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Assessment and future development of the WHO/WPRO standardization of acupuncture point locations

- Questionnaire survey to teachers at Japanese universities, colleges, vocational schools, and training centers for anma-massage-shiatsu, acupuncture and moxibustion therapies -

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The Second Japan Acupuncture Point Committee

Abstract

[Objective] In 2006 the WHO/WPRO agreed on standard acupuncture point locations. To promote these standards, in 2009 the Second Japan Acupuncture Standardization Committee published a Japanese edition of "WHO STANDARD ACUPUNCTURE POINT LOCATIONS FOR THE WESTERN PACIFIC REGION". Based on this Japanese edition, a new textbook was published by the Japan Association of Massage & Acupuncture Teachers and the Japan College Association of Oriental Medicine. One year has passed since the start of education based on standard meridian point locations at Japanese universities, colleges, vocational schools and training centers for anma (Japanese traditional massage), massage, and shiatsu (acupressure), acupuncture and moxibustion therapies. In this survey, we administered a questionnaire as an evaluation of international standardization and the problems of introducing standard meridian point locations.

[Subjects and methods] Subjects were mainly teachers and a small number of researchers, clinicians, and other groups concerned with acupuncture and moxibustion. We used the questionnaire that we originally created by the Working Group of the Japan Standardization of Acupuncture Point Locations Committee between in Oct. 2010 and in Feb. 2011.

[Results] Among the 180 institutions surveyed, we obtained answers from 149 people from 93 institutions. Agreement on the question of standard meridian points, "functional existence" (44.3%) was most common, and "anatomical existence" came next at 26.6%. As for the question on acupuncture treatment, 82.4% replied with "use of both meridian points and reactive points". As for issue of agreement with international standardization, "no comment" was 41.7% and 51.7% for "agreement". However, both of those groups appreciated the necessity of globalization of acupuncture and moxibustion expressed in a common language. There were many differing opinions about proportional bone measurement. Specifically, opinions indicated a change "from the elbow crease to the wrist crease" (from 10 B-cun to 12 B-cun) and a need for proportional bone measurement of the upper arm. Whereas, for each meridian point, opinions expressed the difficulty of locating the newly defined meridian points and not understanding reasons for changes and notations including body surface landmarks.

[Discussion] We were able to classify the opinions collected into the following groups: (1) problems that can be corrected immediately, including typographic errors, (2) problems that need to be reviewed at the next international gathering, and (3) problems that need to be investigated by making full use of related documents.

[Conclusion] We were able to gather data from a wide range of teachers, revealing problems understanding individual meridian point locations, including consideration of changes in meridian point locations, evaluation of standardization of meridian point locations, and other guidelines.

Key words: *meridian point location, WHO/WPRO standardization of acupuncture point locations, questionnaire survey*

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I. Introduction

Since 2003 the Western Pacific Region Office of WHO (WHO/WPRO) had lead the push for international standardization of meridian point locations, which reached final agreement at the Tsukuba Conference in 2006. Then in May of 2008 WHO/WPRO issued the official English edition of "WHO Standard Acupuncture Point Locations in the Western Pacific Region[1]". The Working Group of the Second Japan Acupuncture Point Committee (hereinafter referred to as the "Working Group") supervised the translation and in March of 2009 issued a Japanese edition titled "WHO/WPRO Standard Acupuncture Point Locations Official Japanese Edition[2]" (hereinafter referred to as the "Official Japanese Edition"). At the same time the Working Group also cooperated to edit the textbook "Newly Edited, Introduction to Meridians and Acupuncture Point Locations[3]". In June 2009 the Working Group issued the "Detailed explanation, Guideline for Acupuncture Point Locations ― From classics to WHO standard[4]" (hereinafter referred to as "Detailed Guideline") which discusses reasons for decisions of meridian points. Furthermore, in September, the group reprinted and published the "Reprinted Edition of Compilation of Acupuncture Points[5]" originally published by the (Primary) Acupuncture Points Committee. With this series of publications the movement toward international standardization of meridian point locations in Japan finished the first step. The next step involved consideration and review of the meridian point locations. The process for international standardization of meridian point locations carried out by Japan, China, and South Korea, included an opinion from early times, which is the idea to review only after waiting a certain period of time.

Accordingly, the Working Group at first assessed the ideas for meridian points and standardized meridian point locations, next the group prepared a questionnaire to answer specific problems about the guideline and meridian point locations of the Official Japanese Edition and gathered opinions mainly from instructors teaching theory of meridian points at training schools for therapists of anma, clinical massage and shiatsu, acupuncture and moxibustion as well as from researchers, therapists, academic societies, etc.

II. Subjects and Methods

The subjects were teachers who belong to training schools for anma-massage-shiatsu, acupuncture and moxibustion (such as universities, vocational schools, special needs education schools for the visually impaired, and rehabilitation centers for the visually impaired) and teach meridian points and researchers of acupuncture, moxibustion, and anma, massage and shiatsu, therapists and members of acupuncture and moxibustion-related organizations (such as academic societies, therapeutic societies, etc).

The methodology was to mail separately "Questionnaire 1" (Table 1) and "Questionnaire 2," which were prepared by the Working Group, to the heads of the subject institutions and organizations of the survey and collect responses by mail, fax, or e-mail.

The survey was administered two times; first from October to December 2010 for training schools (colleges and rehabilitation centers for the visually impaired) in the jurisdiction of the Ministry of Health, Labour and Welfare, and second from December 2010 to February 2011 for universities and special needs education schools for the visually impaired (former blind schools) in the jurisdiction of the Ministry of Education, Culture, Sports, Science and Technology.

For the survey results of Questionnaire 1, simple calculations were performed for each question item and the reasons for the answers were reviewed by the KJ method. Questionnaire 2 was organized by item, reviewed the indicated problems (excluding opinions on the textbook), and listed the explanations.

III. Results

Out of 180 facilities to which the questionnaire was sent 149 people from 93 facilities returned answers to Questionnaire 1 (Table 2).

Among the facilities, special needs education schools for the visually impaired showed the highest recovery rate, 60.3%.

Table 3 shows the results for "Questionnaire 1".

1. Questionnaire 1

1-1. Point of view about meridian points

For the question "What do you think about the existence of acupuncture points?" the most common answer, 44.3% of the answers, was "Believe in *functional existence**", followed by "Believe in anatomical existence", 26.6%. When treating a sickness, 71.9% of the respondents "think that meridians and meridian points are equally important" and as many as 82.4% of respondents use both meridian points and reactive points (like ashi points) for treatments.

On the other hand, as a problem of education, students cannot remember meridian point notations (Kanji or Chinese characters) and do not feel as much about meridian points.

*functional point means that in a healthy person, that point may not be apparent and that point becomes reactive or apparent when a related disorder or the patient's condition becomes worse.

1-2. Assessment of international standardization of meridian point locations

For the evaluation of international standardization of meridian point locations; 51.7% responded "Has value", 4.6% responded "Does not have value" and 41.7% responded "Neither".

The most common reason for "has value" was because internationalization of acupuncture and moxibustion uses an official common language it would contribute to the development of research, clinical practice, and education.

Table1. Questionnaire 1 (Standardization of meridian points)

Questionnaire 1 (International standardization of meridian point locations)

For questionnaire items, please place a circle within < > when it is applicable, and fill in between parentheses ( ) freely.
1. Institution Name: ( )
2. Name: ( )
3. Occupation: [< > Teacher, < > Researcher on meridians/meridian points,
< > Clinician, < > Other, specifically: ( )]
4. Age: ( ) years old
5. Sex: < Male, Female >
6. Working experience
(1) Teaching experience: ( ) years
(2) Teaching experience on meridians and meridian points: ( ) years
(3) Clinical experience: ( ) years
(4) Research experience on meridian points: ( ) years
7. What do you think about international standardization of meridian point locations?
(1) Has value: < >
Reason: ( )
(2) Does not have value: < >
Reason: ( )
(3) Neither: < >
Reason: ( )
(4) Other comments: ( )
8. In case of medical treatment, what do you think about the use of meridians and meridian points?
(1) Meridians should be considered to be more important than meridian points. < >
(2) Meridian points should be considered to be more important than meridians< >
(3) Both meridians and meridian points should be considered to be of equal importance. < >
(4) Other comments: ( )
9. In the clinic how do you consider treatment points?
(1) I think treatment should adhere to meridian points. < >
(2) I think treatment does not need to adhere to meridian points, but instead reactive points should be treated. < >
(3) I think both meridian points and reactive points should be considered for treatment. < >
(4) Other comments: ( )
10. In your opinion, what kind of theory should be applied to acupuncture and moxibustion treatments?
(1) I think classical theory should be applied to treatments. < >
Reason: ( )
(2) I think western medical theory should be applied to treatments. < >
Reason: ( )
(3) I think that both classical theory and western medical theory should be applied to the same degree. < >
Reason: ( )
(4) Other comments: ( )
11. Have you ever written a paper, book, report, thesis, or printed materials for teaching about meridians or meridian points?
(1) Yes, I have. < >
(2) No, I have not. < >

12. What do you think about the existence of meridian points?
(1) I think they actually exist anatomically. < >
Reason: ( )
(2) I think they have a functional existence and appear only during sickness. < >
Reason: ( )
(3) I do not think they actually exist. < >
Reason: ( )
(4) Other comments: ( )
13. When teaching meridian points, what is the most troubling issue?
(1) Meridian point locations cannot be indicated accurately. < >
(2) Students cannot really sense where the meridian points are located. < >
(3) Students did not know the terms written in kanji (Chinese characters) or had difficulty learning them. < >
(4) Other issue: ( )
14. What do you think about the internationalization of Oriental medicine including acupuncture and moxibustion?
(1) Internationalization is desirable. < >
Reason: ( )
(2) Internationalization is not desirable. < >
Reason: ( )
(3) It does not matter whether internationalization occurs or not. < >
Reason: ( )
(4) Other comments: ( )

15. Standardization of aspects other than meridian points
    (1) International standards should be made for aspects other than meridian points. < >
        Please specify what things you think need to be standardized: ( )
    (2) Standardization of aspects other than meridian points is unnecessary. < >
    (3) Other comments: ( )
16. Did you know that the standard glossary for general Oriental medicine "WHO International Standard terminologies for traditional medicine in the Western Pacific region" was published by WHO/WPRO in 2007?
        I knew. < >, I did not know. < >
17. Do you think it is good for the development of Oriental medicine to publish the standard glossary mentioned above in 16.?
    (1) It is a very good idea. < >
    (2) I t is a good idea. < >
    (3) It is not a very good idea. < >
    (4) It is not a good idea. < >

Table 2. Recovery rate of Questionnaire 1

Training facilities	Number of facilities to which the questionnaire was sent	Number of facilities that responded to questionnaire	Recovery rate (%)	Number of respondents
Universities/colleges	8	2	25.0	4
Vocational schools	95	48	50.5	72
Rehabilitation centers for the visually impaired	7	3	42.9	7
Special needs schools for the visually impaired	63*	38	60.3	53
Related organizations	7	2	42.9	13
Total	180	93	51.7	149

*Of 71 schools, 8 schools that do not have a training course for practitioners of anma-massage-shiatsu, acupuncture and moxibuscion therapies were excluded.

The reason for the response "Neither" is because respondents felt muddled the meridian point locations they have actually used and taught in Japan would move to other locations while valuing standardized acupuncture and moxibustion by a common language.

Also, for international standardization related to acupuncture and moxibustion other than meridian points, 46.6% of the answers were that "there was no need for international standardization". However, for international standardization of Oriental medicine, 66.7% of the answers were affirmative. About the "WHO International Standard Terminologies on Traditional Medicine in the Western Pacific Region[6)]" published by WHO/WPRO, although only 49.3% of respondents claimed "I know it", 92.2% claimed "It is a meaningful publication".

2. Questionnaire 2

Questionnaire 2 asked about the guideline within the contents of the "Official Japanese Edition", which summarizes the policies for deciding those locations and individual meridian point locations.

2-1. About the guideline

There were 47 opinions described, for "Proportional bone (skeletal) measurement method (24)", "Reference meridian points (2)", "Regions of body (8)", "Landmarks on the body surface (9)," "Following the route of the meridian(2) ", and "Other (2)".

2-1-1. The proportional bone (skeletal) measurement method

The length of a forearm was changed from 10 B-cun to 12 B-cun, which lead to many changes in forearm meridian point locations. There were many opinions that 10-cun is preferable since it is easier from a training and teaching point of view.

There was an opinion that when the length of the upper arm (posterior end of the axillary fold - cubital fossa) is 9 B-cun, it is necessary to indicate the Proportional Bone (Skeletal) Measurement of the whole upper arm.

About the center of the navel; the proportional bone (skeletal) measurement method should be according to "*Ling Shu*" not "*Jia Yi Jing*". The meridian point CV2 and Qugu (midaxillary lines) are not the same and there is a difference of 1.5 B-cun in the Chapter 14 Proportional Bone (Skeletal) Measurement in "*Ling Shu*", *Spititual Pivot*, There was an opinion that the meridian point CV2) is at the hairline of the pubic hair, and it is not at the superior border of the pubic symphysis.

2-1-2. Landmarks on the body surface

There were opinions about the reference meridian point for the back, "It should be the vertebra prominens (C7) instead of vertebra magna", "It is necessary to supplement the explanation of the term ‘striation’, and the description of the striation formed on the line connecting the distal end of the styloid of the ulna with the distal end of the radius styloid. When palmer flexion and dorsal flexion are made and two or more striations appear, there is an opinion that striation exists on the dorsum of the hand." Also there were other opinions such as "The junction of red and white skin" cannot be used as an index to locate meridian points for a visually impaired person.

Table 3. Results of Questionnaire 1

Questionnaire items	Choices	Answers	Frequency of choice for each question (%)
Occupation	Teachers	131	84.0
	Researchers of meridians and meridian points	5	3.2
	Clinicians	20	12.8
	Other	0	0.0
Age [years old] *		43.5 (23-77)	
Sex [Name]	Male	109	73.1
	Female	36	24.2
	Unsigned	4	2.7
Work experience [No. of year(s)] *	Teaching experience	11.7 (0.5-43)	
	Teaching experience on meridians and meridians	7.7(0.5-40)	
	Clinical experience	13.5(1-42)	
	Research experience on meridian points	10.7(0.5-24)	
International standardization of meridian points	Has value. <Reason>	78	51.7
	Does not have value. <Reason>	7	4.6
	Neither. <Reason>	63	41.7
	Other <Reason>	3	2.0
Meridians and meridian points in medical treatment.	Place greater value on meridians.	11	7.5
	Place greater value on meridian points.	17	11.7
	Place equal value on meridians and meridian points.	105	71.9
	Other <Reason>	13	8.9
Points of treatment	Using meridian points.	4	2.7
	Not limiting use to only meridian points, but using reactive points as well.	14	9.5
	Combining both ideas.	122	82.4
	Other <Reason>	8	5.4
Theory of medical treatment	Place greater value on classical theory. <Reason>	13	8.6
	Place greater value on modern medicine. <Reason>	16	10.6
	Place equal value on classical theory and modern medical theory. <Reason>	110	72.8
	Other <Reason>	12	7.9
Have you published paper(s) on meridians and meridian points, etc.?	Yes, I have.	51	34.5
	No, I have not.	97	65.5
Existence of meridian points	They actually exist from an anatomical perspective.	42	26.6
	Meridian points that have functional existence and appear only when sick. <Reason>	70	44.3
	I do not think that they actually exist. <Reason>	6	3.8
	Other <Reason>	40	25.3
The most difficult aspect of teaching meridian points	consis	32	16.4
	Students cannot really sense where the meridian points are located.	53	27.2
	Students did not know the terms written in kanji (Chinese characters) or had difficulty learning them.	46	23.6
	Other <Reason>	32	16.4
	Other <Reason>	32	16.4
Internationalization of Oriental medicine including acupuncture and moxibustion	Internationalization is desirable. <Reason>	102	66.7
	Internationalization is not desirable. <Reason>	9	5.9
	It does not matter whether internationalization occurs or not. <Reason>	32	20.9
	Other <Reason>	10	6.5
Standardization of aspects other than meridian points	International standards should be made for aspects other than meridian points. <Example>	45	34.4
	Standardization of aspects other than meridian points is unnecessary.	51	38.9
	Other <Reason>	35	26.7
Did you know that the standard glossary for general Oriental medicine "WHO International Standard terminologies for traditional medicine in the Western Pacific region" was published by WHO/WPRO in 2007?	Yes, I knew.	73	49.3
	No, I did not know.	75	50.7
The significance of publication of a standard glossary for the development of Oriental medicine.	It is a very good idea.	51	36.2
	It is a good idea.	79	56.0
	It is not a very good idea.	7	5.0
	It is not a good idea.	4	2.8

*For age and work experience, mean values and the minimum and maximum values are indicated in ( ).
There is overlap of answers or no answers, The number of total respondents of each item and total of 149 respondents for Questionnaire 1 are not necessarily the same.

Table 4. Views on acupuncture points mentioned in Questionnaire 2

Items	Subitems	Points at issue	Changes, reasons, etc.
Body surface classification	HT2	Medial surface of the upper arm.	It should be "inside part of the upper arm".
	GV14	Posterior region of neck.	It should be "upper back".
	GV3	Lower thigh tibia side.	It should be the inner tibia (Shin side).
Location of meridian point	BL64	It is difficult to locate the meridian point.	It is necessary to mark the area for 'recess'.
	TE16	It is difficult to locate the meridianpoint.	It is possible to locate the fixed point at the same height with the lower jawbone.
	GV17	It is difficult to locate the meridian point.	It is possible to locate the fixed point through the recess in the area superior to the occipital external protuberance. (Note: Paranemic)
	GB20	It is difficult to locate the meridian point.	It is possible to locate the meridian point. (Note: Paranemic)
	GB12	It is difficult to locate the meridian point.	It is possible to locate the meridian point.
Reason for change	GB3	The reason for change from "kyakushujin" to "Shangguan (GB3)."	The ruling by the Acupuncture Terminology Standardization International Conference of 1989 was followed.
	Sequence of KI5 and KI6	The reason for the switch in sequence	The ruling by the Acupuncture Terminology Standardization International Conference of 1989 was followed. Based on 'ebb and flow acupuncture' in "Ling Shu" Channels section.
	ST42	The reason for change in the location of the meridian point.	The change for the location of the meridian point was based on the description of "interosseous artery" in classics such as "Jia Yi Jing".
	Sequence of GB35 and GB36	The reason for the switch in sequence.	The view that "San yang" in the classics such as "Jia Yi Jing" is interpreted as Zu Tai Yang Jing (disease of foot taiyang meridian) is supported as well as the idea that GB35 is located close to GB35 behind the fibula and GB36 in front of the fibula.
	PC9	The reason that only PC9 is said to be located at the tip of the middle finger.	Although there are many explanatory notes in the "Yellow Emperor's Classic of Internal Medicine" that state that it is located in the “inner side”, most of the classics state that it is at "the tip of the middle finger". and only Zhenjiu Daquan (A Complete Collection of Acupuncture and Moxibustion) clearly insists that it is located at the "inner side". The relationship between Ex-UE11 and other “well” points is still unclear.
Description	Meridian points for the head	The description for meridian points from the frontal hairline is not standardized.	The descriptions for the areas "from the frontal hairline" and "the hairline at back of neck" should be standardized.
	“Well” points, excluding PC9	The description is not easy to understand.	The description is complicated but accurate.
	“Web”	The description is not easy to understand.	"Web" is recognized as an appropriate anatomical term.
	The junction of red and white skin	The description is not easy to understand.	It is presently defined as "The body surface index for meridian point localization". However it is necessary to review this definition because it is limited to a visual description.
	TE10	The description is not easy to understand.	The length of “one B-cun” should be determined by measuring the length (9 B-cun) between the anterior end of the outer armpit striation and the bend of elbow; this is located at the recess or olecranon fossa (an explanatory note is given).
Other	ST30	Description of an artery pulsation region may be unnecessary.	Although an iliac artery runs outward, the ST30 does not touch an artery and this description needs to be revised in the future. However, the explanation for the process of locating the meridian point could not be understood by acupuncturists in other countries. In another Japanese translation of other meridian points, the term "artery pulsation region" is used for points where the pulse can be felt and "in artery" for deep acupuncture points in an artery.
	LR14	When using acupuncture, it is advisable to put in a notation which calls for caution to prevent the occurrence of pneumothorax.	Revising the location for this meridian point used in Japan would be a major change. Although the change is justifiable, if it is implemented, it will be necessary to add explanatory notes to most of the meridian points in the thoracic cage region. It is necessary to review whether the description is limited to LR14. ST19 has an explanatory note.
	LR8	The recess between tendons and the striated muscle inner end are not consistent.	By using the inner end of the popliteal space striation as the point of reference, it can be located at the recess between the semitendinosus muscle and semitendinosus muscle tendons.
	LR8	The recess between tendons is not consistent with the striated muscle inner end.	By using the inner end of the popliteal space striation as the point of reference, it can be located at the recess between the semitendinosus muscle and semitendinosus muscle tendons.
	BL10	What areas cannot be touched are indicated.	The height has been determined according to the reference to GV15 in "Meridians and meridian points" (Kazuo Komai) which states "between the first and second cervical vertebrae" and the height of the second cervical vertebrae spinous process superior border can be regarded as the location of GV15.
	ST35	It is at the same location as the outer eye of the knee and not consistent with the eight meridian points for beriberi.	Another theory in past textbooks in Japan was adopted as the regular meridian point, and is at the same location as the outer eye of the knee. According to the “Qian Jin Fang”, the eight meridian points for beriberi is located at the extra point in the recess of the upper region of the outer superior angle; the past conventional view is considered incorrect.
	SI6	One theory states that it should be located at the "ulnar recess," not the radial side of the ulnar head.	According to classics such as "Jia Yi Jing" it can be interpreted to be located at the "ulnar recess"; in Ajioka Sampaku’s work entitled "Igaku Shiyo-sho (Essence of Medicine)", it states that the radial side of the ulnar head has been commonly used, and acupuncturists in the three countries accept this theory.

2-1-3. Region of body classification

There were opinions such as, "It is easier to understand point location given an illustrated region of the body", "Classification of the lateral region of the neck is not specified," and "Classification should conform to the anatomical index".

2-2. About meridian point locations

There were 24 opinions about new meridian point locations. The opinions were divided broadly into region of body classification, difficulty in locating meridian points, vagueness of the reasons for the changes from the conventional Japanese meridian points, unclear notation, and others. Table 4 lists the opinions with the answers.

IV. Discussion

During the WHO official conference held in Tsukuba in 2006, the delegates from two organizations and 9 countries deliberated and reported their findings about international standardization of meridian point locations. And in a supplementary item to the report, in order to encourage the use of the new meridian point locations, a request was made to readers inviting a broad range of views in an effort to update and improve the contents.

According to the supplementary item in Japan the "Official Japanese Edition[2)]" and "Textbook[3)]" on this bases were published, and education about the new meridian point locations was started at colleges for anma-massage-shiatsu, acupuncture and moxibustion practitioners. Furthermore, along with the "Official Japanese Edition", a "Detailed Guideline[4)]" summarizes each meridian point location and shows how the three countries of Japan, China and South Korea discussed meridian points at a non-official conference, which led to the decisions at the official conference in Tsukuba. This was part of the promotional activities of international standardization of meridian point locations by the Working Group of the Second Japan Acupuncture Point Committee. Based on these publishing and activities, at the time after one year had passed since the education about the new internationally standardized meridian point locations had begun, this questionnaire was conducted. With these results and the revision proposal that was created by the Working Group, the Working Group planned to request to host the WHO/WPRO Advisory Committee. But, there was an opinion that it would be difficult to host the conference since in the international realm, the International Statistical Classification of Diseases and Related Health Problems (ICD) as well as the International Organization for Standardization (ISO), and others also examine the field of acupuncture and moxibustion. If a formal conference could not be held, then it was necessary to summarize the opinions voiced at the informal conference with South Korea and China that create a unified textbook, as in the case of Japan, prior to holding the international conference.

1. Questionnaire 1

Questionnaire 1 asked teachers and instructors, etc. their opinions about the existence of meridian points and gathered a variety of answers. Moreover, about the standard meridian point locations determined at this time, although it seems that the respondents feel lost about differences between conventional meridian point locations, fewer than 5% of the answers reported that respondents did not value standardization and even those who answered "Neither" showed agreement with globalization of acupuncture and moxibustion.

2. About the Guidelines

The opinions about the guideline for the "Official Japanese Edition[2)]" and meridian point locations are as follows.

2-1. The proportional bone (skeletal) measurement method

The proportional bone (skeletal) measurement method of the arm, the guidelines only specify "the armpit crease (anterior/posterior) to the cubital fossa: 9 B-cun" and does not specify the length between the acromial angle to the olecranon. Therefore, dimensions for arm meridian points use this 9 B-cun as the standard. With the "Textbook[3)]" although the arm is indicated as 10 B-cun for descriptive purposes, this description causes contradiction in the arm meridian point locations. Therefore, care must be taken whether arm meridian points are located starting from the elbow or from the acromial angle when locating a meridian point accurately. For example, LI14 should be located above LI11, using LI11 as the starting point and TE13 should be located down from the acromial angle. LI14 should be "7/9 of the way along the line from LI11 to the anterior border of deltoid when the line connecting the anterior axillary crease with LI11 is 9 B-cun". Furthermore, TE12, etc. should use L114 as the starting point, while TE13 is "3 B-cun (determined by using the F-cun) below the acromial angle at the posterior lower border of the deltoid muscle". Since the proportional bone (skeletal) measurement method is not determined from the acromial angle to the axillary crease, exact location is determined by using the F-cun. When comparing the height of LI14 and that of TE13, TE13 is slightly higher.

For “the center of the navel – using the superior border of the pubic symphysis, 5B-cun”, ("Ling Shu 8"), the proportional bone (skeletal) measurement method describes the distance "from navel to pubis is 6.5 B-cun". At this time the accepted description is "on the line from the center of the navel to the public symphysis, 5 B-cun" in "Shen Ying Jing[9)]" and the description "For the line under the center of the navel to the pubic symphysis (qugu, RN 2)" in "Lei jing [10)], 5 B-cun".

2-2. Region of body

About region of body, "Japanese Edition[2)]" indicates the classifications and boundaries in the "Nomina Anatomica Japonica[11)]," which is pursuant to "Interna-

tional Anatomical Terminology". But, there are some meridian point locations which can be considered to be inappropriate in region of body. Furthermore, there are some points that are imaginable only as a linguistic expression, and illustration should be a matter to be reexamined at the review meeting.

2-3. Meridian point locations

Table 2 shows the opinions and answers about meridian point locations. Most of the answers were based on the "Detailed Guideline[4)]".

For international standardization of meridian point locations, although the names of meridian points were determined at the Geneva meeting in 1989, it was not accepted at that time. WHO/WPRO took the lead, and Japan, China, and South Korea drafted a document after 2003, and agreement was reached at last in 2006. Mayanagi[7)] reported that standardization of meridian point locations was attempted three times during the approximately 2000 year history of Oriental medicine. He also determined that the first attempt was a "concept level" (about the 1st century), second was "theory level" (about the 2nd century), and third was "national level" (11th century). Then he placed international standardization of meridian point locations according to classical writings this time as an international diffusion into the modern era, and the fourth is "Objective standardization on a world level". Furthermore, Lim[12)] also assessed the significance of international standardization of meridian point locations.

In Japan, those who teach meridian point locations or meridian points are temporarily confused, since there are many changes from conventional meridian point locations. However, in regard of the determination of meridian point locations by careful palpation, which is considered to be a special feature of Japanese acupuncture and moxibustion, some clinicians think that the standardized meridian point locations do not deviate greatly from the range of palpation in routine medical care, except for some meridian points, and the standardized meridian point locations are used as reference in routine medical care. In Japan, clinical palpation is thought to be important, and there is enough of a possibility to develop standardized meridian point locations while respecting the meridian point locations based on classic writings.

Based on these valuable opinions, through the 5-year proliferation period after international standardization in 2006, it was necessary for Japan, China, and South Korea to create a draft for reviewing, to make efforts toward revision, and also to consider how to deal with the 6 meridian points that have two locations and the extra point locations. It is necessary to press to understand the answers about the issues pointed out in the questionnaire, and also to summarize Japan's proposal for the revision, include them and discuss them at the official conference.

V. Conclusion

One year passed since education on meridian point locations based on WHO/WPRO international standardization acupuncture point locations, and the questionnaire survey was administered to teachers mainly at training facilities for anma-massage-shiatsu, acupuncture and moxibustion therapies on 1. opinions about meridian points and meridians and evaluation of standardization of meridian point locations, and 2. concrete issues about the guidelines, meridian point locations, etc. Accordingly, answers were obtained from 149 people from 93 facilities out of 180 surveyed facilities. Consequently, it is recognized that there is a diversity of opinions about meridian points and meridians in 1. However, even though there are different valuations of standardization of meridian point locations, it is agreed that standardization is good for acupuncture globalization. For 2, among the guidelines, the most opinions were expressed about proportional bone measurement. For each meridian point location, there were opinions about the difficulty of locating meridian points, ambiguity of reasons for the change, notation of the locations, etc.

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