We Get Letters & E-Mail

Reigniting the Debate over Educational Standards in Acupuncture

Dear Editor:

I am writing this letter as the chair of the CSOMA Education Committee in response to the articles written by Dort S. Bigg and Elizabeth Goldblatt in the July issue of *Acupuncture Today*. Many of us in the profession are well aware of the rather active debate that has been ongoing with regard to our educational standards.

Before offering my opinions on this most important discussion, I would like to observe that over the past several months, comments have been made from both sides of the discussion that were somewhat personal and off-topic. It does not serve the discussion or the profession for either side of an argument to show disrespect for each other. I have always worked on the assumption that everyone involved in this discussion has taken the time to do so because they have acted in what they feel is the best interest of the profession and our patients.

I would never suggest that one side had a particular personal or financial interest, nor would I oppose the appointment of an individual to any board or commission based upon their disagreement with my particular point of view. I equally would be shocked and surprised if I discovered that Dr. Goldblatt or CCAOM attempted to block or oppose the appointment of professional members for a state board because a prospective board member didn't agree with their view on an issue. Such actions are simply not appropriate in a sincere search for what policies will serve the profession and our patients. Inasmuch as mutual respect is important, Mr. Bigg and Dr. Goldblatt may wish to note in future correspondence that Ted Priebe is Dr. Priebe, not Mr. Priebe.

As I read both of their letters, several points of misunderstanding and some incorrect information have come to my attention. There are also some points with which I agree.

To begin with, both letters refer to data collected by the California Acupuncture Board stating that there were 173 cases over a period of seven years. As it turns out, those were the number of cases submitted in one year (1998), not seven. Furthermore, the interpretation of this data is weak at best. As I stated quite clearly in an article published in the January 2000 issue of *Acupuncture Today* ("Should the California Acupuncture Board Raise the Number of Hours Required for Licensure?"), most malpractice cases are not seen or reviewed by a licensing board. I can certainly speak with regard to my experience on the California Acupuncture Board. I became aware of many cases that went through legal action and never appeared before our board, the reason being that most malpractice cases are settled out of court and are never brought up for disciplinary action. Furthermore, the number of cases is increasing. Each year from 1997 through 2000, the number of malpractice cases tripled in two years and doubled in one year compared to the previous three. We really cannot judge the safety record of acupuncture by the cases of disciplinary actions of the state boards.

It has been suggested that most problem cases have been generated by practitioners trained under

the older and shorter educational standard. To suggest this without a complete analysis of the data is a yet another unsubstantiated argument, especially since the new educational standard has been in effect for over 12 years. I would agree that such an analysis would be helpful and possibly lend some good guidance with regard to how different education standards affect the malpractice and safety issues of our profession. However, we must still be aware that data must be collected that is complete and includes what goes on in the malpractice area. We must also be aware that the nature of practicing is also changing.

I am inclined to agree that acupuncture is a relatively safe procedure in the hands of a fully trained and competent practitioner. However, training is extremely important. As we gain the public trust, our patients now come more frequently without a prior visit to a medical doctor or with a Western diagnosis. It is important to remember that when acupuncture first became utilized from 1979 through the early 1990s, most patients came to an acupuncturist as a last resort after having tried Western medicine (and often chiropractic). Therefore, most patients had already been through a complete Western medical workup, and patients with serious, life-threatening illnesses did not typically seek care from an acupuncturist without knowing what diagnosis they had. According to one malpractice carrier I spoke with, the most common malpractice complaint among chiropractors is a missed diagnosis. I hope we are not so bold and arrogant as to believe our profession is above making such an error.

In spite of Dr. Priebe's lucid discussion of the legal responsibilities of being a "primary health care provider" or "portal of entry health care provider," Dr. Goldblatt insists that we should not have the ability to make a Western medical diagnosis, but we should have enough Western medical training to communicate with and refer to Western medical practitioners.

This odd dichotomy of knowing a little but not too much raises many questions. Where do you draw the line? Do you request an x-ray to differentiate an ankle sprain from a fracture, or do you send your patient to a DC or MD, which generates more expense and time for your patient? Every time a practitioner signs an insurance form with a Western medical diagnosis, that practitioner has just made a Western diagnosis. There is no way around that simple fact.

Furthermore, according to California state acupuncture regulations (Title 16, California Code of Regulations), Article 3.5, sec. 1399.436(b) states: "The curriculum shall include adequate clinical instruction · which includes direct patient contact where appropriate in the following: (1) Practice observation· (2) Diagnosis and evaluation-the application of Eastern an Western diagnostic procedures in evaluating patients."

Any acupuncture school seeking California accreditation that fails to adequately instruct for Western diagnostic procedures is in non-compliance with the California regulations on educational requirements. A status of non-compliance could cost a school its California accreditation. Learning to make a basic Western diagnosis is not bad or evil. It is not a reason to cause fear and alienation with medical doctors. The more we learn about Western medicine, the better our communication will be, the deeper our understanding of our patients' health, and the more we can be entrusted by the public and the medical community as primary health care providers. I do agree with Dr. Goldblatt that we should not treat our patients with Western modalities. This area should be left to the medical community, and we should happily refer our patients to an MD, DDS, PT, DO or DC whenever those services are in the best interest of our patients.

There has also been much discussion of the term "primary health care provider." A "primary health care provider" is a health care provider that can safely provide healthcare services without the need for a prior diagnosis or referral from a medical doctor. This should not be confused with the term "primary care physician" or PCP, a term used in managed care for a medical doctor who acts

as a gatekeeper for the services of a managed health care organization. A PCP would deliver or direct all manners of Western medical care and treatments. (*Note:* chiropractors, acupuncturists and naturopaths are defined as "primary care physicians" in some states, and we are clearly "primary treating physicians" in California's WC system. The real confusion comes because of the assumption that this increased responsibility expands our scope of practice significantly into Western modalities.)

As for the term "primary care in Oriental medicine," I had never heard of it before last fall, during the Educational Task Force meetings of the California Acupuncture Board. This term or its concept does not negate our legal and ethical responsibilities to our patients that were so succinctly stated in Dr. Priebe's earlier letter to the editor. The term has no legal status or reference in statute, and may serve only to confuse the insurance industry.

I do agree that Dr. Goldblatt, Mr. Bigg, or any other representative or individual has the right to come and offer constructive discussion before the California Acupuncture Board. You have a warm welcome as far as I am concerned. I would only suggest that we all come to listen as well as talk.

This brings me to my final point: the recent action of the California Acupuncture Board to raise the curriculum requirements to 3200 hours. During the course of the last board meeting, there was considerable debate over this proposal. It appears most schools were comfortable raising the curriculum requirements to 2,800 hours, since most of them are already at 2,700 to 3,300 hours. On the other side, the professional associations strongly support a 4,000 hour professional doctorate as the appropriate standard for licensure.

Earlier this year in *Acupuncture Today* I suggested a 2,800 hour requirement as a reasonable entry-level standard, with the goal of a credible 4,000 hour doctorate in two to three years. I suggested that the schools, the professional associations, and the California Acupuncture Board sit down and discuss this possibility. I am aware that several informal conversations occurred between some of the schools and some CSOMA board members. Some of the schools were supportive of a compromise, but most were not interested.

What happened? Nothing! Nobody pursued any formal discussion with anybody, and everybody went to the board meeting with their heels dug in, without any concern for reasonableness or compromise. The result: the board voted to increase the hours to 3,200 -- not quite halfway between 2,800 and 4,000, but inconvenient for the school accreditation process as the proposed ACAOM research doctorate comes on line.

In my heart, I believe consumers (our patients) will be best served by a practitioner with a 4,000 hour education that is well rounded in all phases of TOM and includes a working knowledge of Western medicine. I had a nice chat with Jack Miller, LAc, the president of Pacific College, who suggested that we develop a list of competencies on which to base our education and noted that such lists are the basis for medical education. I thought it was a good idea worth pursuing. Along the same line, Natalia Egorov, a PharmD and acupuncture student representative on the CSOMA Board, suggested in her testimony that the National Center for Complimentary and Alternative Medicine has grants available to study what levels of education complementary health providers actually need.

That sounds like a great idea. Let's get together and use some grant funding to do an unbiased professional assessment of what educational level our profession actually needs to function in the 21st century. I'm sure it will come up with about 4,000 hours, but if not, at least we will all know the study was conducted with the full participation of the profession, the teachers, the schools and other medical experts.

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