Comparative Survey Study on Integrated Chinese and Western Medicine in China and South Korea

Acupuncture and Ketamine in Treating Chronic Backache

Case Studies: Treating Chronic Post-Surgical Knee and Thigh Pain; Treating Cervical Radiculopathy; and Treating Adhesive Capsulitis

SIO 2011 Conference Report, Part 4: The Future (and Current Reality) of Integrative Oncology

Acupuncture, Medical Necessity, and Automobile Insurance Fraud
At Kan, we have always believed the best way to ensure the consistency, quality, and safety of our products is to manufacture them ourselves. Kan buys herbs in whole raw bulk and tests each incoming lot for over 200 different pesticides as well as toxic metals and bio-burdens, such as yeast, mold, Staphylococcus, E.Coli and Salmonella. Our Certificates of Analysis reflect our commitment to the quality, safety and efficacy of our products.

Chinese Herbal Products You Can Trust

Kan Herbals  |  Kan Traditionals  |  Kan Singles  |  Sage Solutions  |  Gentle Warriors  |  Chinese Modular Solutions  |  MycoHerb  |  Alembic Herbals

We Have Moved!
380 Encinal Street, Santa Cruz, CA 95060
800.543.5233  831.438.9450  www.kanherb.com
Original Research

8 Comparative Survey Study on Integrated Chinese and Western Medicine in China and South Korea
Jun Wang, PhD; Hyun-Ji Lee, PhD; and Seung-Pyo Hong, PhD

13 Acupuncture and Ketamine in Treating Chronic Backache
Lazgeen Mohammed Ahmed, D. Ansth, D. Acup

Case Study

16 Post-Surgical Knee and Thigh Pain with Numbness Treated with Acupuncture and Associated Therapies
Forrest Cooper, Dipl AC (NCCAOM), LAc

21 Treating Cervical Radiculopathy with Acupuncture, Chinese Herbal Formulas and Soft Tissue Manipulation
Misha Payant, DAc, MSOM, Dipl Ac&CH (NCCAOM), LAc

25 Thawing the Frozen Shoulder—Clinical Recommendations for the Use of Acupuncture in Treatment of Adhesive Capsulitis
Ivan Cheng, DAOM (NCCAOM), LAc

Perspectives

30 SIO 2011 Conference Report, Part 4: The Future (and Current Reality) of Integrative Oncology
Claudette Baker, Dipl OM (NCCAOM), LAc

33 Acupuncture, Medical Necessity, and Automobile Insurance Fraud
Steven Schram, PhD, DC, LAc

Book Reviews

40 Integrating East Asian Medicine into Contemporary Healthcare
Reviewed by Steve Given, DAOM, LAc

42 Traditional, Complementary and Integrative Medicine: An International Reader
Reviewed by Elizabeth Sommers, PhD, MPH, LAc

3 President’s Message: Michael J. Jabbour, MS, LAc
5 From the Editor: Jennifer A. M. Stone, LAc
7 AAAOM Board of Directors & Mission Statement
46 AAAOM-SO Update
46 Index to Advertisers
Choose from over 600 Plum Flower® herbs and extract powders to create high quality formulas for your patients. Plum Flower® herbs are true Chinese Pharmacopoeia authenticated species; 5:1 extract formulas are natural yield with no fillers, and single herb extracts contain minimal to no fillers.

- Same day service*
- Free drop-shipping to your patients
- Barcode scanning and integrated scales ensure accuracy
- Single and/or pre-made formula extract powders in your custom formulations
- Turbula® mixer ensures uniform dosing of extract powders
- Encapsulation available**

Mayway.com offers even more convenience:
- Create custom prescriptions using our searchable herb database
- Use or modify our online templates or create your own
- Save your prescriptions online
- Modify and refill existing prescriptions

Visit our Herbal Dispensary at Mayway.com
Or, fax your prescriptions to us at 1-800-909-2828.

*for orders placed before noon PST
**allow up to 2 business days for encapsulating or powdering raw herbs

Authentic Chinese medicine since 1969
Dear colleagues, future colleagues, and supporters:

As we welcome in 2013, the AAAOM continues to move our community and organization forward in response to the needs of our membership and our nation. This coming year will bring the final processes for activation of the Affordable Care Act with state-level determination of Essential Health Benefits (EHB). We are pleased that California, Maryland, Washington, New Mexico, Nevada, and Alaska now include AOM as an EHB service, and we will continue to work with our state partners to pursue coverage in additional states. With the shortage of primary care physicians only increasing, AOM has great potential to help with the provisioning of health care services to those in need. As such, we are working hard to respond to the calls for greater access to AOM as a source of medical care, expanded AOM research, and assistance in organizing and sustaining the businesses of our members.

Even closer to home, the AAAOM continues to work on a myriad of projects that directly benefit our members. We are in the process of ensuring a strong foundation is in place as we move forward in developing better corporate governance with enhancements to the AAAOM and Student Organization Bylaws as well as a comprehensive policies and procedures manual. We remain focused on the strategic initiatives set forth by the AAAOM and our state partners. The American Acupuncturist has completed the transformation required for Medline compliance, and the application for Medline recognition has been submitted. Forty five thousand AOM Info Cards have been printed. Several thousand were distributed at the Democratic National Convention this past September, and the remainder will be distributed through state associations. Our website is in the process of a redesign to allow increased ease of use and access to information and is scheduled to launch in the second quarter of the year. In coordination with this relaunch, we are in the process of implementing our Practitioner Helpline materials and technologies to provide improved online and phone service and support for you and your practices.

The AAAOM board and our terrific volunteers remain committed to our transformation into a service and product-oriented organization focused on meeting the practice and educational needs of practitioners nationwide. We are mindful of one important facet that has received little attention in the past: our communications. As we complete the aforementioned undertakings, our first priority is to overhaul our communications process to continually ensure improvements of this in 2013. We will let you know as these products and services become available, and we welcome your responses and suggestions for improvement.

I look forward to seeing many of you at our Cruise Conference in March and want to wish each of you a healthy and happy new year!

Sincerely yours,

Michael J. Jabbour, MS, LAc
President, AAAOM Board of Directors
GUANG CI TANG® CHINESE MEDICINE
SIMPLY BETTER

True 5:1 concentration and more than double the concentration of other brands*
Pure decoction extracts with little or no fillers and no pharmaceuticals
Heavy metals tested for every batch by an independent U.S. Lab

* Regular concentrated pills are used 8 pills x 3 times daily. Guang Ci Tang® extra-concentrated formulas achieve the same potency at only 5 tablets or pills x 2 times.

GUANG CI TANG® Advantages
Learn more at http://www.activeherbwholesale.com/guangcitang.html

- True 5:1 concentration, more than double the concentration of other brands
- Reduced daily dose, every bottle lasts longer
- Traditional decoction extraction method
- All natural, little or no fillers or binding agents
- Never any sugar, dyes or pharmaceuticals
- Classic as well as innovative, modern formulas
- Available both in tablets and teapills
- Produced in a cGMP certified facility
- Tested for heavy metals and pesticides
- Serving the U.S. market since 1995

Open a new account today and receive a 10% discount

www.ActiveHerbWholesale.com (510) 487-5326 and (858) 847-7310
Welcome to the winter issue of *The American Acupuncturist*. We are pleased to feature two research papers on AOM in other countries: a comparative survey study on integrated Chinese and Western medicine in both China and South Korea and a retrospective analysis of patients treated in two clinics in Iraq that compares the effects of acupuncture plus pharmacotherapy to acupuncture alone for the treatment of chronic lower back pain. In addition, this issue features three case studies that examine the impact of acupuncture and complementary therapies on pain and mobility in orthopedic injuries and conditions.

Our first original research paper is authored by Jun Wang, PhD from San Francisco State University and colleagues of hers from China and Korea. Surveys completed between 2004 and 2006 by 175 doctors from China and 70 doctors from Korea were analyzed to compare both traditional and Western medicine (WM) doctors’ perspectives on the integration of Western and traditional medicine in both of these countries. Second, we are pleased to present a report on data collected from clinic patients in Iraq by Dr. Lazgeen Mohammed Ahmed, anesthesiologist and acupuncturist. Between 2006 and 2010, acupuncture and oral ketamine together were given to 50 patients with low back pain in a TCM center in Baghdad and a private clinic in Duhok. In the Baghdad center, 30 patients were treated with acupuncture alone. This retrospective review discusses the findings.

Our first case study, “A Case of Post-Surgical Knee and Thigh Pain with Numbness Treated with Acupuncture and Associated Therapies” by Forrest Cooper, Dipl AC (NCCAOM), LAc discusses the use of acupuncture, electroacupuncture and TDP lamp on pain and numbness following surgical reattachment of the patellar tendon in a 28 year old athlete. Our second case study, “Thawing the Frozen Shoulder—A Case Study and Clinical Recommendations for the Use of Acupuncture in Treatment of Adhesive Capsulitis” by Ivan Cheng, DAOM (NCCAOM), LAc describes the successful use of acupuncture on a 57-year-old patient diagnosed with adhesive capsulitis that was unresponsive to Western treatments. Our third case study, “A Single Case Study: Treating Cervical Radiculopathy with Acupuncture, Chinese Herbal Formulas and Soft Tissue Manipulation by Misha Payant, DAC, MSOM, Dipl Ac&CH (NCCAOM), LAc discusses the use of electroacupuncture, Chinese herbal formulas, and manual therapy on a 30-year-old patient with severe neck pain and radiating pain and numbness in the right arm and hand.

In addition to our scientific papers, I am pleased to present a timely perspective, "Acupuncture, Medical Necessity, and Automobile Insurance Fraud" by Steven Schram PhD, DC, LAc. Schram's discussion of this topic aids LAc's in becoming aware of the problem of auto insurance fraud. Because some practitioners indeed participate in this type of insurance fraud, the acupuncture community, in his opinion, needs to address this issue internally before reactionary state laws reduce the ability for even highly skilled and ethical practitioners to effectively and legally treat auto accident patients.

We also include Claudette Baker’s final report, “SIO Conference Report, Part 4.” Last year Claudette and I attended the 8th Annual Society of Integrative Oncology’s research conference at Case Western Medical School at the prestigious Cleveland Clinic in Ohio. In this report, Claudette discusses the future of integrative medicine and the necessity of communication and collaboration of health care providers from different fields. She details the keynote speech, “The Future of Integrative Oncology,” presented by Stan Gerson, MD, a Harvard-educated physician and director of the Case Western Reserve University Comprehensive Cancer Center, and a compelling paper presented by Lynda Balneaves, PhD on barriers patients themselves face when attempting to utilize integrative oncology.

Each of our reviewed books are collections of excellent essays on the topic of integrative medicine. The first, *Traditional, Complementary, and Integrative Medicine: An International Reader* edited by Jon Adams, Gavin J. Andrews, Joanne Barnes, Alex Broom, and Parker Magin, is reviewed by Elizabeth Sommers, PhD, MPH, LAc. She reports that this reader is an “impressive array of papers addressing the intersections as well as the unique aspects of traditional medicine (TM), complementary medicine (CAM), and integrative approaches...written by and for all types of practitioners, researchers, policy-makers, and academics, the reader incorporates perspectives from anthropology, economics, bioethics, and public health.”

The second book, *Integrating East Asian Medicine into Contemporary Healthcare*, edited by Volker Scheid and Hugh MacPherson, is reviewed by Steve Given, LAc. He shows us how this collection of essays addresses important questions and concerns on topics including the integration of traditional medical systems into mainstream healthcare; the standardization of traditional systems; the relationship between the technique and therapeutic modalities of traditional medicine and the culture and ritual of providing care and how research can measure the complex interactions in a traditional whole medicine system.

As we begin a new cycle of *The American Acupuncturist* in 2013, I would like to thank all the authors and peer reviewers for their contributions to this issue. Our status as a top rate publication in the AOM field continues to grow due to your efforts. We continue to welcome submission of articles on research topics, case studies, literature reviews, and opinion papers. Please refer to the Author Guidelines, www.aaomonline.org. If you need more information, please contact Associate Editor Lynn Eder at leder@aaomonline.org. Respectfully,

Jennifer A. M. Stone, LAc
Editor-in-Chief, *The American Acupuncturist*
The American Acupuncturist is published quarterly, providing a professional venue for both published and first time authors. We welcome articles on clinical research, case studies, translated works, legislative issues, education developments, commentaries, literature reviews, and other current topics of importance to AOM. We value your AOM perspective. Please review the Author Guidelines at http://www.aaaomonline.org/?page=authorguidelines which also includes the submissions link.
American Association of Acupuncture and Oriental Medicine Mission Statement

The American Association of Acupuncture and Oriental Medicine (AAAOM) is a national membership organization of acupuncture and Oriental medicine (AOM) practitioners and supporters that serves to advance the profession and practice of AOM. The mission of the AAAOM is to support our members and the AOM community through education, occupational resources, media support, and legislative advocacy in our commitment to facilitate access to the highest quality of healthcare in the United States.

전미한의사협회(AAAOM)는 미 진역을 대상으로 회원제로 운영되는 단체로 한의학 종사자 등과 한의학 전문가를 희망하는 사람들의 모임입니다. 협회의 사명은 한의사 및 회원들이 미국에서 최고 수준의 한의학을 제공하도록 교육과 각종 한의학 자료지원 및 연구 지원, 한의학 관련 법안을 제정하는데 기여하는 등의 활동을 하는데 있습니다.

全美中医公会(AAAOM)是一个全国性的针灸和东方医学从业者及支持者的会员组织，致力于促进针灸与东方医学职业和实践。全美中医公会的使命是通过教育、职业支持、媒体支持和立法主张为其会员以及针灸与东方医学行业提供支持，推动在美国提供最优质的医疗保健服务。
Jun Wang, PhD, CMD is an assistant professor at the Institute for Holistic Health Studies, Department of Health Education, San Francisco State University. She received a Bachelor’s degree in Traditional Chinese Medicine from Beijing Capital Medical School and a PhD in Medical Anthropology from UNC-Chapel Hill. Her post-doc research on integrative medicine took place in Korean Oriental Medicine School, Kyung Hee University, South Korea.

Hyun-Ji Lee, on the faculty of Liberal Education, Keimyung University, South Korea received her PhD in Medical Sociology from Keimyung University and her Post-doc in Chinese Academy of Social Science. Her research interests include the process of professionalization of Korean Oriental medicine and Chinese medicine, yin-yang theory, and the philosophy and the status change of Korean Oriental medical doctors and Chinese medical doctors.

Seung-Pyo Hong is an associate professor in the Department of Sociology, Keimyung University, South Korea. He received his PhD in Sociology from Iowa State University. His research interests include modernization of Korean Oriental medicine, East Asian thoughts, and new utopia.

Abstract
Introduction: The integration of Chinese and Western medicine (ICWM) has become increasingly popular in both China and South Korea. Although much research has been done on patients’ beliefs and utilizations of ICWM, little has been done on the medical professionals’ beliefs and experiences with ICWM. The objective of this survey study is to compare both traditional and Western medicine (WM) doctors’ perspectives on the integration of Western and traditional medicine in both of these countries.

Method: The survey questionnaire was conducted during 2004-2006, once in South Korea and three times in China. The survey focused on the following three aspects: 1) doctors’ experiences and education of ICWM, 2) perceived effects of ICWM from doctors’ perspectives, 3) perceived problems of ICWM.

Results: This survey study shows that 81.6% of traditional Chinese medicine (TCM) doctors and 32% of WM doctors have clinical experience with ICWM in China. In contrast, 74% of Korean Oriental medicine (KOM) doctors and 0% of WM doctors in South Korea have clinical experience with ICWM. Doctors in China gave a slightly higher evaluation on the overall effectiveness of ICWM. Finally, medical professionals with the most experience in ICWM identified theoretical conflicts between traditional and Western medicine as the most relevant problem concerning ICWM.

Conclusion: Traditional doctors in China and Korea have a more positive attitude toward ICWM and are more likely to engage in ICWM than WM doctors. More Chinese doctors than Korean doctors are engaging in ICWM practice and research. Chinese ICWM education and practice has focused on clinical effects, while Korean ICWM has focused more on basic theoretical issues.

Keywords: integrative medicine; survey study; traditional Chinese medicine; Korean Oriental medicine; complementary and alternative medicine
Full text of this article is available ONLY to AAAOM members and journal subscribers. To become an AAAOM member and receive the complete print or online journal, go to: www.aaaomonline.org

For library-only subscriptions, please contact leder@aaaomonline.org

This issue contains full-text content of the following:
-Oncology by Claudette Baker, Dipl OM (NCCAOM), LAc, p.30
-Acupuncture, Medical Necessity, and Automobile Insurance Fraud by Steven Schram, PhD, DC, LAc, p.33
-Book Reviews by Steve Given, DAOM, LAc and Elizabeth Sommers, PhD, MPH, LAc, p.40 and 42
-Letter from president; the letter from the students, AAAOM-SO and letter from EIC
-Index to Advertisers, printed in full, p. 46

Methodology
A questionnaire of 35 questions was developed that focused on the attitudes and experiences of ICWM among traditional and Western medical professionals. Most of the questions were straightforward and culturally appropriate for both Chinese and Korean doctors. In Korea, a total of 70 medical professionals responded to the questionnaire; this includes 50 (71%) Korean medicine doctors and 20 (29%) WM doctors. In China, a total of 175 medical professionals responded: 38 (21.7%) were TCM doctors, 125 (71.4%) WM doctors, and 12 (6.9%) ICWM doctors.

The survey questionnaire procedure was conducted in Korea and China during 2004-2006. In Korea, the survey was conducted among KOM doctors (from Da Qiu Korean Medicine University Subordinate Hospital), and WM doctors (from Da Qiu Catholic Subordinate Hospital), and ICWM doctors in China start their training in either TCM or WM medical schools and only later do they incorporate the other medicine as a supplementary training and clinical practice.

Most Chinese state run hospitals have an ICWM clinic to serve the increasing demands of patients. The Chinese national economy environment, while in China, the modernization of TCM has gone through a "twist and turn" development process. In the 1950s, WM groups proposed a medical system of using therapeutic diet products, the Hand Acupuncture Association claims the right of using hand acupuncture as non-medicinal treatment service. Subordinate Hospital), and WM doctors (from Da Qiu Catholic Subordinate Hospital), and ICWM doctors in China start their training in either TCM or WM medical schools and only later do they incorporate the other medicine as a supplementary training and clinical practice.

Most Chinese state run hospitals have an ICWM clinic to serve the increasing demands of patients. The Chinese national economy environment, while in China, the modernization of TCM has gone through a "twist and turn" development process. In the 1950s, WM groups proposed a medical system of using therapeutic diet products, the Hand Acupuncture Association claims the right of using hand acupuncture as non-medicinal treatment service. Subordinate Hospital), and WM doctors (from Da Qiu Catholic Subordinate Hospital), and ICWM doctors in China start their training in either TCM or WM medical schools and only later do they incorporate the other medicine as a supplementary training and clinical practice.

Since the late 1950s, the Chinese government has adopted a series of protective policies on traditional medicine, under which a distinct traditional Chinese medicine (TCM) system was established through a reformed educational system as well as scientific research and professional development.

Introduction
Despite the adoption of the educational system, China's traditional medicine has replaced traditional Chinese medicine in many countries as a vital part of their medical service. The Chinese national government endeavored to establish a new medical system through a reformed educational system as well as scientific research and professional development. From 1958 to 1978, the Chinese government adopted a series of protective policies on traditional medicine, under which a distinct traditional Chinese medicine (TCM) system was established through a reformed educational system as well as institutional structures. In Korea, the modernization of TCM and WM was conducted by a powerful governmental administration. As a result, an innovative integrated medicine and modern Western medicine, zhongxiyi jiehe in Chinese, has been formed and developed over several decades in China and South Korea under different state policies and contexts. The modernization of TCM in China and South Korea has not only avoided total replacement by Western medicine (WM) but has also continuously developed as a parallel medical system through the processes of modernization and professionalization under different state and institutional policies and contexts.

The modernization of TCM in China and South Korea was conducted by a powerful governmental administration. As a result, an innovative integrated medicine and modern Western medicine, zhongxiyi jiehe in Chinese, has been formed and developed over several decades in China and South Korea under different state policies and contexts. The modernization of TCM in China and South Korea has not only avoided total replacement by Western medicine (WM) but has also continuously developed as a parallel medical system through the processes of modernization and professionalization under different state and institutional policies and contexts.

In Korea, the modernization of TCM and WM was conducted by a powerful governmental administration. As a result, an innovative integrated medicine and modern Western medicine, zhongxiyi jiehe in Chinese, has been formed and developed over several decades in China and South Korea under different state policies and contexts. The modernization of TCM in China and South Korea has not only avoided total replacement by Western medicine (WM) but has also continuously developed as a parallel medical system through the processes of modernization and professionalization under different state and institutional policies and contexts.

Since the late 1950s, the Chinese government has adopted a series of protective policies on traditional medicine, under which a distinct traditional Chinese medicine (TCM) system was established through a reformed educational system as well as scientific research and professional development. From 1958 to 1978, the Chinese government endeavored to establish a new medical system through a reformed educational system as well as institutional structures. In Korea, the modernization of TCM and WM was conducted by a powerful governmental administration. As a result, an innovative integrated medicine and modern Western medicine, zhongxiyi jiehe in Chinese, has been formed and developed over several decades in China and South Korea under different state policies and contexts. The modernization of TCM in China and South Korea has not only avoided total replacement by Western medicine (WM) but has also continuously developed as a parallel medical system through the processes of modernization and professionalization under different state and institutional policies and contexts.

Since the late 1950s, the Chinese government has adopted a series of protective policies on traditional medicine, under which a distinct traditional Chinese medicine (TCM) system was established through a reformed educational system as well as scientific research and professional development. From 1958 to 1978, the Chinese government endeavored to establish a new medical system through a reformed educational system as well as institutional structures. In Korea, the modernization of TCM and WM was conducted by a powerful governmental administration. As a result, an innovative integrated medicine and modern Western medicine, zhongxiyi jiehe in Chinese, has been formed and developed over several decades in China and South Korea under different state policies and contexts. The modernization of TCM in China and South Korea has not only avoided total replacement by Western medicine (WM) but has also continuously developed as a parallel medical system through the processes of modernization and professionalization under different state and institutional policies and contexts.

Since the late 1950s, the Chinese government has adopted a series of protective policies on traditional medicine, under which a distinct traditional Chinese medicine (TCM) system was established through a reformed educational system as well as scientific research and professional development. From 1958 to 1978, the Chinese government endeavored to establish a new medical system through a reformed educational system as well as institutional structures. In Korea, the modernization of TCM and WM was conducted by a powerful governmental administration. As a result, an innovative integrated medicine and modern Western medicine, zhongxiyi jiehe in Chinese, has been formed and developed over several decades in China and South Korea under different state policies and contexts. The modernization of TCM in China and South Korea has not only avoided total replacement by Western medicine (WM) but has also continuously developed as a parallel medical system through the processes of modernization and professionalization under different state and institutional policies and contexts.
This issue contains full-text content of the following:

- Acupuncture, Medical Necessity, and Automobile Insurance Fraud by Steven Schram, PhD, DC, LAc p.33
- Book Reviews by Steve Given, DAOM, LAc and Elizabeth Sommers, PhD, MPH, LAc pages 40 and 42

Letter from president; the letter from the students, AAAOM-SO and letter from EIC
In China, ICWM has developed for more than 50 years under favorable government policy and directions. TCM and WM are two complementary medical systems. Therefore, ICWM can increase clinical benefits for patients.16 Korean doctors in general also agree on this point but some KOM doctors are concerned about “being polluted” by WM.17 KOM and WM doctors have been rivals since the 1950s under Korean government’s non-interference policy. Korean WM doctors have with ICWM.3,17

Discussion

Although ICWM has enjoyed increased popularity among patients, increased medical expenses are more prevalent among WM doctors who have the least experience of ICWM, i.e., WM doctors in Korea had a low response rate (20 out of 200) and the sample population’s range is also very small. In addition, it was not possible for this survey to conduct “random sampling,” i.e., the sample respondents are not representative of their target population. Thus, this study can contribute to this ongoing discussion on how to improve the level of integration of traditional medicine and Western medicine in China and South Korea.

This study shows that the concerns about clinical conflicts between traditional and Western medicine are more prevalent among WM doctors who have the least experience of ICWM, i.e., WM doctors. Medical professionals who have extensive experience with clinical integrative medicine, i.e., Chinese TCM and ICWM doctors, reported much less concern about the conflicts between the two approaches and more confidence with clinical efficiency. Stroke is a good example in both Korea and China, where it is the disease most often managed using the ICWM approach.8,14

Finally, we are aware that there are ongoing debates on the definitions of TCM, KOM, and ICWM.14 For example, KOM (a new name of the still popular name, Han Bang, which means the “Han-Chinese medicine” in Korean) only started to be used by Korean doctors in the 1990s. In addition, recent studies indicate that the distinction between TCM and ICWM has become less meaningful due to decades of institutional transformation of TCM under the policies of scientism and modernization in China.18,19 In fact, the outcomes of ICWM have been a continuous subject of debate among health care providers and policy makers in China in the past two decades. It is our hope that this preliminary survey study can contribute to this ongoing discussion on how to improve the level of integration of traditional medicine and Western medicine in China and South Korea.

Limitations

It was not possible for this survey to conduct “random sampling,” and the sample population’s range is also very small. In addition, WM doctors in Korea had a low response rate (20 out of 200) in answering the questionnaires. Therefore, this is a preliminary cross-nation study on ICWM, and the results require further data to investigate the subject more thoroughly.

Table 4. Perceived Problems of ICWM

<table>
<thead>
<tr>
<th>Problems</th>
<th>N(%): China</th>
<th>N(%): Korea</th>
<th>N(%): Total</th>
<th>N(%): China</th>
<th>N(%): Korea</th>
<th>N(%): Total</th>
<th>N(%): China</th>
<th>N(%): Korea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflicts from patients</td>
<td>22(0.3)</td>
<td>12(0.6)</td>
<td>34(0.4)</td>
<td>9(0.5)</td>
<td>1(0.0)</td>
<td>10(0.8)</td>
<td>18(1.1)</td>
<td>1(0.8)</td>
</tr>
<tr>
<td>Increased medical expenses</td>
<td>7(10.0)</td>
<td>2(10.0)</td>
<td>9(10.0)</td>
<td>6(3.4)</td>
<td>4(3.2)</td>
<td>10(8.3)</td>
<td>12(7.4)</td>
<td>7(5.8)</td>
</tr>
<tr>
<td>Confusions from patient</td>
<td>42(61.4)</td>
<td>31(15.5)</td>
<td>73(18.0)</td>
<td>20(11.8)</td>
<td>14(7.0)</td>
<td>34(26.9)</td>
<td>36(11.3)</td>
<td>24(11.9)</td>
</tr>
<tr>
<td>Other</td>
<td>2(2.9)</td>
<td>1(5.0)</td>
<td>3(3.0)</td>
<td>19(10.9)</td>
<td>16(12.8)</td>
<td>35(27.4)</td>
<td>37(11.3)</td>
<td>23(11.6)</td>
</tr>
<tr>
<td>No response</td>
<td>3(4.3)</td>
<td>0(0.0)</td>
<td>3(4.0)</td>
<td>13(7.4)</td>
<td>11(8.8)</td>
<td>24(18.8)</td>
<td>14(4.3)</td>
<td>12(5.8)</td>
</tr>
</tbody>
</table>

This issue contains full-text content of the following:


- Acupuncture, Medical Necessity, and Automobile Insurance Fraud by Steven Schram, PhD, DC, LAc p.33

- Book Reviews by Steve Given, DAOM, LAc and Elizabeth Sommers, PhD, MPH, LAc pages 40 and 42

- Letter from president; the letter from the students, AAAOM-SO and letter from EIC

- Index to Advertisers, printed in full, p. 46

Full text of this article is available ONLY to AAAOM members and journal subscribers.

To become an AAAOM member and receive the complete print or online journal, go to: www.aaaomonline.org

For library-only subscriptions, please contact leder@aaaomonline.org
Conclusions

This is a preliminary questionnaire survey study conducted among Korean and Chinese medical professionals about their perceptions on ICWM. We hope the discussions can contribute to future ICWM studies and policies in China, Korea, and Western countries. Our study has posed more questions than answers, such as: What kind of ICWM model can justify the relationship between traditional and Western medicines? How can different medical systems integrate so that each maintains its merits and independence and thus result in the best clinical effects for the benefit of patients?

Conflict of Interest

No conflict of interest declared.

Acknowledgements

We give our sincere gratitude to all medical professionals from China and Korea who kindly coordinated with our research surveys. We are thankful to Korean Academic Development Consortium who provided financial support for this research project.

References


Innovative & Traditional Concentrated Chinese Herbal Formulas,
Needles & Clinic Supplies, Books, Charts & Essential Oils.
Safe. Effective. Quality you can trust.

Great Formulas for the Winter Season*

Five Mushroom Formula (Wu Gu Fang) is a versatile formula which builds immunity, regulates respiration, transforms phlegm, and supplements wei qi.

Jade Windscreen Formula (Yu Ping Feng San) supplements wei qi and stabilizes the exterior. Can be used for acute attacks of wind-cold in those too weak to tolerate dispersing formulas.

Xanthium and Magnolia Formula (Jia Wei Xin Yi San) dispels wind-cold, dries dampness, and frees the nasal passages.

Fritillaria & Pinellia Formula (Chuan Bei Ban Xia Tang) resolves phlegm-heat in the lungs, directs the qi downward, and relaxes tightness in the chest. Available in tablets or syrup.

Our line of pediatric formulas includes Children’s Clear and Release, Children’s Clear Lung, Children’s Jade Defense, and Children’s Ear. These flavored liquids are a must for the family medicine cabinet!

*For a complete description of these and our other formulas, give us a call or visit our website.

Toll-Free 1.800.729.8509
Email info@gfcherbs.com
Find us on Facebook www.gfcherbs.com

GOLDEN FLOWER CHINESE HERBS

Serving the OM community since 1990

Innovative & Traditional Concentrated Chinese Herbal Formulas,
Needles & Clinic Supplies, Books, Charts & Essential Oils.
Safe. Effective. Quality you can trust.

Great Formulas for the Winter Season*

Five Mushroom Formula (Wu Gu Fang) is a versatile formula which builds immunity, regulates respiration, transforms phlegm, and supplements wei qi.

Jade Windscreen Formula (Yu Ping Feng San) supplements wei qi and stabilizes the exterior. Can be used for acute attacks of wind-cold in those too weak to tolerate dispersing formulas.

Xanthium and Magnolia Formula (Jia Wei Xin Yi San) dispels wind-cold, dries dampness, and frees the nasal passages.

Fritillaria & Pinellia Formula (Chuan Bei Ban Xia Tang) resolves phlegm-heat in the lungs, directs the qi downward, and relaxes tightness in the chest. Available in tablets or syrup.

Our line of pediatric formulas includes Children’s Clear and Release, Children’s Clear Lung, Children’s Jade Defense, and Children’s Ear. These flavored liquids are a must for the family medicine cabinet!

*For a complete description of these and our other formulas, give us a call or visit our website.

Toll-Free 1.800.729.8509
Email info@gfcherbs.com
Find us on Facebook www.gfcherbs.com

GOLDEN FLOWER CHINESE HERBS

Serving the OM community since 1990
Lazgeen Mohammed Ahmed, anesthetist and acupuncturist, received his Diploma in Acupuncture in Malaysia in 2010 and his Diploma in Anesthesiology in Iraq in 1985. He has three certificates from the Academy of Traditional Chinese Medicine, Wangjing Hospital, Beijing, China, and certification from the Huaihua Red Cross Hospital, Hunan province, China. From 2003-2007, he managed the TCM center in Bagdad, Iraq; this is the only center in Iraq belonging to the Ministry of Health. He now lives in the Kurdistan area, an independent regional area, and works in the Rapareen Hospital as a consulting anesthetist. He is currently working to establish a pain center in this area with the help of the general manager of health in Erbil, the capital of Kurdistan. This center will use acupuncture to treat pain.

Acupuncture and Ketamine in Treating Chronic Backache

[Ed. Note: Ketamine has been used for about 30 years as a general anesthesia drug. It activates the limbic system and depresses the cerebral cortex, producing analgesia, slight respiratory depression, cardiovascular stimulation, and amnesia. In recent years the drug has been under investigation for use in severe, difficult to control neuropathic pain such as reflex sympathetic dystrophy and complex regional pain syndrome. In the U.S., the oral use of ketamine has been briefly studied but is not considered standard of care for the treatment of low back pain.]

Abstract

Chronic backache is a common clinical symptom in Iraq. Most painkilling medications, such as non-steroidal anti-inflammatory drugs, have undesirable side effects, particularly affecting the stomach. Ketamine is an anesthetic drug that can be used intramuscularly, intravenously, or orally. It has an analgesic effect with no side effects on the stomach if taken orally. This report provides an overview of available clinical data on the use of acupuncture and oral ketamine in the treatment and management of chronic back pain.

Keywords: backache, acupuncture, ketamine, alternative medicine, complementary medicine
Introduction
The primary aim of this research was to determine if the use of acupuncture and ketamine together could reduce the number of acupuncture treatments needed for relief of chronic back pain.

Background
Ketamine, a derivative of phencyclidine, was introduced into clinical practice in 1965 and started being used in Iraq around 1978. This drug is a water soluble compound which may be administered by intravenous (IV) or intramuscular (IM) injection or ingested orally. The analgesic effect of ketamine is primarily based on the antagonism of the N-methyl-D-aspartate (NMDA) receptor. Activation of NMDA receptors may play a crucial role in the pathogenesis of chronic pain because ketamine's actions interfere with pain transmission in the spinal cord. Ketamine inhibits nitric oxide synthase, an enzyme that plays a role in the production of nitric oxide, a neurotransmitter involved in pain perception; hence, it further contributes to analgesia.

The pharmacologically active metabolite norketamine is believed to contribute to the analgesic effect of oral ketamine. Ketamine is absorbable via IV, IM, oral, and topical routes due to its water and lipid solubility. However, ketamine can cause an increase in blood pressure, tachycardia, and hallucination, especially when given intravenously or intramuscularly.

Chinese medicine treats any aching, discomfort, or weakness in one or both sides of the lower thoracic, lumbar, sacral, or buttock areas as part of the general term “low back pain.” In traditional Chinese medicine, this is due to stagnant qi in that area. Many patients with chronic low back pain have found that acupuncture treatment can help break the pain as well as allow them to reduce intake of pain medications and participate more vigorously in physical daily activities. Acupuncture has been used in Iraq since 1996 to treat painful conditions when there was a severe shortage of drugs due to the embargo on Iraq.

The study described here was carried out in two traditional Chinese medicine (TCM) clinics between 2006 and 2010. From 2006-2007, it was done in a TCM center operated by the Ministry of Health in Baghdad, Iraq. By 2009 there was only this one treatment center using acupuncture in Iraq. I managed this center from 2006-2010, it was done in a TCM center operated by the Ministry of Health in Baghdad, Iraq. This center was in a smaller private TCM clinic, which I operated in Duhok, Iraq, during those years.

This study compared the effects of acupuncture plus pharmacotherapy (acetaminophen and ketamine) with pharmacotherapy alone in the treatment of chronic lower backache. The participants were engineers or teachers; several were doctors. None had serious comorbid conditions. Most of the patients were men between the ages of 28 to 35, who complained of chronic lower backache with symptoms present for 12-20 weeks. Plain X rays and magnetic resonance imaging (MRIs) showed reduction in the intervertebral disc space as well as lateral foraminal compression. Forty patients were given ketamine as the control group. The study in a smaller private TCM clinic, which I operated in Duhok, Iraq, during those years.

Material and Methods
Acupuncture and Medical Necessity, and Automobile Insurance Fraud by Steven Schram, PhD, DC, LAc pages 40 and 42

“Acupuncture has been used in Iraq since 1996 to treat painful conditions when there was a severe shortage of drugs due to the embargo on Iraq.”

Results
1) In the Study group, 29 out of 50 patients (58%) became pain-free. These patients were given ketamine along with acupuncture.

2) Thirteen out of 50 patients (26%) experienced a decrease in pain by one half. These patients were given ketamine along with acupuncture.

3) The remaining 8 out of 50 patients (16%) had no response during the first course of treatment. Among these eight participants, six

Full text of this article is available ONLY to AAAOM members and journal subscribers. To become an AAAOM member and receive the complete print or online journal, go to: www.aaaomonline.org

For library-only subscriptions, please contact leder@aaaomonline.org
The advantages of treatment which includes ketamine with acupuncture:

1. Safe
2. Economic if compared with surgical interferences
3. Free of complications
4. Time of treatment is shortened (1-2 courses) if compared with those treated with acupuncture only (2-4 courses).

Conclusion
Acupuncture alone may not be enough when treating chronic backache. Longer treatment time may be needed. When acupuncture is combined with ketamine, the treatment time is reduced with good results. Acupuncture has an analgesic and sedative effect which can possibly override the side effects of ketamine (an increase in blood pressure, pulse rate, and possible hallucinations which can occur if ketamine is given orally in large doses and common if ketamine is used IV or IM alone).

Full text of this article is available ONLY to AAAOM members and journal subscribers. To become an AAAOM member and receive the complete print or online journal, go to: www.aaaomonline.org

For library-only subscriptions, please contact leder@aaaomonline.org

This issue contains full-text content of the following:

- Acupuncture, Medical Necessity, and Automobile Insurance Fraud by Steven Schram, PhD, DC, LAc p.33
- Book Reviews by Steve Given, DAOM, LAc and Elizabeth Sommers, PhD, MPH, LAc pages 40 and 42
- Letter from president; the letter from the students, AAAOM-SO and letter from EIC
- Index to Advertisers, printed in full, p. 46
A Case of Post-Surgical Knee and Thigh Pain with Numbness Treated with Acupuncture and Associated Therapies

By Forrest Cooper, Dipl AC (NCCAOM), LAc

Forrest Cooper, LAc is on the faculty at the Oregon College of Oriental Medicine where he teaches tuina and advanced tuina and supervises in the acupuncture and tuina clinics. A graduate of the University of Michigan and the Oregon College of Oriental Medicine, he is currently enrolled in the Doctor of Acupuncture and Oriental Medicine at the Oregon College of Oriental Medicine. His paper, “A Chart Review from an Oriental Medicine College: Comparing Patients Who Came for Only One Visit and Those Who Came for at Least Five Visits,” appeared in Medical Acupuncture, June 14, 2011, (23) 2.

Abstract

A 28-year-old woman completely ruptured her left patellar tendon, which was reattached surgically. A month after surgery her recovery of range of motion was slow, and she suffered from stiffness and pain of the quadriceps femoris. She also experienced a complete lack of sensation in a semicircular area lateral to a surgical scar running the length of the patella. Treatment was given using acupuncture, electro acupuncture, infra-red heat emitting TDP lamp, and tuina massage. Treatment consisted of local and distal needling, with electrostimulation of the local points. Four treatments were performed over the course of two weeks, and a fifth was performed two weeks after the fourth. After five treatments, her pain was completely gone and she had full range of motion. Her sensation in the area lateral to the patella was slower to recover.

Keywords: pain, post-surgical, knee, sports medicine, acupuncture, electroacupuncture

Background

Ruptured patellar tendon is an injury commonly due to trauma, especially in athletic people under the age of forty. For the best prognosis, surgical repair should be done as soon after the injury as possible. However, as with any surgery, it is not without risks of adverse side effects. Chronic post surgical pain occurs in 10-50% of patients after common surgeries, yet this is a poorly studied phenomenon. One mechanism for this pain is the damage of peripheral nerves from the surgery, which may also cause numbness.
In traditional Chinese medicine (TCM), post-surgical pain and other complications such as nerve damage are regarded as being due to trauma, Qi and blood deficiency, or some combination of these. Treatment for pain generally consists of local and distal needling. Tuina, or Chinese medical massage, is based on the function of the twelve channels and meridians of the body. There is relatively little research into the efficacy of this modality, although there has been research into the use of heat, TDP lamps, and acupuncture to expedite the healing of her knee. She was unable to rest the leg as much as her surgeon wanted her to because she worked at a job where she was standing for much of the day. She responded roughly to the acupuncture points Baichongwo, ST-32, ST-33, and GB-32 acupoint areas. Her pulse was wiry on the right and thin on the left, and her tongue was slightly puffy and coated with a thin yellow coat.

Differential diagnosis, etiology and pathology: The pain, stiffness, and loss of sensation could be caused by Bi syndrome, Qi and blood stagnation in the channels, imbalance of the yin and yang channels. The diagnosis was qiao mai, and blood deficiency in the channels. These syndromes could be the result of adhesions formed during the surgery, the immobilization of the leg after the surgery, the patient's prior athletic activities, or some combination of the three.

Diagnosis: The diagnosis used was qiao mai and blood stagnation in the Stomach foot yangming, Spleen foot taiyin, and Gall Bladder foot shaoyang channels due to acute trauma, Qi and blood deficiency in the area lateral to the patella due to blockage of the blood, imbalance between the yin and yang qiao mai. The diagnosis of qi and blood stagnation in the Spleen foot taiyin, Stomach foot yangming, and Gall Bladder foot shaoyang channels was based on the presence of pain, the location of pain, and the history of trauma. The diagnosis of qi and blood deficiency could be cold due to the patient's history of chronic pain.

This case presents a patient suffering from post-surgical pain and decreased range of motion with an area of numbness. After five treatments utilizing the procedures above, the patient’s pain and range of motion were completely resolved; however, the area of numbness improved but was not resolved.

The Case

Subjective and History: A 28-year-old female presented on 10/27/11 complaining of left knee pain, swelling, tightness, and soreness in the left quadriceps as well as a complete lack of sensation in a semicircular area approximately five centimeters in radius lateral to the left patella. On 8/18/11 she took a bad tackle while playing rugby and reported that she was diagnosed with an 80/20 rupture of the patellar ligament. She said her surgeon indicated that the ligament was approximately 80% torn and required surgery. She underwent surgical repair of the ligament on 9/18/2011. It was explained to her that during the surgery, she suffered nerve damage that left the area lateral to the patella with complete numbness. She had pain and tightness in the quadriceps femoris and a reduced range of motion in flexion of the knee. Her knee and quadriceps pain were made worse by flexion and standing for extended periods of time. The pain was alleviated by rest, although without this assistance she could not flex the knee past 80 degrees. She reported that there were sore spots on the left thigh that corresponded roughly to the acupuncture points Baichongwo, ST-32, ST-33, and GB-32 acupoint areas. Her pulse was wiry on the right and thin on the left, and her tongue was slightly puffy and coated with a thin yellow coat.

Full text of this article is available ONLY to AAAOM members and journal subscribers. To become an AAAOM member and receive the complete print or online journal, go to: www.aaaomonline.org

For library-only subscriptions, please contact leder@aaaomonline.org

Observations: The patient wore a knee brace. She had slight edema around the entire knee. A needle tube prick performed for a sensory screen elicited complete lack of sensation in an area approximately five centimeters in radius on the lateral aspect of the patellar ligament. There was tenderness on the medial aspect along a scar running from acupoint Heding to the insertion of the patellar ligament. She also had tenderness at the left acupoint Baichongwo, ST-32, ST-33, and GB-32 acupoint areas. Her pulse was wiry on the right and thin on the left, and her tongue was slightly puffy with a thin yellow coat.
The TCM treatment principles were to move qi and blood in the channels, nourish qi and blood in the Stomach and Gall Bladder channels, and balance the yin and yang qiao mai.

Methods:
Consent was obtained prior to treatment. All treatments used Acutech (China) brand needles for acupuncture and electro-acupuncture. The table describes the size, angle, and direction of insertion for each point. All needles were inserted either until deqi was obtained or until there was ~3 mm of the shaft that was not inserted.

<table>
<thead>
<tr>
<th>Acupuncture Point</th>
<th>Size of Needle</th>
<th>Angle and Direction</th>
<th>Rationale for Use</th>
<th>Source Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yintang</td>
<td>0.22 x 30 mm</td>
<td>Perpendicular</td>
<td>Quiets spirit</td>
<td>Ellis, A, Wiseman, N &amp; Boss, K (1991) p 399</td>
</tr>
<tr>
<td>Baihui (Gv-20)</td>
<td>0.22 x 30 mm</td>
<td>Perpendicular</td>
<td>Clears the spirit-disposition</td>
<td>Ellis, A, Wiseman, N &amp; Boss, K (1991) p 383</td>
</tr>
<tr>
<td>Right scalp lower extremity sensory zone</td>
<td>0.22 x 30 mm</td>
<td>Horizontal, Inferior</td>
<td>Pain in left lower extremity</td>
<td>O Conner, J, Bensky, D (1987) pp 498-501</td>
</tr>
<tr>
<td>Hegu (Li-4)</td>
<td>0.22 x 30 mm</td>
<td>Perpendicular</td>
<td>Frees channels, relieves pain</td>
<td>Ellis, A, Wiseman, N &amp; Boss, K (1991) p 95</td>
</tr>
<tr>
<td>Sanyinjiao (Sp-6)</td>
<td>0.22 x 30 mm</td>
<td>Perpendicular</td>
<td>Frees qi Stagnation</td>
<td>Ellis, A, Wiseman, N &amp; Boss, K (1991) p 151</td>
</tr>
<tr>
<td>Jiexi (St-41)</td>
<td>0.22 x 30 mm</td>
<td>Perpendicular</td>
<td>Pain in foot or knees</td>
<td>Ellis, A, Wiseman, N &amp; Boss, K (1991) p 137</td>
</tr>
<tr>
<td>Baiqihong</td>
<td>0.22 x 40 mm</td>
<td>Perpendicular</td>
<td>Local pain and tightness</td>
<td>Cheng, X &amp; Deng, L (1997) p 241</td>
</tr>
<tr>
<td>Futu (St-32)</td>
<td>0.22 x 40 mm</td>
<td>Perpendicular</td>
<td>Warm channels and dissipate cold, paralysis of lower limbs</td>
<td>Ellis, A, Wiseman, N &amp; Boss, K (1991) p 130</td>
</tr>
<tr>
<td>Duzhong (Gb-32)</td>
<td>0.22 x 40 mm</td>
<td>Perpendicular</td>
<td>Soothes sinews, Bi, numbness of lower limbs</td>
<td>Ellis, A, Wiseman, N &amp; Boss, K (1991) p 318</td>
</tr>
<tr>
<td>Two needles along scar</td>
<td>0.22 x 40 mm</td>
<td>Horizontal, Inferior</td>
<td>Ashi for local pain and numbness</td>
<td></td>
</tr>
<tr>
<td>Yishi (St-33)</td>
<td>0.22 x 30 mm</td>
<td>Perpendicular</td>
<td>Paralyzation and pain, inhibited flexion of leg</td>
<td></td>
</tr>
<tr>
<td>Yanglingquan (Gb-34)</td>
<td>0.22 x 30 mm</td>
<td>Perpendicular</td>
<td>Soothes sinews, pain and swelling in knee, numbness in lower leg</td>
<td>Ellis, A, Wiseman, N &amp; Boss, K (1991) p 319</td>
</tr>
<tr>
<td>Neixiyan</td>
<td>0.22 x 40 mm</td>
<td>Horizontal, Lateral</td>
<td>Numbness, pain or swelling of knee</td>
<td>Ellis, A, Wiseman, N &amp; Boss, K (1991) p 408</td>
</tr>
<tr>
<td>Taichong (Lv-3)</td>
<td>0.22 x 30 mm</td>
<td>Perpendicular</td>
<td>Rectify qi, quicken blood</td>
<td>Ellis, A, Wiseman, N &amp; Boss, K (1991) p 335</td>
</tr>
<tr>
<td>Zhaohai (Ki-6)</td>
<td>0.22 x 30 mm</td>
<td>Perpendicular</td>
<td>Free channels, harmonize construction, master of Yin Qiao Mai</td>
<td>Ellis, A, Wiseman, N &amp; Boss, K (1991) p 250</td>
</tr>
<tr>
<td>Shenmai (Bl-62)</td>
<td>0.22 x 30 mm</td>
<td>Perpendicular</td>
<td>Soothes sinews, master of Yang Qiao Mai</td>
<td>Ellis, A, Wiseman, N &amp; Boss, K (1991) p 232</td>
</tr>
<tr>
<td>Ashi point ~3 cun inferior to St-35 along the GB Channel</td>
<td>0.22 x 40 mm</td>
<td>Perpendicular</td>
<td>Ashi Point for local pain</td>
<td></td>
</tr>
<tr>
<td>Ashi point ~5 cun inferior to St-35 along the GB Channel</td>
<td>0.22 x 40 mm</td>
<td>Perpendicular</td>
<td>Ashi Point for local pain</td>
<td></td>
</tr>
<tr>
<td>Zusanli (St-36)</td>
<td>0.22 x 40 mm</td>
<td>Perpendicular</td>
<td>Frees and regulates qi and blood of the channels</td>
<td>Ellis, A, Wiseman, N &amp; Boss, K (1991) p 132</td>
</tr>
<tr>
<td>Heding</td>
<td>0.22 x 40 mm</td>
<td>Horizontal, Medial</td>
<td>Knee pain</td>
<td>Cheng, X &amp; Deng, L (1997) p 242</td>
</tr>
</tbody>
</table>
Full text of this article is available ONLY to AAAOM members and journal subscribers. To become an AAAOM member and receive the complete print or online journal, go to: www.aaaomonline.org

For library-only subscriptions, please contact leder@aaaomonline.org

This issue contains full-text content of the following:
- Oncology by Claudette Baker, Dipl OM (NCCAOM), LAc p.30
- Acupuncture, Medical Necessity, and Automobile Insurance Fraud by Steven Schram, PhD, DC, LAc p.33
- Book Reviews by Steve Given, DAOM, LAc and Elizabeth Sommers, PhD, MPH, LAc
- Acupuncture, Medical Necessity, and Automobile Insurance Fraud by Steven Schram, PhD, DC, LAc p.33
- Oncology by Claudette Baker, Dipl OM (NCCAOM), LAc p.30
- Book Reviews by Steve Given, DAOM, LAc and Elizabeth Sommers, PhD, MPH, LAc

Letter from president; the letter from the students, AAAOM-SO and letter from EIC

Index to Advertisers, printed in full, p. 46
Full text of this article is available ONLY to AAAOM members and journal subscribers.
To become an AAAOM member and receive the complete print or online journal, go to: www.aaaomonline.org.

For library-only subscriptions, please contact leder@aaaomonline.org

This issue contains full-text content of the following:
- Acupuncture, Medical Necessity, and Automobile Insurance Fraud by Steven Schram, PhD, DC, LAc p.33
- Book Reviews by Steve Given, DAOM, LAc and Elizabeth Sommers, PhD, MPH, LAc pages 40 and 42

Letter from president; the letter from the students, AAAOM-SO and letter from EIC

Index to Advertisers, printed in full, p. 46

References:
A Single Case Study: Treating Cervical Radiculopathy with Acupuncture, Chinese Herbal Formulas and Soft Tissue Manipulation

Abstract
This single case reports a 30-year-old male patient who presented with severe neck pain, decreased cervical range of motion, and shooting pain down the right arm with numbness of the index and middle finger. The patient was treated with electroacupuncture, Chinese herbal formulas, and manual therapy over a course of six weeks. After the first treatment the patient felt immediate relief—the pain scales dropped from ten out of ten (ten being the highest amount of pain) to six out of ten.

This article may aid in clarifying the diagnosis and treatment of cervical radiculopathy (CR) for Oriental medicine practitioners. More research is needed to investigate the role of Oriental medicine in the treatment of CR.

Keywords: acupuncture, cervical radiculopathy, Chinese herbal formulas, Oriental medicine

Biomedical Perspective
Cervical radiculopathy (CR) is defined as a disorder of the cervical spinal nerve root and is most commonly caused by a cervical disk herniation or other space-occupying lesion, resulting in nerve root inflammation, impingement, or both.1 The term “radiculopathy” is used to describe the process in which one or more spinal nerve roots are negatively affected.2 Cervical radiculopathy is more prevalent in the fifth decade of life, affecting approximately 83 per 100,000 people.3 CR affects predominantly more males than females.4
Treating Cervical Radiculopathy with Acupuncture, Chinese Herbal Formulas and Soft Tissue Manipulation

There is some evidence that indicates patients improve with a conservative approach (rest, manual therapy or medication) to CR pain.7 CR pain follows the path of the nerve that originates from the neck to the lower forearm, with or without radiation to the hand. Common signs and symptoms of CR include paresthesia or numbness, weakness, and radiating pain.3

Nerve encroachment may be caused by a variety of factors. Unlike the lumbar region, herniation of a cervical disk is extremely rare for patients who have not been injured. CR pain due to cervical herniation is typically radiating pain from the neck to the arm. A person 30 years or younger is unlikely to present with disk herniation or osteophytes) and electrodiagnostic exams.2 The examination and diagnosis for CR is obtained by a combination of orthopedic examinations, which include:12 Spurling maneuver, Jackson compression, Soto-Hal, O'Donahue's test, Adson's test, brachial plexus compression test and brachial plexus tension test. The variability in CR presentations requires several examinations to rule out other causes such as foraminal compression, Adson's test, brachial plexus compression test and brachial plexus tension test. The variability in CR presentations requires several examinations to rule out other causes such as thoracic outlet syndrome.1 Other diagnostic tools include neuro-muscular examination, imaging studies (X-rays, magnetic resonance imaging (MRI) and computed tomography (CT) scans may verify disc herniation or osteophytes) and electrodiagnostic exams.2

Biomedical Treatment

The main objective in treating CR is to relieve the compression from the nerve root.4 The treatment protocol may range from a conservative approach (rest, manual therapy or medication) to surgery. There is some evidence that indicates patients improve more with conservative therapies versus those who choose surgery alone.11 More than 25% of patients who elect to have surgery continue to experience pain.14

The use of nonsteroidal anti-inflammatory drugs (NSAIDs) is administered to reduce inflammation and pain; additionally, oral corticosteroid dose-packs may be prescribed.39 There is no evidence to verify the effectiveness of anti-inflammatory drugs in treating CR. A soft neck collar may be used to reduce the patient's range of motion and provide support.2

The prognosis may vary depending on the contributing factor leading to CR. An injury due to acute trauma (a sports injury for example) has a high success rate.2 Degeneration of a disc or bone may cause delays in recovery.

For library-only subscriptions, please contact leder@aaaomonline.org

This issue contains full-text content of the following:


- Acupuncture, Medical Necessity, and Automobile Insurance Fraud by Steven Schram, PhD, DC, LAc p.33

- Book Reviews by Steve Given, DAOM, LAc and Elizabeth Sommers, PhD, MPH, LAc pages 40 and 42

Case History

Letter from president; the letter from the students, AAAOM-SO and letter from EIC

- Index to Advertisers, printed in full, p. 46

Table 1. Drug Side Effects

<table>
<thead>
<tr>
<th>Medication</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cyclobenzaprine hydrochloride</td>
<td>Drowsiness, dry mouth, fatigue, headache, abdominal pain, acid regurgitation, constipation, diarrhea, dizziness, nausea, irritability, decreased mental acuity, nervousness, upper respiratory infection and pharyngitis</td>
</tr>
<tr>
<td>Hydrocodone bitartrate with acetaminophen</td>
<td>Lightheadedness, central nervous system (CNS)/respiratory depression, nausea, vomiting, constipation, urinary retention, rash, abuse potential and hepatotoxicity (overdose)</td>
</tr>
</tbody>
</table>

For library-only subscriptions, please contact leder@aaaomonline.org

To become an AAAOM member and receive the complete print or online journal, go to: www.aaaomonline.org
Full text of this article is available ONLY to AAAOM members and journal subscribers. To become an AAAOM member and receive the complete print or online journal, go to: www.aaaomonline.org

For library-only subscriptions, please contact leder@aaaomonline.org

This issue contains full-text content of the following:

-Acupuncture, Medical Necessity, and Automobile Insurance Fraud by Steven Schram, PhD, DC, LAc p.33

-Book Reviews by Steve Given, DAOM, LAc and Elizabeth Sommers, PhD, MPH, LAc pages 40 and 42

-Letter from president; the letter from the students, AAAOM-SO and letter from EIC

-Index to Advertisers, printed in full, p. 46

Chinese Medicine Treatment Rationale and Strategy

The majority of a general TCM practitioner’s patient base relates to pain conditions. Data has shown that acupuncture can, in the short term, relieve chronic pain in approximately 50% to 70% of patients. As noted above, in this particular situation concerning neck and arm pain due to nerve root entrapment, the patient reported standing outside in extremely cold and windy weather. It was after spending the day outside that the neck pain, distally radiating arm pain, and finger numbness began. Exogenous Wind-Cold invaded the body and caused the free flow of qi and blood in the channels and collaterals to be blocked.

Also noted above, the patient has had Crohn’s disease for the past 12 years. Crohn’s disease is often due to Damp accumulation and leads to blood stasis. This underlying blood stasis and Damp accumulation can contribute to aches and pain in addition to numbness. All of these symptoms can be directly linked to the patient’s presenting TCM evaluation.

The patient’s tongue with its thick white coat and swollen scalloped body indicated a cold condition with Damp accumulation. The dark full sublingual veins were indicative of blood stagnation. The wiry pulse was a sign of stagnation. The left guan pulse was replete, again a sign of stagnation. The right guan pulse, however, was deficient. A deficiency in Spleen led to an accumulation of Damp.

TCM Diagnosis

Blockage of qi in the channels and collaterals due to invasion of Wind and Cold with underlying Spleen qi deficiency and damp accumulation.
Full text of this article is available ONLY to AAAOM members and journal subscribers. To become an AAAOM member and receive the complete print or online journal, go to: www.aaaomonline.org

For library-only subscriptions, please contact leder@aaaomonline.org

This issue contains full-text content of the following:


- Acupuncture, Medical Necessity, and Automobile Insurance Fraud by Steven Schram, PhD, DC, LAc p.33

- Book Reviews by Steve Given, DAOM, LAc and Elizabeth Sommers, PhD, MPH, LAc pages 40 and 42

Letter from president; the letter from the students, AAAOM-SO and letter from EIC

Index to Advertisers, printed in full, p. 46

Outcomes/Results and Prognosis

The patient found considerable relief from the pain and numbness after the second treatment, reporting a pain level of five out of ten (ten being the most pain.) As the weather changed, the pain and numbness would worsen until the patient’s next treatment, after which he would again feel relief.

The patient was advised to follow up with the MRI after the third week of treatment. The MRI was performed the first week of March 2012, which confirmed the diagnosis of cervical radiculopathy. The MRI revealed a slight herniation in the C6 vertebrae.

With completion of the six week therapy protocol, continued acupuncture, manual therapy, Chinese herbal formulas, and rest were recommended to provide continued relief without surgery or the need to take Western medication. From the starting date of treatment, the patient’s pain scores steadily decreased to as low as two out of ten. His positive response to treatment is attributed to a positive prognosis. He agreed to follow up treatments, once every three weeks to prevent further injury.

continued on page 40
Thawing the Frozen Shoulder—A Case Study and Clinical Recommendations for the Use of Acupuncture in Treatment of Adhesive Capsulitis

By Ivan Cheng, DAOM (NCCAOM), LAc

Ivan Cheng, LAc, DAOM is a practitioner of East Asian medicine in private practice in Vancouver, WA. He graduated from the University of Oregon with a degree in Exercise and Movement Science and completed both the master’s and doctoral degree programs at the Oregon College of Oriental Medicine.

Abstract

This is a case study of a 57-year-old male diagnosed with frozen shoulder who received acupuncture treatments using a protocol characterized by two different approaches over a three month period. The first protocol, distal acupuncture with joint mobilization, was used primarily for pain relief. Local acupuncture with electrical stimulation was then used to address remaining pain and range of motion deficits. This treatment resulted in full resolution of a condition that had been ongoing for 14 months. Patients diagnosed with a frozen shoulder may benefit from this particular treatment plan for relief of pain and restoration of range of motion within a reasonable timeframe.

Keywords: acupuncture, electro-acupuncture, shoulder pain, shoulder impingement, frozen shoulder

Introduction

Adhesive capsulitis, commonly known as "frozen shoulder syndrome," is a very common condition, but it is poorly understood by biomedical physicians. It is most notably characterized by pain and stiffness in the shoulder as well as severe loss of range of motion. It can occur idiopathically as a primary condition or secondarily from an underlying condition.¹ Time from diagnosis to resolution can be 1 to 2 years.² Even though adhesive capsulitis is a benign condition and is self-limiting, patients typically choose not to endure the pain and seek treatment once the symptoms become intolerable and their activities of daily life are significantly affected.
There are three sequential phases or stages to frozen shoulder syndrome. The first is the painful stage, characterized by the maturation of capsule scarring, resulting in increased restriction of movement and pain. This stage is typically non-invasive and very conservative upon initial presentation. First-line drug treatment with nonsteroidal anti-inflammatories may be administered. If the patient's pain persists, corticosteroids may be injected to reduce pain and inflammation. Electrical stimulation, low-voltage current, ultrasound, and transcutaneous electrical stimulation (TENS) may be used in conjunction with physical therapy as the reduction in pain will enable patients to become less guarded and more functional. Intra-articular corticosteroid injections may be given in conjunction with physical therapy as the reduction in pain will enable patients to become less guarded and move through the stages of the condition more effectively. Capsular distension through hydrodilation may be performed surgically. Lastly, the most aggressive surgical option is joint manipulation under anesthesia and capsular release. Arthroscopic surgery would only be recommended if all non-surgical treatments prove ineffective.

Chinese medicine categorizes shoulder pain as an obstruction or impediment type of condition that is commonly due to excess conditions. This Painless Obstruction syndrome, or Bi syndrome, results from three etiological factors that cause shoulder pain: Wind, Cold, and Damp. According to Sionneau and Gang, the inability to raise the shoulder is categorized into four disease differentiations: painful impediment, frozen shoulder, chest impediment, and inability to raise the shoulder is categorized into four disease differentiations: painful impediment, frozen shoulder, chest impediment, and inability to raise the shoulder. Lastly, with traumatic injury, the literal damage to muscles and sinews will disrupt normal range of motion.

Medical management of frozen shoulder using currently available treatments is not effective when compared to surgical treatments. A meta-analysis of studies comparing nonoperative and operative treatment of adhesive capsulitis, reviewed by Rolf et al., concluded that a multimodal nonsurgical treatment program is effective for most patients. While it has been shown that the combination of regular acupuncture and physical therapy is effective in the treatment of adhesive capsulitis, traditional biomedical treatment for adhesive capsulitis is typically non-invasive and very conservative upon initial presentation. First-line drug treatment with nonsteroidal anti-inflammatories may be administered. If the patient's pain persists, corticosteroids may be injected to reduce pain and inflammation. Electrical stimulation, low-voltage current, ultrasound, and transcutaneous electrical stimulation (TENS) may be used in conjunction with physical therapy as the reduction in pain will enable patients to become less guarded and move through the stages of the condition more effectively. Capsular distension through hydrodilation may be performed surgically. Lastly, the most aggressive surgical option is joint manipulation under anesthesia and capsular release. Arthroscopic surgery would only be recommended if all non-surgical treatments prove ineffective.

This issue contains full-text content of the following:
-SIO 2011 Conference Report, Part 4: The Future (and Current Reality) of Integrative Oncology by Claudette Baker, Dipl OM (NCCAOm), LAc p.30
-Acupuncture, Medical Necessity, and Automobile Insurance Fraud by Steven Schram, PhD, DC, LAc p.33
-Book Reviews by Steve Given, DAOM, LAc and Elizabeth Sommers, PhD, MPH, LAc pages 40 and 42
Letter from president; the letter from the students, AAAOM-SO and letter from EIC
-Index to Advertisers, printed in full, p. 46

Full text of this article is available ONLY to AAAOM members and journal subscribers. To become an AAAOM member and receive the complete print or online journal, go to: www.aaaomonline.org

For library-only subscriptions, please contact leder@aaaomonline.org
"Prescription and over-the-counter pain medication were prescribed. The patient did not improve and the patient did not receive any cortisone injections."

For library-only subscriptions, please contact leder@aaaomonline.org

Full text of this article is available ONLY to AAAOM members and journal subscribers. To become an AAAOM member and receive the complete print or online journal, go to: www.aaaomonline.org

Table 1. Acupoint and Muscle Correlations

<table>
<thead>
<tr>
<th>TX #</th>
<th>Acupuncture Points Needled</th>
<th>Pain Rating Pre-Tx</th>
<th>Pain Rating Post-Tx</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>(R) Tiaokou ST 38-Ashi, Hegu LI 4, Taichong LV 3</td>
<td>8/10</td>
<td>4/10</td>
</tr>
<tr>
<td>2</td>
<td>(R) Tiaokou ST 38-Ashi, (R) Shen Guan 77.18</td>
<td>6/10</td>
<td>2/10</td>
</tr>
<tr>
<td>3</td>
<td>(R) Tiaokou ST 38-Ashi, (R) Zu Wu Jin 77.25, (R) Zu Qian Jin 77.24</td>
<td>5/10</td>
<td>1/10</td>
</tr>
<tr>
<td>4</td>
<td>(R) Shen Guan 77.18, (L) Jian Zhong 44.06</td>
<td>3/10</td>
<td>1/10</td>
</tr>
<tr>
<td>5</td>
<td>(R) Shen Guan 77.18, (R) Si Hua Zhong 77.09</td>
<td>2/10</td>
<td>2/10</td>
</tr>
<tr>
<td>6</td>
<td>(R) Zu Wu Jin 77.25, (R) Zu Qian Jin 77.24, (L) Jian Zhong 44.06</td>
<td>2/10</td>
<td>2/10</td>
</tr>
<tr>
<td>7</td>
<td>(L) Jian Qian (M-UE-48) connected to SI 10, LI 14 connected to LU 16, GB 21, SI 9, SI 11, SI 13, SI 14</td>
<td>3/10</td>
<td>1/10</td>
</tr>
<tr>
<td>8</td>
<td>(L) HT 1, Jian Qian (M-UE-48) connected to SI 10, LI 14 connected to LU 16, SI 11 connected to SI 13, GB 21, SI 9, SJ 14</td>
<td>2/10</td>
<td>0/10</td>
</tr>
<tr>
<td>9</td>
<td>(L) HT 1, Jian Qian (M-UE-48), SI 10, LI 14, LI 16, GB 21, SI 9, SI 11, SI 13, SI 14</td>
<td>0/10</td>
<td>0/10</td>
</tr>
</tbody>
</table>

Table 2. Local and Distal Treatment Results with Pain Ratings

This issue contains full-text content of the following:

- Acupuncture, Medical Necessity, and Automobile Insurance Fraud by Steven Schram, PhD, DC, LAc p.33
- Book Reviews by Steve Given, DAOM, LAc and Elizabeth Sommers, PhD, MPH, LAc pages 40 and 42
- Letter from president; the letter from the students, AAAOM-SO and letter from EIC
- Index to Advertisers, printed in full, p. 46
Thawing the Frozen Shoulder—A Case Study and Clinical Recommendations for the Use of Acupuncture in Treatment of Adhesive Capsulitis

After reaching a therapeutic plateau during the fifth and sixth treatment, the patient continued to have decreased pain and improved range of motion after each of the first four treatments. The patient stated that his shoulder pain was greatly diminished and range of motion moderately improved. Two to four days post-treatment, the pain would return but not to its previous level. During this period, the patient reported that his shoulder pain was less than the prior week’s and that he felt like his shoulder was “less stiff and frozen.”

Discussion

With an unknown etiology and pathophysiology of frozen shoulder, biomedical management of this condition can be poor. Also, there is no high-level evidence to support or refute many of the commonly used treatments for adhesive capsulitis. This case study suggests an effective distal-local treatment protocol that offers a rapid response in providing effective analgesia while restoring range of motion.

Biomedical interventions should not be the only solution in the management of frozen shoulder because intra-articular corticosteroid injections may only provide short-term pain relief of up to six weeks. Additionally, patients are typically limited to three injections over a period of four months to reduce the risk of significant complications. Arthroscopic surgery to release or remove scar tissue or to incise tight ligaments may itself eventually produce scarring. Acupuncture may be considered in lieu of injections or surgical intervention since there was stronger evidence indicated for the effectiveness of conservative therapies over surgical interventions.

During the first four treatments, the higher levels of shoulder pain were addressed by the distal needling because it was important to reduce pain at this stage. The stimulation of contralateral distal acupuncture points has been shown to share the same high level afferent pathway in acupuncture analgesia as ipsilateral stimulation, so ST 38 and Master Tung points were chosen to activate the obstructed meridians and to allow for the unrestricted flow of qi and blood. Subjective pain ratings showed substantial improvements whereas range of motion was not as noticeably improved. The plateau reached during the fifth and sixth treatments can now be seen as a pivotal point in the treatment plan in which joint stiffness, rather than pain, was the predominant factor of the frozen shoulder. This indicates a change in treatment focus from reducing pain to increasing range of motion.

Table 3. Master Tung Points

<table>
<thead>
<tr>
<th>Master Tung Point</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jian Zhong</td>
<td>44.06 3 cun inferior to the acromion process</td>
</tr>
<tr>
<td>Si Hua Zhong</td>
<td>77.09 4.5 cun inferior to ST 36</td>
</tr>
<tr>
<td>Shen Guan</td>
<td>77.18 4 cun inferior to knee joint, just below medial epicondyle of tibia</td>
</tr>
<tr>
<td>Ce San Li</td>
<td>77.22 1.5 cun lateral and 3 cun inferior to lateral edge of lower border of patella</td>
</tr>
<tr>
<td>Zu Qian Jin</td>
<td>77.24 0.5 cun lateral and 5.5 cun inferior to ST 36</td>
</tr>
<tr>
<td>Zu Wu Jin</td>
<td>77.25 0.5 cun lateral and 7.5 cun inferior to ST 36</td>
</tr>
</tbody>
</table>

This issue contains full-text content of the following:

- Acupuncture, Medical Necessity, and Automobile Insurance Fraud by Steven Schram, PhD, DC, LAc p.33
- Book Reviews by Steve Given, DAOM, LAc and Elizabeth Sommers, PhD, MPH, LAc pages 40 and 42

Letter from president; the letter from the students, AAAOM-SO and letter from EIC

- Index to Advertisers, printed in full, p. 46
Treatment of Adhesive Capsulitis

Thawing the Frozen Shoulder—A Case Study and Clinical Recommendations for the Use of Acupuncture in Treatment of Adhesive Capsulitis

Full text of this article is available only to AAAOM members and journal subscribers. To become an AAAOM member and receive the complete print or online journal, go to:

www.aaaomonline.org

For library-only subscriptions, please contact leder@aaaomonline.org

This issue contains full-text content of the following:


- Acupuncture, Medical Necessity, and Automobile Insurance Fraud by Steven Schram, PhD, DC, LAc p.33

- Book Reviews by Steve Given, DAOM, LAc and Elizabeth Sommers, PhD, MPH, LAc pages 40 and 42

Letter from president; the letter from the students, AAAOM-SO and letter from EIC

- Index to Advertisers, printed in full, p. 46

References


27. ibid.
By Claudette Baker, Dipl OM (NCCAOM), LAc

Claudette Baker, Dipl OM (NCCAOM), LAc, president emeritus AAAOM (1996-8) and ILaaom (Illinois) (94-97 & 2002-5) has been practicing Oriental medicine with a focus on oncology since 1985. She is the founder and medical director of the Glenview Healing Arts Center. A pioneer and leader in the AOM profession nationally and locally, Ms. Baker has worked to incorporate Oriental medicine into the Illinois and U.S. health care delivery system, taught Chinese herbal medicine for oncology, is an SIO member, and is currently the chairperson of the State of Illinois Board of Acupuncture.

The November 2011 Society for Integrative Oncology conference opened with the keynote speech, “The Future of Integrative Oncology,” presented by Stan Gerson, MD, a Harvard-educated physician and director of the Case Western Reserve University Comprehensive Cancer Center. Since 1983 he has been the director of the Ireland Cancer Center of the University Hospitals of Cleveland, the chief of the Division of Hematology/Oncology since 1995, and, in 2003, he became the founding director of the Ohio Wright Center for Stem Cell and Regenerative Medicine. Dr. Gerson is known for his work with stem cell, hematologic malignancies, and developmental therapeutics programs. He is the recipient of multiple NIH grants and has authored more than 170 publications, 190 abstracts, and 20 book chapters. Dr. Gerson holds seven patents in stem cell and drug discovery.

Dr. Gerson gave a slide presentation about the Seidman Cancer Center—Case Western Hospital’s impressive new state-of-the-art facility that opened in July 2011. The Seidman Center provides a more integrated approach to healing cancer, with services from a variety of complementary providers in addition to conventional biomedicine. He described some of the successes that they have already seen, including a soon-to-be published positive study on pain management, which introduced music and art into the patients’ therapy schedule.
Dr. Gerson also spoke about the emerging data regarding the importance of good nutrition and cancer prevention. He first acknowledged that Max Gerson, MD (a distant relative) was well ahead of his time in the late 1920s when he developed the “Gerson Therapy.”

“Speaking about the success of integrative oncology and lessons learned, he reminded us that it is a complex field and ‘integration is a process that we’re never really done with.’ He predicts that it will flourish when efforts can coordinate science, clinical trials, observation, and patient management.”

To activate the body’s ability to cure disease and cancer by using an organic vegetarian diet, raw juices, and natural supplements to treat toxicity and nutritional deficiencies that underlie the causes of chronic disease.

Dr. Gerson highlighted a recent study by Chen-Yu Zhang that shows we literally are what we eat! When we consume broccoli and other plants, they produce, as we do, regulatory molecules called microRNAs that are critical in turning on and turning off a variety of genes. For instance, three very important microRNAs that come from broccoli get metabolized in our gut travel, through our liver and end up in our bloodstream to modulate the proteins and DNA products that are being produced in the cells. As Dr. Gerson said, “this shows there really is biology regarding nutraceuticals and whole foods, and there is a real hard-core impact when we eat broccoli or other vegetables and fruits because many of the genes that our cells are expressing will change as a result. I believe that this is just the tip of the iceberg as we try to understand the effect that our diet has on our biology.”

Speaking about the success of integrative oncology and lessons learned, he reminded us that it is a complex field and “integration is a process that we’re never really done with.” He predicts that it will flourish when efforts can coordinate science, clinical trials, observation, and patient management. This requires an open mind, patience, and linking outcomes to evidence. To succeed, the field of integrative oncology will benefit from a huge degree of buy-in.

When a doctor in the audience asked, “How do we get others involved in this field?” he responded: “For physicians, it starts with getting them out of their individual practice styles and into a multi-disciplinary approach, to remind them that their curative treatments are for life-long disease and illness, and that the surgeon can’t walk away after the case; they need to be involved longitudinally. We need to educate the entire physician population about the field of complementary medicine and embrace supportive and complementary care.

“For academic center buy-in we need to start integrative oncology training at the beginning of medical school, create research centers, career development and faculty appointments, i.e., professorships, and make an investment in the field of integrative oncology. For health care professionals, it will require cross-training, pain/palliative/psycho-social care, and oncology nursing because long-term survivorship for patients is critical. We need to improve our capacity to deliver complementary services.

“For companies, a great example is one of our conference co-sponsors, Parker Hannifin. They are leading the way through employee education by promoting a healthy lifestyle, by balancing health benefits, and by supporting the academic and community efforts that are so critical for this to move forward. In terms of health care reform, they have learned that the best way to reduce health care costs and premiums is to begin well before the diagnosis of cancer by promoting and supporting improved lifestyles.

“For government buy-in, for instance, the National Institutes of Health and the Center for Medicare Services, it means reimbursing for complementary medical care (which is rarely done), funding research on supportive and complementary interventions, linking integrative oncology to care paths and quality evaluations, and paying for the performance of integrative oncology.”

When asked what the greatest barrier integrative oncology faces moving forward, Dr. Gerson replied, “Getting the word out! There is a lot of confusion about what integrative oncology is. How do we publicize our interests in the lay press, in the community and in academic literature, and through training as well as evaluation in our medical centers? The barrier to integrative oncology that had been very apparent a decade ago has lessened. Many medical centers are starting to bring together complementary medicine and integrative oncology. However, it is worrisome that they aren’t making the connections between all of the therapies, as you can see when they have their comprehensive cancer centers in one location and the complementary oncology services in another location. The connections are not there. The integration of the effort must start at the top.”

A paper presented by Lynda Balneaves, PhD during the “The Best of SIO” session is a prime example of the problems that arise when the integration of therapies are not designed from the top. Her study, “The Experience of Integrative Oncology: Just on
To achieve this end, hospital administrators must bring licensed acupuncturists, herbalists, and other holistic practitioners onto their teams to insure cohesive care under one roof. It is also essential to have fully trained, board-certified acupuncturists on research teams that are studying acupuncture and herbal efficacy. This will ensure their expertise on the design and execution of the studies, likely resulting in a more accurate picture of the benefits of AOM. As Dr. Gerson suggested, “If integrative oncology is to flourish, it truly must be designed at the top, and not as an afterthought.”

References
2. Lynda Balneaves, PhD, designed and presented this sub-study for the Path Study research team, led by principal investigator Marija Verhoef, PhD, University of Calgary, and included Mary Koithan, University of Arizona, Sara Warber, University of Michigan, Emily McKenzie, University of Calgary, and Andrea Mulkins, University of Calgary. Contact: Lynnda Balneaves, University of British Columbia: Lynnda.Balneaves@nursing.ubc.ca
Abstract
This article presents an overview of automobile insurance fraud with a focus on the role of the acupuncturist in delivering care. The locus of treatment is a specialized multi-disciplinary facility typically referred to as an auto insurance treatment mill. A discussion on common patient treatment patterns, billing irregularities, problems in defining medical necessity, and creating standards of care is presented so the acupuncture community may understand the nature of this problem in greater detail. It is important for the profession to recognize and address these problems before outside regulators are forced to act.

Keywords: acupuncture, automobile insurance fraud, no-fault fraud, automobile accidents, medical necessity.

Overview of Automobile Insurance Fraud:
Insurance fraud has always been a problem for insurers. A study twenty years ago estimated that automobile insurance fraud cost insurers over 8 billion dollars per year. It is certainly a higher figure today as car repair and medical costs have risen with monetary inflation.

Automobile insurance fraud can take many forms:
• Accidents can be staged.
• Claims can be filed for claimants not actually in an accident.
• Victims can file more than one claim for a single injury or file claims for unrelated injuries.
• Victims can misreport wage losses.
• Victims can report higher costs for car repairs.
Medical fraud takes these forms:
• Providers can pad claims with services not delivered.
• Providers can render and charge for medically unnecessary treatments.
• Providers can render and charge for ineffectual care.
• Providers can treat long past the time that care is medically necessary.

Fraud, law and legislation:
As fraud causes higher insurance costs, combating automobile insurance fraud is an important priority for both law enforcement and legislative bodies. Sometimes fraud is singular as with this Florida acupuncturist who allegedly billed for treatments that were never performed. Other times, fraud can be enormous as it was in this recent $279 million New York case against 36 defendants (including ten doctors, four acupuncturists and three attorneys) involved in a systematic scheme to defraud private insurance companies under New York’s automobile insurance law. When a case is large, the fraud is generally more organized as described in the 2011 Connecticut Operation Running Man, where the conspirators “…routinely established six-month treatment regimens for patients, regardless of medical need. They also conspired to falsify medical records, including fake patient assessments and exaggerated injury reports.”

The dollar value of acupuncture fraud in automobile accident treatments is most certainly only a small part of the total. But regardless of its size, and even though only a small minority may be involved, fraud has major potential consequences for the rest of the acupuncture and Oriental medicine (AOM) profession because documented fraud motivates state legislators to take action. For example, in March 2012, Florida legislators completely rewrote the personal injury protection (PIP) no-fault law and eliminated reimbursement for both acupuncture and massage therapy. In New Jersey, a recent law puts a $99 cap on certain (but not acupuncture yet) daily visit charges. In 2011, a bill capping treatments and eliminating acupuncture was considered by the NY Senate and Assembly. Other states may also be planning actions as well.

For the practitioner who is caught, the consequences for fraud conviction can be severe—loss of license, fines or even jail are distinct likelihoods. Even more significant are the potential consequences in both public relations and legislative reactions. It is therefore in our community’s best interest to be aware of the problem and educate our members so they can avoid inadvertent participation. In addition, useful treatment guidelines need to be developed so all AOM practitioners can better treat the automobile injury patient.

From the auto accident to the treatment mill:
An auto accident is prerequisite for an auto accident injury claim. This can be staged or real. Resultant injuries may range from non-existent to severe. Getting treated for these injuries is usually the next step; this is where the automobile treatment mills come into play. Patients can be referred into them by numerous routes including, but not limited to, hospital staffers and lawyers that specialize in automobile injuries.

There are two types of auto accident clinics that treat auto accident patients. Each has different treatment goals. In a legitimate clinic, the treatment goals are patient-centric and focus on restoration of function and elimination of pain. In a treatment mill, the goals are to maximize clinic revenue by providing as many services and treatments as possible, regardless of medical necessity. The sole purpose of this type of clinic is to defraud insurance companies—its focus is entirely on profit, not patient care. While there are many subtle variations, what follows is a description of how a typical treatment mill works.
The dollar value of acupuncture fraud in automobile accident treatments is most certainly only a small part of the total. But regardless of its size, and even though only a small minority may be involved, fraud has major potential consequences for the rest of the acupuncture and Oriental medicine (AOM) profession because documented fraud motivates state legislators to take action.

The treatment mill:

The treatment mill is a specialized facility purposely designed from the top down to defraud insurance companies. Commonly a layperson known as the controller creates the clinic, chooses its location, establishes the lease, and pays for its setup. It is the controller who recruits the medical professionals and has them incorporate as professional corporations so they can bill insurance companies. As detailed in a recent lawsuit filed by Allstate against a number of NY acupuncture clinics, these professional service corporations were illegally owned and controlled by laypersons rather than by the licensed professionals.

In a treatment mill, the lead professional is the medical director, whose role is to document the patient’s “injuries.” Their reports often contain exaggerated findings that make even minor or non-existent injuries appear significant and profound. Based on these fictitious and exaggerated findings, the medical director makes numerous recommendations for both costly diagnostic tests and extensive care. The care recommendations allow the patient to be tested and treated by the modality specialists—the major income generators for the clinic.

The modality specialists provide treatment (e.g., acupuncture, chiropractic, physical therapy, neurology, psychology, pain management, orthopedics, audiology and manipulation under anesthesia), diagnostic services (e.g., MRIs, x-rays, range of motion tests, outcome assessments, and functional capacity evaluations) and supplies (e.g., durable medical equipment). While the modality specialists are also incorporated as professional corporations, as is the medical director, the real (but hidden) owner of the corporation is the modality clinic controller, not the modality specialist. The insurance payments that pass into the billing corporations are funneled back to the controller, who in turn pays the providers.

The most important thing to realize is that the modality providers are not directly in charge of patient care. They are told what and how to treat by the modality clinic controllers. Their goal is maximized billing, not patient care. This becomes evident from the treatment records. The treatment and billing by the modality specialists continues until the patient withdraws from care, the insurance policy limits are reached, or an independent medical examine determines that care is no longer medically necessary.

On the insurance side:

A major concern of the insurance carrier paying the bills is payment for care that is not medically necessary. Because the providers’ exam and treatment records exaggerate the severity of the injuries, it is difficult to differentiate the truly injured from the uninjured or mildly injured patients. One part of the solution is an independent medical examination (IME), which the carrier schedules for the patient after a few months of treatment. The purpose of the IME is to evaluate current patient status and effectiveness of the prior treatments. The IMEs are given by impartial providers hired by the insurance company to examine the patient. The assumption of impartiality must be tempered by recognizing that they are hired by the insurance company.

Different IMEs are needed to deal with provider specialties. Medical doctors evaluate the need for continued medical care or physical therapy, chiropractors evaluate chiropractic care, and acupuncturists evaluate acupuncture care. Each IME stands alone, and each can have different findings regarding continuation of care. In the case of acupuncture, the IME evaluates the patient’s need for more care, but this determination may be tempered in consideration of quality of care, including needle count, needle placement and treatment frequency.

Even when the examiner encounters poor response concomitant with sub-par care, they may recommend more care at a reduced frequency along with a follow-up IME. If the patient has still not improved, care is terminated. Sometimes the patient will be functionally sound and at a state of pre-accident wellness. If so, care is terminated appropriately. Since the patient has “recovered,” the examiner will often report that the mill’s treatments were medically effective and necessary since the treatments were successful. But the unanswered question is whether or not the treatments were ever medically useful or necessary in the first place. This can be very difficult to determine if the records are inaccurate; resolving that question takes more than an IME. This is where a detailed records review comes into play.

Evaluating acupuncture treatments through a records review:

When reviewing the records provided by the acupuncturist, the accident report, intake forms, daily treatment notes, points needled, and bills are each examined closely. While there are minor variations, in automobile injury clinics the acupuncture intake forms focus on areas of pain. Body diagrams let the provider mark painful locations and indicate the degree of pain on a 1-10 scale. Range of motion limitations may be noted for each area of indicated pain. Following the pain section is a diagnosis section.

In the records I examined, the acupuncture based diagnosis was always “qi and blood stagnation along with the meridian(s) traversing the area of pain.” International Classification of Disease (ICD) codes are also listed for each body area and are checked off if applicable. (These codes are reported to the insurance carrier on the insurance bill.) Potential treatment points for each channel are listed.
Next is a boilerplate treatment plan stating that ear, body, or limb points may be used in treatments. This is followed by another boilerplate paragraph on how acupuncture can affect the meridians and reduce pain. Some providers quote WHO documents11 to justify acupuncture treatments, and many add a few lines describing the type and quality of the acupuncture needle they will use. At the end of the intake form a paragraph on treatment recommendations may be included, with a blank space for the number of treatments per week and the number of needles to be used. There are also additional forms asserting causality and medical necessity along with signatory pages for informed consent, assignment of benefits, and other regulatory forms as required by state laws. All documents appear, at least facially, to be appropriately signed and dated.

These intake forms are the enabling documents that provide the rationale and basis for initiating acupuncture care and continuing treatment. Once treatment begins, another set of forms are used for the daily notes. In treatment mills, these notes have a number of common characteristics that are not specific to any patient or particular date of service but, instead, appear as general patterns.

**Common characteristics of mill acupuncture treatments:**

Because the basic purpose of the treatment mill is to overbill and under treat, there are a number of common treatment characteristics:

- Treatments use a very limited selection of points.
- The same limited sets of points are used repeatedly.
- Only a few needles are used per treatment regardless of the number or severity of complaints.
- High frequency treatments continue month after month.
- Treatment notes are devoid of relevant clinical content.

The following treatment examples show typical point usage in treatment mills:

- Low back complaints are primarily treated with Mingmen DU-4 and Shenshu UB-23. Sometimes Zhishi UB-52 replaces Shenshu UB-23. Moxa is never reported. Secondary low back protocols use Yaoyangguan DU-3 and Dachangshu UB-25 in place of Mingmen DU-4 and Shenshu UB-23. Rarely used are Hua Tu JiaJi points, or points on the ankle or even the command point for the low back, Weizhong UB-40.
- Upper back and neck are treated with Dazhui DU-14 and Dazhu UB-11 with Jianjing GB-21 sometimes replacing Dazhu UB-11. Rarely used are Hua Tu JiaJi points or the command point for the neck, Lieque LU-7.
- Limb, scalp, hand, foot, extra-ordinary or auricular points are rarely reported.
- The four needle combination of Hegu LI-4 and Taichong LV-3, widely recognized for its effectiveness in treating *qi* and *blood* stagnation, is rarely reported.

“The common thread here is the recommendation for treating pain with varying point formulas using both local and distal points. A long-term treatment combined with repetitious use of the same two or three points does not meet this recommendation.”

- Extremity complaints, often noted in the diagnosis and complaint area, are rarely treated.

Treatment frequency starts at three to five treatments per week, continuing for many months with only a slight decrease in frequency. Concurrent with acupuncture treatments are additional specialty treatments such as physical therapy and chiropractic. Daily notes consistently reflect little to no progress, yet treatment continues using the same few points over and over again.

Treatment notes list the points needed; there also may be checkboxes for the areas of complaint or use of a brief abbreviation such as PUB (pain upper back). There may be a checkbox for the degree of improvement (minimal improvement is frequently checked) and another checkbox for the recommendation for continued care. All of this lacks both details on what is better or worse from previous treatments and comments on other entrance complaints. The sparse nature of the notes is concomitant with rapid treatments and non-existent interval exams. (Please note that the above critique on minimal point selection does not pertain to specialized treatment styles, e.g., Japanese, Korean, Tung, community, and others that are point minimal by design.)

**Comparison of mill treatments to classical recommendations:**

Given that the mills always emphasize the severity of the pain and document many different complaints and complaint areas, the disparity between the actual treatment and the severity of the problems is in stark contrast to classical recommendations. In the section titled “Principles of Point Selection,” Cheng Xinnong, in *Chinese Acupuncture and Moxibustion*, recommends selecting points that are local, nearby and distal.12 Regarding treatment of pain, he refers to chapter 59 of *Miraculous Pivot* and quotes “A mild case should be treated by selecting a few points while a severe case is treated by selecting many points.”13

In the more recent *Manual of Acupuncture*, Deadmen writes: “Local points are … perhaps the most obvious method of point selection. Points on the limbs … have a wide application in treating disorders of the head, chest, abdomen (the three ends) and additionally the back.”14 When acupuncture is given frequently… it is common practice to alternate points or point prescriptions to avoid over-stimulation of or damage to points.”15
In Maciocia’s *The Foundations of Chinese Medicine*, we find “… the use of local points only might sometimes be sufficient, but it is much more common to balance local points with distal points. The distal points actually play an important role in clearing the channel from obstructions (which may… only be from stagnation of qi and/ or blood).”16

The common thread here is the recommendation for treating pain with varying point formulas using both local and distal points. A long-term treatment combined with repetitious use of the same two or three points does not meet this recommendation.

Billing issues:
The treatment mill acupuncturist bills two or more units of care per treatment regardless of how few points are needled. It is common to see claims for three or four units of care. The problem is that these multiple unit billings are unsupported by the treatment notes.

In a recent email17 from Dr. David Wells, who presented the acupuncture position to the Relative Value Committee of the AMA, he wrote “Every MD at the table of the Relative Unit Committee knew that acupuncturists customarily leave the patient unattended during the period of needle retention. They were absolutely clear that no reimbursement would be paid for unattended time. We made the case that about 15 minutes is normally required in a patient encounter for one period of needle insertion.”

In developing the reimbursement value for the acupuncture treatment, the treatment was understood to contain a number of distinct components:

• Reviewing the chart and obtaining a brief account from the patient of the results of previous treatment along with any significant changes that have occurred since the last visit
• Point selection and location including palpation
• Marking and cleaning the selected points
• Selection of appropriate gauge and length needles
• Hand-washing in accordance with NCCAOM Clean Needle Technique guidelines
• Insertion and manipulation of the needles to obtain qi sensation
• Manipulation of needles and monitoring of patient response.
• Removal of needles, closing the points, and disposing of used needles
• Assessment of response to treatment and final charting

Billing for additional treatment segments can only be done if specific requirements are met. With few exceptions (detailed in the identical American Association of Acupuncture and Oriental Medicine18 and Acupuncture Society of New York19 position statements), the term “reinsertion” in the secondary code definition requires insertion of new needles. But simply inserting new needles is insufficient to require a second billing unit without a valid clinical reason to support the new insertions. One valid rationale does occur when the additional treatment points are inaccessible during the first treatment period as with front and back treatments. Another valid justification for an additional billing segment could be met when the case is complex and many needles are being inserted. But when the needle count is small, the interval exam negligible, and all of the points accessible in one position, billing more than one unit is unjustified.

It should be noted that besides inserting new needles, most of the elements listed above would also need to be performed because reinsertion is not just a matter of inserting more needles. This is a completely separate period of acupuncture treatment within the same patient encounter.

Can acupuncture treatments ever be medically unnecessary?
It is difficult to reach consensus on the definition of general medical necessity since this varies between providers, courts, government insurers, private insurers, and patients. The provider’s evaluation depends on the patient’s response to care along with personal judgment—but the provider maintains a perverse (monetary) incentive to always continue rendering care. The insurer asks if the benefit is worth the cost. If the patient were paying for the services themselves, they should be asking the same question as the insurer: is it worth the time, effort and cost to get the treatments?

In essence, this question goes to the heart of the fraud because these treatments have no medical value. As such, they become unnecessary and should not be reimbursable by third party payers. Practitioners who deliver treatments in this manner clearly violate AOM’s professional Code of Ethics.20 In addition, they break trust with the public and do a disservice to our profession.

Recommendations:
There are a number of stakeholders involved in the problem of automobile injury treatment fraud, including patients with legitimate injuries, insurance carriers, practitioners, law enforcement, and politicians. Our solution must focus on the practitioners—in particular those practitioners who treat the injured patient.

One practical step in this direction is to develop automobile treatment guidelines; this does not mean “cookbook” point prescriptions for specific diagnosis or channel obstructions. Those points are well known and already listed as potential treatment points on the mill’s patient intake forms. Rather than mindlessly using listed points, guidelines are needed that address the spirit of treatment in a broad manner that allows for the wide variability of practice styles and methods.

These guidelines should not be point prescriptions; they need to address issues such as treatment frequency, expected milestones, and what to do when patients don’t respond or the case is highly complex. Creating such guidelines must be done with great care because they can easily become a double-edged sword that can be used against practitioners whose cases fall outside the established norms.
As a community, we need to become aware of the problem and acknowledge that some of our practitioners do participate in medical insurance fraud. It behooves us to address this issue internally before reactionary state laws reduce the ability for even highly skilled and ethical practitioners to effectively and legally treat auto accident patients.

Other professions including physical therapy and chiropractic have successfully developed practice guidelines. Doing this requires leadership, a commitment of time, and especially a firm desire to include the viewpoints from stylistically varied practitioners.

Discussion:
As noted, automobile insurance fraud is a large problem for insurers, patients and law enforcement. While the dollar value of acupuncture fraud is relatively small compared to the total costs, it remains part of the problem and an easy target for legislators, law enforcement, and insurance carriers to identify. While it might be unfair to those who practice legitimately, the crosshairs of legislators and law enforcement are indeed on our profession.

We need to recognize and understand that it is unacceptable for any practitioner to participate in this type of fraud by billing for and delivering ineffective and unnecessary treatments. As previously discussed, clear markers for medically unnecessary treatments of auto accident victims include long term, high frequency treatment that uses minimal and repetitive points. Billing of multiple treatment segments unsupported by documented clinical needs is another clue. Providers who treat and bill in this manner do a disservice not only to their patients but to the entire AOM profession as well.

As a community, we need to become aware of the problem and acknowledge that some of our practitioners do participate in medical insurance fraud. It behooves us to address this issue internally before reactionary state laws reduce the ability for even highly skilled and ethical practitioners to effectively and legally treat auto accident patients.

Disclosure of Conflict of Interest and Financial Disclosure:
There are no current conflicts of interest or financial concerns.

References
13. ibid, p. 355
15. ibid; p. 60
17. D. Wells, personal communication, August 2, 2012
Do you want—

• Increased **public and professional awareness** of your profession

• Greater **career stability**

• A **salary commensurate** with similar medical professionals

• To **protect and expand** your scope of practice

• **Discounts** from companies supporting AOM

• Support to **start and grow your practice**

Since 1981, AOM practitioners have fought for what our profession has achieved today. As a member of your national professional organization, you will be supporting our continued efforts. You sacrificed a lot for your right to practice; make those sacrifices mean something—advance the profession by joining today!

**Join the AAAOM today!**

aaaomonline.org
Over the past few decades, the acupuncture profession has made remarkable strides from a relatively marginalized “alternative” healthcare system to a mainstream profession that is progressively more integrated into the healthcare marketplace. Evidence for this includes the fact that a recent search of the National Library of Medicine on PubMed.gov yielded 2,265 hits for “integrative medicine.” Mainstream institutions such as the University of San Francisco (Osher Center for Integrative Medicine, www.osher.ucsf.edu) and Stanford University (Stanford Center for Integrative Medicine: Clinical Services for Mind and Body, http://stanfordhospital.org/clinicsmedServices/clinics/complementaryMedicine/) have clinical facilities modeling integrative care in a mainstream setting. In addition, the periodical, *Integrative Medicine: A Clinician’s Journal* (http://www.imjournal.com/index.cfm) examines issues on integrative medicine.

These strides belie a complex terrain. On the face of it, integrative medicine can be seen as the integration of multiple healthcare professions in order to enhance clinical outcomes and promote a patient-centered care model. Questions arise as to the impact of integration on traditional medical systems such as acupuncture and East Asian medicine. On what terms will complementary and alternative medicine (CAM) providers such as acupuncturists integrate? The new volume, *Integrating East Asian Medicine into Contemporary Healthcare*, edited by Volker Scheid and Hugh MacPherson with a forward by Ted Kaptchuck, examines how integration impacts traditional medicine and how disparate medical traditions co-exist.

This volume provides no easy answers. Twenty-one contributors from the fields of East Asian medicine, biomedicine, history, anthropology, medicine, humanities, ethics and international development explore the complex relationship between modern biomedicine and East Asian medicine in a series of reflective and well-conceived essays. Twelve additional authors provide vignettes that enrich each essay.

The authors examine issues that clinicians and researchers have struggled with for several decades: How does integration of traditional medical systems into mainstream healthcare alter the traditional medicine? How are traditional medical systems that evolved as family and regional traditions altered by standardization? What is the relationship between the technique and therapeutic modalities of a traditional medicine and the culture and ritual of providing that care? How can research measure the complex interactions that were previously the domain of the humanities and social sciences?

Of particular importance to this analysis is the cogent examination of integration from the humanities and social sciences viewpoint. As stated by Scheid and MacPherson, “This book is a conscious effort to overcome these divides” (between medicine and the humanities and social sciences). This reviewer wholeheartedly agrees with the premise that looking at the intersection of two medical cultures using these non-biomedical tools is very critical. Medical traditions are not best compared as an arms race of efficacy and safety. Chapters by Volker Scheid, Judith Farequhar, and Elizabeth Hsu contribute greatly to our understanding of the social and cultural forces that act on medical traditions and come into play regarding its integration.

Research in the field of acupuncture and East Asian medicine has grown meteorically since the 1970s. A single example is the examination of searches for acupuncture at the website PubMed.gov. A search using the single term “acupuncture 1970-1980” and the dates 1970-1980 yields 81 citations for clinical studies. The same search for the period 2001-2011 yields 2296 citations. Since the Consensus Conference on Acupuncture at the National Institutes of Health (NIH Consensus Statement. 1997 Nov 3-5;15(5):1-34.), many acupuncture and East Asian medical providers have embraced the idea that biomedical research is extremely important to the medicine and will enhance our success in the integration of both medical traditions.

Andrew Flower, Voker Scheid, George Lewith, Hugh MacPherson, Ted Kaptchuk, Ayo Wahlberg, and Claudia Witt examine the relationship between evidence and practice. If evidence
does contribute to the development of integration, then what is the impact of evidence-based medicine? The authors find a complex relationship between East Asian medicine and the principles of evidence-based medicine that may ultimately be difficult to define. How East Asian medical providers are perceived will impact their acceptance, which in turn will impact the rate of acceptance by the dominant medical culture.

One of the most interesting fields examined by the authors of these essays is in the arena of best practices. What defines best practices? What constitutes best practice in a medical tradition that has evolved in diverse locations and from multiple practice models? Volker Scheid and Judith Farquhar examine this concept of best practices. Sonya Pritzker, Christopher Zaslavski, Myeong Soo Lee, Sean Hsian-lin Lei, Chiao-ling Lin and Hen-hong Chang consider the challenges of its standardization.

These challenges and opportunities are not unique to the United States. The international stage is examined by Paul Kadetz, Laurent Pordie, Vivienne Lo, and Adrian Renton. How have other cultures embraced the integration and impact of East Asian medicine? What other solutions to the challenges of integration have evolved? Kadetz’s essay on traditional medicine is especially significant in light of the current work on the part of the World Health Organization on the ICTM database (ICD 11 Beta, http://www.who.int/topics/en/).

Trina Ward looks at the verities of practice style and considers Chinese medical practice from multiple styles or enactments of Chinese medicine. Each enactment brings a different perspective to practice. Is Chinese medicine independent and equal to biomedicine? Is Chinese medicine a classical tradition in parallel with biomedicine? Is Chinese medicine a profound qi (气, 氣)-based medicine that has been rediscovered in the West? Must Chinese medicine remain a separate tradition handed down from teacher to student? Is it possible to combine multiple traditions and biomedicine into a coherent whole? Ward states, “Rather than being competing version of what is the real Chinese medicine, the various enactments can be seen to encompass different types of knowledge that coexist, each being drawn upon to some extent by most practitioners when useful.”

The last word is left to Kathryn Montgomery. Her essay on integration ends with this quote (in part), “Medical practice focuses on the care of patients, and interpretation is essential to this task no matter how standardized and scientific the practice becomes. Room must be left for the expert’s well-considered autonomy and the inspired hunches or insight that could make the difference. Studies of the theory and practice of Asian medicine can point the way to a clearer assessment of vitally important matters: the nature of healing, the characteristics of good medical care, and the power of the patient-physician relationship—all of which are still poorly understood or seldom examined in biomedicine.”

This volume is an important contribution to the discussion of the integration of East Asian medicine into mainstream healthcare for what it does and what it does not do. The authors provide a cogent, rich, and nuanced examination of the issues that surround the integration of East Asian medicine into the dominant Occidental medical paradigm. The authors do not provide easy answers to a difficult question. I unreservedly recommend this volume to providers and administrators involved in the complexities of integration.

Steve Given, DAOM, LAc holds master’s and doctoral degrees in acupuncture and Oriental medicine. He is currently the dean of the Department of Clinical Education and director of Academic Assessment at the American College of Traditional Chinese Medicine in San Francisco. Dr. Given is also a commissioner on the Accreditation Commission for Acupuncture and Oriental Medicine. He has an extensive experience in integrative medical practice in the areas of supportive care for HIV, oncology, and orthopedics, and pain management. He also has a passion for the history of medicine.

---

**THE CAREER CONNECTION**

Connect to the Right People and Opportunities with NYCC’S CAREER OPPORTUNITIES DATABASE...

**FREE!**

**Finger Lakes School of Acupuncture & Oriental Medicine of New York Chiropractic College**

Career Development Center

For more information:  
PHONE: 1-315-568-3039  
WEB SITE: www.nycc.edu

Sell your Acupuncture Practice  
Hire an Acupuncture Associate/LIC  
Sell Acupuncture Equipment  
Rent Acupuncture Office Space

Send postings by:  
FAX: 1-315-568-3566  
E-MAIL: career@nycc.edu
This new collection of readings by an international array of multidisciplinary scholars and researchers represents an opportunity to “take the pulse” of the nascent movement of integrative healthcare. The reader offers an impressive collection of papers addressing the intersections as well as the unique aspects of traditional medicine (TM), complementary medicine (CAM), and integrative approaches. Written by and for all types of practitioners, researchers, policy-makers, and academics, the reader incorporates perspectives from anthropology, economics, bioethics, and public health. These frameworks are used as lenses through which are viewed a full complement of CAM and TM approaches, including acupuncture and traditional Chinese medicine, homeopathy, massage, Ayurveda, biofeedback, chiropractic, meditation, naturopathy, yoga, herbal approaches and dietary supplements.

The reader is divided into three main sections: utilization throughout the life cycle and according to the nature of illness; the praxis of TM and CAM in terms of professional intercommunication and education; and the role of research and evaluation. A public health perspective of health promotion and disease prevention is adopted throughout, and the articles represent innovative and thought-provoking insight into all aspects of the integrative paradigm. Each chapter is replete with references and recommended readings which collectively create a mosaic reflecting the multi-faceted natures of TM and CAM.

Part A of the reader, “Utilization: Populations and Individuals,” begins with the premise that CAM represents a major healthcare resource for addressing illness and promoting wellbeing in most advanced industrialized countries. CAM approaches are used by individuals at all levels of society and in both urban and rural settings. Although cultural, racial, and ethnic factors may play a role in types of CAM used, none of these demographic factors unilaterally rule out CAM use. Authors describe the value of self-care, self-education in decision-making, and empowerment as facilitators of CAM use. A number of large-scale national datasets such as the National Health Interview Survey (NHIS) are described, which are already in place to evaluate citizens’ use of CAM (David Sibbritt and Jon Adams). The value of a cross-cultural perspective is recognized as being especially valuable.

Authors explore use of CAM and TM by women during pregnancy; by infants, children, and adolescents; and among ageing populations. Issues such as medico-legal considerations are discussed. Other readings examine specific conditions (viz. acne, cancer, mental health, HIV/AIDS) and the role and uses of CAM and TM. The section concludes with a discussion on the importance of wellbeing as a health indicator (Richard Harvey).

Part B, “Practice, Provision and the Professional Interface,” takes an international perspective by examining the role of biopolitics and TM in countries such as Vietnam, China, and India. This section also provides an overview of the assessment of issues related to medical hegemony (“Which Medicine? Whose Standards? Critical Reflections on Medical Integration in China” by Ruiping Fan and Ian Holliday). The vision for replacing a pathology-based focus with a “salutogenic,” i.e., health-promoting focus for health care, is described by David Rakel and colleagues.

This section also examines patient/provider dialogue in Hispanic and Native American communities (“They Don’t Ask so I Don’t Tell Them; Patient-Clinician Communication about Traditional, Complementary and Alternative Medicine” by Brian Shelley et al.). An article focusing on pharmacists’ role in providing education and access to dietary supplements and natural health products expands on ethical considerations inherent to pharmacy practice (Heather Boon and colleagues).

Part C, “Knowledge Production, Research Design, and Perspectives,” offers pointed critiques about what constitutes evidence and the role of the biomedical paradigm. Issues such as safety and regulation are addressed from an international perspective. Christine Barry makes the case for adopting an anthropological perspective in research. This would mean augmenting a biomedical “scientific” base of evidence gleaned mostly from results of randomized controlled trials, with an approach that is organic, process-based, interactive, and based in a social context. Christopher Duran and colleagues provide a clear and concise review of economic methods used in CAM research, comparing and contrasting designs.
“While the book includes and addresses all types of CAM, acupuncture and traditional Chinese medicine are the most frequently cited approaches, making the book particularly salient for our profession.”

This section concludes with three articles focused on next steps (“Future Agendas: Key Debates and Themes”). While addressing current questions and concerns about the future of integrative health (or medicine, depending on your perspective), authors are not prescriptive. Instead, they posit basic areas of interest and offer considerations to assess as we continue to develop this new integrative paradigm. Ian Coulter offers commentary on the synthesis of CAM and integrative medicine, noting that this will involve more than a simple addition of one paradigm to the other. He astutely observes that this process will likely be driven by consumers (patients). Drawing on the international experience of the Network of Researchers in the Public Health of Complementary and Alternative Medicine (NORPHCAM), Adams et al. (“Research Capacity Building in Traditional, Complementary and Integrative Medicine: Grass-roots Action Toward a Broader Vision”) describe key factors to create sustainability in the areas of research and scholarship.

While the book includes and addresses all types of CAM, acupuncture and traditional Chinese medicine are the most frequently cited approaches, making the book particularly salient for our profession. In “Women’s Use of CAM during Pregnancy: A Critical Review of the Literature,” Adams and colleagues include two studies on Chinese herbal medicines and three studies on acupuncture and acupressure. Likewise, acupuncture is cited in both pediatric treatment (“CAM Use Among Infants, Children and Adolescents” by Denise Adams et al. and in working with seniors (“‘Getting On with Life: The Experiences of Older People Using Complementary Health Care” by Tina Cartwright).

Examining the evidence for the role of acupuncture in addressing mental health, Jerome Serris and James Lake (“Mental Health and CAM”) review the literature and conclude that there is demonstrated therapeutic benefit for treating mood, anxiety, and sleep disorders. They also point to the area of neuroimaging as an important contributor to our understanding of the mechanisms by which acupuncture results in physiological changes.

Ayo Wahlberg (“Biopolitics and the Promotion of Traditional Herbal Medicine in Vietnam”) points out that acupuncture and herbal medicine are incorporated into medical school curricula in that country. Both of these approaches are very popular among citizens there as well. In India, the practice of acupuncture is part of the normalized health protocol (“Hierarchies of Health, Politics of Tradition, and the Economics of Care in Indian Oncology” by Alex Broom and colleagues). The chapter on economic evaluations cited earlier describes acupuncture studies in Germany on low back pain and chronic neck pain as well as studies in the United Kingdom on chronic back pain and headache, which conclude that acupuncture is a validated approach to managing chronic pain.

Regulations addressing acupuncture in British Columbia include some important and highly relevant sections designed to specify the definition of acupuncture and scope of practice (“Liberalization of Regulatory Structure of CAM: Implications for Consumers and Professions” by Michael Weir). In particular, the proviso that “Only an acupuncturist or TCM practitioner can insert acupuncture needles under the skin for the purpose of practicing acupuncture…” may be instructive to acupuncturists in the U.S. who seek to address the issue of dry needling.

This is a book to ponder, savor, and discuss. Although no ultimate definition is provided for integrative medicine, key concepts are raised for stakeholders’ consideration. By including such an array of topics and perspective, the editors demonstrate their appreciation of “it takes a village” to properly understand and implement promoting global health. My only criticism of this reader is that, although it includes chapters on Vietnam and India, it focuses primarily on the developed world. A more inclusive approach, recognizing the history and contributions of traditional medicine in Africa and Latin American, would enrich our understanding. Despite this gap, I strongly recommend this dynamic and cohesive book. The readings can inspire and invigorate our professional dialogue on aligning acupuncture and TCM with global efforts toward promoting health and wellbeing.

Elizabeth Sommers, PhD, MPH, LAc is director of research and education at Pathways to Wellness and serves on the faculty at Boston University School of Public Health in the Department of Health Policy and Management. Dr. Sommers is co-chair of the American Public Health Association’s specialty group on complementary and alternative health practices. Graduating from the New England School of Acupuncture in 1979, she studied under Dr. James Tin Yau So and has been practicing since that time. Her special areas of interest include treatment for HIV/AIDS and chemical dependency, and she has conducted clinical trials and other types of observational assessments in these areas. Dr. Sommers has published papers on cost-effectiveness and price elasticity of integrative services as well as numerous papers on public health aspects of acupuncture. She was the guest co-editor for the 2012 public health issue of the European Journal of Integrative Medicine.
Full text of this article is available ONLY to AAAOM members and journal subscribers. 
To become an AAAOM member and receive the complete print or online journal, go to: www.aaaomonline.org

For library-only subscriptions, please contact leder@aaaomonline.org

This issue contains full-text content of the following:


-Oncology by Claudette Baker, Dipl OM (NCCAOM), LAc p.30

-Acupuncture, Medical Necessity, and Automobile Insurance Fraud by Steven Schram, PhD, DC, LAc p.33

-Book Reviews by Steve Given, DAOM, LAc and Elizabeth Sommers, PhD, MPH, LAc pages 40 and 42

Letter from president; the letter from the students, AAAOM-SO and letter from EIC

-Index to Advertisers, printed in full, p. 46
AAAOM CRUISE CONFERENCE 2013

Liberty of the Seas – casting off from Ft Lauderdale

Space is Limited – Don’t Delay, Register today!

For conference details: http://aaaomonline.org/cruise2013

To make a reservation contact David Locke:
david.locke@AvoyaTravel.com, 800-706-0338

Coming together to expand our knowledge: from treatment room to practice management.

Enjoy our cruise and get your CEUs

March 21-25, 2013
AAAOM-SO Update
For Students, By Students

We have quickly moved into the winter energy this year, and, despite nature’s signals that it was time to slow down, we students have been busier than ever through the months of autumn, the winter holidays, and the weeks remaining until spring. From coast to coast, all of us are preparing for the NCCAOM exams, mid-terms, finals, and juggling clinic hours and class projects that keep us all on our toes. We know that many fellow students have been working tirelessly to balance family, work, and social lives as well.

As this new year settles in, we take this opportunity to acknowledge each of you and the hard work you do throughout the year. We send a huge “thank you” to you all! Thank you for your commitment to become an excellent practitioner—someone who has chosen as their life’s work to help people bear their suffering and improve their well-being. You will each continue to treat patients who have unique needs and who are often coping with some challenging circumstances. Spending time with them, feeling their pulses, listening to their stories, and carefully designing your treatment strategy does make a difference. The patients who choose you to treat them are so fortunate to have you on their healthcare team!

The work each of us does with our patients is truly inspiring. This is why the board of the AAAOM Student Organization is continuously working to support you in your journey as you become a practitioner. As we continue to move forward in 2013, we want to hear from you about what we, the national student organization, can do to support you. Is there a special benefit you’d like from your AAAOM-SO membership? Let us know—anything goes! We want to make a difference in your life as an AOM practitioner. Tell us how at so@aaaomonline.org.

Don’t forget! The AAAOM Cruise Conference 2013 will be departing from Ft. Lauderdale, Florida. Join us March 21 – 25 on the Liberty of the Seas. Topics span from advanced pain management to business development. Register now for special student pricing!

Thank you AA Advertisers!
In the same way that your business depends on us as practitioners, our business is made possible by the products and services you offer. AAAOM extends heartfelt appreciation to those advertisers that have traveled the distance in giving your support, and we extend a sincere welcome to those of you that recently joined our family.

INDEX TO ADVERTISERS

| ActiveHerb Technologies, Inc. | 4 |
|--------------------------------|
| 510-487-5326 1-888-805-HERB(4372) |
| AOMA - Austin | 34, 47 |
| (800) 824-9987 ext. 209 |
| American Acupuncture Council | 48 |
| 800-838-0383 |
| Blue Poppy | 45 |
| 800-487-9296 |
| Five Branches University | 47 |
| 408-345-2656 |
| Golden Flower Chinese Herbs | 12 |
| 800-729-8509 |
| Golden Flower Trading Co. | 15 |
| 303-500.5150 / 888-490-6388 |
| Kan Herb Company | Inside Front Cover |
| 800-543-5233 |
| Lhasa Medical Inc. | Back Cover |
| 800-722-8775 |
| Mayway | 2 |
| 800-2-MAYWAY |
| Seirin America | Inside Back Cover |
| 800-337-9338 |
| Thé Career Connection | 41 |
| 315-568-3039 |
AOMA’s regionally accredited DAOM program affords students the highest level of academic and professional recognition in the field. Prepare to take a leadership role in the national advancement of TCM.

Modular format for professionals
Specialty in pain & associated psychosocial phenomena
Apply online at aoma.edu/doctoral-program

4701 West Gate Blvd. Austin, TX 78745
800.824.9987

AOMA’s regionally accredited DAOM program affords students the highest level of academic and professional recognition in the field. Prepare to take a leadership role in the national advancement of TCM.

FINANCIAL AID AVAILABLE!

Doctor of Acupuncture and Oriental Medicine DEGREE PROGRAM

- Study with recognized TCM experts and Stanford MD professors
- Option of earning your Ph.D. in China
- Enhance your expertise with the classics taught by clinical specialists
- Broad core program and multiple specializations
- Explore the latest integrative medicine research
- Flexible program with monthly 4-day modules
- Doctoral modules available to LAc’s as CEU courses. See schedule at www.fivebranches.edu/news/818

Quarterly Admissions

Dr. Shunfa Jiao, inventor of head acupuncture and FBU faculty member, teaching doctoral class

FIVE BRANCHES UNIVERSITY
Graduate School of Traditional Chinese Medicine
doctoral@fivebranches.edu (408) 345-2656
3031 Tisch Way, San Jose, California 95128

www.fivebranches.edu


24. Yang, op. cit.

25. Yan, op. cit.


29. Lu, Y. course lecture, Electroacupuncture and Microsystems, Oregon College of Oriental Medicine, Summer, 2007


34. Ellis, Wiseman and Boss, op. cit., p 11.

Full text of this article is available ONLY to AAAOM members and journal subscribers. To become an AAAOM member and receive the complete print or online journal, go to: www.aaaomonline.org

For library-only subscriptions, please contact leder@aaaomonline.org

This issue contains full-text content of the following:


- Acupuncture, Medical Necessity, and Automobile Insurance Fraud by Steven Schram, PhD, DC, LAc p.33

- Book Reviews by Steve Given, DAOM, LAc and Elizabeth Sommers, PhD, MPH, LAc pages 40 and 42

Letter from president; the letter from the students, AAAOM-SO and letter from EIC

- Index to Advertisers, printed in full, p. 46
My choice is SEIRIN, What’s Yours?

For painless acupuncture treatments I always trust Seirin J-Type. New patients are surprised by its comfort, and my regular clients ask for it by name.

The Professional’s Choice

Seirin J-Type acupuncture needles are now available in bulk-packaging that folds into a functional needle dispenser, keeping needles sterile and accessible during treatment.
Same Day Shipping!

plus FREE shipping on any order when you purchase $50 or more worth of herbs from our extensive line of Golden Flower Chinese Herbs or Kan Herbs.

ONE STOP SHOPPING FOR NEEDLES, HERBS, AND MORE!

NEED PRODUCT FAST? Place an order by 5 PM ET Monday - Friday, and we will ship it to you the same day (excluding holidays) for products that are in stock in our warehouse.

NO SALES TAX (EXCEPT IN MA)  SAFE PACKING ASSURANCE  LIVE CUSTOMER SERVICE  30 DAY NO RISK RETURNS  100% SATISFACTION GUARANTEED

One Call Gets It All.
1-800-722-8775  www.LhasaOMS.com

PRICE GUARANTEE - Lhasa OMS will match all competitive pricing.

Lhasa OMS
everything acupuncture