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California Acupuncture Board Responds to Little Hoover Commission's Findings

Editorial Staff

Last September, in response to an official request by the California Legislature, the Little Hoover Commission issued a report on the state of the acupuncture profession in California. Included in the commission's analysis were a series of six findings related to scope of practice, educational requirements and other important matters, along with recommendations on how to improve the profession and the state's regulatory agency, the California Acupuncture Board.

Shortly after the publication of the Little Hoover Commission's findings, the California Acupuncture Board sent a reply to Tara Dias, a consultant with the state's Joint Committee on Boards, Commissions, and Consumer Protection. Because the board did not have a full contingent of members to respond to the commission, it based its response using the historic position of previous boards.

The following pages contain the board's complete response to Ms. Dias, minus the Little Hoover Commission's findings and recommendations. Explanations of acronyms have been inserted where necessary, and any errors in spelling and punctuation in the original reply have been corrected for this publication.

California Acupuncture Board's Response to Little Hoover Commission's September 2004 Findings and Recommendations

Dear Ms. Dias: This is in response to the Joint Committee's September 30, 2004 request that the board addresses the findings and recommendations that the Little Hoover Commission (LHC) identified in their September 2004 report. Not having a full complement of board members to respond to these findings and recommendations, each issue is being addressed with the historic position of previous boards. Once a quorum is re-established, these issues will be forwarded to the board for discussion. In the meantime, the following is the board's response.

Response to Finding/Recommendation #1 1. Keep licensure focused on traditional Oriental medicine. The board agrees and feels the scope of practice and educational curriculum requirements are focused on traditional Oriental medicine (TOM) and are clearly defined in the laws and regulations that regulate an acupuncture and Oriental medicine practitioner. The educational curriculum requirements provide the licensee with the foundation to practice within their defined scope of practice. The board addresses this issue on pages 18 and 19 of the board's *2004Sunset Review Report*. Business & Professions Code, Sections 4927 and 4937, in conjunction with Legal Opinion 93-11, prepared by the board's legal counsel in 1993, defines acupuncture and the wide range of modalities to treat most common disorders and diseases. The board believes that the current scope of practice for a practitioner of acupuncture and Oriental medicine is adequate and is not lobbying to have it expanded.

The legislative intent in B&P Code Section 4926 defines an acupuncturist as individuals practicing acupuncture subject to regulation and control as a primary health care profession. B&P Code Section 4927(d) defines acupuncture to mean "the stimulation of 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." B&P Code Section 4937 authorizes an acupuncturist to utilize Oriental medicine treatment modalities and procedures used to promote, maintain and restore health, including the use of Oriental massage, acupressure, breathing techniques, exercise, heat, cold, magnets, nutrition, diet, herbs, plant, animal, and mineral products, and dietary supplements. Acupuncturists were included as primary treating physicians in the workers' compensation system in 1989 and approved as a qualified medical evaluator (QME) (Labor Code Section 3209.3(a)). Since the elimination of requiring a physician referral in 1979, an acupuncturist's scope of practice has expanded to include diagnosis. Thus an acupuncturist is allowed to diagnose, prescribe and administer treatment in the practice of acupuncture and Oriental medicine.

2. Define primary care practitioner. "Primary health care" is a universal term among health care practitioners. Primary health care means a licensed health care provider who provides initial health care services to a patient and who, within the scope of their license, is responsible for initial diagnosis and treatment, health supervision, preventative health services, and referral to other health care providers when specialized care is indicated. As a primary health care professional, an acupuncturist may provide comprehensive, routine and preventative treatments, that include but are not limited to traditional Chinese medicine (TCM) diagnosis, palliative, therapeutic and rehabilitative care. Page 18 of the Little Hoover Commission's September 2004 report lists a compilation of definitions for the term "primary care provider." Patients have direct access to either a Western or Eastern practitioner, and each of these definitions and responsibilities would apply to either practitioner. This is further recognized by the LHC in its September 2004 report, wherein on page ii of the executive summary, they state that "clear statutory language is needed to affirm that consumers have 'direct access' to acupuncturists who can diagnose patients using traditional Oriental techniques ... ."

3. Authorize and define traditional Oriental diagnosis. The board agrees and addresses this issue on page 19 of the board's September 2004 *Sunset Review Report*, and provided proposed language to the Joint Committee to amend B&P Code Section 4937, adding the term "diagnose" to the language. Legal Opinion 93-11 found that the Legislature, in repealing B&P Code Section 2155 (i.e., eliminating the need for a physician referral as a precondition for treatment by an acupuncturist) (Statutes of 1979, Chapter 488, effective January 1, 1980), authorized acupuncturists to diagnose a patient's condition prior to providing any treatment. Thus, although an acupuncturist is authorized to diagnose, this critical function was inadvertently omitted and therefore is not clearly stated in the law. Since 1980, acupuncturists have been authorized to diagnose and treat within their scope and in their daily practice as "initial contact health care providers." Amending Section 4937 would accurately reflect the current authority, scope and practice. On a daily basis, acupuncturists assess and diagnose patients to provide an effective and quality treatment plan.

This was recognized in 2002 by the Joint Sunset Review Committee and the Department of Consumer Affairs in the written comments reported in their final recommendations regarding issue #1, relating to continuance of regulating the profession, wherein they stated, "Acupuncturists diagnose, administer treatment, and prescribe various treatments and herbs to promote patient health." This is further recognized by the LHC in their September 2004 report, wherein on page ii of the executive summary,

they state that "clear statutory language is needed to affirm that consumers have direct access to acupuncturists who can diagnose patients using traditional Oriental medicine techniques," and again on page v, in recommendation #1, wherein they state, "The scope of practice should include an explicit authorization to conduct traditional Oriental medicine diagnosis."

4. Require disclosure of critical information. The board agrees with the LHC's recommendation. As the integration of Eastern and Western medicine continues to expand, the Eastern practitioner should be required to offer information regarding Western interaction - and the Western practitioner should offer information on complementary medicines, including acupuncture. The DHS/FDA (Department of Health Services/Food and Drug Administration) has jurisdiction for approving devices. However, the board acknowledges the LHC's recommendation to regulate single-use disposable needles and will amend current regulations to conform with FDA rules. The board concurs that acupuncture needles should always follow FDA regulations. Single-use disposable needles are already the norm and have not been an issue. The 1996 *Occupational Analysis* reflected that 99.6 percent (99.3 percent English, 100 percent Chinese and 100 percent Korean) of licensees "only" used disposable needles in their practice, and fewer consumer complaints have been filed with the board involving multiple-use needles. June 1996 FDA rules have required manufacturers to label their acupuncture needles for "single use only," and historically, students are taught this in their theoretical and practical training.

The board has been responsive to the consumer by ensuring strict education requirements on clean needle technique (CNT) and testing the exam applicant on CNT protocol. The board also enforces state and federal laws relating to standards of care, sterilization, and condition of office (i.e., OSHA, CNT, hazardous waste, health and safety codes, etc.). The board's 2004 revised consumer brochure, released in June 2004, also contains language addressing single-use needles (page 8) and herb-drug interactions (page 10).

5. Allow for acupuncture-only licensure. Not having a full complement of board members, this issue is being addressed with the historic position of previous boards. One a quorum is re-established, this issue will be forwarded to them for discussion. In the past, the board has taken action to oppose this type of proposal. The board has always felt that while there are different modalities utilized to treat specific conditions that vary depending upon the needs of the patient, that acupuncture and Oriental medicine is one medicine and should be learned as one medicine. Once learned, it is the discretion of the practitioner to utilize the application of the full complement of modalities making up the medicine, or specialize in selected portions thereof. Issuing licenses that only focus on one of the modalities of the medicine could actually be more confusing to the public, and contradicts the fundamental premise of an acupuncturist treating the whole being, utilizing all of the modalities of acupuncture and Oriental medicine. Rather than implementing a new licensing structure, it would perhaps be more efficient to solicit underutilized practitioners to address the needs for drug and alcohol addiction treatments in California.

Response to Finding/Recommendation #2 1. Educate within scope. The board addresses this issue on pages 20 and 21 of the board's *2004 Sunset Review Report*. The board feels the scope of practice and educational curriculum requirements are focused on traditional Oriental medicine and are clearly defined in the laws and regulations that regulate an acupuncture and Oriental medicine practitioner. The educational curriculum provides the licensee with the foundation to practice within their defined scope of practice. Since the commencement of licensure in California in 1975, health care and related technology have changed tremendously. The current level of education (i.e., 2,348 hours) has not kept pace with the expanded role of a primary health care practitioner. It is the responsibility of the board

to maintain an adequate level of educational requirements that match the entry-level knowledge, skills and abilities required of a licensed practitioner in California today. B&P Code Section 4939(b) requires a minimum 3,000-hour curriculum requirement, effective January 1, 2005. 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. China, Korea and Taiwan have established international education standards for their health care professions. 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.

With the increased use of acupuncture, the need for a common language to facilitate communication in teaching, research, clinical practice and exchange of information had become pressing. Therefore, in 1989, the World Health Organization (WHO) convened a scientific group that approved a "Standard International Acupuncture Nomenclature" which is being widely disseminated and applied. The scientific group also recommended that the organization develop a series of statements and guidelines in acupuncture relating to basic training, safety in clinical practice, indications and contraindications, and clinical research. According to WHO's guidelines on basic training and safety in acupuncture, released in 1995, a minimum of 2,500 hours is considered the minimal standard for the student of "acupuncture" alone, not including 450 to 650 hours for training in herbal medicine. Of the 2,500 hours, 500 hours are recommended for the study of Western medicine. The standards released by WHO are intended to assist national health authorities in setting standards and establishing official examinations, and also medical schools and institutions, to define training programs.

In the past, the board has supported an eventual entry-level standard of 4,000 hours commensurate with the profession's status as a primary health care professional and in alignment with international accepted standards. However, before the board ever took action to proceed with any further increases in educational requirements, it would need to evaluate the educational outcomes and practice proficiencies of licensees trained at the 3,000-hour level.

2. Devote adequate curriculum to patient safety, including coordination (i.e., up-to-date infection control practices; improving coordination with Western medicine). The board agrees, and its main objective is to set a standard that protects the consumer and assures a level of education that is consistent with all other first-contact health care professionals who provide comprehensive and routine care. All medical practitioners need a core medical curriculum leading to basic medical understanding, and an awareness of the strengths and weaknesses of other modalities, to know when to refer and how best to communicate with other practitioners. It is in the patient's best interest that all medical practitioners possess common core knowledge of medical terminology and knowledge to promote good professional communication, patient case management, and continuity of care.

All health care professionals must keep up with constant changes and improvements in modern science and medicine. Acupuncturists, as well as all providers listed in the California Labor Code, Section 3209.3 as "physicians," are required to complete accurate, uniform, and replicable evaluations. The procedures require an evaluation of anatomical loss, functional loss, and the presence of physical complaints to be supported, to the extent feasible, by medical findings based on standardized examinations and testing techniques generally accepted by the medical community. The board feels the scope of practice and educational requirements are primarily focused on traditional Oriental medicine and are clearly defined in the laws and regulations that regulate an acupuncture and Oriental medicine practitioner. The board also feels a licensee should have a core education and knowledge of the biomedical sciences as currently taught in school. Knowing how to establish a

working diagnosis, when to refer, and how to communicate and interact with Western-trained practitioners ensures the health, safety and protection of the consumer.

3. Teach within area of expertise. The board agrees that the basic science courses could be taken outside of their acupuncture and Oriental medicine (AOM) educational program, and the majority of the new enrolling students enter their AOM program already having taken these courses. This would "free up" the program hours designated to the basic sciences to be utilized in other critical educational program components. Title 16, California Code of Regulations, Section 1399.436(i) requires that "all instructors shall be competent to teach their designated courses by virtue of their education, training and experience." Therefore, instructors of both TOM and biomedical courses teach within their area of expertise.

Response to Finding/Recommendation #3

1. Specify courses (to keep practitioners current on certain conditions/procedures). The board agrees and already took action to specify courses in the proposed regulatory changes in Attachment M of the board's *2004 Sunset Review Report*. The proposed regulatory changes will require a mandatory four hours in drug/herb interaction as a condition of renewal every two years. The proposed regulatory changes also specify categories that continuing education courses must fall within, and limit the number of hours a licensee can take on courses not directly related to acupuncture and Oriental medicine, Western medicine (as it relates to acupuncture practice), and scope of practice. Enforcement complaints do not reflect this is an issue; however, the proposed regulations could be amended to include or define specific courses recommended by the commission. Once a quorum of the board is re-established, this issue will be forwarded to them for discussion.

2. Require examination (require testing for material related to patient safety). Patient safety is a primary focus in the daily theoretical and practical training of an acupuncture student, and is included on the licensing exam a candidate must pass prior to licensure. Patient safety is also a fundamental part of a licensee's daily practice. The board has addressed patient safety, new requirements and standards, and other health issues in its annual newsletter to the licensees and through its website. While the board has addressed this issue and the low enforcement statistics relating to safety issues reflect this, there will always be more that any entity can do, and the board is open to suggestions. The board does not have a method of re-examining its licensees, nor does it concur that there is a need to do so. Re-examining licensees is not a practice of licensing professions in California.

Response to Finding/Recommendation #4

1. Demonstrate knowledge of critical components of safe practice (must-pass modules). Historically, a candidate "must pass" the entire licensing examination. The examination covers five content areas that reflect the current job competencies in the practice of acupuncture and Oriental medicine in California. The five content areas and their associated weights include: 1. patient assessment (25%); developing a diagnostic impression (20%); 3. providing acupuncture treatment (29%); 4. prescribing herbal medicinals (17%); and 5. regulations for public health and safety (9%). A module testing for laws, regulations, scope of practice and safety standards has been discussed with the board and the Department of Consumer Affairs' Office of Examination Resources (OER) since 1999, when the practical component of the exam was eliminated. The board is also concerned that only nine percent of the current licensing exam tests for all of these subjects. However, discussion and decisions of modifications to the exam since the 2001 sunset review process had been suspended until the issue of

who will conduct the exam was resolved. Based on the board's historic position and confirmed in the LHC's findings and recommendations, it appears California will retain the development and administration of the licensing exam. The board and OER can now strategize a way to enhance the exam with the components of the eliminated practical (i.e., point location, herb identification/usage, CNT, diagnosis) and a "must pass" module.

2. Competitive examination administration (continue to contract out). The board agrees with the LHC's findings and recommendations on this issue and will continue to contract out.

3. Develop strategy for implementing internship. The board agrees with the LHC's findings and recommendations on this issue. The board also has discussed and supported the issue of requiring postgraduation, pre-examination clinical internships; however, the board has not been able to follow through on this, as the same opportunities for a fully integrated clinic or hospital environment for acupuncturists have not existed in the past. Acupuncture and Oriental medicine is relatively new in California, with only 30 years of licensure; however, with the speed in which the medicine is being integrated into the Western health care system, opportunities for implementing internships have increased over the last few years, and the board is confident internships will become a reality in the near future. Several acupuncture schools have also established very successful externships in integrated clinics as part of the student's clinical requirements for graduation.

Response to Finding/Recommendation #5

The board is opposed to naming any specific accrediting agency in law. If required, the legislative language should remain generic to recognize any school accredited by an accrediting agency approved by the U.S. Department of Education. The board addresses this issue on pages 34 through 36 of the board's *2004 Sunset Review Report*. In 2001, the board began to focus on reviewing and evaluating the school approval process. Public meetings were held to review the application and the board's site visit manual, policies and regulations relating to school approval, the Bureau for Private Postsecondary & Vocational Education's (BPPVE) approval process and the Accreditation Commission of Acupuncture and Oriental Medicine's (ACAOM) accreditation process. In addition, BPPVE and ACAOM made presentations about their approval processes and how California could utilize or partner with them. ACAOM's didactic and clinical training program hour requirements have historically been well below that of California's. The board is monitoring several accusations that surfaced in June of 2004 against ACAOM of professional and ethical misconduct, which was raised by three ACAOM commissioners who were removed from the commission. Also in June, ACAOM had undergone organizational restructuring with the deletion of the longstanding director and office in southern California.

In May 2002, a new accrediting agency was incorporated and began the process to become recognized by the U.S. Department of Education. The National Oriental Medicine Accreditation Agency (NOMAA) will accredit acupuncture schools offering a professional doctor of Oriental medicine (DOM) degree. South Baylo University in Los Angeles in June 2004 launched the first NOMAA doctor of Oriental medicine degree program in the state. The board will continue monitoring the progress of the program.

Accreditation is not a replacement for governmental regulation. Public institutions receive their approval to operate through the state constitution and legislative action. Accreditation is a voluntary, private-sector evaluation. Accrediting bodies cannot force institutions to comply with state and federal laws, and do not view their role as regulatory. There are three types of accrediting bodies: regional

associations (e.g., the Western Association of Schools and Colleges [WASC]); national accrediting bodies (e.g., the Association of Independent Colleges and Schools or the National Association of Trade and Technical Schools); and specialized accrediting bodies (e.g., ACAOM, NOMA, the American Bar Association, the National Education Association). The board is opposed to naming any specific accrediting agency in law. If required, the legislative language should remain generic to recognize any school accredited by an accrediting agency approved by the U.S. Department of Education.

National scope, practice or educational standards do not exist in this profession, which is largely due to the variance in the scope of practice from state to state. The spectrum is wide and diverse. For instance, 11 states do not license acupuncture and Oriental medicine providers, others still require a referral from an allopathic doctor, and some states have a limited scope of practice, while the profession in California has a broader scope. Therefore, in June 2002 and again at the September 23, 2003 board meeting, the members took a position to retain the board's school approval process as a requirement for a graduate student to qualify for the CALE. Recognizing other approval or accrediting authorities may limit or compromise the board's ability to improve educational and approval standards.

Response to Finding/Recommendation #6

1. The board needs to develop a patient safety strategy. As stated above in point #4 of recommendation #1, the board acknowledges LHC's recommendation to regulate single-use disposable needles and will amend current regulations to conform with FDA rules. The board would like to restate its concurrence that acupuncture needles should always follow FDA regulations. Single-use needles are already the norm and have not been an issue with the board. The 1996 *Occupational Analysis* reflected that 99.6 percent (99.3 percent English, 100 percent Chinese and 100 percent Korean) of licensees "only" used disposable needles in their practice, and few consumer complaints have been filed with the board involving multiple-use needles. June 1996 FDA rules have required manufacturers to label their acupuncture needles for "single use only," and historically, students are taught this in their theoretical and practical training.

The board has been responsive to consumers by ensuring strict education requirements on clean needle technique (CNT) and testing the exam applicant on CNT protocol. The board also enforces state and federal laws relating to standards of care, sterilization, condition of office (i.e., OSHA, CNT, hazardous waste, health and safety codes, etc.). The board's 2004 revised consumer brochure, released June 2004, also contains language addressing single-use needles (page 8), in addition to herb-drug interactions and a caution to keep both a physician and acupuncturist apprised of all products a patient is taking (page 10). The board's consumer brochure further addresses the research findings from the National Institutes of Health (NIH) on page 6.

In addition, the proposed regulatory changes in Attachment M of the board's *2004 Sunset Review Report* will require a mandatory four hours in drug/herb interaction as a condition of renewal every two years. The proposed regulatory changes also specify categories that continuing education courses must fall within, and limit the number of hours a licensee can take in courses not directly related to acupuncture and Oriental medicine, Western medicine as it relates to acupuncture practice, and scope of practice. Enforcement complaints do not reflect this is an issue; however, the proposed regulations could be amended to include or define specific courses recommended by the LHC. Once a quorum of the board is re-established, this issue will be forwarded to them for discussion.

2. Develop consumer protections for herb products. The board recognizes and agrees with the LHC regarding the concerns and importance of herb-drug interactions, herb purity and potency, accurate labeling, and reporting of adverse effects. "Regulating herbs" was a primary issue in the board's 1997, 1998, and 1999/2000 Strategic Plans. The board discussed this issue for the first time at a public meeting on September 28, 1997, and again on February 23, 1998; May 28, 1998; February 23, 1999; and June 27, 2000. In 1997, the board felt that in order to protect consumers against the potential danger of medicinal-grade herbs, it was essential to review the need to regulate the distribution, sale and/or use of herbs in California. During that time, the board assisted the California State Food and Drug Branch of the Department of Health Services (DHS), the state agency having authority over herbs and herbal products, to identify Asian patent medicines for the 1997-1998 *Compendium of Asian Patent Medicines*. This publication was compiled to educate the public, herbal industry and medical community on the potential danger of some patent medicines. Dr. Richard Ko, of the DHS Division of Food and Drugs, testified numerous times before the board, but specifically on September 28, 1997, February 23, 1998, and May 28, 1998 regarding herbal regulation. At the February 23, 1999 meeting, the board's legal counsel cautioned the members about carrying this issue any further, advising that the board has no legal authority to regulate herbs, as herbs are not regulated by anyone. He also cautioned that the coalitions of dietary herb companies and pharmaceutical companies are far too strong for this board to take on in this highly sensitive and political battle, and should be left up to the state agency (DHS) with the authority to do so.

3. Restructure the regulator to benefit consumers. Longstanding laws have been in place governing DCA boards or bureaus that designate the number and composition of the board structure as well as designating the appointing source. It has been the policy of the legislature to require a public majority on licensing boards for all professions excepting the health care boards, wherein the statutes designate a professional majority. Any changes to these laws and policies will need to originate through the governor's office and the legislature.

The board appreciates the opportunity to respond to the Joint Committee's questions and would be happy to provide any additional information as requested.

Sincerely,
Marilyn Nielsen
Executive Officer

Editor's note : The Chinese Herb Academy has created an online "blog" so that interested parties can discuss the impact of the Little Hoover Commission's report, along with the CAB's response. For more information, visit http://chineseherbacademy.org/LHCblogs.shtml.

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