education, while developing a mechanism to ensure that state-specific curriculum standards are met. To achieve that goal, policy-makers have two options:

- ❑ ***Contract with ACAOM.*** California could establish a memorandum of understanding with ACAOM to certify that California-specific requirements have been met by individual schools and ensure that aggregated information is publicly available.
- ❑ ***Require schools to document.*** California could require that schools document that they have met any California-specific legal requirements that exceed national accrediting standards. California uses this model for schools of podiatry.

Oversight Concerns

Finding 6: The California Acupuncture Board has missed significant opportunities to protect the public, particularly in the areas of consumer information and herb-related safety.

Many of the specific issues that the Governor and the Legislature asked the Commission to review have festered because the Acupuncture Board has often acted as a venue for promoting the profession rather than regulating the profession. As a result, the board also has missed opportunities to protect the public by providing accurate and complete information on individual practitioners and the therapies they can provide.

The board also has not adequately incorporated emerging scientific evidence into board policies, regulations and public communications.

Accurate Public Information

One critical example is the board's presentation of the scientific evidence regarding the efficacy of acupuncture. The National Institutes of Health found that acupuncture needle therapy is effective for "postoperative and chemotherapy nausea and vomiting and postoperative dental pain." NIH also stated that it may be appropriate therapy for a variety of other conditions for which there is not yet clear evidence. However, the Acupuncture Board's Web site, fact sheet and consumer brochure implies efficacy for a broad range of ailments. Moreover, those materials do not provide cautionary information to consumers about the limits of what may be expected from traditional Oriental medicine, the need to coordinate with MDs, or how to go about selecting a high quality practitioner.

Safety Concerns Include:

- ✓ Potential to miss critical diagnoses due to a lack of coordination with Western medicine.
- ✓ Lack of adoption of the National Institutes of Health recommendations for single-use disposable needles.
- ✓ Lack of strict infection control protocols and enforcement.
- ✓ Blood-borne viral infections from alcohol resistant mycobacteria that can be transmitted via acupuncture and are difficult to diagnose.
- ✓ Potential to inappropriately respond to red-flag conditions.
- ✓ Lack of knowledge to protect patients from herb-drug interactions.
- ✓ Lack of controls for the potential of herbs contaminated with toxins or prescription medicine and inadequately labeled herbs.
- ✓ Inaccurate or over-reaching information provided by the regulatory board that appears to promote -- rather than provide balanced, unembellished information about - acupuncture and traditional Oriental medicine.

Clear differentiation regarding provider capacity should be indicated. The term "doctor" could be confusing to consumers in differentiating MDs from practitioners of traditional Oriental medicine.

Source: Advisory Committee discussions and expert interviews including California Poison Control Center and Department of Health Services staff; and Lester Breslow, dean emeritus. UCLA.

For example, the board's "fact sheet" goes beyond the accepted research findings for acupuncture, by stating: "There are numerous conditions that acupuncture can treat, including migraines, sinusitis, the common cold, tonsillitis, asthma, inflammation of the eyes, addictions, myopia, duodenal ulcer (damaged mucous membrane in a portion of the small intestine) and other gastrointestinal disorders, trigeminal neuralgia (severe facial pain), Meniere's disease (ringing in the ears coupled with dizziness), tennis elbow, paralysis from stroke, speech aphasia (loss of language abilities due to brain damage), sciatica and osteoarthritis. Acupuncture also has been found to be very effective in the treatment of a variety of rheumatoid conditions, pain management, various addictions, mental disorders and AIDS."¹¹⁸

This broad statement on behalf of California regulators is posed as factual, and yet research findings that meet the standards of the National Institutes of Health, do not support the board's conclusions. Statements that appear in official materials of government agencies are expected to fulfill the highest standard of accuracy because they carry the imprimatur of the State. California consumers should be able to trust that government "fact sheets," especially on medical treatment efficacy, convey only substantiated research findings that have been published in respected peer-reviewed journals. This pattern of communicating is of particular concern given that the mission of the Acupuncture Board is to protect consumers, not to sell the public on alternative health care treatments.

Disease Protection

The board also has not forcefully responded to emerging information about basic public safety concerns. The Council of Acupuncture and Oriental Medical Associations, in arguing for improved education standards, submitted to the Commission an audit by a managed care company which found that "18 percent of acupuncturists did not have the required sanitary hand washing facilities and 15 percent did not comply with safe needle disposal requirements."¹¹⁹

These issues could readily be addressed through practitioner education and standard audits of clinics and practitioner offices. Appropriate hand-washing and proper disposal of needles that could contain diseases are fundamental public health matters.¹²⁰ Given life-threatening contagious diseases such as human immune deficiency disease and hepatitis, professional oversight bodies must be diligent in advancing basic public health measures of infection control.

Similarly, the board has not adopted in its regulations federal recommendations for exclusive use of sterile, single-use needles. NIH recommended this protective measure in 1997 and the FDA requires

manufacturers to label acupuncture needles for single-use only. However, as of fall 2004, the board had not adopted this standard.¹²¹

The board did not respond to written requests to explain its position on the NIH recommendations.¹²² However, the executive director stated that the board has been overwhelmed by other issues and the recommendation has not been a major focus of board attention.¹²³

With the evolution of stronger diseases that are resistant to antibiotics, it has become increasingly difficult to sterilize all health care equipment, leading to a general shift in the rest of the health care system to disposable instruments.

Finally, the *Journal of Clinical Microbiology* reported in 2002 that difficult-to-diagnose infections are occurring among acupuncture patients due to newly emerging, relatively alcohol-resistant, mycobacteria.¹²⁴ These and other blood-borne pathogens can be avoided through strict prevention measures, such as stronger disinfectants to clean the sites where needles will be inserted.¹²⁵ However, inexplicably, these research-based prevention measures have not been implemented, nor agendized for public discussion by the board.

Acupuncture Needles

The 1997 NIH consensus statement on acupuncture recommended shifting to the use of single-use needles by acupuncturists instead of following the older practice of sterilizing equipment between uses. This is in part due to the evolution of AIDS and antibiotic-resistant bacteria that can be life threatening. It states:

"Use of acupuncture needles should always follow FDA regulations, including use of sterile, single-use needles. It is noted that these practices are already being done by many acupuncture practitioners; however, these practices should be uniform."

The FDA requires that acupuncture needles be labeled as single-use only. However, in California, single-use needles are not mandatory. California regulations are as follows:

Title 16, article 5, Standards of Practice 1399.450. Condition of Office.

- (a) "Every acupuncture office shall be maintained in a clean and sanitary condition at all times, and shall have a readily accessible bathroom facility in accordance with Title 24, Part 2, Building Standards Code Sections 494A.1 and 1994 Uniform Building Code Section 2902.3."
- (b) "In all offices where non-disposable needles are used, there shall be functioning sterilization equipment."

Section 1399.451(b) states:

"All acupuncture needles and other instruments shall be sterilized before and between uses in a manner which will destroy all microorganisms. All needle trays which contain sterile needles shall also be sterile. Each time needles or other instruments are sterilized, the acupuncturist shall use a tape or strip indicator which shows that sterilization is complete."

Source: Acupuncture. NIH Consensus Statement 1997 Nov 3-5; 15(5):1-34; California Code of Regulations.

Herb Safety

Much greater attention also needs to be placed on the portion of the scope of practice related to prescribing herbs. These substances are not regulated for purity, potency or effectiveness by the federal Food and Drug Administration nor California authorities.¹²⁶ Yet there are growing concerns about herb-drug interactions, mislabeling and impurities.

This issue extends beyond the purview of California regulators, and beyond the regulation of this profession.¹²⁷ However, since California includes herbs in the scope of practice for acupuncturists, regulators are obligated to take actions that are within their purview to protect the public. If California wants to be a leader in regulating this profession it would explore the public policy issues that have the potential to harm consumers or discourage consumers from pursuing the potential benefits of herbs.

Herb-drug interactions pose an increasing risk to the public that was not present when ancient herbal practices were developed. Further, in California, herbs from around the globe are used, posing further risk of herb combinations that were unknown in ancient Asian practice, but can result from the intermingling of healing practices.

A significant concern is impurities found in processed herbs, including pesticides, pharmaceuticals and heavy metals. The Department of Health Services in 1998 studied "Asian patent medicines," the term it uses to describe herbs, plants, animal parts and minerals. In the 260 products tested, significant numbers contained dangerous contaminants: 17 included undeclared pharmaceutical components, 24 included lead, and 36 included arsenic. In addition, of the products tested, 32 percent contained undeclared pharmaceuticals or heavy metals and 9 percent had more than one adulterant.¹²⁸

According to the lead scientist of that study, the situation appears to be improving. However, no follow-up study has been conducted due to budget constraints. He estimates that he receives calls regarding problems with herbs from the California poison control center or a coroner's office approximately once per month.¹²⁹

This issue has recently been gaining national attention. The Institute of Medicine in 2002 published a framework for improving federal rules on the safety of dietary supplements, including herbs. It identified some problems with the federal Dietary Supplement Health Education Act of 1995. Chief among them:

- ❑ Consumers have assumptions and expectations about safety (believing products would be screened by government to ensure that they are as safe as over-the-counter medications, when in fact they are not tested for safety, purity or efficacy).
- ❑ The act limits the authority of the Food and Drug Administration to oversee these products as it does pharmaceuticals.
- ❑ Safety controls are less rigorous than those used in many other countries.¹³⁰

In May 2004, Consumer Reports magazine reported that dangerous supplements are readily available due to lack of controls.¹³¹ The magazine profiled several patients who experienced organ failures as a result of consuming Chinese herbal potions.

Those specific cases did not occur in California and problems with herbs extend beyond those that are used in traditional Oriental medicine. But California has a duty to ensure that it is employing the policy mechanisms that protect the public. Policy-makers could explore the following mechanisms:

- **Require mandatory centralized reporting of adverse events.** This is a recommendation from the medical director of the state poison control center.¹³² Because reporting is voluntary and not made to a central location, there is not enough information to analyze patterns so steps could be taken to prevent problems. The concept is supported by the American Herbal Products Association and the American Medical Association.¹³³
- **Certify and label for purity and strength.** Until federal rules are updated, California could require that herbs sold in California are certified by private sector laboratories that are capable of providing reliable "certificates of analysis" that many herbal companies already use to verify purity and strength.¹³⁴
- **Improve labeling.** Ingredients should be listed in English according to internationally recognized plant classifications and standards recognized by medical professionals globally.¹³⁵ In addition to the labeling concerns raised in the DHS study, herbs distributed by individual herbalists and acupuncturists can carry handwritten, unspecific labels. Without clear labeling using universally understood terms, it is difficult or impossible for other medical professionals to know the actual contents of herbal formulas – creating particular difficulty in determining the potential of herb-drug reactions.¹³⁶
- **Improve public notice.** Retailers should be required to post warning signs near displays of herbs and dietary supplements regarding the lack of regulation for safety and efficacy.¹³⁷

- **License all distributors.** The State could license or certify non-acupuncturists who distribute herbs – similar to the standards required of acupuncturists – to ensure that herbalists have the skills, knowledge and abilities necessary to protect consumers. Training should include responding to allergic reactions, herb-drug interactions and procedures to follow in medical emergencies. This training should encompass herbs from all regions of the world and may be connected to degrees in pharmacy.
- **Require consumer cautions.** In the absence of standards for herbalist training and licensure, individuals who recommend the use of herbs could be required to prove they follow the "buyer beware" disclosures established in SB 577 (Burton), Chapter 820, Statutes of 2002. This statute applies to unlicensed elements of complementary and alternative medicine, and requires written disclosure including practitioner education and a statement that the activity is not licensed by the State.

Board Structure

Regulatory capture is a long-standing concern with professional boards, and should clearly be of concern in this case. At one point during this study, the board's chairperson confirmed this concern by asserting in writing that: "The Chair of the Acupuncture Board is the only representative and advocate speaking on behalf of the entire profession in California."¹³⁸ Domination of the board by elements of the profession – rather than by consumers, health advocates and others who do not economically benefit from the profession – appears to limit the regulator's ability to navigate the issues referred to the Little Hoover Commission.

"The Chair of the Acupuncture Board is the only representative and advocate speaking on behalf of the entire profession in California."

Acupuncture Board letter to the Commission, December 18, 2003.

While thousands of acupuncture professionals lobby the board regarding what is good for the profession, it is not always the case that those desires are in alignment with what is best for California consumers. This is evidenced by the Acupuncture Board pursuing the agendas of the professional associations to the detriment of meeting their basic public safety duties.

A review of board meeting agendas and materials provided to the Commission by the board indicate a proclivity toward expending public resources on issues of interest to professional associations. None of the agendas over the last five years included a discussion of disposable single-use needles or emerging research on threats to public health. However, there was a pattern of frequent discussions regarding enhanced title and various means of restricting entry into the profession.¹³⁹

The Fox and the Hen House

The following is excerpted from testimony to the Commission by Julianne D'Angelo Fellmeth, administrative director, Center for Public Interest Law:

"There has really been an epiphany here. As the Legislature has more carefully scrutinized the performance of these industry-dominated occupational licensing boards — with their typical tendencies to enhance the barrier to entry to promote the prestige of the profession or keep out the infidels from other states, adopt standards of practice that benefit the profession or a vocal subset of the profession, and engage in almost no meaningful discipline, the Legislature has slowly but surely replaced many of these industry-dominated boards with public member majorities — recognizing the importance of a regulator who is truly independent of the profession, and willing to and capable of making decisions on their merits and in the public interest.

We have strongly supported this conversion — in fact, we believe that no member of any regulatory board should be a member of the trade or profession regulated by that board. No decision maker on any regulatory board should stand to benefit in any way from his/her own government decision making.

Requiring these boards to be comprised of licensees presents two problems: (1) an apparent conflict of interest, and (2) very often, an actual — if unintended — conflict of interest.

The first problem is obvious — it's the old "fox guarding the hen house" problem, and consumers lack confidence in regulatory boards which are controlled by the profession being regulated by that board.

The second problem is more subtle: Members of professions have endured the same educational requirements, taken the same difficult exams together, and become acculturated by their peers to certain "tribal rules" which — although they may be anticompetitive or injurious of the public interest — generally go unquestioned. These are the very "tribal rules" which state regulatory boards should examine and eliminate — but that will not happen if boards are dominated by members of the profession being regulated. ...

Most trade associations argue that public members are not capable of understanding the complex, technical, profession-specific issues which frequently come before regulatory boards — and chafe at the notion of public members judging the performance or competence of a licensee in a disciplinary matter. However, we ask juries and judges — none of whom are physicians — to decide medical malpractice cases every day. They listen to the evidence, receive an explanation of technical matters and expert opinions about whether the conduct at issue deviates from acceptable standards, and make decisions. And many issues that come before regulatory boards — and most disciplinary cases — do not concern complex, technical, profession-specific issues; they involve drug or alcohol abuse, improper sexual contact, criminal conduct, and other matters which a public member is as capable of understanding as is a professional member.

So we think public member majorities — even all public members — on boards that must make decisions in public and that encourage public participation is one way to marry expertise with independence. Those boards will get the profession's view — no doubt about it. If they don't, they can convene an advisory committee of professionals and get it. For the past 23 years, we have observed these boards being absolutely overwhelmed with testimony and input from the regulated industry — there is simply no reason to require that industry members be the decision makers as well."

Source: Testimony of Julianne D'Angelo Fellmeth, Administrative Director, Center for Public Interest Law to the Little Hoover Commission Acupuncture Advisory Committee, October 22, 2003.

It is possible that the relative inattention to evolving public health issues and the promotion-oriented communications may stem from not requiring public health backgrounds among board members and staff.

Most states do not have acupuncture boards. The majority of states that regulate acupuncture do so under a broad regulatory framework for all health professionals, often under a department of health.¹⁴⁰ This is consistent with the California Performance Review recommendation to move the regulation of all health professionals under the purview of a quality assurance branch of Health and Human Services.

Recommendation 6: The Governor and the Legislature, through the Sunset Review Process or other mechanisms, should ensure that the California Acupuncture Board becomes a strong advocate for consumers. Among the steps that should be taken:

- ***The board needs to develop a patient safety strategy.*** This strategy should ensure that federal recommendations for improving patient safety – for instance, the exclusive use of single-use needles – are quickly adopted in policies, examinations and written materials such as the consumer brochure. The California regulator could be required to submit, as a regular part of their Sunset Review Process, or annual report, what their compliance is with federal recommendations along with new research findings from the NIH. The board should study malpractice trends and publish the results. California regulators also should bolster efforts to work with individual practitioners and clinics to ensure ongoing compliance with evolving consumer protection laws.
- ***Develop consumer protections for herb products.*** California should empanel legal and scientific experts to explore herb-drug interactions, herb purity and potency, accurate labeling, and reporting of adverse effects. The panel should identify regulatory and other policy steps the State could take to protect consumers.
- ***Restructure the regulator to benefit consumers.*** If policy-makers believe a board is desirable, the majority of the members should not have an economic interest in acupuncture. They should include consumers as well as experts in infection control and research methodology. And the regulator should develop standing advisory panels that are more representative of the various cultures throughout the world that are integrating traditional Oriental medicine into health care and regulatory schemes.

Conclusion

The issues before the Commission are central and routine to essentially all professional licensure. Moreover, it is not uncommon for disputes, particularly over scope of practice, to be raised in both the regulatory and the legislative arenas.

But in the case of acupuncture, policy-makers have had difficulty resolving these issues. The debates have been confused by conflicting facts and by the fundamental and philosophical differences between traditional Oriental medicine and Western biomedicine. And while some in the profession want to preserve and enhance traditional therapies, others see the profession's future as a blend of traditional Oriental and modern biomedicine.

In addition, the law is clear that the public goal is to provide consumers with an alternative to Western medicine and to give consumers direct access to acupuncturists. But the statute is silent on the authority of acupuncturists to diagnose patients and how they should interact with other health care professionals.

To resolve these issues, lawmakers will need to establish in statute the role of acupuncturists in the health care system and define the "medicine" that practitioners may practice. The Commission believes the public will be best served if lawmakers affirm the existing policy to license traditional Oriental medicine separately from modern biomedicine. Practitioners who want to master both health methods should continue to be dually licensed.

Other states and nations, in fact, are looking for ways to encourage dual training, co-location or other forms of integration that provide access to both healing paradigms. These models allow choice while reducing the risk that some may be misdiagnosed or inappropriately treated because of the limitations of their "primary care provider," be they trained in traditional Oriental or modern biomedicine.

- ❑ New Hampshire requires a baccalaureate, registered nursing or physician's assistant degree as a prerequisite for acupuncture licensure.¹⁴¹ This provides acupuncturists with a grounding in Western biology and familiarity with the overall health care system, while encouraging professionals to be dually trained and licensed.
- ❑ Alternatively, the director of the University of Minnesota's Center for Spirituality and Healing recommends requiring all nursing programs to include traditional healing cultures in their curriculum, asserting

that because nurses are ubiquitous in the health care system, they could help patients access simple and often inexpensive traditional therapies.¹⁴²

- ❑ In many Asian nations, acupuncturists often practice in the same clinics or hospitals with physicians trained in Western medicine. This collaborative model is sometimes referred to in America as “shoulder to shoulder” medicine.
- ❑ An Israeli task force on complementary medicine has recommended that within the first month or eight visits to an acupuncturist, a patient see an MD for a standard physical to ensure that all available treatment options are considered.
- ❑ Many of California’s academic medical clinics that provide patients the option of acupuncture and other traditional Oriental healing practices operate collaboratively with MDs.
- ❑ The University of Arizona’s Health Sciences Program on Integrative Medicine suggests sharing clinical information between medical doctors and practitioners of traditional Oriental therapies, along with ongoing involvement of MDs to ensure care from the proper specialists.

Most of these solutions were not fashioned by regulators, but by professionals willing to work in collaboration. All of these options enhance consumer choice in ways intended to also improve patient outcomes.

The sole purpose of professional licensure is consumer protection, and that should be the basis for making statutory and regulatory changes. In the biomedical health care system, consumers also benefit from any number of other efforts to improve the outcome for patients by improving the preparation and practices of professionals. But most of those efforts are private and go far beyond the minimum requirements that are the basis of professional licensure.

Appendices & Notes

- ✓ *Public Hearing Witnesses*
- ✓ *Advisory Committee*
- ✓ *UCSF – Study of Education Issues and Current Educational Programs for Acupuncture and Oriental Medicine*
- ✓ *UCSF – Study of Scope of Practice*
- ✓ *CSUS – Evaluation and Comparison of California's License Examination and NCCAOM's Certification Examinations*
- ✓ *UCSF – Study of School Approval and Accreditation of Acupuncture and Oriental Medicine Programs*
- ✓ *Legislative Counsel – Legal Opinion on Scope of Practice*
- ✓ *Notes*

Appendix A

Little Hoover Commission Public Hearing Witnesses

Witnesses Appearing at Little Hoover Commission Acupuncture Hearing on August 8, 2003

Brian C. Fennen, L.Ac., Executive Director
Council of Acupuncture and Oriental
Medicine Associations

Richard G. Fong, D.C., L.Ac.

Christina Herlihy, Ph.D.
Chief Executive Officer
National Certification Commission for
Acupuncture and Oriental Medicine

Lixin Huang, President
American College of Traditional Chinese
Medicine, and President of the Council of
Colleges of Acupuncture and Oriental
Medicine

Gary Klapman, M.D., L.Ac.

Michelle Lau, L.Ac., President
Council of Acupuncture and Oriental
Medicine Associations

Penelope Ward
Director of Professional Services
Accreditation Commission for Acupuncture
and Oriental Medicine (ACAOM)

Witnesses Appearing at Little Hoover Commission Acupuncture Hearing on September 25, 2003

Shari Asplund, Vice Chair
California Acupuncture Board

Sandra Bressler, J.D., Vice President
Center for Medical and Regulatory Policy,
California Medical Association

Harley Goldberg, D.O.
Director of Complementary and Alternative
Medicine, The Permanente Medical Group,
Kaiser

Norman R. Hertz, Ph.D., Former Chief
Office of Examination Resources, California
Department of Consumer Affairs

Marilyn Nielsen, Executive Officer
California Acupuncture Board

Steven Rosenblatt, M.D., Ph.D., L.Ac., Co-
founder and former Clinical Director, UCLA
Acupuncture Clinic; Former Director,
Complementary Medicine Program, Cedars-
Sinai Medical Center

Alan Trachtenberg, M.D., M.P.H.
Former Planning Chair, NIH Consensus
Conference on Acupuncture
Medical Director, Office of Pharmacologic
and Alternative Therapies, U.S. Public
Health Service, Center for Substance Abuse
Treatment

Pei Li Zhong-Fong, L.Ac., Chair
California Acupuncture Board

Appendix B

Little Hoover Commission Acupuncture Advisory Committee

The following people served on the Acupuncture Advisory Committee. Under the Little Hoover Commission's process, advisory committee members provide expertise and information but do not vote or comment on the final product. The list below reflects the titles and positions of committee members at the time of the advisory committee meetings in 2003.

Marilyn Allen
American Acupuncture Council

Shari Asplund, Vice Chair
California Acupuncture Board

Matthew Bauer, L.Ac.
La Verne Acupuncture

Sandra Bressler, J.D., Vice President
Center for Medical and Regulatory Policy
California Medical Association

Jackson Chau, L.Ac., President
California Certified Acupuncturists
Association

DaRen Chen, L.Ac., QME, OMD
President, Academy of Chinese Medicine

John Chen, PharmD, Ph.D., OMD, L.Ac.

Andrew S. Cho, J.D., M.P.H.
Vice President
South Baylo University

Benjamin Dierauf, L.Ac.
California State Oriental Medical
Association/Acupuncture & Integrative
Medicine College – Berkeley

Alex Feng, L.Ac., Ph.D.
Zhi Dao Guan
Clinic for Traditional Chinese Medicine

Brian Fennen, L.Ac., Executive Director
Council of Acupuncture & Oriental
Medicine Associations

Andrew Fitzcharles, MS, L.Ac.
Los Gatos Oriental Medicine

Thomas R. Haines, Ph.D.
Director, Academic Affairs
Pacific College of Oriental Medicine (PCOM)

Christina S. Herlihy, MA, Ph.D.
Chief Executive Officer
National Certification Commission for
Acupuncture & Oriental Medicine

Lixin Huang, President, Council of Colleges
of Acupuncture and Oriental Medicine
American College of Traditional Chinese
Medicine

Linda S. Jordan, OMD, L.Ac., RN

John Jung Min Kim, L.Ac., OMD, Ph.D.

Deke Kendall, OMD, Ph.D., L.Ac.
Director for Education and Research
National Guild for Acupuncture and
Oriental Medicine

Gary Klapman, M.D., L.Ac.
Former Member, California Acupuncture
Board and Chair of the Acupuncture Board
Task Force

John Kolenda, L.Ac.
Former Board Exam Liaison, California
Acupuncture Board and Drug and Alcohol
Detoxification Subject Matter Expert

Howard Kong, L.Ac., President
California State Oriental Medical
Association

Marete Kunze, L.Ac., OMD
Long Life Medical Clinic

Michelle Lau, L.Ac., President
Council of Acupuncture and Oriental
Medicine Associations

Yong Sup Lee, L.Ac.
Executive Vice President
Association of Korean Oriental Medicine
and Acupuncture of California (AKOMAC)

LITTLE HOOVER COMMISSION

Fred Lerner, DC, Ph.D., Chairman
National Board of Acupuncture Orthopedics

Brian Chee Loh, L.Ac., OMD, President
United California Practitioners of Chinese
Medicine

Neal S. Miller, L.Ac., CCAA, CCOMD
Studio City Oriental Medical Center

Howard Moffet, MPH, L.Ac.
Research Project Manager
Kaiser Permanente – Division of Research
and Former Member, California
Acupuncture Board

Will Morris, OMD, L.Ac., Academic Dean
Emperor's College of Traditional OM

Marilyn Nielsen, Executive Officer
California Acupuncture Board

Robin Martin Okada, Study Coordinator
Department of Psychiatry and Behavioral
Sciences, Stanford University, School of
Medicine

David Pacheco, Principal Consultant
Assembly Business & Professions
Committee

Rebecca Patchin, M.D.
Chair, Council on Legislation
California Medical Association

Ted Priebe, OMD, QME, L.Ac., President
National Oriental Medicine Accrediting
Agency

Steven Rosenblatt, M.D., Ph.D., L.Ac.
Co-founder and former Clinical Director,
UCLA Acupuncture Clinic; Former
Director, Complementary Medicine
Program, Cedars-Sinai Medical Center

Elad Schiff, M.D., Fellow
Program in Integrative Medicine
College of Medicine, University of Arizona
and Former Chair, Israel's Complementary
Medicine Task Force

Betsy Smith, Director of State Relations
National Certification Commission for
Acupuncture & Oriental Medicine

Angela Tu, L.Ac., OMD
Diablo Acupuncture & Pain Control Clinic

Jeanne Tumanjan, L.Ac., Former Member
California Acupuncture Board

Michael Turk, L.Ac.
East/West Health Center

Raymond Victorio, L.Ac., DOM (FL)
President, Acupuncture & Integrative
Medicine College, Berkeley

Penelope Ward
Director of Professional Services
Accreditation Commission for Acupuncture
& Oriental Medicine (ACAOM)

David Wells, DC, L.Ac.
Former President, Council of Acupuncture
& Oriental Medical Associations

Kristy Wiese, Deputy Director
Legislative and Regulatory Review Unit
California Department of Consumer Affairs

Bill Wong, Chief of Staff
Office of Assemblymember Judy Chu

Wen Shuo Wu, L.Ac., Dean of Acupuncture
Oriental Medicine, Southern California
University of Health Sciences (SCUHS)

Benjamin Chi-Kuo Yang, C.A., OMD, L.Ac.
Member of National Advisory Council for
Complimentary & Alternative Medicine NIH
Member of Industrial Medical Council
State of California

Ron Zaidman, MBA, Co-founder and
President, Five Branches Institute

Pei Li Zhong-Fong, L.Ac., Chair
California Acupuncture Board

Laura Zuniga, Senior Consultant
Assembly Republican Caucus

Appendix C

Acupuncture in California: Study of Scope of Practice Overview of Current Status and Issues to Consider

Executive Summary

**Prepared for the Little Hoover Commission by the
University of California at San Francisco, Center for the Health Professions
May 2004**

The legal scope of practice for licensed acupuncturists (L.Ac.'s) in California is one of the areas of concern to the California State Legislature as evidenced by the passage of SB 1951 (Figueroa, 2002) and the request for a study of the issue. This report provides background, interpretation and context for acupuncturists' legal scope of practice. It also offers some options and alternatives for policy makers and professionals to consider when addressing ongoing areas of concern and uncertainty.

For California acupuncturists, the practice act is found at California Business & Professions Code (CA B&P) sections 4925-4979. In addition, the regulations issued by the California Acupuncture Board (CA Code of Regulations, Title 16 §§1399.400 *et seq.*), particularly §§ 1399.450-1399.456 regarding Standards of Practice, contain relevant information about the legal scope of practice. The third major resource for this profession is the compilation of legal opinions issued by the state's Department of Consumer Affairs. A number of state and federal laws regarding health and safety, labor and food and drugs also apply. Finally, the practice acts of the other health professions provide both context and boundaries, often defining for example, what acupuncturists and others not licensed in those professions may *not* do.

Based on these sources, there are services and treatment modalities that are clearly within the authorized purview of licensed acupuncturists in this state, including acupuncture, 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. Unlike some other health professions, there are no limitations on area of the body that licensed acupuncturists may treat.

However, several aspects of the current legal scope of practice are unclear. Over the years, the California Department of Consumer Affairs has been asked many times to issue opinions addressing areas of the statute that are vague or incomplete. Although the DCA opinions do not carry the same legal weight as statutory or case law, they do currently stand as valid interpretations of unclear areas of the acupuncture practice act and could be used to interpret unclear areas of the statute absent anything else from a higher authority. However, the internal inconsistencies within the series of opinions themselves coupled with the apparent continued confusion among practitioners indicate ongoing problems. Among the substantive issues are questions of whether licensed acupuncturists are legally authorized:

- **To diagnose and, if so, whether this includes Oriental medicine and/or Western/allopathic diagnostic theory** – Based on a review of law, legal opinions, and other materials, there is considerable justification for including Oriental medical diagnostic authority within the licensed acupuncturist’s legal scope of practice. There is considerably less justification for including the full range of Western/allopathic medicine diagnostic authority (in fact, several legal opinions indicate that acupuncturists definitely may not diagnose cancer and other diseases and conditions within the allopathic model). There are likely some Western diagnoses that licensed acupuncturists are competent to make but the parameters around their Western diagnostic authority should be clarified by legislation and/or regulation.
- **To order and/or interpret laboratory and radiology tests** – Based on a review of relevant legal materials, the authority to order Western diagnostic tests and studies is linked to a profession’s authority to diagnose, interpret and use the results of such tests; any parameters and limits that surround diagnostic and related authority would necessarily carry over to limits on authority to order laboratory, radiology and other Western medical tests. Once the diagnostic authority is clarified as noted above, the corresponding implications for ordering tests and studies need to be clarified in the acupuncture statutes or regulations. The capacity to interpret results of such tests is a separate issue, probably requiring demonstration of competency for many of the tests, particularly on the more advanced reaches on the continuum of tests.
- **To treat patients with cancer** – Based on a recent opinion of the Department of Consumer Affairs interpreting relevant California code, acupuncturists may not diagnose, treat, alleviate or cure cancer but treatment of patients with cancer is permitted if such treatment is intended to relieve the side effects of or protect the body from the damaging effect of the therapies used to treat cancer and if it does not counteract the efficacy of or otherwise interfere with the treatments prescribed for the patient by a physician. This opinion helps clarify the question at hand but several issues still remain, including why the opinion focuses on treating “patients with cancer” while the statute deals with treating “cancer”. It would be beneficial for this issue to be clarified and integrated into statute and/or regulation. The profession would benefit from education guidelines on this topic including proper referral procedures as indicated.

There are also several terms used in the practice act that have not been defined, leading to some questions and confusion. For example, “herbs” needs to be defined (or defined by reference to another state or federal source).

One specific area of confusion has been whether the reference to acupuncture as a “primary health care profession” in the legislative intent language of the practice act has any bearing on the scope of practice. As there is nothing in the statute itself, beyond the legislative intent language, that uses or refers to the term “primary health care profession” or anything in the list of modalities acupuncturists are authorized to perform that would need reference to the legislative intent language for clarification, there does not appear to be any relevance of the use of the term in the legislative intent section of the act to the legal scope of practice for

acupuncturists. That is, there is no impact of the use of the term “primary health care profession” in section 4926 (the intent language) on sections 4937 and 4927 (the statutory scope of practice). All indications point to the fact that the Legislature, at the time of including the term in the statute, was underscoring the authority of licensed acupuncturists to treat patients without a prior diagnosis or referral from another health care professional. This recognition does not add to or subtract from the legal scope of practice. Nor does it affect the reality that some acupuncturists are serving as primary health care professionals (under some non-statutory definitions) while others are not.

This study uses several analyses to put the acupuncture scope of practice into perspective:

Compared to most other health care professions in California that have independent practice authority (i.e. no supervision, prior diagnosis or referral is legally required) acupuncturists generally have fewer required hours in formal education and training (particularly in the biomedical sciences) and a correspondingly more limited scope of practice.

Compared to regulated acupuncturists in other US states, California acupuncturists are like those in 15 other states who have independent practice authority and authority to use or prescribe herbs in their practices. The other 24 states that regulate acupuncturists have more limited practice acts (either requiring referral from or supervision by another health care professional or not including herbal authority in the scope of practice). California is among the top three states in terms of length of required professional educational program but may be the only state that (either directly in statute or indirectly through accreditation and national testing requirements) does not require at least two years of undergraduate course work for admission into a professional acupuncture training program.

Compared to the occupational analysis, the California laws regarding the scope of practice for acupuncturists are fairly but not exactly aligned. Overall, there is very little within the acupuncturist’s legal scope of practice that is not being done by practitioners and there is not much being done by practitioners that is beyond the legal scope of practice. However, licensed acupuncturists do find the areas of “Patient Assessment” and “Developing a Diagnostic Impression” (with a non-exclusive focus on Oriental medicine theory) critical to their practices although these activities are not specifically listed or described in the practice act. Also, many of the “auxiliary treatments” included in the practice act are not given much weight in the occupational analysis. The notable exception is herbs, which is reported to be a modality that accounts for a significant portion of acupuncture practice. Even closer alignment between the practice act and the actual practice of acupuncture would benefit the public and the profession.

Options and alternative to consider regarding the legal scope of practice for licensed acupuncturists in California:

- Clarify and define the questionable areas outlined above, including establishing parameters as appropriate.
- Consider the benefits of an expanded scope of practice (e.g. one with more biomedical/allopathic diagnostic authority) for practitioners who can demonstrate

education, training and competency in the expanded area. Models for add-on certificates can be found in several health care professions.

- Consider the benefits of providing standard information to patients about the qualifications and scope of practice for acupuncturists.
- Develop and distribute to licensed acupuncturists clear interpretations of the legal scope of practice and guidelines for practice and referral to assist them in understanding their rights, responsibilities and potential liability.

From a public policy perspective, expanding the legal scope of practice for licensed acupuncturists in California – for example by granting broader diagnostic authority – could improve or ease access to health care for many in the state. In particular, the health care skills and knowledge combined with strong multi-linguistic and cultural competency among California acupuncturists are significant resources for the health needs of Californians. Such a significant expansion of legal scope of practice however would necessitate increased education, training and testing of all applicants for licensure or for any subset of licensed acupuncturists seeking add-on certification.

The full report from UCSF is available on the Commission's Web site at www.lhc.ca.gov.

Appendix D

Acupuncture in California: Study of Education Issues and Current Educational Programs for Acupuncture and Oriental Medicine

Executive Summary

**Prepared for the Little Hoover Commission by the
University of California at San Francisco, Center for the Health Professions
May 2004**

Consistent with recent legislation that raised the minimum number of curricular hours for California Acupuncture Board approved programs from 2348 to 3000 for all students entering such programs on or after January 1, 2005 (AB 1943 (Chu, 2002)), the Board has proposed regulations detailing the requirements of the 3000-hour minimum (http://www.acupuncture.ca.gov/law_reg/2003ammended_language.pdf). With AB 1943 and SB 1951 (Figueroa, 2002), the Legislature indicated a desire for a review of several issues regarding the education of acupuncturists in California. This study presents information about the current and proposed curriculum for acupuncturists, options for licensed acupuncturists who are not subject to the new requirements, and discussion of proposals to increase the minimum hours to up to 4000.

The increase from 2,348 hours to 3,000 hours required of programs whose students enter on or after January 1, 2005, amounts to a 28% increase.¹ Overall, the 652 additional hours will be divided between increases in didactic and clinical components (502 and 150 hours respectively). Furthermore, the Board has proposed that the 502 didactic hours be distributed over eight categories.

As of January 2005, the California Acupuncture Board's 3,000-hour requirement will include a greater number of contact hours for didactic and clinical learning than the minimums required in other jurisdictions that license acupuncturists. It will also be much more detailed and directive than requirements in any other jurisdiction or the national organization that accredits acupuncture programs. Generally, the Board's proposed regulations regarding educational requirements are more detailed and permit less academic flexibility than accrediting and approval processes among other health care professions.

¹The 28% difference in hours required of students who enter programs before January 1, 2005 and those who enter on or after January 1, 2005 (3000-2348=652) compares to a 14% difference in hours required of California Acupuncture Board approved programs and Accreditation Commission for Acupuncture and Oriental Medicine accredited programs in Oriental Medicine as of January 2005 (3000-2625=375). In other words, there will be a significantly greater difference between the credentials of graduates of CAB approved programs before and after the new regulations are in place compared to the difference between the credentials of graduates of CAB approved programs and ACAOM accredited programs after the new regulations are in place.

If reliably enforced, higher standards proposed by CAB could provide greater assurance to the public that graduates of these programs have received one of the highest levels of education in the U.S. in terms of total hours required. However, analysis of current curricula suggested the ability of some programs to meet these requirements is uncertain.

- Some schools are already close to or exceeding the total number of curricular hours required under the proposed regulations. However, the requirements as detailed by category may be more difficult for programs to meet. The review of current course offerings revealed that some CAB-approved schools have educational programs that almost mirror current approval requirements. In other words, these programs teach so close to the current requirements (1,548 didactic and 800 clinical hours) that a significant expansion of their programs will be needed to comply with the new requirements.
- Most schools are likely to have no problem meeting the requirements for the Acupuncture and Oriental Medicine Principles, Theories and Treatments category, although there are serious questions about how “herbs”, which is considered a subset of this category, is being taught and counted towards total hours.
- There are several concerns regarding how programs will meet the Basic Sciences and Clinical Medicine, Patient Assessment and Diagnosis requirements.
- Most programs should be able to meet the Professional Development requirements but many will face challenges meeting the Case Management, Practice Management, and Public Health categories.
- Some programs will have considerable difficulty meeting the increased requirements in Clinical Practice.

In addition, some general comments regarding the proposed changes include:

- The requirements are extremely detailed and directive in nature relative to requirements found in the accrediting and approval requirements for other health care professions;
- The short time frame for implementation of such significant changes is extremely ambitious;
- The requirements are not associated with a corresponding expansion in legal scope of practice (see companion study on scope of practice); however, the requirements do include some increased focus on areas, such as clinical medicine diagnosis and testing, whose inclusion in the legal scope of practice for acupuncturists is currently being debated. In addition, some items, such as “bleeding”, are included in the proposed list of curricular requirements although they are not in the legal scope of practice.

There are also a number of questions and issues raised regarding definitions and interpretations of some of the proposed regulatory changes. With the challenges the schools will face, and the questions regarding interpretations, the Board will likely also face some difficulty implementing and properly enforcing the changes, particularly on the short time frame proposed. It is unknown whether the CAB has developed support mechanisms or contingency procedures to assist schools during this transition. It is also unknown whether or not the CAB has established mechanisms for monitoring compliance, or a system of sanctions related to a program’s inability to satisfy the required hours in each competency area.

The legislative increase to a minimum of 3,000 curricular hours required for approved acupuncture programs in California combined with the regulations proposed by the California Acupuncture Board to implement the legislation carry considerable potential implications for the public, schools, the Board itself, students, and current practitioners.

Implications for the Public

The major implication for the public will be significant differences in the education, training and preparation standards of licensed acupuncturists in California without any required notice of the differences. Within a few years, the pool of California licensed acupuncturists will include people who have had as few as 1,350 hours and as many as 3,000 hours of formal education (with different substantive curricular and clinical requirements within the total numbers). However, there are no plans to clarify for the public the differences among practitioners with varying levels of education and training. There is also no indication or discussion in the proposed regulations that the increase in hours will be associated with maintenance or increase in the quality of the academic programs. The public would likely be served if continuous improvement in the substantive quality of the educational programs for acupuncturists was at least on par with the number of hours that is the current focus of the approving agency.

Implications for Schools

In addition to the specific challenges for schools identified above, some schools may significantly improve their academic programs as they comply with the new regulations. However, some schools, particularly those out of state who currently see CAB-approval as an affordable business decision (to attract students who may seek California licensure at some point) may decide that the added costs (faculty and other) of increasing course offerings is no longer of value and may decline to seek or continue CAB approval status.

Implications for the Board

The California Acupuncture Board will be affected with significantly increased responsibilities for transitioning to the new requirements, assisting schools who wish to make the transition, determining and implementing enforcement mechanisms, and developing ongoing evaluation processes. There is no publicly available documentation describing monitoring or enforcement procedures or guidelines to accompany the impending curriculum changes. In addition to its current licensing and professional oversight responsibilities, and its responsibilities for conducting school approvals, the CAB may need to support 31 AOM programs through a very challenging structural transition on a very brief timeline

Implications for Students

Students will face additional financial and opportunity costs in addition to receiving increased levels of education.

Implications for Current Practitioners

Current practitioners, not subject to the new educational requirements, may or may not find themselves at a practice or marketplace disadvantage due to the difference between the education and training standards they were subject to and those of their more recently licensed peers. There are several options policy makers may want to consider to address this imbalance.

Increasing Curriculum Requirements to 4000 Hours

Given the expected challenges in meeting the 3,000 hour increase in education, combined with no significant changes to the scope of practice or new safety concerns regarding the practice acupuncture in this state, it is difficult to envision the reason for or feasibility of legislatively moving to 4,000 hours as the minimum number of curriculum hours required for California Acupuncture Board approved programs.

For acupuncture, the scope of practice has not changed recently and there are no proposals to expand it significantly in the near future. As such, there are many people who were admitted to practice within this full scope under the current (2,348 hour requirement) or earlier (as few as 1,350 or less) hours of education. There has been no evidence from disciplinary actions or malpractice claims that the public is at risk from those with less education compared to those with more practicing under the same acupuncture practice act. With the increase to 3,000 hours, licensed practitioners will have even more education and training to prepare them for practicing in California although, as noted above, this increase is not tied to an expanded scope of practice. Justifying an additional 1,000 hours without a corresponding expansion of practice authority is difficult to do based on regulatory theory that would align educational requirements with scope of practice.

The full report from UCSF is available on the Commission's Web site at www.lhc.ca.gov.

Appendix E

The Acupuncture Regulation Project: Evaluation and Comparison of California's License Examination and NCCAOM's Certification Examinations

Executive Summary

**Prepared for the Little Hoover Commission by
Lawrence S. Meyers, Ph.D., Department of Psychology
California State University, Sacramento
June 2004**

In September of 2002, the California State Legislature through Senate Bill 1951 and Assembly Bill 1943 asked the Little Hoover Commission to take under consideration several issues pertaining to the licensing of those professionals practicing Acupuncture and Oriental Medicine in the State of California. The particular issue addressed by the present report is contained in Section 4934.1 (a) (3) of Senate Bill 1951, Chapter 714 which asks for a recommendation on whether the national exam developed by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) should be offered in California in lieu of the state examination developed by the Office of Examination Resources (OER) of the California Department of Consumer Affairs.

The national examination program is actually a set of five stand-alone modules ranging in length from 25 to 125 test questions but totaling 410 items across all of the modules. California's examination is a single comprehensive test of 200 test questions.

Testing practice has evolved to the point where there is relative agreement on the general process that needs to be in place to support the inferences from test scores that licensing agencies need to make. These standards are well documented and were applied to both testing programs in the evaluation, comparison, and recommendation process.

A generally accepted testing process entails properly completing the following steps:

- *Performing a job or occupational analysis*
- *Developing the examination process*
- *Administering the examination*
- *Assessing the quality of the examination*
- *Determining the pass point*

The present report traced the development of each licensing exam by discussing and evaluating how each of the testing agencies fulfilled these steps. An evaluation of the two tests, starting with the occupational analysis, ranging through the development and administration of the test, and finishing with the quality assessment of the examination and the establishment of a pass point, is summarized in Executive Summary Table 1.

**Executive Summary Table 1
Evaluation Summary of the State and
National Examination Programs**

Portion of Examination Process		California	NCCAOM
Occupational Analysis	Form expert panels	Consistent with professional standards	Consistent with professional standards
	Identifying tasks	Consistent with professional standards	Consistent with professional standards
	Identify knowledge elements underlying the tasks	Consistent with professional standards	Not explicitly documented
	Organizing the job content	Consistent with professional standards	Consistent with professional standards
	Sampling respondents for job survey	Consistent with professional standards	Consistent with professional standards
	Statistical analysis of important job components	Acceptable but less than best practice	Consistent with professional standards
	Reliability of the job analysis questionnaire	Rater reliability: not computed	Rater reliability: not computed
Internal consistency: very high for tasks; very high for knowledge elements		Internal consistency: very high for tasks; very high for knowledge elements	Internal consistency: very high for tasks (no knowledge elements were on the survey)
Developing the exam	Weighting of the content areas	Consistent with professional standards	Consistent with professional standards
	Crafting items	Consistent with professional standards	Not documented
Administering the exam		Consistent with professional standards	Consistent with professional standards
Quality assessment	Test reliability	Consistent with professional standards	Consistent with professional standards
	Item difficulty levels	Moderate	Relatively easy
	Point-biserial correlations	Consistent with professional standards	Consistent with professional standards
	Comparability of language versions	Seems likely	Not documented
Pass point setting	Process used	Consistent with professional standards	Consistent with professional standards
	Passing rate	Around 55%	75%+ except for lower Korean pass rate
	Maintaining same minimal competency standards	Yes	Not documented

Both examination programs generally conformed to the standards of professional practice in most instances. At the occupational analysis stage, the most serious breach occurred with the national exam process. Both the national and the state groups documented the tasks that practitioners ordinarily perform, and it appears that there is at least rough comparability between California and the rest of the nation represented in the national job analysis in what practitioners do in their professional settings. But unlike the state, the national group did not document the knowledge elements that formed the foundation of profession practice. The problem with this is that tasks may remain relatively unchanged over long periods of time but the knowledge base of a discipline steadily grows and changes. Because it is a bit of a “moving target,” it is very important to document what knowledge elements need to be tested by a license examination at any given time.

Generally, both testing programs produced very reliable exams using items of good quality as judged by the analysis of their correlation statistics. I would characterize California’s test as moderate in difficulty and the national modules as relatively easy. It is also the case that California tends to pass around 55% of its candidates regardless of the language in which candidates were tested. NCCAOM tends to pass someplace in the neighborhood of 75% of the candidates who sit for the exams that are administered in either English or Chinese, but their Korean language exam samples seem to fare much worse and show a large degree of variability.

Based on all of the documentation made available to me for this project, one cannot help but conclude that, despite some weaknesses or documentation failures here and there, both testing programs conscientiously strive toward excellence and have in fact produced very good products. The two testing programs have each captured a weighted composite of the tasks performed in professional practice, have generated items of high quality, and have determined passing criteria in accord with accepted practice.

Nonetheless, the documentation that was provided does allow us to distinguish somewhat between these two testing programs. For example, it was possible to determine that a comparable level of minimal competency was maintained between the two California exams administered in 2003. It also appears that there is no substantive difference in either the test statistics or the passing rate of the English, Mandarin, and Korean language groups on the California tests. These are no minor accomplishment and speak extremely well for the quality of OER’s testing program. Not enough information was supplied by the national group to perform a similar analysis on their tests.

The identification of the underlying knowledge elements and their linkage to the tasks and to the content of professional practice is a very important component in the evaluation of a license examination and critical in a comparison of two license exams. Determining the underlying knowledge elements is recognized and—one might judge—even emphasized in the test development standards to which NCCAOM explicitly subscribes; however, these elements were not documented at all in the materials that I reviewed. On the other hand, OER identified and analyzed both tasks and knowledge elements in their occupational analysis, an examination development component that is consistent with the highest standards of professional practice.

While it can be stated with a reasonable degree of confidence that the tasks identified by the national and state occupational analyses are very similar, that is not enough to support the claim that the two examinations are testing for the same knowledge. Since knowledge almost always changes faster than tasks, and since knowledge forms the basis of the tests, it is necessary to compare the tests on this aspect as well as the tasks. Without that documentation from the national testing program, it is difficult to say that the national exams actually test for the same knowledge elements that are tested in the California examination.

Therefore, I offer my considered opinion based on everything contained in my full report: It is my judgment that the California testing program is to be preferred over a very good national testing program. I recommend that OER should be complemented on its high quality work and that this agency be charged with the continued development and administration of the acupuncture license exam. I would also suggest that if some of the small modifications which I have offered to OER in various places in the full report are felt to be reasonable, that they be implemented if possible.

As the California exam is currently structured, candidates must achieve a particular score on the licensing test. But it is possible that candidates may lack knowledge in certain areas, such as the regulations pertaining to public health and safety, and still pass the exam if they demonstrate considerable knowledge on the other topics. Thus, candidates may theoretically do quite poorly on health and safety questions but still be awarded a license to practice.

The practice of acupuncture and oriental medicine involves procedures that directly involve health, safety, and ethical matters. For example, in the course of their normal practice acupuncturists may use implements (e.g., needles) to penetrate the skin of their patients, may have their patients ingest certain substances (e.g., herbs), and may talk with their patients about topics that are very personal, private, and intimate. Other professions whose practitioners have considerable physical or emotional interaction with their patients build into their licensing process a way to separately assess for knowledge concerning public safety and ethical issues.

I therefore recommend that the state give serious consideration to instituting a “must pass” stand-alone and separately scored module into the examination process. Such a module would test for health, safety, and possibly ethical issues and would require that candidates demonstrate a satisfactory level of knowledge in these content areas before earning a license to practice acupuncture. OER certainly has the expertise—if not the funding—to develop such a test. Consideration should also be given to the possibility of holding current license holders responsible for this knowledge as well.

The full report from CSUS is available on the Commission's Web site at www.lhc.ca.gov.

Appendix F

Acupuncture in California: Study of School Approval and Accreditation of Acupuncture and Oriental Medicine Programs

Executive Summary

**Prepared for the Little Hoover Commission by the
University of California at San Francisco, Center for the Health Professions
May 2004**

This study reviews the processes of approval and accreditation for Acupuncture and Oriental Medicine (AOM) training programs preparing applicants for California acupuncture licensure. It focuses on U.S. trained applicants who have studied in formal education programs (many states, including California, provide alternative routes for foreign trained applicants and those prepared through tutorial or apprenticeship programs). To conduct the analyses and comparison outlined below, we relied on a literature review, an environmental scan of AOM-related Internet resources and organizational publications, a survey of California Acupuncture Board-approved educational programs, and key informant interviews.

Comparing How California and Other US States Approve AOM Educational Programs

To be eligible to take the California licensing examination, U.S. trained applicants must have graduated from a formal education program that has been approved by the California Acupuncture Board (CAB). A prerequisite for CAB approval is approval by the California Bureau of Private, Postsecondary and Vocational Education (BPPVE) or equivalent agency in other states. In 39 of the 40 other U.S. jurisdictions¹, where acupuncture is regulated as a health profession, applicants for licensure must have attended a program accredited by the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) (either directly by state reference to ACAOM accreditation or indirectly via state reference to examination and/or certification by the National Certification Commission for Acupuncture and Oriental Medicine, which requires its candidates to have attended programs meeting ACAOM standards).

Comparing Educational Program Approval Processes Among Major Health Professions Within California

Aside from nursing (which uses a process much like CAB), most of California's major health professions (including medicine, osteopathy, dentistry, naturopathic medicine, podiatry, and chiropractic) all rely on accreditation by a national entity, which is US Department of

¹Louisiana does not require "acupuncturist" applicants to have attended ACAOM accredited/candidacy programs (relying on state-based approval of programs) but does offer passing of the NCCAOM examination (which requires attendance at a program meeting ACAOM standards to be eligible to take the examination) as one route for certification as an "acupuncture assistant".

Education approved, specific to the profession as a requirement from which applicants for licensure must have graduated. Podiatry offers an interesting model in which national accreditation is the primary basis for approval but documentation of compliance with California podiatric laws that exceed national accreditation standards must be submitted.

Comparing the Approval and Accrediting Processes Available to Programs

Three approval and accrediting processes (CAB, ACAOM, BPPVE) are available, and required to varying degrees for various purposes, for AOM training programs whose graduates intend to seek licensure in California. Our main focus, with findings included below, is a review of the similarities (which may lead to redundancies) and differences between the approval and accreditation processes used by the California Acupuncture Board and the Accreditation Commission for Acupuncture and Oriental Medicine.

Although, in order to grant degrees legally within the state of California, schools or institutions must be BPPVE-approved (with regional accreditation being an exemption), the BPPVE requirement is generally viewed to be more about protecting the public and students from “diploma mills” and fraudulent education than about profession-specific requirements. The BPPVE is also viewed as an overburdened agency. As such, limited review of BPPVE is included here and limited attention is placed on BPPVE’s role and capacity to provide an effective cross-check on the CAB.

Findings

Notable Similarities Between CAB Approval and ACAOM Accreditation

- The vast majority of CAB approved programs also hold ACAOM accreditation (28 of 31).
- There are many parallels between CAB and ACAOM in philosophy and process and the two organizations have collaborated formally and informally on various activities.
- The wording in several sections of each organization’s site visit guidelines is similar or identical.
- Both CAB and ACAOM are increasing their standards for total number of curricular hours required of approved/accredited programs over the next year.

Notable Differences Between CAB Approval and ACAOM Accreditation

Substantive differences: pre-admission requirements, curricular content and program hours

- CAB approves “acupuncture” programs but these programs, and the CAB requirements for approval, include acupuncture, herbs and other modalities. ACAOM offers accreditation of either “acupuncture” (acupuncture focus) or “Oriental medicine” (including both acupuncture and herbs) programs under separate tracks with different requirements. Of the two types of programs ACAOM accredits, its “Oriental medicine” programs are most comparable to California’s approved “acupuncture” programs.
- CAB currently requires a higher number of total curricular hours for programs (2348) compared to ACAOM’s standards for acupuncture programs (1725) and Oriental

medicine programs (2175). After January 2005, CAB requirements will be 3000 hours compared to ACAOM's requirements for acupuncture programs (1905) and Oriental medicine programs (2625). Between July 2004, when ACAOM increases go into effect, and January 2005, when the new CAB increases would go into effect, the CAB requirements for total curricular hours (2348) will be higher than ACAOM's standards for acupuncture programs (1905) but lower than ACAOM's standards for Oriental medicine programs (2625).

- ACAOM-accredited programs must require program applicants to have completed 60 semester credits (2 years) of "education at the baccalaureate level that is appropriate preparation for graduate level work, ..."; ACAOM also requires programs to require English language competency of all students seeking admission to the program taught in English. Although the CAB is proposing new regulations that would require two years of baccalaureate preparation, it currently requires candidates for admission to an approved program only to have successfully completed an approved high school course of study or have passed a standard equivalency test; there are no CAB baccalaureate prerequisites for program approval. CAB has no English language proficiency requirements for approved programs to require of applicants.
- Three CAB approved programs have lost or never achieved ACAOM accreditation or candidacy status.²
- The CAB curricular requirements by category, especially under proposed regulations scheduled for implementation in January 2005, are more detailed and directive than those of ACAOM.

Procedural differences

- ACAOM accredits programs for defined period of time ranging from one to five years depending on stability and quality of program and routinely investigates and sanctions programs (including withdrawing candidacy or accreditation status) for variances to requirements. No stated length of time for which CAB approval is granted is available for the approved programs. Aside from requiring programs to submit information about changes to their programs, there appears to be no written CAB policy or compliance record regarding monitoring, renewal or sanctioning processes for variances to requirements once a program has been approved.
- ACAOM has more extensive, detailed and publicly accessible documentation of procedures, guidelines, practices, history, accounting, reporting, and decision-making than does the CAB.

² China International Medical University, Kyung San University, Southern California University School of Oriental Medicine and Acupuncture (not to be confused with Southern California University of Health Sciences – College of Acupuncture and Oriental Medicine, which is approved by the CAB and in candidacy status with ACAOM). See footnote 14, page 30 for more details).

Cost differences

- ACAOM fees for accreditation are significantly higher than those charged by CAB for approval. ACAOM's application fees are double those of the CAB. Further, in addition to assessing a fee per student on top of the basic fee for each step of the process, ACAOM has several steps, including eligibility, candidacy, accreditation, sustaining, and re-accreditation, each of which has fees associated with it. Over a ten-year period that involves many of the ACAOM steps but just the one approval step that CAB offers, a program might spend ten times or more on ACAOM accreditation than on CAB approval.

Options to Consider

With the apparent redundancies combined with a very ambitious agenda to implement new requirements for approved AOM programs (3000 hours minimum total with detailed curricular standards) that must be in place for students entering programs January 2005, California could consider several options regarding approval and accreditation.

In particular, it is worth considering the benefits of relying on a national accrediting agency at least for the standards and requirements that are the same or in excess of the California requirements. For California standards and requirements that might be in excess of national accrediting standards, such as higher number of total curricular hours or specific course requirements, California might either rely on the national accrediting organization to ensure that the state standards are met through a supplemental process or take on the job itself of ensuring that accredited programs are meeting the state standards. One model to look to for this latter approach is the process the California Board of Podiatric Medicine uses to approve podiatry programs. The positive aspects of both these approaches would include freeing up the Acupuncture Board to focus its resources on other regulatory responsibilities, including assisting the schools with the transition to increased hours. Although some may question the impact on costs to programs, it is evident that California-approved schools are already going through ACAOM-accreditation (if they qualify) and thus already paying ACAOM fees in addition to CAB approval fees. Others may question the impact of such a move on quality of programs (leading to impact on competency of practitioners). However, there has been no documentation of lower quality of programs or competency of graduates based on differences in the two approval/accreditation processes. Notably, out-of-state educational institutions reported that they seek CAB approval not because of enhanced quality of education or higher educational standards but to enable their graduates to license and practice in California and perhaps to attract California students to out-of-state programs.

The full report from UCSF is available on the Commission's Web site at www.lhc.ca.gov.

Appendix G

Legislative Counsel – Legal Opinion on Scope of Practice

April 16, 2004

Honorable Christine Kehoe
5150 State Capitol

Acupuncturists - #8545

Dear Ms. Kehoe:

Question

Do the provisions of Section 4926 of the Business and Professions Code that state “the Legislature intends to establish in this article, a framework for the practice of the art and science of oriental medicine through acupuncture” and, “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” authorize the holder of an acupuncturist’s license to engage in a broader scope of practice than is authorized by Section 4937 of the Business and Professions Code?

Opinion

The provisions of Section 4926 of the Business and Professions Code that state “the Legislature intends to establish in this article, a framework for the practice of the art and science of oriental medicine through acupuncture” and, “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” do not authorize the holder of an acupuncturist’s license to engage in a broader scope of practice than is authorized by Section 4937 of the Business and Professions Code.

Analysis

By way of background, the Acupuncture Licensing Act (Ch. 12 (commencing with Sec. 4925), Div. 2, B& P.C.; hereafter the act)¹ provides for the licensure and practice of acupuncturists. The Acupuncture Board is established by the act for the purpose of administering the act (Sec. 4928).

Section 4926 declares the intent of the Legislature with regard to the act as follows:

“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.” (Emphasis added.)

The terms “oriental medicine” and “primary health care profession” are not defined for purposes of the act. However, the scope of practice authorized by an acupuncturist’s license is explicitly set forth in Section 4937, which provides as follows:

“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,

¹ All section references are to the Business and Professions Code, unless otherwise specified.

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.” (Emphasis added.)

Section 4927 defines the term “acupuncture” as follows:

“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.” (Emphasis added.)

Section 4937 specifically sets forth the authority that is conferred by a license to practice acupuncture and Section 4927 expressly defines the term “acupuncture”² for these purposes. We think that these provisions are clear and unambiguous. When statutory language is clear and unambiguous, there is no need for construction (see *People v. Woodhead* (1987) 43 Cal.3d 1002, 1007-1008), and a court generally will not consider statements of legislative intent or statements of legislative findings and declarations (see *People v. Hinks* (1997) 58 Cal.App.4th 1157, 1164-1165; *People v. Reyes* (1997) 52 Cal.App.4th 975, 986-987), unless giving statutory language a literal meaning would result in absurd consequences that the Legislature could not have intended (*In re J.W. Walter* (2002) 29 Cal.4th 200, 210). In the construction of a statute, a court’s function is simply to ascertain and declare what is in terms or in substance contained therein, not to insert what has been omitted, or to omit what has been inserted (Sec. 1858, Civ. C.; *Palmer v. GTE* (2003) 30 Cal.4th 1265, 1279). We do not think that applying the provisions of Section 4937 with regard to the scope of practice authorized by an acupuncturist’s license would produce an absurd result. Therefore, we do not think that interpreting the provisions of Section 4937 requires an analysis of legislative intent on that basis.

Moreover, statements of legislative intent generally do not have the force of a mandate for action, even if cast as such (see *Mullen v. State* (1896) 114 Cal. 578, 587). Rules of statutory construction dictate that a legislative enactment is to be construed in accordance with the ordinary meaning of the language used (for example, the Legislature knew what it was saying and meant what it said) and declared legislative design does not enact provisions not actually contained in the statute (see *Pac. Gas & E. Co. v. Shasta Dam etc. Dist.* (1958) 135 Cal.App.2d 463, 468; see also *Coulter v. Pool* (1921) 187 Cal. 181, 185). Thus, for example, a

² Practice of acupuncture in violation of the Acupuncture Licensing Act is a crime (Sec. 4935, B.& P.C.).

statute that simply expresses a statement of legislative intent, and nothing more, cannot be expanded by the court beyond that statement. Because the Legislature utilized “intent” language and “declaratory” language in Section 4926, it apparently did not intend for that language to expand the type of conduct that the holder of an acupuncturist’s license regulated under the act is authorized to perform. If the Legislature had desired that result, we think that it would have used clear authorizing language in Section 4937.

In this regard, the court in *Coulter v. Pool*, supra, at page 185, explained:

“[A] legislative declaration, whether contained in the title or in the body of a statute, that the statute was intended to promote a certain purpose is not conclusive on the courts, and they may and must inquire into the real, as distinguished from the ostensible, purpose of the statute...”

On occasion the courts have departed from applying the plain meaning rule, even when the language of the statute is clear. For example, in the case of *Friends of Mammoth v. Board of Supervisors* (1972) 8 Cal.3d 247 (hereafter *Friends of Mammoth*), overturned on other grounds in *Kowis v. Howard* (1992) 3 Cal.4th 888, at pages 895-896, the issue was whether the term “projects” as used in the California Environmental Quality Act applied to private projects. The California Supreme Court found a legislative intent to include private activities, even though the statute provided for the filing of an environmental impact report as part of another report required only with respect to direct activities of a public agency (*Friends of Mammoth*, supra, at p. 255). The court stated:

“Because of the failure of the Legislature to expressly delineate the meaning of ‘project,’ we must rely on a cardinal principle of statutory construction: that absent ‘a single meaning of the statute apparent on its face, we are required to give it an interpretation based upon the legislative intent with which it was passed.”

* * *

“Once a particular legislative intent has been ascertained, it must be given effect ‘even though it may not be consistent with the strict letter of the statute.’ Citations omitted.] As we stated nearly a half century ago in *In re Haines* (1925) 195 Cal. 605, 613 [234 P. 883]: “The mere literal construction of a section in a statute ought not to prevail if it is opposed to the intention of the legislature apparent by the statute; and if the words are sufficiently flexible to admit of some other construction it is to be adopted to effectuate that intention. The intent prevails over the letter, and the letter will, if possible, be read as to conform to the spirit of the act.” (*Friends of Mammoth*, supra, at pp. 256 and 259.)

More recently, in *In re Kali D.* (1995) 37 Cal.App.4th 381 (hereafter *Kali*), the Court of Appeal applied the uncodified legislative intent language rather than the plain meaning of Section 496 of the Penal Code when the intent language was contradicted by the plain meaning of the statute. The court found that the plain meaning of Section 496 of the Penal Code “is that a thief may be convicted of either receiving stolen property or theft” but that the intent of the Legislature as expressed by uncodified intent language was “to provide for the prosecution

of principals in the actual theft of property who continue to possess that property *after the statute of limitations has run on the theft of the property*" (Id., at p. 385; emphasis in original). With regard to the plain meaning of the statute, the court stated "the 'plain meaning' rule does not prohibit a court from determining whether the literal meaning of a statute comports with its purposes' and provisions relating to the same subject matter must be construed together and 'harmonized to the extent possible'" (Id., at p. 386, quoting *Lungren v. Deukmejian* (1988) 45 Cal.3d 727, 735).

However, in two subsequent cases, *People v. Reyes*, supra, and *People v. Hinks*, supra, the courts declined to follow the reasoning and conclusion reached in *Kali* and instead applied the plain meaning of the statute. In *People v. Reyes*, supra, the court stated the following:

"We are constrained to literally interpret the statute, unless doing so would violate the Legislature's intent... [w]e conclude that it would not, as there is no indication that the Legislature intended to *limit* prosecution of a thief under section 496 to situations in which a theft charge was no longer an option..." (*People v. Reyes*, supra, at p. 987; italics in original.)"

In a similar vein, the court in *People v. Hinks*, supra, stated as follows:

"The court must look first to the language of the statute; if clear and unambiguous, the court must give effect to its plain meaning. [Citations omitted.] The role of the court 'is simply to ascertain and declare what is in terms or in substance contained therein, not to insert what has been omitted, or to omit what has been inserted...' [Citations omitted.]..."

* * *

"Had the Legislature intended that its 1992 amendment of section 496, subdivision (a), apply *only* when the statute of limitations had expired on the original theft, it certainly could have inserted language to that effect into the second paragraph of that subdivision. Its failure to do so suggests it did not intend to so limit the amendment's application, even though its primary purpose in amending the statute was to address the situation. By inserting such a limitation when the Legislature failed to do so, the *Kali D.* court exceeded its role of simply ascertaining and declaring what is in terms or in substance contained in the statute, rather than inserting what has been omitted or omitting what has been inserted. (Code Civ. Proc., §1858.)" (*People v. Hinks*, supra, at pp. 1162-1164; italics in original.)"

Although there are instances in which a court has applied the intent language when that intent language has contradicted the plain meaning of the statute, that situation is very much the exception (see *In re Kali D.*, supra, at p. 385, wherein the court describes the situation as "novel"). It is our opinion, and we think the better view, that if the substantive language is clear, a court will give effect to its plain meaning and will not consider statements of legislative intent or legislative findings and declarations. Therefore, generally, a court will not give the same weight to legislative findings and declarations and legislative intent language as it does to

substantive language. Thus, we conclude that the use in Section 4926 of the term “oriental medicine” in the intent language and the declaration regarding the need for the regulation of acupuncture as a primary health care profession would not be the basis for a court to expand, by judicial construction, the functions that an acupuncturist’s license authorizes a licensee to perform under Section 4937.

However, even if a court were to accord the language in Section 4926 the same weight as it accords the substantive licensure provisions of Section 4937, we do not think that there is a conflict between those sections. Section 4926 states a general intention by the Legislature to “establish in this article, a framework for the practice of the art and science of oriental medicine through acupuncture.” Furthermore, the statement regarding the need for regulation of acupuncture as a primary health care profession is part of a paragraph that begins “[t]he purpose of this article ...” . First, it should be noted that Section 4926 is in Article 1 (commencing with Section 4925) of Chapter 12 of Division 2 (hereafter Article 1), whereas Section 4937 is in Article 2 (commencing with Section 4935) of Chapter 12 of Division 2 (hereafter Article 2). Because Section 4937 is not in the article specifically referenced by Section 4926, under a plain meaning analysis of the statute, the intent provisions do not apply to Section 4937, and thus do not represent a statement as to the intent behind Section 4937, or its intended application.

Furthermore, even if a court was to find that Section 4926 applies to all of Chapter 12 (commencing with Section 4925) of Division 2, including Article 2, Section 4926 merely declares the intent of the Legislature with regard to regulating acupuncture in general and declares the need to regulate and control acupuncture as a primary health care profession, whereas Section 4937 specifically states what functions an acupuncturist’s license authorizes the holder to perform. There is no indication in Section 4926 that the Legislature intended to authorize the holder of an acupuncturist’s license to perform every function that constitutes “oriental medicine” or every function that may be performed by other categories of primary health care professionals.” Thus, we do not think that these provisions are in conflict with Section 4937.

Finally, even assuming, for the sake of argument, that the provisions of Section 4926 could be read as conflicting with the provisions of Section 4937, it is a rule of statutory construction that, when a general and particular provision are inconsistent, the latter is paramount to the former (Sec. 1859, C.C.P.). A specific provision relating to a particular subject will govern a general provision, even though the general provision standing alone would be broad enough to include the subject to which the specific provision relates (*San Francisco Taxpayers Assn. v. Board of Supervisors* (1992) 2 Cal. 4th 571, 577; *Jones v. Pierce* (1988) 199 Cal.App.3d 736, 742). Because Section 4937 contains specific provisions regarding the authorization conferred by an acupuncturist’s license, whereas Section 4926 merely makes a general statement with regard to a framework for, and the need to regulate the practice of, acupuncture, we think that, even if a court determined that Sections 4926 and 4937 were in conflict, the provisions of Section 4937 would govern in determining what functions an acupuncturist’s license authorizes a licensee to perform.

For the foregoing reasons, it is our opinion that the provisions of Section 4926 of the Business and Professions Code that state “the Legislature intends to establish in this article, a framework for the practice of the art and science of oriental medicine through acupuncture” and, “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” do not authorize the holder of an acupuncturist’s license to engage in a broader scope of practice than is authorized by Section 4937 of the Business and Professions Code.

Very truly yours,

Diane F. Boyer-Vine
Legislative Counsel

By
Lisa C. Goldkuhl
Deputy Legislative Counsel

LCC:dil

Notes

1. The Acupuncture Board also has "adopted for reference" a document prepared by a professional acupuncture association describing "standards of practice" for acupuncturists (The Council of Acupuncture and Oriental Medical Associations, 1997, "Scope of Practice for Licensed Acupuncturists"). That document varies from California statute and regulation. The Acupuncture Board's attorney, Donald Chang, stated that the board's action was the equivalent of receiving a report, October 21, 2003, direct communication).
2. Larry Meyers, Ph.D., Professor, Department of Psychology, California State University, Sacramento, July 2004, written communication regarding "Standards for Educational and Psychological Measurement."
3. Kathleen Hamilton, former Director, California Department of Consumer Affairs, Sacramento, 2004, written communication.
4. California Code of Regulations, Title 16, section 1399.489: "The required number of CE Unit Hours that must be completed in a 2-year renewal period cannot be less than thirty (30)," http://www.acupuncture.ca.gov/ce/ce_require.htm, accessed 8-12-04.
5. National Institutes of Health, Consensus Panel Proceedings, November 3-5, 1997, Washington D.C., "Consensus Statement #107: Acupuncture," Journal of the American Medical Association, November 4, 1998, 280:1518-1524. Also, http://consensus.nih.gov/cons/107/107_intro.htm, accessed August 2004. Also, World Health Organization, 1999, "Guidelines on Basic Training and Safety in Acupuncture," p. 1, www.who.int/medicines/library/trm/acupuncture/acupdocs.shtml accessed July 2004.
6. Ted J. Kaptchuk, Associate Director, Center for Alternative Medicine Research and Education, and Assistant Professor of Medicine, Harvard Medical School, 2002, "Acupuncture: Theory, Efficacy and Practice," Annals of Internal Medicine Journal, Volume 136, pages 374-383, <http://www.annals.org/cgi/reprint/136/5/374.pdf>, accessed September 2004. Also, Donald E. Kendall, 2002, p. 25, "The Dao of Chinese Medicine: Understanding an Ancient Healing Art," New York, Oxford University Press.
7. World Health Organization, see footnote 5. Also, Paul U. Unschuld, 1998, "Chinese Medicine," pages 95-96, Brookline, MA, Paradigm Publications. See also, Donald E. Kendall, endnote 6.
8. William Collinge, 1997, "The American Holistic Health Association's Complete Guide to Alternative Medicine," Chapter 2, p.5, www.healthy.net/collinge/chinese.htm accessed July 27, 2004.
9. Qiao Wangzhong, 1996, "The Education of Traditional Chinese Medicine in China," Page 3, web published by Deputy Party Secretary, Beijing University of Traditional Chinese Medicine and the Geneva Foundation for Medical Education and Research, http://www.gfmer.ch/TMCAM/Hypertension/Education_Traditional_Chinese_Medicine_China.htm, accessed September 2004. Also, Linda L. Barnes, "The Acupuncture Wars: The Professionalizing of American Acupuncture - A View from Massachusetts," Medical Anthropology, 22:261-301, 2003. Also, Changzhen Gong, PhD, MS, President, American Academy of Acupuncture and Oriental Medicine, March 2004, "Educating America on Traditional Chinese Medicine: The New Mainstreaming of an Old - Very Old - Medical System," Web site accessed September 2004, <http://www.tcwellness.com/issues/1998/07/modernchinese.html>.

10. Linda L. Barnes, see endnote 9.
11. National Institutes of Health, see endnote 5.
12. Franklin Miller, Stephen Straus, et al, February 4, 2004, "Ethical Issues Concerning Research in Complementary and Alternative Medicine," Journal of the American Medical Association, Vol. 291, No. 5, pp. 599-605.
13. National Institutes of Health, see endnote 5.
14. National Center For Health Statistics, Centers For Disease Control and Prevention, U.S. Department of Health and Human Services, Advance Data, #343, Household Survey, May 27, 2004.
15. State of Hawaii, direct communication and document review, August 2004. Also, www.acupuncture-hi-com/history.htm, accessed July 2004. Also, Changzhen Gong, see endnote 9. Also see, William Collinge, endnote 8, Chapter 2, page 1.
16. William Collinge, page 16, see endnote 8. Also, National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), <http://www.nccaom.org>, accessed August 2004.
17. David M. Eisenberg, Ronald C. Kessler, Cindy Foster, Frances E. Norlock, David R. Calkins, and Thomas L. Delbanco, "Unconventional Medicine in the United States -- Prevalence, Costs, and Patterns of Use," New England Journal of Medicine, January 28, 1993. Volume 328:246-252. Also see, Qiao Wangzhong, endnote 9. Also, Timothy N. Gorski, MD, F.A.C.O.G, Assistant Clinical Professor, University of North Texas Health Science Center, Board Member, National Council Against Health Fraud, Associate Editor, Scientific Review of Alternative Medicine, Testimony to United States Senate Special Committee on Aging, hearing entitled "Swindlers, Hucksters and Snake Oil Salesmen: The Hype and Hope of Marketing Anti-Aging Products to Seniors," September 10, 2001.
18. Institute of Medicine, April 2004, "Dietary Supplements: A Framework for Evaluating Safety of Dietary Supplements."
19. Agency For Health Care Quality and Research, United States Department of Health and Human Services, Public Health Service, Acupuncture Technology Assessment, June 17, 2003 (21 CFR 901.109).
20. National Institute of Health, see endnote 5.
21. White House Commission on Complementary and Alternative Medicine Policy, www.whccamp.hhs.gov/cm.html, accessed August 2004. Also, Effie Poy Yew Chow, Member, White House Commission on Complementary and Alternative Medicine Policy, personal communication, September 14, 2004.
22. California Health Line, "Alternative Medicine Trend in Hospitals," March 28, 2004, www.californiahealthline.org/index.cfm, accessed July 27, 2004. Also, Hilary McGregor, Los Angeles Times, "His Path From Patient to Healer," July 26, 2004. Also, Cedars-Sinai Medical Center News www.csmc.edu/pdf/Orientalmed.pdf, accessed July 2004.
23. Kuo, Burke, et al, "Policy Brief: Findings from the Licensed Acupuncture Collaborative Study, Provider Perceptions of Oriental Medical Education and Practice," Los Angeles, CA, Department of Family Medicine, David Geffen School of Medicine and the Center for Health Care Provider Behavior, University of California, Los Angeles, June 2004. See also, Acupuncture Board, July 14, 2003, "Initial Statement of Reasons," page 5.
24. Letter to Governor Reagan from Assemblyman Gordon Duffy, December 6, 1972. Also, Assembly Health Committee analysis of AB 976 Duffy, November 13, 1972.

25. California Business and ProfessionCode, Chapter 267, statutes of 1975.
26. Acupuncture Board, background information for Sunset Committee, 2001.
27. Department of Consumer Affairs analysis of AB 1391 (Torres), September 4, 1979.
28. Assembly Committee analysis of AB 3040 of 1980.
29. Health and Welfare Agency analysis of AB 3040 of 1980. Also, May 27, 1980, Acupuncture Association letter (bill sponsor).
30. Acupuncture Board, Initial Statement of Reasons, Regulatory Package Hearing, July 14, 2003; Educational Curriculum Requirements.
31. Acupuncture Board, 2001, "Background Information and Overview of the Current Regulatory Program, and Response to Issues Identified by the Joint Legislative Sunset Review Committee," pages 5 and 30, referencing Business and Professions Code, Chapter 67, statutes of 1999.
32. Marilyn Nielsen, Executive Director, Acupuncture Board, 2004, direct communication. Also, Little Hoover Commission Acupuncture Advisory Committee meeting discussions, 2003. Also, National Institute of Health Consensus, see endnote 5.
33. Acupuncture Board, Strategic Plan, June 7, 2004, Sacramento, CA, page 5.
34. Linda L. Barnes, see endnote 9. Also, David Eisenberg and Ted J. Kaptchuk, March 2002, Harvard Medical School, Center for Complementary Therapies, Boston, MA, "Acupuncture: Theory, Efficacy and Practice," Annals of Internal Medicine, p. 374-383.
35. Linda L. Barnes, see endnote 9.
36. National Institute of Health, see endnote 5.
37. National Institute of Health, see endnote 5.
38. Linda L. Barnes, see endnote 9.
39. Robin Martin Okada, Study Coordinator, Department of Psychiatry and Behavioral Sciences, Stanford University, Palo Alto, CA, August 24, 2004, written communication. For additional studies, see Acupuncture Clinical Trials, National Center for Complementary and Alternative Medicine, <http://www.nccam.nih.gov/clinicaltrials/acupuncture.htm>, accessed 2003 - September 2004.
40. Joannie Shen, MD, MPH, PhD, 2001, "Research on the Neurophysiological Mechanisms of Acupuncture: Review of Selected Studies and Methodological Issues," Journal of Alternative and Complementary Medicine, Volume 7, Supplement 1, pp. S-121-S127, Bethesda, MA, National Institutes of Health, Clinical Center.
41. Harris, et al, U.S. Preventative Services Task Force, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, 2003, "Current Methods of the U.S. Preventative Services Task Force: A Review of the Process," Web site www.ahrq.gov/clinic/ajpmsuppl/harris3.htm, accessed July 29, 2003. Also, Stephen Straus, NIH, see endnote 12. Also, Ted J. Kaptchuk, Associate Director, Center for Complementary and Integrative Medical Therapies and Assistant Professor, Harvard Medical School, direct communication, 2004.
42. Donald Chang, Acupuncture Board and Department of Consumer Affairs attorney, written communication to the Commission, December 12, 2003, legal opinion 03-07.
43. Council of Acupuncture and Oriental Medical Associations, Scope of Practice for Licensed Acupuncturists, 1997. Also, Donald Chang, see endnote 42.
44. Business and Professions Code, "Legislative Intent," Section 4926.

45. The Acupuncture Board's Strategic Plan states: "Subsequent legislation in 1978 established acupuncture as a 'primary care profession' by eliminating the requirement for prior diagnosis or referral." In actuality, that intent language was added in 1980, but more importantly, as intent language, the Legislature arguably did not "establish acupuncture as a 'primary health care profession'." Also, see appendix G, Diane F. Boyer-Vine, Legislative Counsel opinion #8545, April 16, 2004, Sacramento, CA, Legislative Counsel Bureau.
46. Department of Consumer Affairs, Executive Office written communication, July 8, 2004, and 1980 "Annual Report," page 70, Sacramento, CA.
47. Legislative Counsel, see endnote 45.
48. California Department of Consumer Affairs Legal Office, Legal Opinion No. 93-11, Sacramento, CA, December 14, 1993, page 4.
49. Legal Opinion No. 93-11, see endnote 48.
50. Letter from the Department of Consumer Affairs to Peter Betcher, Practice Manager, and Mark Denzin, C.A., February 14, 1986.
51. Legal Opinion 93-11, see endnote 48.
52. University of California, Center for the Health Professions, May 2004, "Acupuncture in California: Study of Scope of Practice," page 5, San Francisco, CA.
53. Marilyn Nielsen, Executive Director, Pei Li Zhong-Fong, Chair, Acupuncture Board, Sacramento, CA, August 8, 2003 written testimony to the Commission.
54. California Code of Regulations, Title 16, Section 1399.436.
55. Council of Acupuncture and Oriental Medicine Associations, August 1996, "Standard of Care for Licensed Acupuncturists, Revision 2.3, page 19, Sacramento, CA.
56. Gary Klapman, former Board Member and Chair of Competency Task Force, Acupuncture Board, Sacramento, CA, August 28, 2003, testimony to the Commission.
57. Elmar Peukar, 2001, "Risk Information and Informed Consent In Acupuncture - A Proposal From Germany," page 137, Bochum, Germany, The Gronemeyer Institute of Microtherapy, www.medical-acupuncture.co.uk/aimintro.htm, accessed November 2003.
58. Little Hoover Commission based on direct communication with Andrew T. Weil, Clinical Professor of Medicine and Director, Program in Integrative Medicine, College of Medicine, Tucson, AZ, October and December 2003; Elad Schiff, former Chair, Israel's Task Force on Complementary Medicine and Fellow, Program in Integrative Medicine, College of Medicine, Tucson, AZ, September 2003; Effie Poy Yew Chow, President, East-West Academy of Healing Arts, San Francisco, CA, May 2004; Ted J. Kaptchuk, Associate Director, Division of Research and Education in Complementary and Integrative Medical Therapies, Harvard Medical School, Boston, MA, April 2004. Also, Eisenberg, et al, December 17, 2002, "Credentialing Complementary and Alternative Medicine Providers," Annals of Internal Medicine, volume 137, page 968.
59. University of California San Francisco, Center for the Health Professions, see endnote 52, Page 31.
60. Lawrence S. Meyers, Professor, California State University, Sacramento, July 2004, written communication regarding "Standards for Educational and Psychological Measurement."
61. Department of Consumer Affairs, Sacramento, CA, July 30, 2004, written communication.

62. Reference: Herbsleb, J. D., Sales, B. D., & Overcast, T. D., 1985, "Challenging Licensure and Certification," American Psychologist, 40 (11), 1165-1178, page 1166.
63. Department of Consumer Affairs analysis of AB 1391 (Torres), September 4, 1979.
64. SB 86 (Moscone-Song), Chapter 267, Statutes of 1975.
65. Kathleen Hamilton, former Director, California Department of Consumer Affairs, August 11, 2004, written communication to the Commission.
66. Board proposed regulations to implement new-3000 hour curriculum, pending.
67. University of California, Center for the Health Professions, May 2004, "Study of Education Issues and Current Educational Programs for Acupuncture and Oriental Medicine," p. 4, San Francisco, University of San Francisco (see also appendix).
68. UCSF, see endnote 67, p. 4.
69. Acupuncture Board, 2003, "Statement of Reasons, Educational Curriculum Requirements" Regulatory Package Hearing, July 14, 2003.
70. World Health Organization, see endnote 5, Pages 6 - 9.
71. Kuo, et al, see endnote 23.
72. Michelle Lau, President, Council of Acupuncture and Oriental Medicine Associations, August 2003, written testimony to the Commission.
73. Acupuncture Board, September 2003, written testimony to the Commission.
74. Lynn Morris, former Deputy Director, Department of Consumer Affairs and former Acupuncture Committee Executive Officer (now named Acupuncture Board), June 30, 2004, written communication to the Commission.
75. Michelle Lau, see endnote 72.
76. Brian Fennan, Executive Director, Council of Acupuncture and Oriental Medicine, Sacramento, CA, August 28, 2004, testimony to Commission, p. 9 and questionnaire. See also, Michelle Lau, endnote 72.
77. Andrew Weil and Elad Schiff, Integrative Medicine Program Director and Fellow, respectively, University of Arizona, School of Medicine, Tucson, 2003, joint response to Commission questionnaire. See also, Qiao Wangzhong, endnote 9, charts on variety of education in China, <http://www.gfmer.ch/TMCAM/Hypertension/Images/serrano005.jpg>, and <http://www.gfmer.ch/TMCAM/Hypertension/Images/serrano006.jpg>, accessed September 17, 2004.
78. Alan Trachtenberg, former Planning Director, NIH Consensus Conference on Acupuncture Efficacy, September 25, 2003 testimony to the Commission.
79. Pew Health Professions Commission, 1998, "Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation," Page i., San Francisco, CA, Pew Charitable Trusts.
80. Acupuncture Board, 2003, "Statement of Reasons, Educational Curriculum Requirements" Regulatory Package Hearing, July 14, 2003, page 2.
81. UCSF, see endnote 67.
82. John Gemello, Provost and Vice President for Academic Affairs; Donald Zingale, Dean, College of Health and Human Services, Adam Burke, Associate Director, Institute for Holistic Healing Studies, San Francisco State University, February 2004, written communication.

83. San Francisco State University, Office of the Provost and Vice President of Academic Affairs, February 20, 2004, written communication, "It is our strong recommendation that California acupuncture schools be required to have a minimum entrance standard of a bachelor's degree or its equivalent, or higher..."
84. Qiao Wangzhong, see footnote 9. Also, Teri A. Reynolds, Lawrence M. Tierney, Jr., May 5, 2004, *Student Journal of the American Medical Association*, 2004; 291:2141, <http://jama-assn.org/cgi/content/full/291/17/2141>, accessed July 14, 2004. Also, Anna Chan Chennault, Chair, Chinese Medicine Research Association of Hong Kong, July 15, 2004, telephone interview.
85. Qiao Wangzhong, see endnote 9. Also see Anna Chan Chennault, endnote 84.
86. Effie Chow, see endnote 21.
87. Qiao Wangzhong, see endnote 9. Also see Anna Chan Chennault, endnote 84.
88. Qiao Wangzhong, see endnote 9. Also see Anna Chan Chennault, endnote 84.
89. Sohachi Tanzawa, President, the Japan Society of Acupuncture and Moxibustion, "Acupuncture and Moxibustion in Japan," 2004, www.jsam.jp/english/admission/janmeeting.htm, accessed August 2004.
90. Bill Moyers, 1993, "Healing and the Mind," Public Broadcasting Service. Also, Mathew Bauer, advisory committee member, Sacramento, CA, September 18, 2003, written testimony to the Commission. Also, among the examples: Department of Health, England, March 2004, "Regulation of Herbal Medicine and Acupuncture: Proposals for Statutory Regulation," London, England, <http://www.Dh.gov.uk/Consultations/LiveConsultations/LiveConsultationsArticle/fs>, accessed April 16, 2004. Also, Acupuncture Today, "British Columbia Creates New Registration System for TCM Practitioners," July 2003, <http://www.acupuncturetoday.com/archives2003/jul/07/bc.html>, accessed September 16, 2003.
91. Anna Chan Chennault, see endnote 84.
92. Chinese Medicine Registration Board of Victoria, Australia, www.cmr.vic.gov.au/cgi-bin/cmweb.exe/intro, accessed July 27, 2004.
93. University of Technology, Sydney, Australia, 2000, "Handbook 2000, Traditional Chinese Medicine."
94. Diane Applebaum, US Director, MEDICC, April 2004, written communication.
95. World Health Organization, see endnote 5.
96. Department of Consumer Affairs, September 1979, Enrolled Bill Report on AB 1392 (Torres), Sacramento, CA.
97. Acupuncture Board, August 18, 2004, written communication. "Of the 10,003 licenses ever issued in California, only 7,069 are still valid and of those, 482 of the licensees have moved out of state and 159 live in other countries."
98. CCR, Title 16, section 1399.489: "The required number of CE Unit Hours that must be completed in a 2-year renewal period cannot be less than thirty (30)" http://www.acupuncture.ca.gov/ce/ce_require.htm, accessed August 8, 2004.
99. CCR, Title 16, section 1399.489, see endnote 98, http://www.acupuncture.ca.gov/ce/ce_require.htm, as of August 12, 2004.
100. American Board of Internal Medicine, Web site accessed summer 2004, http://www.abim.org/info/IM_Cert_Instructions.htm. Also, Lawrence S. Meyers, Professor, Department of Psychology, California State University, Sacramento, June

- 2004, "The Acupuncture Regulation Project: Evaluation and Comparison of California's License Examination and NCCAOM's Certification Examinations," report to the Commission (See Little Hoover Commission Web site www.lhc.ca.gov to download the full report.)
101. Lawrence S. Meyers, Professor, Department of Psychology, California State University, Sacramento, June 2004, "The Acupuncture Regulation Project: Evaluation and Comparison of California's License Examination and NCCAOM's Certification Examinations," report to the Commission.
 102. Norman R. Hertz, former Chief, Office of Examination Resources, California Department of Consumer Affairs, September 25, 2003, written testimony to the Commission.
 103. Christina Herlihy, former Chief Executive Officer, National Certification Commission for Acupuncture and Oriental Medicine, Alexandria, VA, August 28, 2003, written testimony to the Commission.
 104. Lawrence S. Meyers, Professor, Department of Psychology, California State University, Sacramento, June 21, 2004, written communication.
 105. Acupuncture Board, November 1, 2002, staff meeting notes.
 106. These requirements do not apply to schools outside of the US and Canada, (Sections 4938 and 4939, Business and Professions Code). In 2002, 36 graduates from foreign equivalency programs passed the California examination (January 2002 Examination Results).
 107. John Barth, United States Department of Education, personal and written communication, 2004; www.ed.gov, accessed July 2004. However, a newly formed organization, The National Oriental Medicine Accreditation Agency, intends to apply for accreditation status with the US Department of Education for the purpose of accrediting "entry-level doctorate accreditation," http://www.nomaa.org/index_m.htm.
 108. Meeting notes from initial Little Hoover Commission staff meeting with Acupuncture Board chair and executive director, November 2002.
 109. John Barth, United States Department of Education, personal and written Communication, June 2004. Also, www.ed.gov, accessed July 2004.
 110. John Barth, July 13, 2004, written communication: "The State of California Acupuncture Board would not be eligible under our criteria to be recognized as an accrediting agency." The only exception is the state of New York, which was grandfathered in at the inception of the USDE deputizing program. (34 CFR 602 and 603).
 111. Business and Professions Code, Section 4939.
 112. University of California, San Francisco, Center for the Health Professions, May 2004, "Study of School Approval and Accreditation of Acupuncture and Oriental Medicine Programs," report to the Commission.
 113. www.acaom.org, accessed August 2004. Also, University of California, see endnote 112.
 114. University of California, see endnote 112.
 115. University of California, see endnote 112, page 13.
 116. Gary Klapman, former Acupuncture Board member, 2003, questionnaire submitted to the Commission.
 117. University of California, see endnote 112.
 118. Acupuncture Board Web page <http://www.acupuncture.ca.gov/what/fact.htm>, accessed August 11, 2004. Also, see NIH, endnote 5. Also, see Ted J. Kaptchuk, endnote 6.

119. Brian Fennan, Executive Director, Council of Acupuncture and Oriental Medicine Associations, written materials submitted with written testimony, August 28, 2003, "Oriental Medicine Education Standards: Need for Improvement," p. 7, 2001, Sacramento, CA.
120. E. Ernst and K.J. Sherman, 2003, "Is Acupuncture a Risk Factor For Hepatitis? Systematic Review of Epidemiological Studies," Exeter, England, Journal of Gastroenterology and Hepatology, pages 1231-1236.
121. Marilyn Nielsen, Executive Director, California Acupuncture Board, October 21, 2003, personal communication and written communications, 2003-2004 (written requests for related information October 9, 2003, April 9, 2004, May 11, 2004). See also, NIH, endnote 5.
122. Marilyn Nielsen, see endnote 121.
123. Marilyn Nielsen, Acupuncture Board Executive Director, statement, October 21, 2003.
124. Woo, et al, Department of Microbiology, The University of Hong Kong Queen Mary Hospital and Hong Kong University-Pasteur Research Center, Hong Kong, "Relatively Alcohol-Resistant Mycobacteria Are Emerging Pathogens in Patients Receiving Acupuncture Treatment," Journal of Clinical Microbiology, April 2002, p. 1219-1224.
125. Woo, et al, see endnote 124.
126. Consumer Reports, May 2004, "Dangerous Supplements Still At Large." Also, Richard Ko, Senior Research Scientist, California Department of Health Services, direct communication, April 2004.
127. Consumer Reports, see endnote 126. Also, James Kirkland, Holly F. Mathews, et al, "Herbal and Magical Medicine: Traditional Healing Today," New England Journal of Medicine, volume 328: 215-216, January 21, 1993. Also, World Health Organization, Traditional Medicine Strategy 2002-2005, see endnote 5, states: "The natural resource base upon which certain products and therapies depends must be protected. Raw materials for herbal medicines, for instance, are sometimes over-harvested from wild plant populations." Policies should consider the implications for the ongoing availability of the plants, animals, sea life and coral that are the basis of natural medicines, but can be damaged or ruined if overly or ineptly harvested. Increasing global consumer demand for natural healing substances creates an intense economic interest from potential suppliers that may threaten endangered species.
128. Richard Ko, Senior Research Scientist, California Department of Health Services, September 17, 1998, letter, New England Journal of Medicine, volume 339; <http://www.dhs.ca.gov/common/PrinterFriend.htm>, accessed April 28, 2004.
129. Richard Ko, see endnote 126.
130. Institute of Medicine, 2002, "Proposed Framework for Evaluating the Safety of Dietary Supplements," Washington, D.C., National Academy Press.
131. Consumer Reports, see endnote 126.
132. Kent Olson, Medical Director, California Poison Control Center, April 28, 2004, telephone interview. Also, American Herbal Products Association, notice, June 7, 2004, Silver Spring, MD. Also, American Medical Association, Chicago, IL, Policy H-150.954, provided April 2004.
133. Richard Ko, See endnote 128.
134. Aileen Trant, herbal researcher, Stanford University Medical School, telephone interview, June 2004.
135. Aileen Trant, see endnote 134.

136. Aileen Trant, see endnote 134, direct communication, May 27, 2004.
137. Consumer's Union, June 2004, telephone interview.
138. Acupuncture Board, written communication to the Commission, December 18, 2003.
139. The board has devoted significant board meeting time and resources to raise educational requirements – apparently at the expense of adequately examining concerns about the spread of harmful blood-borne diseases. While recent changes in law increased the required number of hours of study as of January 1, 2005, the scope of practice was not expanded. However, the proposed regulations require the teaching of Western clinical science and practices (such as on p. 3, item C-5 ordering diagnostic imaging, radiological, and laboratory tests) that are not explicitly within an acupuncturist's scope of practice as stated in Section 4937 of the Business and Professions Code. The proposed regulations also require learning Oriental practices that are not covered by the authorized scope of practice, such as, on page 3, item 2(J): "Adjunctive acupuncture procedures, including bleeding, cupping, gua shua and dermal tacks." While "cupping" is specified in the scope, the other three items are not. Also, while Oriental diagnoses may possibly be inferred from their authorized scope, Western diagnosis cannot be according to the UCSF legal analysis, 2004.
140. Federation of Acupuncture and Oriental Medicine Regulatory Agencies, "United States Regulatory Agencies and Medical Boards and Laws for Acupuncture and Oriental Medicine," http://taotoearthmpubs.com/links_mb_us-a.html, accessed August 5, 2004.
141. State of New Hampshire Statutes of 1999, Acupuncture, 302.03, Degree Requirements, <http://gencourt.state.nh.us/rules/acp100-600.html>, accessed April 16, 2004.
142. Mary Jo Kreitzer, Director, University of Minnesota, Center for Spirituality and Healing, 2003 testimony to The Institute of Medicine and telephone interview, May 13, 2004.

