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Acupuncturists as Entrepreneurs: Experiences of New Professionals Founding Private Practices

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Acupuncturists as Entrepreneurs: Experiences of New Professionals Founding Private Practices

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ABSTRACT

The entrepreneurship aspects of private professional practice has been largely overlooked in both the literature and most graduate school professional programs, including acupuncture and oriental medicine (AOM). Because self-employment in a private practice is the path for the majority of acupuncturists at the present time, they must exhibit entrepreneurial behaviors, and they receive little support from the profession. This research explored 12 new professionals' experiences founding their private practices in depth using narrative methodology in order to gain insights to guide future research and interventions.

Analysis focused on cognition/perception **(C)**, social capital **(S)** and entrepreneurial learning **(L)** process aspects in the experiences of these professionals at the individual, community/profession, and larger society levels using Salzer's (1998) and Rappaport's (1994) conception of socializing influences as lenses. All three factors appear to be important to entrepreneurship in a professional context, and they interact with each other on multiple levels.

As to Cognition/Perception (C), the study found that those embracing entrepreneurship aspects of practice had enhanced success, while those resisting it experienced difficulty until their perceptions changed. Thus, findings supported Hofer and Sandberg's (1987) contention that entrepreneurship can be learned. As to Social Capital (S), those whose focus is inward and engagement is primarily within the profession experienced isolation and difficulty to a greater degree, while those who engaged the larger society and built cross-profession

networks found their connections more satisfying and helpful. Those who adopted an outward-looking, society-focused, transformational vision for their practice seemed to enjoy the most business success, professional development and satisfaction. As to Entrepreneurial learning (L), Daley's (1999) novice-to-expert professional development model was adapted to describe mutually-reinforcing, interactive professional and business learning trajectories. Those engaging in experiential learning and reflective behaviors reported increased levels of both business and professional development. Participants provided a rich trove of insights based upon their experiences that may be helpful to new professionals starting private practices, including seeking a business mentor rather than one from the profession at first, engaging the larger society with a transformational healthcare vision, locating in an underserved area and removing cultural barriers as important practices.

Recommendations for future research and suggested interventions for improving experience and outcomes for new professionals are offered.

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APPROVALS

CHAPTER ONE: INTRODUCTION AND RATIONALE FOR THE RESEARCH

Who Are Acupuncturists?

Acupuncture and Oriental Medicine (AOM) is a system of healthcare originating in China some 2,500 years ago. It includes several allied disciplines used in a holistic, systematic fashion, including acupuncture, herbal medicine, tongue and pulse diagnosis, and therapeutic massage. Acupuncture is the use of hair-thin needles inserted in the skin to stimulate specific points corresponding to the systemic need of the patient. In 21st century America, an "acupuncturist" is likely to use some or all the modalities in concert, even if he or she centers practice on acupuncture. In this paper, we will use the term "acupuncturist" in this more inclusive manner.

In most states in 2015, acupuncturists may be either an MD who has received additional training in acupuncture technique or a Licensed Acupuncturist (LAc). LAcs typically have Master's or doctoral degrees and have passed national board exams in order to practice. Training for LAcs includes over 3,000 hours of classroom and clinical training; MDs may have as little as 600 hours additional training in this discipline.

AOM is one of the branches of complementary and alternative medicine (CAM) overseen in the USA by a special branch of the National Institutes of Health, the National Center for Complementary and Alternative Medicine (NCCAM). Most sponsored research into the efficacy of AOM is funded through NCCAM. Because of the lack of current perceived profit potential for the private sector, particularly of herbal formulas and acupuncture treatments, there are few private companies or organizations investing in

the kind of rigorous double-blind studies needed to make the case for AOM's integration with the Western medical mainstream. Therefore, sponsored AOM research lags and its adoption is led by the public rather than the mainstream healthcare or pharmaceutical industries. As a result, acupuncture use by the public is still fairly small. According to the 2008 National Health Information Survey of complementary and alternative medicine use (Barnes, Bloom & Nahin, 2008), just 1.4% of the adults in the survey had used acupuncture in the past year, compared to over 8% for chiropractic, for example. The same survey reported rapidly increasing usage when compared to 2002 results however, while chiropractic use growth rates were flat.

Though the earliest practitioners of Chinese medicine in North America were Chinese immigrants, most practitioners today are no longer of Asian descent. According the 2008 NCCAOM Job Task Analysis survey, just 21.6% of respondents were Asian, while over 70% were white (Ward-Cook & Hahn, 2010). They are also most likely to be female, aged early 30s, highly-educated, and have chosen AOM as their first career choice (Sloan, Reeves, Sledd & Stein, 2012). Though the majority of practitioners are no longer primarily clustered in the major cities of California, the state still hosts about a quarter of all AOM practitioners in the USA (Acupuncturist Density Map, September 3, 2014), and the distribution of the other three-quarters is far from even. Both coasts and the Sunbelt regions have seen especially strong growth in numbers over the past ten years, while acupuncturists in the central states are still relatively rare and regulatory environments are less welcoming in general to the medicine.

What This Research Can Contribute

Contribution to the AOM Profession

The AOM profession is still fairly early in its development, without strong sponsors lobbying to protect its interests in the public space or to advance its adoption into the mainstream medical system. Without strong economic drivers to pique financial support by the private business sector as seen in much of the rest of the US medical care system, the profession remains largely marginalized. Without strong organizational leadership at the national level or compelling legitimacy in the eyes of new graduates, the professional association structures in place for acupuncturists currently do not provide the kind of support, help with integration into the profession, guidance and accountability that are available in many other professions upon graduation and licensure (notably mainstream medicine and law, to name two). Compounding the risk, most new acupuncturist graduates are constrained to start and run their own professional practice businesses without help from the profession or their teaching institutions, and many lack any business or management experience (New Student Survey, 2010, 2011 as examples). In summary, graduates leave AOM graduate schools to launch professional practice businesses in a hostile environment, often with a lot of debt and little knowledge and experience that might serve as a guide. There exists very little high-quality research into the outcomes of these professional practice efforts, and the research we have raises more questions than it answers. In view of these rather unfavorable environmental characteristics and how little we know about acupuncturists' experiences after

graduation, the primary focus of this research was exploratory, aiming to provide a basis for future inquiry.

Contribution to the Understanding of Entrepreneurship

In addition to contributing to the understanding of acupuncturists' professional practice startup experiences, the research explored opportunities to contribute to the understanding of entrepreneurship as well. First, there exists little useful entrepreneurship research at present into the special needs and constraints of a professional practice venture. Adams (1980), Blane (1991), Colyer (2004) and Backof and Martin (1991) described the characteristics of professions that distinguish these businesses from other entrepreneurial ventures: They depend on the principal's licensure based on a specialized knowledge and technical ability; the professional is autonomous yet accountable in practice of their profession; they are constrained by codes of conduct and ethics; there is a public service component that must be realized to maintain legitimacy; and governmental and professional oversight bodies have a much larger stake in business decision-making and strategy. These constraints often confound the kind of growth scale that would attract venture capital (or even bank lending). Still, there may be room within this highly constrained business type to develop new models and approaches that would increase satisfaction, sustainability and economic outcomes for those in professional practice businesses.

Second, understanding the process of founding professional practices in one professional discipline could perhaps provide insights for improving outcomes across a

number of other disciplines where private practice is common, such as veterinary medicine, counseling, social work and clinical psychology, to name a few. While some professions have well-developed induction and support structures in place through strong professional associations or large numbers of paid employment opportunities available to graduates just starting out, many in these other professions do not. They are facing similar challenges to acupuncturists in starting and maintaining successful and satisfying practices in their own fields. In recent years, even established professions have endured great turbulence, leaving many professionals unemployed or considering striking out on their own. What is learned in this project could potentially be useful to administrators in higher education, academics and practitioners in a range of other disciplines as well.

Third, and perhaps the most compelling reason for this project, however, lies in the moral and ethical responsibility an institution of higher learning has to provide students in professional training programs with readiness for the chosen career path. Because self-employment in a professional practice is the dominant path for the overwhelming majority of acupuncturist graduates at the present time, they must be familiar with and exhibit entrepreneurial behaviors to practice in their chosen fields or face marginalization or failure. It is well-known that today's graduate students on average carry more debt going into their professional career than ever before, further raising the personal long-term financial risk a graduate takes in entering this career. If the training institutions preparing these professionals do not address the post-graduate practice realities and needs in addition to the specialized knowledge and techniques of the craft,

they will forfeit legitimacy in the eyes of regulators (particularly the US Department of Education, the primary student lender), the public and the students themselves.

Rationale for the Research and Methodology

Support from the Literature

At present, there is very little knowledge of what the experience of transitioning into the AOM profession and founding a private practice is really like. We do not know what meaning these professionals make of the experience and how that subjective understanding shapes the ways they choose to structure their businesses, approach business strategy and ultimately, how it shapes outcomes. In such a situation as this, the best way of gaining this knowledge, according to Creswell (1998, 2009) and Denzin and Lincoln (1994), is a qualitative study, focusing on a social or human problem, where the researcher builds a holistic understanding of a complex phenomenon by analyzing the words of the informants and interpreting the phenomenon through the meanings the informants bring to the experience. Ragin (2014) further contrasts qualitative inquiry's focus on a few cases and many complex variables and interactions with the dominant quantitative research paradigm where researchers deal with many cases and a few controlled variables. Given the lack of foundational understanding into what variables may affect the professional start up process of acupuncturists and others founding private practices without strong support structures, quantitative methods are necessarily of limited usefulness. Qualitative inquiry methods, therefore, seem to be the most useful in beginning to shed light onto the complex research area considered in this study.

Once qualitative inquiry methods are deemed appropriate to approach the research area under consideration, the objectives of the research drive the research design choices (Creswell, 1998, 2009; Seidman, 2006). I started with a social constructionist philosophy (Berger & Luekmann, 1967; Lincoln & Guba, 1985) assuming that the subjective meanings people make of a common experience and its challenges are socially constructed on multiple levels of interaction including personal, professional community, and larger society levels (Salzer, 1998).

Sarbin (1986) characterized the personal narrative as an essential psychological and sociological construct of human existence, providing the organizing principle for understanding human action, experience and sense-making. In recent years, use of personal narrative has provided a powerful and useful tool for research in sociology (Hughes, 2009; Karnieli-Miller, Taylor, Cottingham, Inui, Vu, & Frankel, 2010; Scott, 2011), psychology (Hammack, 2008; Taylor, 2006) and other disciplines such as history (Rigney, 2010; Ronfeldt & Grossman, 2008) and entrepreneurship (Johansson, 2004), where human sense-making is at the core of research. Many of the narrative studies using the story method, especially Johannson (2004), Kucera, Higgins and McMillan (2010), Daley (1999), and Hughes (2009), allow observers to go deep into the thought and reflection processes of the individual as he/she interacts with self, community and larger society to make sense of and successfully adapt to experience. By opening a window to these inner processes, the story method provides an excellent fit between the research problem and the method chosen to collect data. Therefore the research approach centered on collecting narratives from a variety of acupuncturists currently in practice to learn

their stories of transitioning from being a student to a professional in private practice, capturing their subjective perceptions as well as the chronology of historical events, and inviting reflection on the experience. By enabling the participants to reconstruct personal stories of the experience, a fuller, richer understanding of the phenomenon appears, one that is necessary for charting a course for future research.

In this research project, the objective was to understand the individual experiences, as constructed by the participants in collaboration with the researcher (Lincoln & Guba, 1985) through the creation of stories with beginnings, middles and ends with narrative devices such as themes and settings as well as characters and plot. The interview method further enhances meaning by focusing attention on distinct context, history and reflection phases of questioning in order to ensure that the story told conveys as much meaning as possible for the hearer as well as the narrator (Schutz, 1967; Seidman, 2006). The use of open-ended questions allows the participant room to make decisions about what is important to the story, (Seidman, 2006), and targeted prompts tied to the central constructs under inquiry anchor the personal narrative to the research questions under consideration (Haigh, 2008).

As mentioned previously, the narrative construction approach to research is broad and complex involving a continuum ranging from cognitive objectivist approaches, which position narrative as the 'expression' of an underlying identity (such as Schank and Abelson, 1995), to more social constructionist accounts which prefer to emphasize the active nature of narrative in identity construction (for example, Gergen & Gergen, 1988; and Sarbin, 1986). In this project, I sought to add depth to the understanding of the

process context by identifying the socializing influences within the individual, his/her interactions with the professional community and the wider societal view that impacts the path of the profession as a whole (Salzer, 1998). By adding narrative analysis for these layers of interaction, a more multi-dimensional view of the phenomenon arose, perhaps shedding more light on the processes at work. Given the importance of socializing influences to the study, I adopted a social constructionist position in which I assumed that participants are expressing through narrative an identity that is being constructed as the participant interacts on the personal, professional community and larger society levels as suggested by Salzer (1998).

Finally, it was my objective to examine the "entrepreneur" embedded in the personal narratives in order to contribute to understanding of entrepreneurship as a discipline, particularly how this subset of entrepreneurs' cognitive, social and learning processes are involved in founding and developing a private professional practice. By undertaking this project, my ultimate goal was to gain insights into improving both the business and professional development progression as described by Dreyfus and Dreyfus (1980) and Daley (1999), enhancing the career satisfaction of AOM and other new professionals in private practice.

Research Questions and Focus Areas

The key objective of this research was to seek deeper understanding of an under-researched phenomenon, the transition process that new professional graduates must navigate in order to establish successful private practices. I sought understanding through

participants' thoughts, feelings and interpretations of experience within the socializing influences of self, community/profession, and the larger society (Salzer, 1998) as expressed in constructed narratives (Sarbin, 1986). Within these levels of interaction, I looked for instances of how factors such as internal cognition/perception, social capital, and entrepreneurial learning helped to shape the experience of the participant. For ease of reference, these three general factor categories are referred to as C (internal Cognition/Perception), S (Social Capital), and L (Entrepreneurial Learning). Summarizing the topics by level of socializing influence, I then organized the research focus into the following matrix:

Figure 1. Interaction of professional entrepreneurial constructs with Salzer's (1998) levels of socialization during the founding process of a professional practice

Levels of Socialization	Cognition/Perception factors	Social Capital factors	Entrepreneurial Learning factors
1. Individual	C1-Individual perceptions and thought processes at work during the founding process	S1-Individual's social capital impact on business founding and outcomes	L1-Individual learning processes during founding
2. Profession	C2-Individual's perceptions about the professional community's support and relation to profession	S2-How the individual fit into the professional community and interacted with it over time	L2-Contribution of the individual's professional network and organizations to learning
3. Society	C3-Individual's perceptions of how he/she is seen in society as an acupuncturist, including mainstream medicine, development of individual/society relationship	S3-How the individual used social capital to interact with the larger society level, building a market niche, managing business environment	L3-How the acupuncturist learned to relate his/her practice to the larger society and built/maintained legitimacy

While I have organized the concepts from the literature into neat categories in this framework, the qualitative process is, as Bloomberg and Volpe (2008) point out, "messy," requiring a certain flexibility of design that allows for the research to address unforeseen issues and insights as the research process unfolds. I recognized that there might be multiple ways of categorizing the data, and the neat categories might overlap or interact with each other in unexpected ways. I also approached this project aware that iterative data analysis might call for refinements or changes in emphasis (Creswell, 2009; Swanson & Holton,

eds., 2005; Bloomberg & Volpe, 2008.) In this study, this involved recognition of the dual nature of the professional and business development processes that arose in data analysis, for example.

Whatever one may learn from this study about the professional entrepreneurial process in the realm of AOM, the ultimate aim of the research is to ensure that the voices of the participants are heard faithfully in their own narratives. By being mindful of *meaningful intent* as well as stated content of the interviews and by employing a collaborative narrative creation process (described in Coffey, 1996, and Harrison, MacGibbon & Morton, 2001, for example), I hoped to provide a catalyst for the participants and stakeholders in post-graduate professional education to raise unconsidered issues, to give useful feedback to educators and to spur improvements across professional school curricula that result in successful, satisfying practices after graduation.

Terms of Reference and Definitions

AOM – Acupuncture and Oriental Medicine, refers to an ancient medical profession using acupuncture, herbal medicine and therapeutic massage.

Cognition/Perception – A psychology construct, refers to the way one perceives and frames his/her reality, such as opportunities, risks, attitude toward difficulties, etc.

Entrepreneur – a person who founds a new venture for the purpose of fulfilling a vision larger than merely supporting himself/herself economically.

Entrepreneurial learning – The process in which a founder applies experience, observation and reflection to affect a lasting positive business trajectory.

Narrative – A story, a sequence of connected events with a coherent plot, characters, setting and themes used to make sense of experience and express identity.

Narrative construction – A person constructs an identity through making sense of an experience through the story-telling process.

Profession – A mission-focused service industry practicing a particular skilled craft, constrained by licensure, common mores, ethics, codes of conduct, professional judgment and public service motive.

Social capital – The sum of embedded skills and abilities a person has that enable him/her to effectively operate within social networks.

Social construction – Identities are constructed in a social context, e.g., in interaction with the self, one's community and with society as a whole.

CHAPTER 2: LITERATURE REVIEW

To provide the proper basis for this study, we will first examine the general entrepreneurship literature that provides the theoretical foundation for understanding the process and the conceptual factors involved in starting any business enterprise, together with the dynamics affecting its performance and survival in the early stages of establishment. Because consideration of entrepreneurship within the professions is a neglected topic within the larger study of entrepreneurship, it is also important to consider the special constraints imposed by membership in a profession. These include the special linkages with others in the professional community, licensing requirements, regulation, codes of ethics, and the expectation of community service to name a few. In spite of these special constraints, however, professionals starting private practices are engaging in the entrepreneurship process. The ability to develop an economically successful practice context may be essential to finding satisfaction as a practicing professional.

Once the broader entrepreneurship literature is considered, especially in the professional domain, the focus turns to the acupuncture and oriental medicine (AOM) profession, one which is fairly new and somewhat obscure as yet in the USA. Because there has been little high-quality research into the AOM profession to date, and because there are few truly generalizable findings regarding acupuncturists' businesses, it is advisable to begin with an exploration of the history and context of today's AOM profession. By understanding the geographic, demographic and environmental factors

that provide the context, a foundation for further research and deeper understanding of the profession and the professional can take shape.

Part I: Review of the Applicable Entrepreneurship Literature

This study is concerned with the experiences of a group of professionals entering careers that primarily are entrepreneurship-based. By this, I mean that the majority of new graduates must conceive, build and grow their own independent business ventures in order to practice their profession (consistent with the definition of entrepreneurship as used by Chrisman, Bauerschmidt and Hofer, 1998). It may be true that many in the profession do not see themselves as "entrepreneurs" in the sense that they are not primarily motivated to build a growth-oriented business enterprise or "innovate". In spite of this (and with apologies to Gartner, 1990), each self-employed acupuncturist pursues a profession in which business development and entrepreneurial activities are necessary and critically important activities, so consideration of the entrepreneurial aspects of founding a practice cannot be ignored.

The literature on entrepreneurship provides the most useful framework for understanding the new venture founding phenomenon and resulting practice success outcomes. Following Gartner's (1988) admonition to clearly define the entrepreneur before designing the research, I have chosen to define these entrepreneurs as professionals who must engage in business planning, strategy formulation, and start-up activities to launch their practices, and once launched, do the ongoing work of gaining

customers (patients), managing operations and guiding the course of the business' life cycle. In this study, therefore, those who are "merely self-employed" are entrepreneurs as well as those who build innovative new structures for doing their craft. They can be treated as variations along a special sort of professional entrepreneurship continuum.

The scholarly study of the general entrepreneurship phenomenon is relatively new, dating from the 1970s and early 1980s. In those early stages of conception prior to much empirical research, entrepreneurs were primarily considered through the lens of their macroeconomic contributions, as in Schumpeter (1934). They were widely assumed to be a breed apart, that their ability to start and grow new ventures successfully was due to some sort of set of innate personality traits that made them special, such as abnormally high tolerance for risk and ambiguity, a high locus of control, and an innovative creativity the average person could not emulate (McCraw, 2010; Scott, 1965). The empirical studies undertaken in the 1980s failed to support these contentions to a great degree, particularly a generally higher preference for risk-taking. In addition, they showed much more complexity in the entrepreneur's behavior than previously thought (Brockhaus, 1980; Dyer & Sarin, 1982; Keller, 1985; Weber & Milliman, 1997), shifting researchers' attention to the new venture itself and the processes by which it is created for insight into the entrepreneurship phenomenon. This line of inquiry has been far more fruitful in terms of understanding new businesses, how they start and how they might survive and thrive no matter what flavor of entrepreneurship is being employed. The literature relating to the new venture, the nascent entrepreneur and their interaction during the startup process are explored next.

Entrepreneurs, Entrepreneurship Framework, and the Startup Process

The systematic study of the entrepreneurship phenomenon is relatively new, dating from the early 1980s. Prior to that time, when thought was guided by more by theoretical macroeconomic assumptions and cultural myths (Brockhaus, 1980; Chell,1985), entrepreneurs were assumed to be a breed apart, that their ability to start and grow new ventures successfully was due to some sort of set of innate personality traits that made them special, such as higher tolerance for risk (Palmer, 1971; Brockhaus, 1980; Hornaday & Aboud,1971) a high locus of control (Kets de Vries, 1977; Pandey & Tewary, 1979), a high need for achievement (McClelland, 1967), ability to identify opportunities and an innovative creativity not found in the average person (Burch, 1986; McCraw, 2010; Schumpeter, 1934; Scott, 1965). While this "entrepreneurial personality" assumption has remained popular in some form ever since, more recent empirical studies have established a more complex picture and debunked some of these contentions completely (such as in Caliendo, Fossen & Kritikos, 2009; Hongwei & Ruef, 2004; and Rosen & Willen, 2002). The evolving understanding of entrepreneurs, the enterprise and entrepreneurship owes much to perspectives, influences and advances in other disciplines.

For example, in the 1980s, open systems theory and the resource-based theory of the firm provided the basis for taking a more input-based, configurational approach to understanding how organizations work based on identifying and manipulating variables within a system. The current dominant new venture performance (NVP) framework

paradigm championed by Chrisman, Bauerschmidt and Hofer (1998) is an attempt to describe new ventures as open systems comprised of interacting variables or component constructs.

In the 1990s, advances in the fields of neurobiology and sociology contributed to understanding how human cognition, perception and social networks impact personal efficacy. For example, social capital (Kenney, 1994; Nahapiet & Ghoshal, 1998) and emotional intelligence (Goleman, 1995) are two social psychology concepts that made their way into the research and theory of entrepreneurship largely in this decade. In historical terms, watershed developments in other disciplines have been systematically applied to entrepreneurship and new venture performance, leading to an ongoing process of reconsideration and redefinition of the field. There is no reason to assume that this process will not continue in the future, providing still deeper understanding of the phenomenon. While the established framework components as established by Chrisman, Hofer and Bauerschmidt (1998) provide the conceptual basis for understanding a new venture, there are three additional factors supported in the literature since 1998 that may help in understanding the entrepreneurship phenomenon in general and this research project in particular.

It is perhaps important to note that there is no single agreed-upon terminology to define the individual parts of the evolving conceptual framework for new venture creation and performance. Scholars have variously referred to these aspects of the framework as variables or system variables, factors, components or constructs without regard to whether the research is qualitative or quantitative. In relation to this study, I will

use the terms interchangeably, with the term "variable" meaning a conceptual factor that interacts with other factors and not in the quantitative sense unless specifically noted.

The New Venture Creation Framework and Its Evolution

While general "entrepreneurship" has been the fodder of theorists for some time in the domain of economic theory, the generally-accepted starting place for the study of new venture creation is William Gartner's (1985) conceptual framework. In this watershed article, Gartner described four mutually-interactive system components of a new venture:

1. *The individual*. Gartner included embedded personality factors of the entrepreneur in this variable (need for achievement, locus of control and risk-taking propensity), but he also included other areas such as previous work experience, whether parents were entrepreneurs, age and education as well, widening the conception of the entrepreneur to include the whole of the founder's *human* capital, skills and experience brought to the new venture.
2. *The environment*. Gartner was arguably the first to apply the open systems perspective made popular by Katz and Kahn (1966) to the new venture, including the environmental context in which it is brought forth. In his framework, the environment interacts with the other variables in shaping the organization's needs, structure, and the processes by which it operates. Some of the environmental factors he included in this system variable were: location,

governmental influences, availability of venture capital, technical ability of the labor force, barriers to entry at work in the industry, level of competition in the marketplace and the accessibility of potential customers.

3. *The organization*. In Gartner's model, the environmental factors and the individual makeup of the entrepreneur interact to shape the emergent organizational configuration, not just its structure, but also its need for specific resources and the way those resources are deployed. He included business strategy under this heading as well, as strategy can be seen as the collective way an organization has chosen to interact with its environment.
4. *The process*. The framework is completed by the addition of a fourth component, the process by which the new venture comes into being. In Gartner's model, the startup process provides a context for factors to interact and shape the formation of the business. In addition, the process itself varies depending on the type of business, the industry and the unique requirements of the startup process. Internship and licensure, decisions about financing or obtaining specialized permits, for example, may be required at certain stages of the process. Whether and how these are accomplished may have direct, meaningful impacts on the other variables as well. Reynolds (1995), extending Gartner's model relating to process, likened it to the biological life cycle of an organism, having conception (idea), gestation (planning and preparation), and birth (launch) stages that have differing activities, goals and resource needs.

Once Gartner's framework was published, other scholars sought to extend and refine it to improve its usefulness, particularly in seeking a way to understand the factors involved in new venture performance and persistence. Hofer and Sandberg (1987) built upon Gartner's open systems approach in creating their own rudimentary framework for new venture performance. Their framework theorized that new venture performance (NVP) is a function of the entrepreneur (E), industry structure (I) and the strategy of the venture within the industry (S), expressed as:

$$NVP = f[E, I, S]$$

Interestingly, they focused on the entrepreneur's behaviors in new venture creation, excluding personality and other internal drivers and characteristics. They sought to show that industry structure (I) was the most important variable in new venture performance, and they relegated entrepreneurial psychology, human capital and personality to *motivations* to start a new venture, not to its performance (Hofer & Sandberg, 1987, p. 22.) In particular, they attributed an entrepreneur's primary contribution to new venture performance to perception of the environment and willingness to act, to personal efficacy in acting and to the ability to persuade others to act. Since they focused on the entrepreneur's behaviors, they suggested that successful entrepreneurship could be taught. This framework was a decidedly high-level, functional open systems view of the firm in its industry context, and Hofer later collaborated with Chrisman and Bauerschmidt (Chrisman, Bauerschmidt & Hofer, 1998) to produce a major refinement extending the model:

$$NVP = f[E, I, S, O, R], \text{ where}$$

E = Entrepreneur. As in the Hofer and Sandberg (1987) model, this includes the founder's behaviors and actions, but also the sum of personality characteristics, technical skills, education, experience and values brought to the startup. Though this model expanded the conception of the entrepreneur in the ultimate success of the venture, Chrisman, Bauerschmidt and Hofer emphasized the entrepreneur's "behaviors and decisions" as the important determinant within this construct. In this model, it is important to note that the entrepreneur (E) was considered to be a static entity, e.g., the characteristics brought to the process. The internal factors driving the entrepreneur were largely unknown.

I = Industry Structure. As in the original model, industry structure recognizes that every industrial environment is different, and industry has much to do with how businesses within it operate. Industry structure includes competitive dynamics, demand for the product or service, supply chain and production factors, barriers to entry, the nature of the product or service itself and environmental factors.

S = Strategy. Owing much to Michael Porter's "Five Forces" (Porter, 1979), inclusion of strategy as a determining variable points essentially to how a particular firm will order itself to compete effectively in the given industry. Strategy includes competitive and adaptive strategies, risk management and the chosen business model.

O = Organization. This new variable, added by Chrisman, Bauerschmidt and Hofer (1998) in the new venture performance framework considers how the emerging venture is structured, including its operational systems, but it also recognizes the

contribution of its culture and values that shape how the organization interacts with others (Schein, 1993).

R = Resources. The work of Jeffrey Pfeffer and others into resourced-based theory (Pfeffer & Salancik, 1978) and its development in the 1980s raised the issue of how resource availability and competition for resources affects new venture outcomes. In resource-based theory, the outcomes of the firm depend directly on the human, financial, technical, knowledge, relational and other resources available. Pfeffer and Salancik (1979) theorized that how a venture is organized is directly dependent upon the requirements faced in the search for resources. Firms will be structured in the most optimal way to obtain the resources they need to compete in their environmental ecosystems. In applying resourced-based theory to entrepreneurship, Cooper, Gimeno-Gascon and Woo (1991) developed a predictive model of new venture success and growth based on measures of three general categories of resources available at start-up: capabilities, knowledge and financial. Further, they found that the resource types needed for survival were not the same as required for growth of the venture later.

The Chrisman, Bauerschmidt and Hofer (1998) NVP framework remains the dominant paradigm for conceptualizing, assessing and predicting new venture performance in 2015.

More recent insights into entrepreneurship from research

By the late 1990s, the open systems approach to new ventures with emphasis on resource acquisition needs as driver for the new venture development process was widely

accepted, but many scholars were not sure that this resource-focused model explained everything, particularly the diversity of ventures within the same industrial ecosystem. Even more problematic, the entrepreneur as an individual with internal and external interactions remained an enigma. Given the evidence of the "paramount importance of the entrepreneur" (Herron, 1990; Herron & Robinson, Jr., 1993) in new venture performance, a model that considered only external manifestations of behaviors and decisions seemed unsatisfying and incomplete. Seeking to "lift the veil" obscuring understanding of the entrepreneur, scholars applied emerging knowledge from biomedicine, psychology and sociology to entrepreneurial research, seeking to find out whether and how brain chemistry, cognition and social relationships of the founder play a role in new venture performance. Findings from the research, notably Baron's (2000) *Psychological Perspectives on Entrepreneurship: Cognitive and Social Factors in Entrepreneurs' Success*, spurred a flurry of subsequent research that is now providing new levels of insight into how *cognition and perception* (see Arenius & Minniti, 2005; Baron 2004; Gatewood 2002, et al., as examples) and *social capital* (as exemplified by Baron & Markman, 2000; Davidsson & Honig, 2003; Pirolo, 2010) might operate to make some entrepreneurs more successful than others. In the education arena, research into *learning and socialization processes* of professionals (as in Daley, 1999, 2001; Walker & Redman, 1999; and Pfeifer & Borozan, 2011) are adding to understanding of how entrepreneurs in the professions might speed the learning curve, improve decision-making processes and apply learning from other disciplines for solving strategic and business problems. These three new factors are considered next.

Cognition/Perception in entrepreneurship

Cognition/Perception as a construct refers to the way the principal actor perceives and frames the opportunities, risks, encountered difficulties, possible options and decision-making approaches in the process of new venture founding. Entrepreneurial cognition/perception is conceptually parallel to the essential constructs of Social Cognitive Theory (Wood & Bandura, 1989; Lent, Brown & Hackett, 1994), including assumption of self-efficacy in task accomplishment, positive outcomes expectations and goal orientation. Entrepreneurial cognition/perception as described in the literature to date includes attitudes toward risk (Caliendo, Fossen & Kritikos, 2009; Forlani & Mullins, 2000), confidence in one's business acumen (Gatewood, Shaver, Powers & Gartner, 2002), attitude toward being in a self-employment situation (Block & Koellinger, 2009), willingness to deal with the inevitable challenges and difficulties of the operations (Foo, Uy, & Baron, 2009; Van Gelderen, Thurik & Patel, 2011), and the expectations the founder brought to the venture (Gatewood, Shaver, Powers & Gartner, 2002).

With one who is founding a professional practice, there are additional professional expectations toward patients, colleagues and oversight bodies, and the public (Adams, 1980; Buckner, 1992; Daley, 2001; Krejsler, 2005). Some of these include defining a "professional" mode of interaction with patients and peers, choosing a marketing strategy that is in line with the mores of the profession, conforming to regulatory and licensing requirements, and communicating authoritatively the special

knowledge of the profession to the public. These professional expectations provide another lens through which the founder processes his/her perceptions of the experience.

If an entrepreneur's cognition patterns and perceptions are not static, but dynamic, as proposed by Unger, Rauch, Frese and Rosenbusch (2011), among others, then cognition/perception and resultant "decisions and behaviors" (Chrisman, Bauerschmidt & Hofer, 1998) are moderated by knowledge transfer processes and current learning experiences. In this view of entrepreneurship, the entrepreneur's behaviors are driven by developing, malleable perceptions and ongoing learning processes rather than an innate, unchangeable personality. Recent research (notably Arenius, 2005; Baron 2004; and Gatewood, Shaver, Powers & Gartner, 2002) seems to better support perception/cognition as the driver of these internal processes rather than embedded personality. If this view turns out, upon further research, to be a more accurate picture of the dynamics at work, it would have far-reaching implications for entrepreneurship and professional education.

The role of social capital in entrepreneurship

An entrepreneurial venture always takes place in a social context, and an entrepreneur's ability to successfully engage with and use social networks to obtain resources, information and customers is central to survival. In this context, social capital refers to the goodwill, resources and embedded reciprocity that are found in human relationship networks of various kinds that can be leveraged to action on behalf of one of the network's members (Cope, Jack & Rose, 2007; Pirolo & Presutti, 2010).

Until recently, entrepreneurship was seen largely as the work of an individual, and much of the early research did not look beyond the individual's characteristics and actions. For example, the NVP framework includes the entrepreneur, industry structure and resources as key factors, but it omits social relationships, learning processes and entrepreneurial perceptions (Chrisman, Bauerschmidt & Hofer, 1998). However, these constructs include far more than the entrepreneur's personal capital and characteristics envisioned in the NVP framework.

There has been a growing awareness that the individual entrepreneur's actions depend to a great degree upon the ability to use his/her social connections within networks of relationships with others to accomplish more than would be possible alone. For example, Davidsson and Honig (Davidsson & Honig, 2003; Honig & Davidsson, 2000) explored the relationship of social capital to propensity to persist in the process of starting a business. They observed bridging and bonding social capital as described by Coffe´ and Geys (2007) that is, creating and maintaining *both* heterogeneous and homogeneous social network groups, was a robust predictor for moving a nascent entrepreneur from intent to action. Pirolo and Presutti (2010) then examined the roles of various kinds of strong and weak tie configurations at various stages of a new venture start up, finding that it is most advantageous for a start-up to leverage its strong ties (intense and frequent contacts, for example, relationships between founder and partners) early to overcome the liability of newness and smallness and its weak ties (impersonal and infrequent contacts, such as occasional customers) later, as it grows and needs a larger network from which to draw resources. In both cases, it is necessary for the

entrepreneur to learn to effectively use the various kinds of social ties to obtain needed resources and to adapt to the phase of the venture's life cycle.

For the entrepreneur who is a member of a profession, social capital, especially in the professional community socialization process is especially important (Buckner, 1992). Since many professions have restrictions (legal and normative) on how they may attract business, it is extremely important for the new member of the profession to be introduced to the other professionals and join/build a network of support and resources necessary for growth and development of the new practice venture (Dall'Alba & Sandberg, 2006; Daley, 2001; Hall, 1969). If these induction structures are weak or ineffective in attracting and supporting new professionals so that the member does not engage effectively with the rest of the professional community, his/her practice can suffer economically, in accountability, and in personal satisfaction, leading to marginalization or exit from the profession. As research in several allied health professions suggests (see Collins, 2009; Eli & Shuval, 1982; Sabari, 1985; among others), socialization on multiple levels including personal, professional community and society may be necessary for satisfaction and success. Therefore, those professionals with larger reserves of various kinds of social capital *skills* and appropriate socialization *processes* may be the most highly socialized, as well as the most satisfied, successful and enduring in their professions.

It is important to note that, in a sole professional practice, the principal must rely upon an external heterogeneous network of people he/she does not directly control to supply key business functions, and his/her business' social capital depends upon the

quality of those provided functions as well as the central professional activity. In many small professional practices, the ability to use social network connections well can determine the quality of outsourced skills and knowledge the business is able to attract and retain, including much of the public face and service quality not provided by the principal. Examples of these include the website and social media communications, outsourced functions such as billing and accounting, subcontractor services, information technology support for customers, banking, insurance and risk management, and so forth. Therefore, the human and social capital of the entrepreneur includes the human and social capital of the extended network of social connections, not just that of the entrepreneur alone.

Further making the case for social capital as an important entrepreneurship construct, Baron and Markman (2000) found that those entrepreneurs who were the most socially competent were also the most financially successful. The four areas of social competency best supporting this notion were: a) *social perception*—accuracy in perceiving others, b) *impression management*—being able to create and preserve positive reactions in others, c) *persuasiveness*—the ability to win others over to one's point of view, and d) *social adaptability*—the ability to feel comfortable in a wide range of social situations.

All these social competencies help new ventures gain attention and support of customers and other stakeholders at critical stages of the founding process, often long before the firm has developed track record of results (or permanency), a cost advantage, or some other compelling reason for the customer to choose to do business with the new

firm. While it may be true that large established companies use more systematic processes (financial statements, customer referrals, site visits, etc.) to determine what qualifies a new vendor, smaller companies with more informal systems will not always rely upon purely objective, rational processes. In short, social competency may be the determining factor for producing the opportunity to do business—getting one's "foot in the door".

Entrepreneurial learning processes

The literature to date sums up new venture performance as a function of interrelated conceptual variables of which the entrepreneur is but one factor. As noted previously, much of the scholastic history of research into the entrepreneur assumed a *functional* approach within the framework, in which the entrepreneur was a static entity and the research was largely trait-oriented (Gartner, 1988). In the last fifteen years or so, research into the entrepreneur's role within the process has largely shifted to a more complex *behavioral* approach where the entrepreneur is seen as an interactive and dynamic factor (Cope, 2005; Minniti & Bygrave, 2001; Rae, 2000). As Cope frames it:

> Rather than trying to define "who an entrepreneur is," it is argued that it is more productive to view entrepreneurship as a contextual process of "becoming" (Rae, 2000), where the entrepreneur is continually learning and developing in relation to his or her business and the wider environment. (2005, p. 374.)

Building on Kolb's (1984) experiential learning concept, entrepreneurial learning theory centers on the experience-oriented process of adaptation to changing environments

throughout the life cycle of the organization (Gartner, 1985; Reuber & Fischer, 1993), not just during the founding period. Most important to this project, Woo, Daellenbach and Nicholls-Nixon (1994) describe entrepreneurial learning as an ongoing process characterized by experimentation and learning, catalyzed by random events or, as Dalley and Hamilton (2000) call them, "trials by fire."

One emerging stream of research in this area considers the potential of leveraging self-learning capability of professionals and entrepreneurs for better decision-making and higher levels of performance. Since the literature shows that most formal learning avenues for entrepreneurs have been largely underutilized, unavailable, or not focused on the skills actually needed by business founders (Edelman, Manolova & Brush, 2008; Honig, 2004; Martin & Halstead, 2004; Martin, McNally & Kay, 2013), researchers have recently begun to explore how to teach professionals to teach themselves informally using dialogic self-reflection and insight techniques within an experiential learning context (as described by Cope, 2005, Corlett, 2012; Issitt, 2003, among others). This theme appears in a small but growing body of research into the learning processes of health care professionals, notably nurses and clinical psychologists, where internal psychological processes (notably reflective practice) can lead to continuous learning, sudden insight and turning point events (as in Corlett, 2012; Daley, 1999, 2001; Matsuo, 2012; Morgan, 2009; Walker & Redman, 1999).

Cope and Watts (2000) demonstrate how the intersection of active learning by doing, "discontinuous critical events", and reflective practice can spur insights and breakthroughs in problem-solving throughout the entrepreneur's experience. In particular,

there seems to be an important role for random events in the learning process. Whether called “crises”, “discontinuous events”, “critical events”, “epiphany” or “trials by fire”, an occurrence which forms the context for reflection, questioning of assumptions, reframing of problems and gaining insight into a significant issue or challenge seems to be an important part of the learning process for the entrepreneur. Framed as a form of epiphany experience as described by Miller (2004) and McDonald (2008), entrepreneurial learning events act as catalysts for positive change in the venture’s trajectory. As Reuber and Fischer (1993) observe, however, much more research needs to be done in order to understand how these experiential episodes affect the entrepreneur and the emerging enterprise.

While the potential of energizing the entrepreneurial learning process to spur higher levels of performance and better business decision-making is a tantalizing prospect in concept, research in this domain is still in its infancy, and there is no dominant and universally-accepted paradigm for entrepreneurial learning as yet (Bygrave & Hofer, 1991; Cope, 2005; Erdélyi, 2010; Minniti & Bygrave, 2001). It may be that the multi-level complexity of the phenomenon and the need for interdisciplinary approaches addressing the psychological, sociological and process aspects of entrepreneurial learning will uncover understanding slowly. However, if research uncovers general principles for self-training, especially in the realm of insight generation, the implications for entrepreneurial learning and new venture performance would likely be very significant.

One further aspect of entrepreneurial learning bears noting. Taylor and Thorpe (2004), Sullivan (2000) and Cope (2005), among others, emphasize that learning

processes occur in a social context, and they theorize that the learning process may affect social capital as well. Trust, reciprocity and emotional ties can be built or strengthened as the entrepreneur engages with mentors, spouses, and others in his/her network for emotional support, advice, and as a "sounding board" while wrestling with an issue (Cope, 2005; Sullivan, 2000; Tolar, 2012). Still, the extent of and mechanisms for learning and the relationships with other framework factors have yet to be explored. It may be that entrepreneurial learning may have integral connections with perception/cognition and social capital factors as well as other aspects of the entrepreneur and the new venture performance framework that are not yet apparent.

The founding process

Much of the thinking about the dynamics of new venture creation focuses upon the components of the framework and how they interact rather than the common *processes* in founding a new venture. For example, the first new venture creation framework proposed by Gartner (1985) included the startup process as one of four variables, but its role was not well understood. At the same time, scholars building upon open systems theory began to apply biological principles to organizations in order to gain understanding of organizations as organisms (von Bertalanffy, 1950; Lawrence & Lorsch, 1967; Morgan, 2006; Whetten, 1987). Reynolds and Miller (1995) applied this organic biological metaphor to entrepreneurship, suggested that all new ventures experience a similar basic process of coming into being: conception, gestation and birth.

Later research has built upon this process-based framework, examining the impact of various factors on the startup process and their optimal placement in the process, such as writing a business plan (Bewayo, 2010), maintaining high levels of personal efficacy (Gatewood, Shaver & Gartner, 1995), engaging in intensive start-up activities immediately prior to launch (Carter, Gartner & Reynolds, 1996), and engaging with business management and planning support services (Beresford & Saunders, 2005), to name a few examples. Using the life-cycle construct as proposed by Reynolds and Miller (1995), new ventures experience conception (idea is formed), gestation (pre-launch activities) and birth (launch). It is not hard to conceptually extend this metaphor into the early years of "childhood" to examine the important formative experiences that set the pattern for the rest of the venture's organizational life cycle (growth, maturity, decline, transition/death). While Scott and Bruce (1987) attempted to describe a model for small business growth and development in an industrial context, research into the "formative years" of other kinds of new ventures remains somewhat general because of the variety of types of firms, purposes, business models and industrial contexts. Professions are yet another special case in which growth stages might hold important commonalities. While these common growth period indicators are only beginning to be recognized, they might yield clues about common issues that might lead to unconsidered interventions for younger, less developed professions such as AOM. They could be an important basis for further research in similar professions such as veterinary medicine, clinical psychology, counseling and social work, where professionals founding private practices must engage in business development as well as practicing as profession.

Entrepreneurship in the professions

Chrisman, Bauerschmidt and Hofer (1998) distinguished their NVP framework from earlier models in part by describing factors generic to all new ventures. Though some might take issue (Gartner, 1995, for example), it is my contention that the professional practice is a specialized case of entrepreneurship. For example, a professional practice varies from a tech start up in size and funding sources, and it also has a difference in vision and purpose, but the founding process and general factors affecting survival and performance are in essence the same.

For research purposes, the component factors of the traditional NVP framework must be viewed through the lens of a professional practice business. In this context, the role of the entrepreneur is even more critical to survival than in other kinds of new ventures due to licensure and specialized, non-transferrable knowledge or skills. Business strategy is constrained in many ways to conform to the standards and ethics of the professional community; resource acquisition depends more on the entrepreneur's human, financial and social capital than in other kinds of businesses. Organizational structure and culture is much less prominent a factor due to the very small size of these businesses on the whole. According to Adams (1980) and Coe (1970), professional practices are distinguished from other businesses as:

a. Having an intentional and focused mission in a specialized craft area;
b. Having entry by licensure or other sanction granted by a professional association and governmental or regulatory bodies that specify scope of practice. Government and regulatory bodies set the boundaries on what is

permissible practice and what is not, and it may also have a great deal to say with how services are delivered;

c. Practice uses professional standards and a common body of knowledge;
d. Practitioner is allowed and expected to use independent judgment within the scope and definition of practice,
e. Professional is expected to engage in ongoing professional developmental learning to stay current with the body of knowledge and improve skills;
f. Business is run with an expectation of a public service ethic balancing pursuit of profit.

Additionally, an idealized professional image (created and imprinted upon new members as they are inducted and have interactions with other seasoned members of the profession) will guide which business behaviors are considered "professional" and which are not considered appropriate. Thus, peer pressure, professional standards and canons of professional ethics work to limit the range of variation in what an acupuncturist's professional practice may look like and how it will operate. Nevertheless, even a constrained professional venture will be subject to market forces, and long-term survival depends upon the ability of the professional to operate effectively in a dynamic environment.

In addition to the characteristics of professional practice businesses, there are processes shaping professional development that all new professionals must navigate. Daley (1999) built upon the work of Dreyfus and Dreyfus (1980) and Benner (1984) in her exploration of how nursing professionals progress through stages of learning from

novice to expert. These process stages, observed in a wide range of other professions, "demonstrated that professionals grow in their chosen career as they gain experience within the context of their work setting" (Daley, 1999, p. 134). Daley described professional development in five stages:

1. Novice. The novice is without experience, relying upon theory learned in classrooms or books. Without real world experience, concepts are not well-understood, and the professional must rely upon the wisdom and expertise of those more seasoned in order to apply theory to practice. Daley (1999) described novice nurses as often "overwhelmed" and "scared to make a mistake." A novice finds a helpful mentor a great buffer and confidence-builder for dealing with uncertainty in real world situations (Chrisman, McMullan & Hall, 2005.) Those entering this world without training or mentors can be especially adrift.

2. Advanced Beginner. The advanced beginner has gained a little experience and has begun to "recognize recurrent components of meaningful situations" (Daley, 1999), but he/she may not yet be able to differentiate the important from the unimportant. The advanced beginner is still in need of connection with other professionals with more experience to gain ideas and suggestions for dealing with common situations and avoiding mistakes.

3. Competent Professional. According to Daley (1999), the competent professional commonly has about three years of experience in the profession and has grown in ability and confidence, so that unpredictable situations do not throw him/her into turmoil. He/she may need help in those situations but has developed a bank of

resources, including other more experienced professionals, and he/she accesses these resources when needed. He/she shows ability to plan and organize his/her own activities and is consciously aware of the plan.

4. Proficient Professional. According to Daley (1999), the proficient professional has moved beyond confidence in his/her ability to cope with unpredictable situations and starts to "gain a holistic sense of the work" (p.135). He/she uses "rules of thumb" based on learned patterns, can diagnose issues accurately and is able to consider the whole system characteristics and interactions in appraising a situation. This proficient professional is able to develop responses, prioritize them based on given sets of criteria and judge which are most appropriate in the situation.

5. Expert Professional. On Daley's (1999) continuum of progression, the expert has gained an intuitive ability to immediately appraise situations and zero in on what is important without considering time-consuming and unfruitful lines of inquiry. The expert is able to recognize patterns embedded in a profusion of data and prioritize levels of problem-solving in complex and uncertain situations. The expert has developed a deep bank of understanding based on experience and is able to apply past relevant experience to new and unfamiliar situations.

Categories of entrepreneurship success factors

The ultimate motivation for research in this domain is to discover what preparation, behaviors and interventions can enhance the new venture performance outcomes of professionals (such as acupuncturists) who must start and grow their own

private practices. Since there as yet exists no specialized research in this area, it is my contention that qualitative research into the experience narratives of this group of new professionals may be the best way to gain foundational understanding upon which to build future research. However, it is advantageous to sum up the rather large body of the literature indicating the factors enhancing entrepreneurial success as a backdrop for the research at hand. These factors can be summed up in two general categories: general new venture survival and professional success.

New venture success in general

The first category of literature summation, new venture survival, indicates that, *in general*, new venture survival and performance is enhanced:

a. When a specific range of management skills and new venture planning are addressed (Chrisman, McMullan & Hall, 2005; Dimov, 2010; Gartner, 1985),
b. When ongoing social capital formation, including network formation and professionalism, is included as a meaningful part of the process (Baron & Markman, 2000; Davidsson & Honig, 2003; Kessler & Frank, 2009),
c. When the venture is planned and realized with determination, as if the business is expected to be full-time, to provide financial security for the founder and to present itself as a legitimate business (Kessler & Frank, 2009),
d. When the nascent entrepreneur receives meaningful mentoring by an experienced guide and there are many points of similarity between the mentor's experience

and the nascent entrepreneur's proposed venture experience (Chrisman, McMullan & Hall, 2005),

e. When the entrepreneur engages with appropriate professional support services to upgrade his/her business management skills (Beresford & Saunders, 2005; Dyer & Ross, 2008),

f. When the nascent entrepreneur's perceptions of risk and self-efficacy are explored and his/her abilities and areas of weakness are strengthened (Arenius & Minniti, 2005; Hmieleski & Baron, 2009),

g. When the entrepreneur does not live alone, e.g., has a cohabiting partner, possibly for emotional and financial support, especially in the early days of the process (Kessler & Frank, 2009),

h. When detailed planning and the bulk of startup activities are accomplished immediately prior to launching the venture (Dimov, 2010; Liao & Gartner, 2006),

i. When the founder has access to sufficient financial and other resources to carry out the business plan (Kessler & Frank, 2009; Petrova, 2012; Schiff, Hammer & Das, 2010), and

j. When the founder is deeply engaged in ongoing learning processes based on reflective practice in order to spur better decision-making, heightened insight and deepened understanding of the issues facing his/her new venture (Corlett, 2012; Daley, 2001).

Success in a professional practice

Finally, the literature regarding professions indicates that professionals are more successful with their practices when:

a. The profession has legitimacy in the eyes of the general public and other professionals interacting with it for matters within its scope of practice (Nedrow, 2006; Nottingham, 2007),
b. There is an established induction structure in which new members of the profession are introduced to the other professionals and join/build a network of support and resources necessary for growth and development of the new practice venture (Dall'Alba & Sandberg, 2006; Daley, 2001; Hall, 1969),
c. There are adequate and appropriate continuing professional development opportunities to allow the practitioner to continue to build knowledge and technical skill competencies (Bandura & Schunk, 1981; Daley, 2001), including business skills (Buckner, 1992; Cortois, 1992; Kuo, Burke, Coulter, & McNamee, 2004), and
d. Where there is a mentor to assist with sense-making, network-building and as a sounding-board as needed (Buckner, 1992; Canter, Kessler, Odar, Aylward & Roberts, 2012; Tolar, 2012),
e. Where the individual engages in self-reflective practice for enhanced learning, problem-solving and psychological stress reduction (Issitt, 2003; Walker & Redman, 1999; Matsuo, 2012; Morgan, 2009).

Part II: Introduction to the Acupuncture and Oriental Medicine (AOM) Profession

Chinese medicine, also known as acupuncture and oriental medicine (AOM), has its roots in several allied disciplines (primarily acupuncture, holistic diagnosis via tongue and pulse reading, herbal medicine and therapeutic massage techniques) which have been developed over the past 2,500 years. While this ancient medicine has been widely practiced in much of eastern Asia for the past two millennia, it was largely unknown in North America until the last quarter of the nineteenth century when immigrant Chinese workers brought acupuncture and herbal medicine to the railway and mining camps of the Western US. In the ensuing years, there were some notable examples of Chinese medical practices extending far from the immigrant enclaves of San Francisco and the West Coast to some remote frontier communities where medical services of any kind were few and far between. One such example is the town of John Day, Oregon, where Chinese medical herbalist, Ing Hay, served as its sole medical provider for much of the period from 1887 until the late 1940s (Barlow & Richardson, 1979; Chung, 2011; Sarvis, 2005).

Despite this history, Americans were largely unaware of Chinese medicine until the 1970s. Journalist James Reston's account of his emergency appendectomy and his successful post-operative pain management experience with acupuncture while he was in China was chronicled in the New York Times (Reston, 26 July, 1971) to great interest among the American public. Americans were intrigued, and acupuncture and oriental medicine (AOM) began its modern history in the US. While it has remained mostly outside the medical mainstream for most of its 40-year recent history, the use of AOM

has grown rapidly in recent years (Eisenberg, 1998) due to growing awareness of the medicine among the American public, strong growth in the number of AOM practitioners, as the limitations of Western medicine become more apparent, and as the general cost of healthcare and pharmaceuticals has grown. While the number of AOM practitioners in America is still extremely small compared to the number of MDs (about 25,000 acupuncturists vs. 809,000 active MDs in 2009), it is on the rise, driven mostly by public demand rather than the endorsement of the Western medical establishment or a large body of rigorous research as to its efficacy.

Growth of the Profession

For much of its recent history in the US, AOM was available in large urban areas with large Asian communities who were culturally familiar with Chinese medicine, primarily Los Angeles, San Francisco and Vancouver, BC. California was one of the first states to enable AOM licensure (the other two being Maryland and Oregon, all in 1973), but California was, as Cohn (2010, 2011) documents, the spiritual center of the acupuncture movement in the USA, as part of the legacy of the political and social movements of the 1960s and early 1970s. This was when interest in Eastern philosophy and religion caused some Anglo-Americans to begin to seek out and understand Chinese and other Asian ways of seeing the world, largely as a rebellion against what they saw as a corrupt society due to war, poverty, racism and gender discrimination. This counterculture mentality and embedded concern with higher spirituality, particularly

Asian philosophy, has become an integral part of AOM thought and practice in the United States and stands in distinction to the western medical system which focuses on the rational and functional aspects of health without much regard for spirituality. In California, therefore, the AOM profession grew fastest and was first to migrate out of the Asian community into the "alternative" Anglo-American community. Today, about one-quarter of all U.S. acupuncturists are located in that state, and slightly more than half of those are clustered in 16% of the zip codes, primarily San Francisco, Los Angeles and the more scenic portions of the southern coast (Dower, 2003; Sloan, Reeves, Sledd & Stein, 2012). Practitioners across the country are also 3.5 times more likely to be of Anglo ethnicity than Asian today (Wang, 2013).

From California, the acupuncture profession spread north in the 1970s, establishing AOM colleges and practices in Portland and Seattle, and east along the Sunbelt states to Florida, supported by senior citizen early adopters looking for relief of age-related, chronic, complex conditions possibly not well-addressed in the traditional healthcare system. Cohn (2010) notes in his history of the profession that at the same time AOM was being embraced by alternative-thinking Anglo-Americans in California, an off-shoot of that group in 1973 moved to Massachusetts to start an acupuncture college and raise awareness of AOM. It was successful in bringing AOM to the northeastern United States, and their spiritual offspring migrated south along the eastern coast and west to the Great Lakes over time, establishing additional AOM colleges in those areas as well. Once the two coasts and the Sunbelt migrations were complete (around 2000), new acupuncturists began to move to the interior states. For example,

between 2006 and 2014, there was a large percentage increase in the number of licensed acupuncturists (LAcs) in places like Boise, Idaho (increased over 150% between 2006 and 2014), even though the total number of LAcs in Idaho at present is still very small for the population (a total of 221, about 7 LAcs for every 100,000 people). Similar comparisons can be made for states like Colorado, Illinois, and Iowa. This is not to suggest that there was any kind of plan to grow in this fashion, but rather, it is an attempt to explain geographically how acupuncture and oriental medicine has been introduced to the US population and why practicing acupuncturists are not evenly distributed throughout the country.

Implications of the way that the profession has grown numerically and geographically over the past forty years still shape the face of the profession today. There are three main implications: the rate of introduction in a community, the geographic distribution of practitioners, and uneven scope of practice laws between states.

The first implication of the way the AOM profession has grown is the impact upon the rate of introduction to the general population coming from having an available licensed acupuncturist (LAc) in a community. General awareness of and acceptance of AOM within the American public has largely grown one patient at a time, by word of mouth, from patients rather than mainstream healthcare authority figures. While the numbers of acupuncturists increased almost exponentially to its current level where it has leveled off over the past few years, it still is tiny in comparison to the U.S. population as a whole, roughly 8 per 100,000, versus 266 MDs per 100,000 in 2013. According to the 2008 National Health Information Survey of complementary and alternative medicine

(CAM) use (Barnes, Bloom & Nahin, 2008), just 1.4% of the adults in the survey had used acupuncture in the past year, compared to nearly 9% for chiropractic, for example. There seems to be a great deal of untapped potential in the overall market, but the profession's growth is currently hindered by its dependence upon spread by word of mouth.

The second major implication of the growth patterns of acupuncturists--their geographic distribution--threatens to choke off the supply prematurely through the appearance of oversupply in some markets. While some observers worry that the market is oversaturated with LAcs (Dower, 2003; Kuo, Burke, Coulter & McNamee, 2004, both California studies), an examination of the distribution of LAcs across the U.S. shows that the "oversupply" is due to the dense clustering of practitioners, especially in areas around any of the 55-60 operating acupuncture colleges. This problem, as might be expected, is worst in California, but it may be starting to present itself in other markets as well as the density of practitioner numbers increase in what are viewed as "desirable" locations for the practitioners, while other locations are without any AOM practitioner. Much of Stumpf's (2008, 2010, for example) concern with the lack of profit potential in private AOM practices might be traced ultimately to pockets of intense competition in these relatively densely populated areas.

The third major implication of the growth patterns of the profession to date are the uneven standards from state to state as to the scope of practice permitted. These present a confusing picture to the public and likely act as a damper on overall acceptance and mainstreaming of the profession. For example, 44 states license the practice of

acupuncture, and one (Wyoming) has declined to regulate it in any way. In the other states, acupuncture may only be done by a qualified MD who may or may not be a licensed acupuncturist, even though the LAc may have many more hours of training in the practice. Recently, there has been a move by chiropractors and physical therapists to do "dry needling", a technique that attempts to mimic acupuncture without actually being acupuncture (Braverman, Baker & Harris, 2009). As a result of this confusion, it is often difficult to know what credentials the person holding the needles has and what a patient might expect from the treatment. This compounds difficulty in gaining legitimacy as a profession and as the profession seeks to integrate into the mainstream healthcare system (Nedrow, 2006; Romm, 2000). As the profession continues to mature, it may tend to work toward standardization of its role in the healthcare system and the public's eyes through a common scope of practice, uniform enabling legislation and licensing requirements within all states and territories to overcome these kinds of issues.

Demographics of the Profession

The AOM profession has been undergoing a major demographic shift in the past fifteen years that can be seen in the changing demographics of the students graduating from AOM programs. The results as seen from an analysis of student profiles over the 32-year history of Oregon College of Oriental Medicine, as one example, are revealing. For OCOM grads, there has been an unmistakable pattern for graduating cohorts to trend younger and more female. (See Table 1, Figure 1 & Figure 2) As the data show, the

average 2011 OCOM graduate is very likely to be female and aged 32. While the 1990 cohort was nearing 40 years of age, 53% male, and mostly entering AOM as a second career, the most recent graduates are 87% female and, on average, are ready to enter their first serious profession at the same time they are, statistically speaking, most engaged in raising families.

Table 1. Demographic data for selected graduate cohorts, 1986-2010 (Oregon College of Oriental Medicine)

OCOM Graduate Cohort Demographic Analysis

1986-2010 (Selected representative cohorts)

Entire Annual Cohort					
Grad Cohort	**Total Grads**	**% of Total**	**Mean Age at Grad**	**Std Dev**	**Median Age at Grad**
1986-1990	55	100%	NA	NA	NA
1991	15	100%	37.93	6.60	37.93
1999	44	100%	37.21	9.84	38.00
2004	54	100%	37.59	9.19	36.00
2009	79	100%	35.59	8.39	33.00
2010	68	100%	32.38	5.92	32.00
Male Graduates					
1986-1990	23	41.8%	NA	NA	NA

1991	8	53.3%	37.00	6.63	37.00
1999	18	40.9%	37.21	9.84	38.00
2004	21	38.9%	38.48	9.15	38.00
2009	20	25.3%	33.35	6.62	31.50
2010	9	13%	31.67	2.50	32.00
Female Graduates					
1986-1990	32	58.2%	NA	NA	NA
1991	7	46.7%	39.00	6.90	39.00
1999	26	59.1%	37.42	8.34	39.00
2004	33	61.1%	37.03	9.31	35.00
2009	59	74.7%	36.36	8.83	33.00
2010	47	86.8%	32.55	2.50	32.00

Note

Data regarding age at graduation was not available for the 1986-1990 cohorts.

Figure 2. Gender change trend in student body (Oregon College of Oriental Medicine)

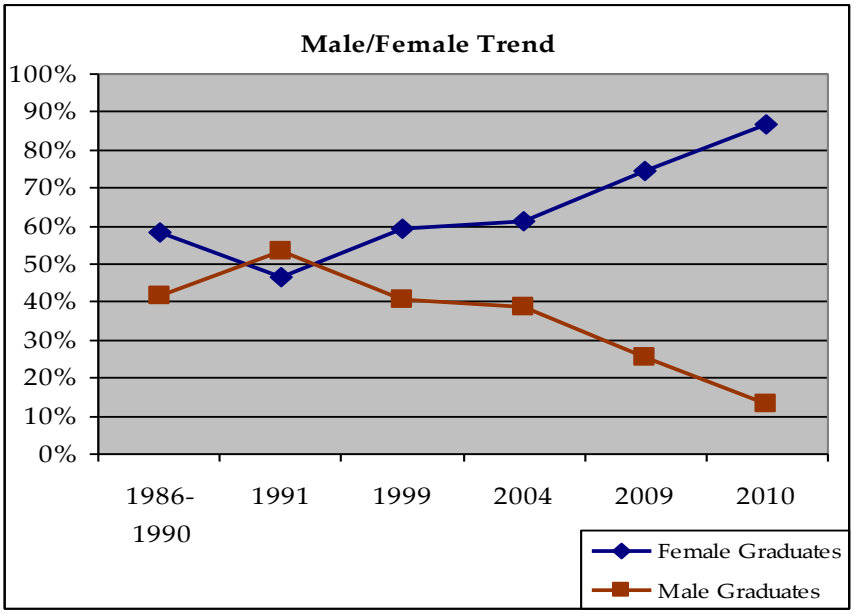
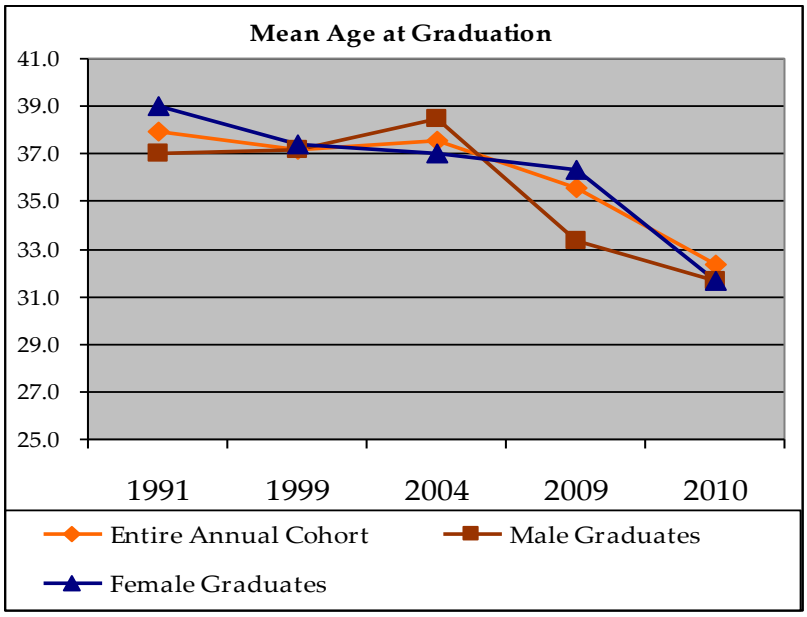


Figure 3. Mean age at graduation trend 1986-2010 (OCOM).



As a caution against generalizing OCOM's experience to the entire AOM profession, it is important to note that empirical evidence of demographic trends such as that analyzed in this study is not divulged by AOM institutions at present. Anecdotal evidence from well-connected sources within the AOM academic community suggests that it is representative, but the reader should be aware that published profession-wide data is as yet unavailable. Nevertheless, if general demographic shifts such as described from OCOM's experience are the trend for the profession, the implications are important.

First, a majority of new graduates starting practices may not *want* to work full-time at first. They may follow the pattern common to female self-employed individuals across all industries and trade off time at work for family responsibilities (Gurley-Calvez, Harper & Biehl, 2009; Guryan, Hurst & Kearney, 2008), and they may still report high levels of satisfaction with their practices due to the ability to balance work and family responsibilities (Sloan, Reeves, Sledd & Stein, 2012). Explaining this dynamic, the Gurley-Calvez, Harper & Biehl study (2009) strengthened the contention of earlier studies (for example, Fischer, Reuber & Dyke, 1993) that the tendency of self-employed women is to be more sensitive to lifestyle factors and to spend more time in child-rearing at the expense of work time, and this tendency increases with education level (Guryan, Hurst and Kearney, 2008). With a curriculum emphasizing balanced living ("living the medicine") and the well-documented Gen Y/Millenial cultural norm against workaholism reinforcing this tendency, it may be that many younger, female acupuncturists are choosing to order their work lives to fit their values instead of merely maximizing their pursuit of economic gain, whether or not family responsibilities are part of the equation.

Further research into the individual stories of acupuncturists will give light into this important but overlooked aspect of how the AOM profession is developing and accommodating this emerging group.

The second major implication of this demographic shift is that new AOM entrepreneurs are at least potentially more likely to make strategic and tactical mistakes in starting their businesses, since they lack business skills, depth of experience in the workplace and large financial reserves to fall back upon. Recent studies (Collins, 2009; Olson, van Bever & Verry, 2008) have documented how established companies, leaders in their industries, have made mistakes that initiated "growth stalls", periods of falling profitability, loss of market share and general decline that, if not corrected early, can make recovery long and difficult at best, and impossible at worst. It is not unreasonable to assume that AOM graduates, overwhelmingly unschooled in business skills and competitive theory but at the same time overwhelmingly confident in their business abilities (a theme repeated in each of the OCOM New Student Survey, 2010, 2011, 2012, 2013), might be especially subject to making business mistakes such as siting a practice in an already-saturated location, failure to manage cash flow well, failure to develop a clear and effective business strategy, or failure to differentiate (develop a brand) that can stall their practice growth and development (Cassar, 2010.) If this is so, the narratives might reflect this clash of expectations with experience and give insight into how the graduates made sense of it.

The Environment of the Profession

Gartner (1985) and Pfeffer and Salancik (1978) tell us that the environment is a key variable in the new venture creation, defining the context in which the venture forms and grows. This is certainly true of the environment in which the AOM profession exists. In addition to the numerical growth, geographic disbursal, and demographic factors at work shaping the context of the AOM profession in recent years, several other environmental factors weigh in the balance that new acupuncturist entrepreneurs must consider in starting and establishing their businesses. In 2015, the most significant of these environmental factors are:

1. *AOM cost advantage*. The cost advantage of AOM and other complementary and alternative medicine (CAM) services makes AOM attractive to cost-conscious Americans, especially for chronic, complex conditions where acupuncture has been shown to be effective, such as osteoarthritis of the knee, low back pain, asthma, PTSD and addiction (Barnes, Bloom & Nahin, 2008; Braverman, Baker & Harris, 2009; Jabbour, Sapko, Miller, Weiss & Gross, 2009). One troubling finding of the 2008 National Health Information Survey (Barnes, Bloom & Nahin, 2008) was the trend toward using AOM as a substitute for conventional care due to the high cost or unavailability of health insurance and pharmaceuticals. Informal evidence from the OCOM Clinics for the period 2008-2012 has reinforced this finding and suggested that the trend increased during the recent economic recession (See Kidwell, 2011). This is problematic to practitioners in most states where primary care is not within the scope of practice and where

patients are presenting with conditions beyond their training and ability to treat because they cannot find affordable treatment elsewhere in the mainstream system.

2. *First, do no harm*. AOM therapies, notably acupuncture and therapeutic massage are generally recognized as having little potential for harm to a patient (see NIH fact sheet at http://nccam.nih.gov/health/acupuncture/#used). However, herbal medicine is more problematic; FDA studies of herbal medicines' safety and efficacy is embryonic, and NCCAM's statement on herbal supplements is guarded in tone (access at http://nccam.nih.gov/health/supplement-safety), though damage claims relating to Chinese herbal preparations are exceedingly rare. Nevertheless, patients who are looking for a more affordable substitute for expensive pharmaceuticals or who are looking for more "natural" medicines are more interested in Chinese herbal medicine due to a perception of safety. However, American consumers of Chinese herbal medicine have put pressure on producers to show that the medicines do not exploit endangered species of animals or plants. Competition for the herbs from the growing Chinese middle class has increased prices as well. Most importantly, increased FDA regulations regarding recordkeeping and clean production techniques in dispensaries is pushing additional costs on practitioners, causing more to abandon this portion of their practices to those who specialize in herbal formulas, in spite of the potential for an additional revenue stream (Reeves, Stump & Chapman, 2010).

3. *Dissatisfaction with the mainstream medical experience*. The well-documented haste and excessive focus on discrete symptoms of most mainstream doctor visits leaves many patients feeling dissatisfied with the experience (Strasen, 1999). Research has shown that patients are naturally gravitating to a kind of care that emphasizes treating the whole person, and they increasingly feel that CAM therapies should be integrated into the mainstream of American medical care (Burke & Upchurch, 2006). Thus, there is a growing demand by the American medical consumer to be able to access CAM therapies as part of his/her regular medical coverage. Cost control measures by the insurers are working against that trend, slowing the adoption and integration of CAM therapies into the mainstream healthcare system.
4. *Available research findings supporting AOM*. More government-sponsored, rigorous research of the kind that passes muster with the academic and medical community's standards for "evidence-based medicine" is being done under the leadership of the National Center for Complementary and Alternative Medicine (a branch of NIH). This research is providing more acceptable evidence of efficacy of specific AOM therapies, especially acupuncture, but funding has been decreasing in recent years, threatening progress. For example, the use of acupuncture for chronic pain management rather than narcotics or to treat osteoarthritis of the knee have both shown promise in research studies, but the methodologies are not consistent from study to study, and existing findings are not uniformly overwhelmingly positive. The realities of the healthcare system

require many studies to create widespread acceptance of a mode of therapy, particularly an alternative one. Further complicating matters, it is not clear that the same research trial designs used for Western interventions are always appropriate for AOM studies. Ironically, funding challenges within NCCAM are moving the research on AOM therapies away from the traditional NIH-style research trials to more practical, clinical studies such as those performed by the Department of Defense's various military hospitals in their search for a way to deal with PTSD, TBI (traumatic brain injury), pain management and other chronic conditions affecting veterans (Niemtzow, 2011; Walter & Burns, 2011). If these Department of Defense clinical studies show AOM to be safe, effective and cost-effective, the result could be a much more favorable environment for AOM research and adoption in the mainstream medical system.

5. *Lack of Medicare coverage*. The largest American insurance program, Medicare, does not cover any AOM service at the present time. House Bill 818 (the latest version of the Hinchey Bill) to add acupuncture as a covered modality of treatment reimbursable under Medicare has been introduced at least six times since 1993, but no action has been taken on this bill to date and, barring some change in Congress' interests, it is not likely to be enacted in the near future. In spite of this, patients are still seeking and paying for CAM care (including acupuncture) themselves in ever greater numbers. Insurance companies in some states are beginning to offer coverage for certain AOM procedures because their

customers are demanding it rather than as a result of the research process (Lasell, 1998; Choe, 2006).

6. *Public's comfort level with Asian culture and thinking*. Many Americans are having increasing contact and interaction with East Asia and its peoples. As a result, they are beginning to bridge the cultural and philosophical divide between eastern and western points of view and feel increasingly comfortable trying these alternative, holistic approaches to healthcare (Burke & Upchurch, 2006). Americans may also be turning to CAM therapies as word of mouth from opinion leaders such as Oprah Winfrey and Dr. Oz tout their worth and as more average Americans try acupuncture and have positive experiences. The acceptance of the medicine is likely to be largely dependent upon the process of socialization of the profession with mainstream America.
7. *Integration's bumpy road*. Some large healthcare systems and teaching hospitals are beginning to integrate AOM modalities into allopathic (traditional western) medicine, but there is a persistent gap in the "ways of seeing" and approaching healthcare that leaves most AOM practitioners outside the US medical care delivery mainstream. Thorny issues of credentialing with regard to practicing in mainstream healthcare settings (Nedrow, 2006), professional standards issues within the profession itself and the philosophical divide among acupuncturists as to whether they *should* be part of the larger healthcare system as it stands now are all complicating integration (Barnes, 2003). At the same time, cost pressures in

western healthcare systems are working to reduce access to new specialties rather than add them. Therefore, the two medicines are still largely separate.

8. *Increasing engagement with insurers*. Due to the lack of employment opportunities in traditional healthcare settings where AOM practitioners can work for a salary, most are essentially harnessed to a fee-for-service business model, and many patients currently pay most or all of the total fee out of their own pockets at the time of treatment (though some can receive reimbursement for a portion or all of the cost from their insurance company if coverage permits.) However, changes in insurance laws and practices responding to consumer demand have initiated a shift to include acupuncture benefits in health insurance plans in many states. Where local law permits this inclusion and where insurance providers have recognized the customer demand by making acupuncture benefits available, patients are starting to pressure their AOM providers join insurance panels and accept insurance reimbursement in larger numbers. The recent economic downturn in conjunction with the continuing rise in the cost of health insurance, however, has put pressure on these newfound gains, with some scaling back of availability in spite of the popularity of the benefits. A second implication of greater engagement with the insurance industry is downward pressure on fees in a local market under the "usual and customary" rules used to determine reimbursement amount, especially in areas where competition has increased or providers have accepted lower reimbursement rates for some other reason (philosophical or economic.)

9. *Fractious profession and external challenges*. The AOM profession in the U.S. began in earnest with the sponsorship of alternative-thinkers who were willing to pioneer a very foreign approach to medicine in an environment that was initially hostile (Cohn, 2010). The independent, counter-culture mentality of those pioneers has infused the professional culture to the point where it spends a great deal of its energy arguing about style and technique, whether it is right to join a medical system they see as essentially corrupt, and whether additional educational credentials (a first professional doctoral degree) are the way forward in the face of the cost of education. Little progress in uniting the profession to action has resulted (Barnes, 2003; Welsh, Kellner, Wellman & Boon, 2004). For example, two major challenges, moving Congress forward on Medicare reimbursement for acupuncture and preventing encroachment into its scope of practice by chiropractors and others who wish to engage in "dry needling" (Braverman, Baker & Harris, 2009), have languished at the national professional society level for lack of financial support from practitioners, lack of organized political and social mobilization action and infighting among the leadership. Some long-time observers of the profession have expressed concern that a relatively small percentage of licensed acupuncturists belong to the national professional organization, fewer support it financially, and the trend might be for the state organizations to be seen as the relevant professional association bodies. If the trend is toward decentralization and focus on local issues, it is unknown how this may impact the long-term development of the profession as a whole. For example,

will this allow for advancement of the profession in the general society and inclusion into the major insurers' panels? If some states allow acupuncturists to be primary care providers and others do not, how will this affect the issues the professionals see as important for the national society to address? At the individual level, will new practitioners continue to lack the kind of useful induction and socialization processes they need to ease the transition and ultimately find success?

10. *Focus of training*. The AOM profession has traditionally relegated business skills training to the bottom of most AOM colleges' curriculum, comprising less than 50 clock-hours (1.6%) on average of a 3,000-hour program (Stein & Sloan, 2011). At this writing, only one AOM college has a full-time faculty member dedicated to "professional development." Similarly, there is no consistency as to what is included under the "business skills" label. Due perhaps to the lack of coverage of business topics in AOM programs, a conglomeration of post-graduate continuing education seminars of varying quality has arisen to fill the gap. However, these mostly consist of tips and tricks used by successful practitioners to market their practices and generally avoid higher-level business development topics. The cost of continuing education is a concern to practitioners as well, and as a result, most LAcs prefer to invest their scarce CPE dollars in training that will enhance their technical and diagnostic skills instead of business skills training. At the present time, while specialist consultants abound, there exists no comprehensive business

management training program within the educational institutions addressing the specific needs of these professionals.

11. *General anxiety about economics of practice*. Since the recent severe economic downturn in 2008, AOM chat rooms, blogs, and finally, scholarly articles have appeared asserting that the private practice model is "a failed business model", in the words of the chief proponent of this view, Dr. Steven Stumpf, an educator and healthcare consultant in Los Angeles (Stumpf, 2008). Dr. Stumpf has pulled a patchwork of fragmentary data from studies spanning 10 years together to lend support to his view that acupuncturists in private practice cannot make a living, that student loan debt is the major cause (Stumpf, 2008; Stumpf, Carr, McCuaig & Shapiro, 2011), and that the proper role for acupuncturists is in state-run clinics where they would be salaried employees providing primary care to low-income people (Stumpf, Kendall, & Hardy, Jan, 2010). These articles have been published in the major professional journals and have resulted in heightened levels of concern among current and prospective students as well as the general AOM community. However, in Stumpf's defense, graduate outcomes data, especially financial data that would shed light upon the current condition of graduates in their professions, has not been published by the AOM colleges; indeed it has been treated as proprietary information, especially among the for-profit institutions, and kept closely guarded up to the present. Our 2012 article sharing contradictory findings to Stumpf and his colleagues for graduates of Oregon College of Oriental Medicine and exploring some of the demographic factors at work behind the

numbers (Sloan, Reeves, Sledd & Stein, 2012) sparked lively debate and controversy within the AOM community, as it highlighted the need for transparency and a common outcomes measurement approach.

Becoming an Acupuncturist: Challenges facing new practitioners

Every year, an estimated 2,000 or so licensed acupuncturists enter this environmental context (Braverman, Baker & Harris, 2009), idealistic and eager to serve. They have, on average, spent some 3,000 hours or more in classroom and clinical training, completed board exams successfully, and attained state licensure. In the process, they have amassed a large amount of student loan debt (well over $100,000 for some) compared to the projected earnings potential they will have in private practice for the first few of the 3-12 years (Chrisman, Bauerschmidt & Hofer, 1998; Reeves, Stump & Chapman, 2010) it will take to build a practice to maturity. At this point, they face a number of challenges which will test both the professional and the practice in three major areas:

1. *As an individual:* This area of challenge involves resolving potentially conflicting internal identity models and perceptions of who they are as entrepreneurs and professionals and what is expected of them (Buckner, 1992; Daley, 2001; Steele, 2006).
2. *As a professional in a community of professionals:* This challenge includes finding one's proper place in a professional network of peers who can lend

support, provide accountability and aid in the induction and acculturation processes of the profession (Daley, 2001; Ronfeldt & Grossman, 2008).

3. *As an entrepreneur relating to the larger society:* This encompasses the challenge of adopting potentially conflicting roles of small business entrepreneur and compassionate professional healer (Kuo, Burke, Coulter & McNamee, 2004; Stumpf, 2008) in founding a business with social legitimacy and a sustainable business model.

Individual Professional Self-Image

The first general area of challenge deals with the internal socialization challenges of constructing a fitting professional self-image. As with many of those who enter the healing and service professions who rely upon fee-based client/patient services (notably veterinarians, clinical psychologists and some social workers and counselors in private practice), AOM practitioners may frequently find themselves struggling with two apparently conflicting role expectations, the professional, compassionate healer/helper and the business owner (See Steele, 2006 for an in-depth examination of the topic in relation to veterinarians). Research has been lacking to date as to what common personality characteristics (if any) and role expectations acupuncturists might bring to their transitions to the profession. For example, one important area for research is to test the common assumption among acupuncturists that they are more likely to be introverted and "compassionate" than average, more likely to see self-promotion and business orientation as undesirable (Bauer, 2010) and more likely to view making money in a

negative light, as the literature shows for other healing professions (Steele, 2006; Krejsler, 2005; Lewis & Klausner, 2003).

The attitude toward making money in a professional calling seems to be especially thorny within the acupuncture profession, perhaps because of the unequal outcomes seen and rumored among practitioners. While Adams (1980) counted a public service orientation and a moderated profit motive as a hallmark of a professional ethos, and most established professions have settled senses of what is an appropriate level of fees for professional services, acupuncturists seem to be struggling to make peace with making money in the service of their calling. For example, in recent years, the Community Acupuncture Network model (http://workingclassacupuncture.org/?id=17) has arisen in vocal opposition to the private practice model because of the perception that care is extended based on an ability to pay. The chief proponents of this movement mince no words in describing their colleagues negatively as seeking status, security and financial gain (Rohleder, 2012), and their unwillingness to compromise on the "right approach" has exacerbated the ambivalence in the professional conversation. Even those supporting pursuit of profitable private practices seem apologetic in tone. For example, Bauer (2010) reflects this assumed attitudinal stereotype in his book, *Making Acupuncture Pay*. He takes great pains to express his altruistic mission as his primary focus. Making a decent living is a "blessing" that he enjoys so that he can fulfill his mission. He justifies making money thus:

> Acupuncturists are in the business of helping others. Private practice is a business and you do need to learn how to manage the business realities, but you also need

> to balance the business issues with the goal of helping your patients as best you can. I settled on *Making Acupuncture Pay* [as the title] even though the book is not primarily about making money because acupuncturists should not shy away from the fact that their practices need to be financially successful in order for them to have the opportunity to help others. (p. 3)

Daley (2001) described an important cognitive and psychological process dynamic which may be at work in the new acupuncture graduate as he/she transitions to professional and entrepreneurial roles. She described the transition to professional practice as a process of constructing meaning about and making sense of their profession. This sense-making process occurs as the new professional engages the body of knowledge and technical skills through mentorship and educational activities such as CPE courses, applies the knowledge gained to practice, and reflects on its real meaning in the individual professional context.

Ronfeldt and Grossman (2008) explored the transition of teachers, clergy and clinical psychologists as they entered their professions and found that new teachers' difficulties with professional socialization created "disillusionment, failure, loneliness and insecurity" in the first five years of teaching, leading to high attrition rates (2008, p. 42). They go on to note that clinical psychologists experienced "personal and professional stress and identity transition," which they attributed to expectations that they perform as seasoned professionals in a role that they had only just entered. All these professionals underwent a period of stressful transition, trying on a range of professional self-identities before constructing one that fits the individual within the professional

norms, values and structures imposed by professional membership. If new acupuncturists, absent guidance of mentors within the profession, are struggling with this process in terms of making sense of two very different professional self-identities simultaneously, there might be a disproportional emphasis on one role to the detriment of others (such as investing in technical skill-building but neglecting business aspects of practice, for example), evidence of internal or external role conflicts, or changing self-definitions based in experience and reflective practice. At present, none of these dynamics has been explored in the research among acupuncturists. In this project, I expected new acupuncturist entrepreneurs to be carrying conflicting sets of values into their private practice start-up experiences and to be actively defining their professional selves while they are building a practice, perhaps evidenced by internal negotiation and compromise strategies. Further, I expected that younger graduates starting their professional practices will experience a greater degree of these psychological effects due to their relative lack of life experience and maturity.

Engagement with the Profession

The second major area of challenge the literature addresses is the way new professionals engage (or not engage) with their professions, adapt to its norms and values, and choose a level of involvement in professional networks of support and accountability. Of particular interest is how the new professional accesses continuing professional learning and support (Daley, 2001), and what role and relationship established professional organizations have with the new practitioner. Professional

organizations, according to Adams (1980), have properties and purposes differing from common trade associations and have important special accountability relationships with both their members and with society (see Backof & Martin, 1991, as an example of how professional organizations developed canons of ethics in response to government intervention). They exist to promote the profession and sustain it (Thomas, Hegarty, Whitman & MacGregor, 2007), define its role and scope of practice with the public (Coe, 1970), promote service in the public good (Parsons, 1968), protect its interests (Backof & Martin, 1991; Colyer, 2004), ensure adherence to a set of generally-accepted practice and ethical standards (Adams, 1980), and serve the needs of its members (Coe, 1970; Marutello, 1981). Over time, professional associations form a quasi-guild, controlling the induction of new practitioners, setting professional practice standards, carving out spaces for autonomy in practice, systematizing the body of knowledge of the profession and means of adding to that knowledge and providing for the continuity of the profession (Hall, 1969.)

Krejsler (2005) observed that professions in general are under siege in our postmodern, pluralistic and information-overloaded society. Increasing governmental intervention, increasing stakeholder demands for input and accountability, erosion of the concept of "expert who knows best" due to the information revolution, the increasing pluralism of society, and increasing marketplace dominance have challenged the traditional role of professions, potentially undermining their legitimacy in the eyes of the public. For a professional association to maintain a strong voice in this environment, it must speak with a relevant, compelling and singular message, both to society and to its

members. If, however, the membership's interests are divided, or if the organization's approach or agenda is seen as irrelevant, or if the exchange value (cost of membership vs. benefit derived from membership) to the new member is insufficient, as Yeager (1981) observed, new members may "opt out", remaining marginalized or inactive. Since the recent entrepreneurship literature emphasizes the importance of social capital and robust network connections across a variety of new venture types as essential to new venture survival and success (Audretsch, Aldridge & Sanders, 2011; Baron & Markman, 2000, 2003; Pirolo & Presutti, 2010; Schoonjans, Cauwenberge & Bauwhede, 2011, as examples), this question arises: Do new practitioners who choose not to engage their usual professional associations build surrogate networks? If so, what aspects are most important to these networks, and are they sufficient to provide the critical social and business connections needed for business and professional success?

Challenges in the larger marketplace

Within the general society, the new professional, in addition to being competent in his/her craft, must be prepared for being a business owner and competitor in the larger marketplace, one where the profession is not considered universally legitimate at the present time (Barnes, 2003; Barnes, Bloom & Nahin, 2008). This extra layer of hostility in the environment coupled with the professional's lack of business skills that would assist in navigating that environment could prove to be a major obstacle for new graduates as they start their careers, as the literature emphasizes that business skills training is an important and effective part of new venture preparation (Chrisman,

McMullan & Hall, 2005; Dimov, 2010; Gartner, 1985; among many others). Most master's-level graduates in this profession have had little business management training either prior to or as part of their programs of study (OCOM New Student Survey, 2010, 2011, 2012, 2013; Lixin Huang, 2005). As a result of this trend, many acupuncturists are potentially unprepared for the realities and stresses of life as a small business owner. The lack of business management training received prior to professional launch, as shown in earlier surveys (Kuo, Burke, Coulter & McNamee, 2004, is a good example) registered the practitioners' feelings of being unprepared for the "real world"--potentially increasing the practitioner's negative view of the entrepreneurial role he or she must assume in order to work in the profession. Block and Koellinger (2009) found that those entered entrepreneurial roles unwillingly (as a result of unemployment, for example) were far less satisfied with their businesses, even if financial returns were good. Paradoxically, recent surveys of new students conducted at Oregon College of Oriental Medicine in 2010 and 2011 showed students entering their professional education indicated that they had little business experience or training, yet overwhelmingly (83%) felt average or greater confidence in their future ability to run their own businesses (OCOM New Student Survey, 2011). Though anecdotal evidence indicates that this unfounded confidence moderates as the student approaches the reality of graduation and founding a practice, it may be that the younger, first career students entering the profession today simply may "not know what they don't know." As such, these practitioners might experience a greater level of turbulence and stress as entrepreneurs and might make more mistakes due to overconfidence during the learning process (Hmieleski and Baron, 2009).

Summary of Literature Review

The AOM profession is fairly young in the United States and is experiencing the growing pains of a profession seeking to discover its own identity amid an environment of turbulent change. Growing acceptance of Chinese medicine practice by the public, a trend toward adding acupuncture to health insurance policies, favorable research findings (see Vickers, Cronin, Maschino, Lewith, MacPherson & Foster, et al., 2012), a generally improving economy and a structural cost advantage over western medicine (Braverman, Baker & Harris, 2009) are all positive indicators for the profession in 2015. At the same time, the profession faces significant challenges: lack of inclusion in the Medicare program and much of the mainstream healthcare system, high levels of graduate debt, a profession that is, as yet, largely unable to provide support and guidance in the transition of new members, lack of low-risk paid employment opportunities for new graduates, lack of business skills and training that would help ensure a successful transition to professional entrepreneurship, and a potentially growing divide between factional interests fueled, in part, by changing demographics of the members (Sloan, Reeves, Sledd & Stein, 2012).

Entrepreneurship in the professions is a neglected topic in AOM colleges, and to date, not much is known about the process of transition of acupuncturists from conceiving a professional practice to start-up to growing it to maturity. The entrepreneurship literature to date, particularly more recent scholarship into factors

affecting the professional/entrepreneur, can provide a holistic framework for describing the factors and the process that acupuncturists must consider as they start and grow their professional practices. For purposes of this study, the major challenges facing new entrants into the AOM profession are organized on three levels: individual professional self-image and perceptions, engagement with the profession, and challenges in the marketplace and the larger society. Melding recent scholarship relating to entrepreneurial cognition/perception, social capital and entrepreneurial learning processes within the lens of the AOM profession can potentially increase understanding of how new professionals navigate these challenges and establish enduring and satisfying professional practices.

CHAPTER 3: RESEARCH FOCUS AND METHODOLOGY

Most of the research done to date in the AOM field has relied upon quantitative measures, focusing especially on approximating hours worked and annual income. Our article on the changing demographic forces in the profession (Sloan, Reeves, Sledd & Stein, 2012) established that broad outcome averages in the areas of hours worked and annual income reported obscure important underlying trends linked to changing demographics, and understanding the goals and values of the different groups within the averages is important to the future development of the profession itself. Quantitative methods used in national surveys of the profession (See Ward-Cook & Hahn, eds., 2008; Wang, 2013) may provide some broad measures and averages, but the data collected to date provokes more questions than answers, especially in the realm of the transition process of becoming an acupuncturist and how the new professional finds his/her way.

Given the nearly-embryonic state of research in the AOM field, research questions about acupuncturists' economic and professional outcomes abound, especially in the face of economic challenges, changing demographics and the major changes occurring in the health care sector at the present time. Scholars in professional education must be ultimately interested in improving outcomes, both qualitative as well as quantitative. However, this field is far from ready for generalizable findings and one-size prescriptions. There must first be exploratory research in order to build the necessary knowledge base to support appropriate interventions. To accomplish this, it is important to understand the processes and challenges actually experienced by graduates as they enter the profession and launch their private practices. By using a qualitative narrative

methodology designed to elicit the individuals' stories and reflection upon experience, as suggested by Creswell (1998), Crotty (1998), Sarbin (1986), Miles and Huberman (1994), Lincoln and Guba (1985), and others, a more complete picture emerges of the issues, challenges and impacts upon the new professional that are experienced in the start-up phase, including possibly some that are as yet unknown. These could well become the basis for further research and appropriately-targeted intervention-building.

Research Method and Rationale

Underlying Methodological World View and Assumptions

Qualitative research, according to Creswell (2009), is a means for "exploring and understanding the meaning individuals or groups ascribe to a social or human problem." As distinguished from the positivist objectivism of quantitative research, qualitative research uses inductive and recursive analysis, appreciation of subjective and complex reality, a more involved role for the researcher and participants (Howe & Eisenhardt,1990; Lincoln & Guba, 1985; Seidman, 2006), and emergent questions and procedures. Rooted in sociological and feminist traditions, qualitative research accepts the idea that all research is values-laden and contains biases, that the researcher should seek to be closer to the subject studied, and that there are multiple realities among participants that are equally valid depending on perception (Creswell, 1998).

In the interest of disclosure of the world view behind the research approach as urged by Creswell (2009), this research assumes that narratives are constructed by an individual as part of the process of making sense of events (narrative construction), and how they are constructed is

influenced by social context (social construction). In distinguishing the two constructionist philosophies, we recognize that the narrative construction process takes place within a social context, and social construction contains multiple levels of interactions that may function as lenses shaping the narrative. Together, they provide a mutually-reinforced, multi-level approach to understanding the way an individual makes sense of his/her world and social experience. This research project focused on gaining an understanding of a phenomenon through participants' thoughts, feelings and interpretations of experience within the socializing influences of self, community/profession, and the larger society as expressed in constructed narratives (Bruner, 1967; Clandinin & Connelly, 2000; Gergen & Gergen, 1988; Salzer, 1998).

Narrative Construction

Narrative inquiry as a qualitative research method relies upon the human practice of organizing events and making sense of experiences through stories—a sequence of connected events with a coherent plot, characters, setting and themes (Holley & Colyar, 2009; Sarbin, 1986; Wolcott, 1994). Within the subjectivity of personal story, a fuller, richer picture of complex events, meanings, impacts and perceptions emerges than could otherwise be gathered, and the researcher obtains a sense of what an experience is like. In short, as Johansson says, "the shortest way from experience to knowledge goes through stories" (2004, p. 273).

Sarbin (1986) observed that narrative is part of human psychology, and he quotes MacIntyre (1981) to support his contention that narrative is essential to understanding human behavior and experience. According to Sarbin, humans naturally use narrative structures to

organize the flow of experience and make sense of it, and narrative forms the basis of how humans think, imagine and make choices and moral judgments:

> The narrative is a way of organizing episodes, actions and accounts of actions; it is an achievement that brings together mundane facts and fantastic creations; time and place are incorporated. The narrative allows for the inclusion of the actors' reasons for their acts as well as the causes of happening (p. 8-9).

Social Construction in Narratives

It is important to note that the narrative construction process does not occur in a vacuum. Individuals construct narratives in a social context, and the social context may have multiple levels of interaction (Salzer, 1998). According to Crotty (1998), social constructionism is a world view characterized by three basic tenets:

First, meaning is created by individual humans interacting with their world. Researchers focus on understanding meaning from the *subject's* point of view, not their own. Still, the interpretation of data will reflect the researcher's own experience as well as the participant's. There is therefore a choice before the researcher as to what degree the narrative includes the researcher's point of view. Thus, the researcher and the participant use the lens of self in making meaning of the narrative. As Harrison, MacGibbon and Morton (June, 2001) and Gubrium and Koro-Ljungberg (2005) demonstrate, the various selves of researcher and participant meeting in the interview space provide for dilemmas and opportunities in co-creating the narrative, requiring reciprocity and negotiation in order to present the data that reflects "intersubjective" reality.

Second, cultural, historical and social perspectives shape the sense-making process, so those who want to understand a phenomenon must attempt to enter the context as much as possible. As demonstrated by Creswell (1998), Twigger-Ross and Uzzell (1996), Chege (2014) and many ethnographers in particular, immersion in these multiple contexts provides the color to the narrative's account, enabling deeper and subtler understanding of the meaning being conveyed through the narrative. In this study, I sought to bolster understanding of the phenomenon under consideration by including visiting the office of the practitioner, observation of office décor and symbols displayed, receiving acupuncture services and observing other patients' interactions with the practitioner. Even when distance precluded an on-site visit, practitioners were encouraged to describe their locale, the local culture and clientele, what the office décor looks like and their individual approach to treating patients.

Third, Crotty (1998) emphasizes that meaning is always generated from social interaction of a human community. In this study, I was interested in understanding not only the individual practitioner's views but also how those are shaped through interactions with the practitioner's professional community and that of the society at large.

Using Narrative to Advance Entrepreneurial Process Understanding

It is this realm of the sense-making individual beyond mechanistic stimulus and response that ultimately draws our interest. Johansson (2004), building on the work of Steyaert and Bouwen (1997), Clandinin and Connelly (2000), Connelly and Clandinin (1990) and Polkinghorne (1988) argues forcefully in favor of using narrative inquiry in the domain of

entrepreneurship research in order to bear fruit where traditional positivist methods have failed to advance understanding, notably in the areas of entrepreneurial identity construction, entrepreneurial learning and reconceptualizing entrepreneurship that are the focus of this research. Narrative methodology enhances understanding, "thereby providing an alternative to the predominant ambition in much entrepreneurial research to explain and predict entrepreneurial behavior and to generalize findings" (Johansson, 2004, p.274).

The field of narrative psychology is best understood as involving a continuum ranging from cognitive approaches to more social constructionist accounts which prefer to emphasize the active nature of narrative in identity construction. In reality however, as pointed out by Milnes (2003), most theorists rather than locating themselves at one of the extreme ends of the continuum, fall somewhere in the middle. Hence, I also take the position that narratives can be seen as both representative of the way in which people make sense of their experiences, but they are also co-constructions which are produced within particular cultural, historical and interactional contexts (Jackson, 1998). This approach does not dismiss the existence of an autonomous self, capable of making informed decisions, but rather sees the construction of self and of individual experience as a socially and culturally mediated process. Given the nature of the research and its objectives, this is an important consideration of the study.

Levels of Social and Cultural Mediation

In developing this idea of individual experience interpreted through social and cultural mediation, the research of Salzer (1998) and Rappaport (1994) provides a valuable lens through

which to study the narrative accounts. Haigh (2008) observes that these narratives occur on three levels. As Haigh explains:

> The first level of narration is dominant cultural narratives. These are societal level narratives (or discourse), widely held beliefs in culture which are transmitted through myths, stories in the media and conversations. The second level of narration is 'community narratives', which are common to members of any given community and can have a powerful influence on the behavior of individuals within that community. The third level is 'personal narratives' which are the unique and idiosyncratic storied accounts that the individual gives of their own life and experiences. Hence, to understand the interactions between society, communities and individual experience, Salzer (1998) argues, that a stance must be adopted which investigates different levels of narration. (2008, p.97-98.)

Therefore, using narrative analysis based on person, community/profession and society as levels of social interactions as proposed by Salzer (1998), the opportunity to understand the professional entrepreneurial experience in much greater depth arises.

Entrepreneurial learning in narratives

One way in which the narrative method serves the purpose of this research is that both story structure (introduction, development and summation) and the process of entrepreneurship occur over time and incorporate chains of cause and effect that, coupled with the founder's internal cognitive processing and resulting changes in behaviors, add up to learning and transformation. Cope (2005), Deakins and Freel (1998), and Rae and Carswell (2000), among

others, have described one powerful branch of entrepreneurial learning as arising from "critical learning events," unusual, impactful, deeply meaningful events which seem to lead the individual to reflection and "higher-level" learning characterized by a shift in mindset or basic assumptions rather than simple refinement of existing practice (Applebaum & Goransson, 1997).

Whether "higher-level learning" happens only in the face of jarring, "trial by fire" events is uncertain, but Cope (2003) and Mezirow (1991) agree that these events have the potential to effect transformational change in the entrepreneur's self-awareness and perceptions. It has been noted previously that most of the new professionals entering the AOM profession have little business or management training and are constrained to take on the role of entrepreneur in order to practice their profession. The pilot story method interviews with part-time faculty and recent graduates emphasized the dominance of the trial-and-error (learn by doing) approach to founding a successful business. In each of the pilot cases, the participant encountered a "trial by fire" event, from which arose reflection, realization of an important truth and course change. In each instance, the sudden epiphanic realization had a major impact on the way she/he navigated the founding process and on his/her interactions at the personal, professional and general society levels.

Epiphanies, according to scholars Miller (2004) and McDonald (2008, p.90), are defined as the "sudden and abrupt insights and/or changes in perspective that transform the individual's concept of self and identity through the creation of new meaning in the individual's life". Because epiphanies are sudden and especially meaningful to the individual, they tend to bring about turning points, the sudden and significant, enduring changes in *action* that individuals make to bring congruence between the new, transformed concept of self and identity and his/her

actualization of that identity. Since the personal narrative method described by Sarbin (1986) is a way of gathering insight into the interaction with the self, epiphany and turning points identified in the narratives should prove useful tools for identifying and describing the socialization process on the individual level.

McDonald notes rightly that the concept and psychology of epiphany is under-researched to date, but the phenomenon seems intensely powerful, profound, unpredictable and probably necessary to the deepest kind of entrepreneurial learning. Moon (2004), Morgan (2009) and Jordan (2010) describe attempts on the part of many educators in the professions to teach professionals (particularly nurses and others who must respond to crisis situations) to self-generate a form of epiphanic insight in real time by employing regular reflective practice as a professional mental discipline. The purpose of engaging in this practice as a professional discipline is to spur deeper self-awareness in moments of stress and crisis, to build a habit of seeing from multiple perspectives, and to improve decision-making and professional skills (Issitt, 2003; Morgan, 2009; Walker, 1999). The professional education literature (for example, Daley, 1999, 2001; Daudelin, 1996; Matsuo, 2012) promotes the use of reflective practice behaviors in which the professional engages in "a reflective conversation with the situation" testing intuitive understandings in the moment (Jordan, 2010; Schön, 1983; Yanow, 2009). This form of reflection rather than the ex post facto type of reflection can lead to epiphany-like transformation, change and learning. While not the kind of all-encompassing, dramatic transformations described in the psychology literature (Bidney, 2004, for example), they are important markers of learning, identity-construction and progress toward a mature practice.

Whether the research participants in this study came to critical decisions in the development of their practices through disciplined (though intuitive) reflective practice or whether they experienced a random kind of epiphany as a result of psychologically processing a "discontinuous event" is likely to provide fruitful grounds for further research. However, the focus of this study is upon the *meaning* made by the practitioner from unexpected insights and events, the turning points that arose from the experience, and how the meaning was socialized on the three levels of self, professional community and society at large (Salzer, 1998).

Summary of Methodology Rationale

As proposed by Creswell (1998), Sarbin (1998), Gergen and Gergen (1988) and Miles and Huberman (1994), I used a narrative social constructionist approach to analyze the participants' narratives. More specifically, I used the story method as explicated by Salzer (1998), Clandinin (Dec, 2006) and Connolly and Clandinin (1986, 1990), wherein sense-making happens as participants make connections between knowledge, insight and lived experience within the individual self, profession and general society levels of social interactions (Salzer, 1998). Since starting a professional practice is an active learning process, the nature of the connections, how the narrative is framed, what events and details the narrator includes and excludes, and the choice of unifying themes can be uncovered by constructivist interpretation and recursive analysis, creating multiple layers of meaning and a richer data set overall (Creswell, 1998, 2009).

The research questions focused on a new professional's social experience and history, sought deep understanding of the phenomenon of starting a new professional practice, and recognized that the meaning of one's experience is made in interaction with others (social construction) on several levels and the self (Salzer, 1998). The research purpose also included examining the role of entrepreneurial learning processes (Cope, 2005), epiphany (McDonald, 2008) and reflection (Daley, 2001) within the founding process. Finally I intentionally created flexibility in the interview format to uncover further questions and issues not anticipated (Creswell, 1998).

Research Assumptions

Certain assumptions underlie this research and should be noted as they affected almost every aspect of the project. These relate to the researcher, the participant, and potential areas of bias in the study.

Assumptions relating to the researcher

As a co-creator of the data and active participant in the research as suggested by Howe and Eisenhardt (1990), Lincoln and Guba (1985) and Seidman (2006), the data reflects the participants' interaction with the investigator. Though having formerly worked for an institution of higher education preparing acupuncturists for the profession and knowing many acupuncturists, I am not an acupuncturist. I am primarily a business person, entrepreneur and scholar who desires to see the new professionals find success and satisfaction as *they* define it.

Perhaps because of my knowledge of some acupuncturists and desire to see them succeed, it is important to disclose that I believe that entrepreneurship is not action based solely on innate characteristics of the individual predisposed to take risks and strike out on one's own. Rather, with Whitford (2010), Hofer and Sandberg (1987), and many others who have studied entrepreneurship, I believe entrepreneurship behaviors can be learned. Hofer and Sandberg made this point when discussing the impact of the entrepreneur on the success of the new venture. As they posit, it is not the personality or demographics of the entrepreneur that determine new venture performance; it is the entrepreneur's *behaviors*, interacting with his/her cognition and perception in four ways:

1) Recognizing a need within a changing environment,
2) Deciding (being motivated) to act on the recognition of a need,
3) Taking individual action based on those perceptions, and
4) Motivating or influencing others to act in a similar manner (1987, p. 22).

According to this view of entrepreneurship, the individual entrepreneur is not simply a static set of skills, an unchanging personality, or a cog in the machine mindlessly carrying out a business plan (either her/his own or another's). Entrepreneurial learning, including professional skills development, growing professional wisdom and confidence, opportunity identification and strategy formulation for accomplishing his/her vision is critical for long-term success, but it is also attainable with the proper education and disciplines. This point of approach is important because the vast majority of acupuncturists, at this point in the development of the profession, have few options for practice other than a cash-based, private practice business model. How they

learn and what they learn in the course of starting their professional practice is a key interest of this project.

Assumptions about the participants

There were several important basic assumptions used in creating the interview structure used in the study. First, I assumed that the majority of new graduate students feel a high degree of initial confidence in their ultimate ability to start and succeed at a private practice in spite of a lack of business or management experience or training, based on repeated New Student Survey results taken at Oregon College of Oriental Medicine over six years, reinforced by the pilot interviews and numerous informal conversations with students and alumni about starting practices. Second, I assumed that most graduates beginning the actual transition have seen their confidence eroded as they set out to realize their goals, and the relative degree of erosion might be related to the gap between expectations and reality. While it might be expected that interest in business and ability to start and run a successful practice varies among acupuncturists (absent evidence to the contrary), I further expected that those who don't naturally have these skills and/or training may be at a distinct disadvantage, while those who are "wired" for business may need little help. Finally, given the lack of cooperative education and formal induction structures for new members of the AOM profession at this point in history, I also assumed that many will have experienced some kind of stressful disconnect between what they expected founding a practice to be like and the reality they discovered. I expected to find participants in the process of learning from these stressful situations and developing coping strategies to help deal with practical and emotional needs that arise in the course of founding a practice.

Mitigation of bias

It may be true that all research is biased in some way. One of the issues qualitative methodology scholars have wrestled with over the past several decades has been the tendency to equate the subjectivity of qualitative inquiry with bias as it is seen from a positivist viewpoint—as a threat to credibility. Narrative inquiry is necessarily subjective through the small sample size and non-random selection methods (such as a majority of participants who are associated in some way with one AOM institution), but it is also inherently subjective to some degree in that it relies upon the perceptions and constructed reality of the researcher and participant. Roulston and Shelton (2015) emphasize that, in qualitative research, strict objectivity is not the goal, nor are generalizable findings. Instead, the goal is to explore the subjective deeply and to properly account for the values, attitudes, experience and other factors that underlie the constructed reality. For example, neither researcher nor participant come to the research as blank slates, and the interaction between the two selves present in the interview space and their negotiated agenda (Harrison, MacGibbon & Morton, 2001) can affect the level of disclosure, degree of candidness and what the participant is willing to say on the record. Though the participant is encouraged to construct a narrative of his/her experience, the researcher can shape and co-create the narrative through the way he/she relates to the participant, the level of trust established, the constructed reality of the researcher (what he/she wants to hear) and the choice of prompt questions, to name a few ways. Scholars in qualitative inquiry have generally proposed reflexive analysis strategy to identify cases where the researcher may be usurping the participant's voice or manipulating the data in some way. Others, particularly ethnographers including Chege (2014), Hill (2006) and Harrison, MacGibbon and Morton (2001), have also engaged in managing reciprocity, disrupting

researcher-subject power relationships and sharing write-ups with participants prior to finalization and inviting their comments and edits as ways to avoid bias in their research reports.

In this research project, the structure and practice aimed to treat participants consistently as to interview structure and questions, leaving room for the conversation to develop organically. I strove to listen carefully as to the meaning participants wanted to convey, to clearly note when the conversation assumes insider knowledge or relationship and to allow participants to have final approval of narrative drafts so that possible manipulation of the message is minimized. As Harrison, MacGibbon and Morton (2001) suggested, I "attended to reciprocity" and disrupted the power relationships of researcher and researched in the data creation process in the interest of increasing trustworthiness. Though a collaborative narrative product required some ongoing negotiation with my participants over who controls the data, the result was a thicker, richer data set that the participants think is faithful to their perceptions. Where possible, I have distinguished my voice from theirs, and the analysis and conclusions are mine. While some degree of subjectivity or bias may be unavoidable, being aware of it may help reduce it or at least alert the reader to areas most ripe for it (Seidman, 2006).

Research Design

The project approaches research into acupuncturists' experiences using a social constructionist research approach as described by Berger & Luekmann (1967), Creswell (2009) and Crotty (1998), among others. Seidman (2006) suggests the best sources of data in a case like this are the practitioners themselves and the best collection method is interviewing. Creswell

(1998) concurs in using a small number of in-depth interviews for biographical and phenomenological studies, ranging from 1 to 325, but usually around 10 (1998, p. 122.) In keeping with the emergent nature of qualitative research, we chose 12 in-depth interviews of practitioners of different ages, states, types of practices, length of practice experience and levels of business sophistication.

Research Instruments and Approach

So far, we have established that the personal storied narrative is an appropriate means of approaching the goal of understanding the lived experience of acupuncturists' entry into private professional practice. However, we need a common structure to spur the reconstruction of the experience with a focus on the areas of research interest and a means of data collection that is flexible enough to explore unexpected avenues of inquiry arising in the narratives (Creswell, 1998). The one-on-one interview can provide a useful technique for accommodating both. As Seidman (2006) opines,

> "If the researcher is interested, however, in what it is like [to be in that situation], what their experience is, and what meaning they make out of that experience—if the interest is in what Schutz (1967) calls their "subjective understanding"—then it seems to me that interviewing, in most cases, may be the best avenue of inquiry" (p. 11).

Interviews and Story Construction

The Acupuncturist Experiences Project relied upon narrative interviews in which the participants were asked to reconstruct their stories of how they made the transition from graduate to professional practice, what happened as they started their businesses and grew them toward maturity, and how they were affected by interactions at the person, community and society levels (Salzer, 1998). Because of the research approach chosen, the characterization of the method and instrument require some redefinition from the dominant quantitative research paradigm. First, I used personal interviews that provided a basic structure for the narrative—a story having a beginning, middle and ending--but allowed room for exploring the unexpected (Lincoln & Guba, 1985). Second, the interviewer served as the instrument (Creswell, 1998), allowing for emergent procedures, e.g., flexibility in probing questions, for example. Because I took a constructionist approach to interpret the meaning the participants made from their experiences, the participants were not asked to *recount* their stories from memory so much as to *reconstruct* it (Creswell, 1998; Seidman, 2006). In making this distinction, the participant is allowed to decide what is included and excluded, what is emphasized, and what meaning is given to the events and experiences. While qualitative approaches cannot lead to generalizable findings, they can provide a trustworthy (Harrison, MacGibbon & Morton, 2001; Lincoln & Guba, 1985) basis for building a foundational understanding that helps to guide future research.

Interview process structure, instruments and data collected

While the goal of qualitative research is not objectivity in the data itself, the research approach provided a consistent structure in order to ensure that the participants were treated

equally, and the researcher's participation did not overtly bias the data. We followed Seidman's (2006) three-pass approach that produces three layers of data:

a. Contextual – The researcher gets to know the participant, gains trust for open communication and gathers necessary contextual information to aid in interpretation of the narrative.
b. Historical – The participant tells his/her story and elucidates the details, feelings and significance of the events. The narrative uses literary devices (setting, plot, characters, themes) and structures (such as flashback, foreshadowing, episodes, change of perspective, etc.) to create the body of the narrative.
c. Reflective – The participant reflects on the meaning of the experience, spurred on by the researcher's occasional questions which seek to probe deeper, clarify any confusion, or address the research questions in more detail or from a different perspective.

Seidman recognizes that not all research projects have the temporal luxury of setting three separate interviews with the participant, but he emphasizes that the narrative research process steps must be completed in order for best results in creating a "thick" data set. In this research project, all three steps were accomplished in order, largely in one interview, with the preliminary survey, transcript review by the participants and follow up clarifying questions by email completing the arc.

Pilot study interviews

In order to develop a workable and efficient interview format for capturing the narratives, four practice interviews were conducted between November, 2012, and June, 2013, with part-time faculty members who are primarily in private practice and consented to assist with interview format development. The two-fold goal of these pilot interviews was to practice eliciting stories and to test ways of prompting for narrative on several areas of interest without being overly leading. The faculty members were asked to give feedback on how the interview could feel "more natural" and flow better. As a result, a two-part format was created in which 1) participants were invited to tell their story starting from their introduction to the field to their experiences as they started their own practices, and 2) participants were prompted to tell their stories in relation to moments of reflection, epiphany or turning points in relation to a main theme of their experience. In all practice sessions, the faculty members felt it was preferable to provide a basic chronology of their start up experience and then return in a spiral fashion to flesh out the major themes through vignettes and flashbacks centered on a moment of significant learning or epiphany and its long-lasting impacts on business trajectory. Taken together, the chronology and vignettes reinforced one another and still seemed to provide a way for the participant to shift topics and add suddenly-remembered points easily. As a result, the interview format provided a cohesive narrative but was also flexible in the case where the participant desired to produce a spiraling rather than perfectly linear narrative. The interview format is included as Appendix B.

The interview-based data collection was accomplished in one meeting that incorporated the aspects of Seidman's (2006) three-pass (interview) structure. First, each potential participant

was asked to complete a screening questionnaire (see Appendix A) that was completed before the interview to save time, acquaint the researcher with the subject prior to the interview, and to provide some basic information upon which to assess appropriateness for inclusion. The survey responses were briefly reviewed with the participant to ensure accuracy and as a prelude to the interview itself.

The interviews were accomplished in person, over the telephone and by video chat in order to accommodate the wide geographic disbursal of the participant group. Most of the participants were personally introduced by acquaintances associated with the Oregon College of Oriental Medicine's doctoral program, though two participants were chosen from those responding to a posting on Acupuncturists on FaceBook. Those interviewed by telephone or video chat were asked for additional contextual description, including a description of their office or work space. One participant provided a video "tour" of her office using the FaceTime smart phone application. All interviews were recorded with the participant's permission, and they were promised an opportunity to review the transcripts and add, correct or change the story as they desire to ensure that it fully expressed what they meant to convey. The interview process usually took 1-2 hours of the participant's time.

Characterization of the research participant in the writing

One result of the qualitative inquiry paradigm shift that must be noted relates to the research "subject". In constructionist qualitative research, the person being studied, like the researcher, is far more personally engaged in the process than when purely quantitative methods are used (Lincoln, 1995; Lincoln & Guba, 1985; Seidman, 2006). In view of the depth of

personal disclosure and potentially sensitive topics involved, special recognition of and sensitivity to the person telling his/her story is appropriate (Corbin & Morse, 2003; Seidman, 2006). I therefore chose to recognize his/her role as a co-creator of the data by referring to the narrator as the "participant" instead of "subject." Additionally, I took extra care in handling the data to protect privacy of the participants, and the participant was given a much greater say in the final form and content of the narratives than normally extended. The unexpected result of the decision to give participants' greater control over the transcripts is discussed further in the Findings chapter.

Role of the researcher

As mentioned previously, one of the major paradigm shifts involved in this kind of research regards the role of the researcher. Under quantitative research methods, the researcher is as deemphasized and distanced as much as possible from the subject in order to keep from tainting the data in some way. By contrast, the literature on narrative inquiry recognizes that the instrument used in this kind of research, a human interviewer, necessarily and unavoidably affects the data creation process through interaction with the subject, to the point where the data is considered a joint creation of both the researcher and participant (Howe & Eisenhardt, 1990; Lincoln & Guba, 1985; Seidman, 2006). There are three implications of this joint creation process: the need to recognize "insider" connection when it occurs between the researcher and the participant, the way the report recognizes the researcher and the participants' contributions, and the ethical responsibilities the researcher owes to the participants regarding the data that is co-created.

First, when the researcher is seen by the participant as an "insider" to some degree, as in this project, there could be some points of the interview that reflect insider knowledge and assumptions. For example, the researcher was known by the participants as a vice president of a leading AOM college and a scholar in the field. It is possible that some of the choice of comments conveyed reflected an implied impression of influential connection with the educational institution in some ways. In reality, there were times in several of the interviews where participants seemed to craft their narratives around the knowledge that the researcher/hearer was aware of the inner dynamics of the profession. Two examples were when a participant wanted to give suggestions for curriculum improvement and when he/she wanted to emphasize the lack of support in the profession's institutional structure. Suggestions received regarding curriculum were delivered (without attribution) to the institution, and they did not affect the narrative. These were specifically noted as beyond the scope of the research project in the transcripts except where the point of the suggestion had to do with a significant aspect of the participant's story. Participants' comments about feeling a lack of support from the profession's institutions (AOM colleges and professional organizations) conveyed the strongest emotions of the narratives but were also the points at which participants wished to speak off the record as well. Nevertheless, it could be that the participants' view of the researcher affected the choices of what elements were included and the degree of emphasis upon them to a degree that would not have been otherwise evidenced had the researcher been seen as a completely disinterested "outsider."

Second, the co-creation aspect of the method affects language used to describe it. As the researcher is herself a participant in the data creation to a significant degree in this kind of

research, so it seems appropriate that the research report (e.g., this dissertation document) should use language that reflects this reality. In contrast to the usual conventions where attention to the researcher is minimized through use of passive voice and third-person references, I am most comfortable adopting an approach using "I" and "we" intentionally. For example, when referring to the researcher co-creating meaning in conjunction with the reader or the participant, I have used "we" in view of the inclusive social construction of meaning being created. This may result in a more informal tone than normally assumed in a doctoral dissertation, but it is, I believe, more faithful to the underlying worldview of the research approach chosen.

The third implication of the joint data creation process is an enhanced ethical responsibility toward the participant's ownership of the data. The researcher has an increased ethical responsibility to distinguish between her voice and that of the research participant, to allow the participant to have a much greater say in the final form of the data collected, and to protect the participant's privacy in all scholarly and other works flowing from the project (Lincoln, 1995; Lincoln & Guba, 1985; Seidman, 2006.) Scholars considering the increased ethical responsibilities of researchers in this domain (Lincoln, 1995, and Seidman, 2006, for example) have greatly expanded consideration of how researchers and participants interact and how the co-created data is used. There seems, as yet, to be wide latitude for the researcher to fit the rules to the situation as long as broad principles established in the *Belmont Report* (1979) are maintained: Respect for persons (autonomy of participants, protection of the vulnerable), beneficence (do no harm), and justice (all are treated fairly). Building on years of experience and the *Belmont Report*, Seidman (2006) summarizes the basic rights of research interview participants as: the right of voluntary participation, right to withdraw, right of reviewing and

withholding interview material, and the right to privacy (meaning that the participant's identity is reasonably protected). All participants in this study were extended those rights, which were specified in the project disclosures and agreement to participate (included as Appendices B, C and D).

The degree of participant control over review and withholding interview material may still be subject to a balancing of interests, however. In this project, for example, the participant was given the final authority to determine what is included and excluded from the final interview data set, but I as researcher reserved the right to write my report as I see fit. While my sponsoring institution may "own" the data, for example, it is my responsibility to ensure that the rights and personal dignity of my participants are honored. As researcher, therefore, I will ensure that any voice recordings, transcripts, or electronic communications are protected from inappropriate or unauthorized access by another party.

Data Analysis and Presentation

Once the interview was completed, the transcript reviewed and approved by the participant, analysis and coding of themes in relation to the research topics was completed. Subjects were occasionally contacted by email or phone for clarification questions that arose during the analysis phase, and notes were added to the transcript as needed to ensure interpretation conformed to the participant's intent and "insider communication" was noted. As Swanson and Holton III (2005), Creswell (1998, 2009), Seidman (2006) and Bloomberg and Volpe (2008) cautioned, qualitative data sets are huge and potentially overwhelming, containing much information that is useful to the inquiry at hand but also containing much that is not.

Therefore, the data analysis process followed "analytic circles, rather than using a fixed, linear approach" as suggested by Creswell (1998, p. 144) in order to reduce it to that which is useful for the research aims of the study. As Creswell (1998), Bloomberg and Volpe (2008) and King (2012) advocated, a short list of codes and themes derived from the theoretical basis of this study (e.g., the template approach) was used to winnow the data to that which bears upon the research aims.

While participants' stories included other NVP framework constructs, we were primarily interested in indications of Cognition/Perception (C), Social Capital (S) and Entrepreneurial Learning (L) interacting across socialization levels corresponding to 1) the individual, 2), the professional community and 3) the society in general (Salzer, 1998). We conceptualized this in Figure 1, which is restated below:

Figure 1. Interaction of professional entrepreneurial constructs with Salzer's (1998) levels of socialization during the founding process of a professional practice

Levels of Socialization	Cognition/Perception factors	Social Capital factors	Entrepreneurial Learning factors
1. Individual	C1-Individual perceptions and thought processes at work during the founding process	S1-Individual's social capital and role in founding a practice	L1- Individual's learning processes while founding a practice
2. Profession	C2-Individual's perceptions about the professional community's support and relation to profession	S2-Social capital and interactions within the professional community, networking	L2-Learning processes relating to professional relationships
3. Society	C3-Individual's perceptions of how he/she is seen in society as an acupuncturist, including mainstream medicine, efforts to change/mold social perceptions	S3-Social capital and interactions with the larger society level, building a market niche, managing business environment	L3-Learning processes relating to the larger society, building/maintaining legitimacy

It is important to note that these categories overlap, and some themes in the narratives may resonate with more than one category or level of analysis. These areas of overlap were either considered from multiple viewpoints or categorized according to major focus as seemed to make the most sense in pulling essential meaning from the data. While this involved some subjectivity, consistency and faithfulness to the intent of the participant were the guiding principles used in this classification process.

Once the data was analyzed, the emerging themes relating to the research areas were considered. As Seidman (2006), among others, points out, interview narrative data can be

presented either through more comprehensive illustrative profiles using one or two participants' stories (as in Haigh and Crowther, 2005), or they can focus on the themes and patterns found in the narratives. The objective is to best describe what has been learned, and as Seidman (2006) again observes, there are strengths and weaknesses of either approach. In this case, the data shows a variety of experience such that natural contrast cannot be captured in one or two profiles, except in one area under consideration, so I have used both approaches as appropriate.

Because the profile approach cannot adequately convey the variety of findings in most areas of this study, I have chosen the more conventional thematic approach for those areas (as presented in Bloomberg and Volpe, 2008), in which presentation centers around themes and patterns found in the narratives, supplemented and illustrated by vignettes, quotations and examples from all the participants. While it may be more difficult to present the feeling of the experience in depth using this method, its strength is that it allows for more focus on emerging themes and patterns, especially those in this exploratory study that might suggest directions for future research in the field.

Human Subjects Research Protections

Because the research involves human subjects, it is subject to the IRB process as specified in the University's Research Manual and the *Belmont Report's* (1979) ethical principles of respect for persons, beneficence and justice. The main risk to a participant in this research is potentially to have disclosed some personal information or feeling that the participant wishes

he/she had not disclosed later. To protect all research participants in the project, the following protections were incorporated:

1. Personal identity of each participant was masked when selected. All participants chosen will be given an alias and his/her location and other identifying information masked in order to make identification by peers or others extremely difficult. All documents and recordings referring to the participant were labeled by the alias. Audio portions of video chats were recorded then reduced to a transcript and the original file deleted to prevent identification of the participant. Reference to a specific participant in any report, article, study or other published work will use the alias and avoid using other potentially identifying information to maintain the privacy of the individual. Transcription work was done by one of three individuals who were chosen in part for their distance from the profession and their ability to handle confidential information appropriately.
2. All participants signed an acknowledgement of disclosures statement indicating they understood the proper and intended uses of their information, the steps to safeguard their privacy that will be taken, and the expectations for their participation.
3. All participants were given the opportunity to read, add to, comment further, correct and approve survey form data and transcripts prior to analysis. This is the primary protection available to the participant if he/she feels embarrassment or thinks better of some comment made in the course of the interview. Participants have the last word in what the transcript says.

4. Original data will be securely stored in accordance with the institution's retention policies and then destroyed per schedule. Personal data that might lead to any kind of identity theft or misuse or harm to an individual was destroyed as soon as the need for it had passed.

Limitations of the Research Approach

As suggested thus far, the choice of research methodology has potential for significant benefit to the profession with regard to forming a foundational understanding of an area of inquiry that has been largely unexplored. However, it cannot hope to provide definitive pronouncements on the experience characteristics of all acupuncturists or state categorically which interventions should be undertaken to ensure professional success and satisfaction. Due to small sample size, non-randomness and the methodological approach chosen, the research cannot be generalized. However, as we have noted, we can aim for a level of "trustworthiness" (Harrison, MacGibbon & Morton, 2001; Lincoln & Guba, 1985) in relation to the interpretations of the major entrepreneurship constructs chosen for examination (C, S, and L) across the levels of socialization suggested by Salzer (1998) for members of the AOM profession at this point in time. Given how little we currently know about acupuncturists' experiences as new professionals, this research may provide at least a start at asking the right questions for further research.

In addition to design and sampling limitations, there is also the potential that the turbulent environment of change in the American healthcare system and the AOM profession might have

dramatic impacts upon the transition experiences of future graduates. As shown in our recent demographics article (Sloan, Reeves, Sledd & Stein, 2012), the profession is undergoing rapid feminization, the average age of new practitioners is dropping, and more new practitioners are entering the profession as their first career, which is very different from the graduates of even a decade ago. At the same time, the average total student loan debt load for graduates of master's programs has mushroomed (the average at OCOM in 2011 was over $100,000), and fewer new entrants into the profession report significant business or management experience prior to opening their private practices (New Student Survey, 2010, 2011, 2012, 2013). Finally, the underlying mainstream healthcare delivery system (including health insurance) is undergoing major changes as payers try to reduce growth in spending and the demand for alternative services such as AOM grows. While recent research has not yet addressed whether these factors impact start-up experience, it is likely that the dynamic environment of the AOM profession may cause the transition narratives of future entrants into the AOM profession to vary significantly from those in this study.

CHAPTER 4: RESEARCH FINDINGS

Three major areas of findings arose in the course of completing this exploratory research project. First, a synthesis of recent entrepreneurship research literature provides opportunities to contribute to our scholarly understanding of the new venture performance (NVP) framework and to apply the novice-to-expert professional development progression to this kind of entrepreneurship. Second, unexpected participant behaviors in relation to the methodology perhaps provides clues to the nature of the narrative method as well as how social capital works in relation to an acupuncturist's relationship with the profession. Finally, the chapter concludes with the findings in relation to the nine areas of research questions.

Findings from Synthesis of the Literature

The large and varied bodies of literature describing entrepreneurship and the professions provided opportunities for synthesis of recent literature and advancement of theory in two areas during the course of this project. First, the New Venture Performance framework described by Chrisman, Bauerschmidt and Hofer (1998) can be redefined to reflect the advances in our knowledge of entrepreneurial cognition/perception processes, social capital effects and the entrepreneurial learning process. Second, the literature in the realm of professional career development from novice-to-expert (Daley, 1999; Dreyfus & Dreyfus, 1980) can also be applied to those founding private practice businesses.

Redefining the New Venture Performance Paradigm

In this study, I explored the effects of cognitive and perceptual factors, social capital, and entrepreneurial learning as important determinants of the entrepreneur's business founding performance. The dominant model for new venture performance (NVP), described by Chrisman, Bauerschmidt and Hofer (1998), as well as other entrepreneurship models proposed to date do not account for these factors. In this study, there was ample evidence of all three factors, C, S and L, at work on the three levels of socialization (Haigh, 2008; Salzer, 1998) as new professionals transitioned into the profession and started their practices. Further, the factors interacted with each other to create a dynamic development process in which participants' perceptions were changed as they engaged in both business and professional development activities. These then worked to guide the entrepreneurial "behaviors and decisions" identified as important to new venture performance by Chrisman, Bauerschmidt and Hofer (1998).

The social context, specifically the lack of mentors and lack of support of the profession, directly affected both the perceptions of the professional and his/her learning behaviors, working to delay the professional and business development progress of those who did not come to the transition embracing the notion of starting a private practice. For those who did not see themselves as "business people" or who lack confidence in their ability to build a business (Gatewood, Shaver, Powers & Gartner, 2002), lack of mentors meant extended time struggling, adrift, stuck at the novice level of both professional and business development domains.

Since these professionals are left to learn on their own for the most part, active learning processes in the situation as spurred by reflection, observation and epiphany take a much more important role in the venture's outcome. For example, some reported specific epiphanic events in

which they decided that they must engage in business development behaviors, particularly patient recruitment strategies, in order to stay in the profession they had chosen. Another reported a realization that he must focus on business activities at first in order to reach the stage of development where he could flip his priority to professional development. Others related how they used reflection and epiphany to decide on the best business model for themselves in order to align business goals with their personal values.

In my view, any model attempting to explain or predict new venture performance must reflect recent research showing how dynamic cognition/perception, social capital and entrepreneurial learning processes affect and contribute to the practice's survival and growth.

Dual learning tracks of entrepreneurs in the professions

Daley (1999) built upon the work of Dreyfus and Dreyfus (1980) and Benner (1984) in her exploration of how nursing professionals progress through stages of learning from novice to expert. These process stages, observed in a wide range of other professions, "demonstrated that professionals grow in their chosen career as they gain experience within the context of their work setting" (Daley, 1999, p. 134). Because acupuncturists and certain other professionals as yet do not have many opportunities to work at paid employment within healthcare organizations, they are largely constrained to start private practices. This dynamic puts them in a position to exhibit professional growth and development in *two* domains simultaneously, the professional and entrepreneurial. In this research, there was evidence that all participants were not only progressing along the novice-to-expert continuum in their professional domain, but also in

business acumen through entrepreneurial learning processes. Second, there was evidence that the entrepreneurial learning domain progression follows similar stages to the professional progression of novice to expert, marked by specific behaviors and emphases. Third, in this kind of context, the two progressions seem to be interactive and act to inhibit or propel growth along both learning tracks. That is, if the professional is actively working to progress from novice to expert along the professional continuum, he/she finds it advantageous to also engage with and progress along the entrepreneurial learning continuum simultaneously. Fourth, the steps of the entrepreneurial development progression as adapted from Daley's (1999) and Dreyfus and Dreyfus' (1980) model of professional career development seem to be sequential and cumulative, meaning that each successive step incorporates the focus of the previous step but expands upon it. For example, the expert practitioner, such as Bruce, is still is concerned about "marketing" but he has progressed to a much more holistic approach to that area of the business, e.g., having developed a "brand" that pervades all aspects of the business and ties it together in an integrated identity and vision. He can use a small set of metrics to manage because he has a very deep understanding about all the interrelationships within the various subsystems of the business and knows how each one impacts the ultimate performance of the business in relation to goal attainment.

While this concept of duality of professional and entrepreneurial career development tracks needs more research to validate and to explore the dynamics of the proposed interrelationship, it is not difficult to assume that professionals who neglect one or the other development track will experience some degree of stagnation or disruption in the development of

both as was evident from the participants in this study. It may be that they must progress together for optimal professional expertise and practice success to occur.

Observations Regarding the Research Methodology

A review of the transcripts shows some 15 times in 12 interviews that the participants asked to go off the record while discussing an aspect of their narrative. In 12 of the 15 times, the topic under discussion was related to socialization issues, either relating the failings of their AOM institution to properly prepare students for founding a practice (individual socialization to the profession) or relating the failings of the various professional associations to provide expected community and support (professional community socialization.) Later, when participants were given the opportunity to review and approve the transcript of the interview sans the 'off the record" portions, nearly half (4 of 9) wished to "sanitize" their comments in some way by softening some language or deleting a sentence here and there. Again, these tended to relate to statements critical of their AOM institutions, professional groups or colleagues' attitudes, and some conveyed strong emotion.

According to Sarbin (1986), Crotty (1998) and Salzer (1998), creating a personal narrative is a dynamic process in which the individual reconstructs his/her reality within a social context on three levels: individual, professional community and society. Seidman (2006) further noted that the data set of a narrative interview is a co-creation of the participant and researcher, in part reflecting the participant's view of the researcher in a social context. If the researcher and the participant have nothing in common in a social context, we would expect the narrative to be

less affected by what the participant thinks the researcher expects. However, in this project, some of the data might have been included or emphasized due to the participants' knowledge of the researcher's connection with a major AOM college and my perceived status as an "insider". Alternatively, use of this control mechanism by participants might have been evidence of resistance similar to that which Chege (2014) observed in her ethnography of Kenyan "beach boys", a case where a sense of vulnerability, sensitive topics and reciprocity intersected. Exercising control in this fashion might have been participants' way of seeking safety in self-disclosure.

While many of the participants seemed to be more open with me in expressing their opinions about the profession's faults because of this common connection, most of the participants wished to be selective as to what they told me on and off the record. Due to inexperience in this type of research, my desire for their candor and a desire to honor the participants' need for safe disclosure (Corbin & Morse, 2003), I decided to give the participants the option to control the creation of "their story." I verbally gave the option to go off the record at the beginning of the interview, and I gave permission for participants to review the transcripts and edit, hoping for additional material, clarifications and the like. I expected very little use of these control mechanisms, but I was surprised by the frequency with which some of the participants used them.

As a compromise with the participants, I agreed not to quote any off-the-record comment directly, but I reserved the right to paraphrase the general content and intent of the comment without tying it to one participant, especially where it might bear on recommendations for improvement. In point of fact, most of the off-the-record comments by some participants were

echoed by other participants who left their comments on the record, though expression of these comments was distinctly muted as compared to those who asked for privacy in expressing their frustration and even in some cases, anger.

Participant Characteristics

General characteristics of the group

Since this qualitative narrative research study did not seek to be generalizable in the same way a quantitative study might be, focus was given to choosing a variety of participants with varying experiences and kinds of practices rather than seeking uniformity of participants. I used general selection criteria in order to meet the general purposes of the study and to ensure a rich data set. Participant characteristics included:

a. **Active professional practice**. The major criterion for participants was that they be actively pursuing a professional practice as their main source of income. While some were yet to develop practices that provided the level of earnings desired, all the participants were actively working toward that goal and satisfied this criterion.
b. **Practice stability**. All participants had practices that had reached a level of stability, e.g., had largely completed the start-up phase of new venture creation. This does not infer profitability or maturity, but rather that the practice has survived initial challenges of survival, and the practitioner intends to continue building it in its location. The entrepreneurship literature (notably Chrisman, Bauerschmidt & Hofer, 1998) puts the time to establish a new venture at from 3–12 years on average.

OCOM's Graduate Surveys (Chapman, 2007; Chapman & Burch, 2007; Reeves, Stump & Chapman, 2010), show that practice hours (full-time or part-time) of most graduates of cohorts since 1994 are largely stable on average within 3 years as well. Though caution should be used in assuming a number of years as a proxy for stability due to the effects of feminization of the profession (Sloan, Reeves, Sledd & Stein, 2012), the study participants had all been in practice for at least five years, and half had established their practices during the recent severe recession (2008-2010). All participants had entered the profession between 1999 and 2010.

c. **Gender.** Half of participants in this study were male, and half were female. Of the females, none were currently balancing family demands such as caring for small children or aged parents to the degree that it affected practice development. One participant had put child-bearing on hold until her practice reaches a size to allow her sufficient time off, however. The average number of people in the participants' households was 1.9.

d. **Age of participants**. Ages of the participants ranged from 33 to 68. Mean age was 43.9 years.

e. **AOM schools represented**. While half of the participants had connections with Oregon College of Oriental Medicine for either master's or doctoral programs, some 8 different major AOM colleges were represented in participants' background training. Five of the 12 participants were involved in or had completed a doctoral degree program.

f. **Locations of practice**. The participants in this study were distributed between small towns (under 20,000 population), medium-sized cities (50,000-100,000) and large urban areas (over 100,000) in Oregon, Washington, Illinois, Vermont, Massachusetts, Arkansas, Florida and Michigan.

g. **Other.** Student loan debt reported ranged from $0 to $192,000. Five of 12 reported that they accept insurance reimbursement, and another three reported providing a superbill to patients to facilitate insurance reimbursement directly to the patient.

Participant profiles

As described previously, the twelve participants in the study represent a wide variety in ages, locations, business acumen and viewpoints. Their names, practice locations and other identifying markers have been changed to protect their privacy:

1. John is in his 40s and practices in a large urban area. He is the only participant of Asian descent, and his parents were both business owners. He originally wanted to become an MD, but his perception that medical students overuse prescription drugs caused him to rethink that path. He decided to center on Chinese medicine as a positive alternative. He holds a part-time practice location at the local hospital, where he occasionally sees physicians as patients. His ultimate focus is for helping the western medical establishment to understand and accept AOM.

2. Robert is in his early 30s and practices in a professional office complex in the small town in which he grew up. He is married and his wife has recently joined him as business manager of his practice. Robert has had recurrent instances where he overworks, then burns out and becomes ill. As a result, he realized that he needed to practice from only one location and to

create some "guard rails" around his tendency to overwork so that he can exemplify health and wellness to his patients. One of his practices is to have each patient create a picture, poem or essay describing their conception of what being in good health means for them. It becomes the basis for co-creating a shared vision that he and his patient work toward through AOM and other healthy lifestyle aspects.

3. Joanne is a single woman in her mid-50s from southern California, who came to AOM from a successful career as a scientist. As a result of her quest to find "meaning, balance and beauty" in her life through East Asian spirituality and "wellness practice," she seeks community with others of similar beliefs. She confesses to "not being a business person," and she would like to focus on helping others through her knowledge of Chinese medicine. She entered her AOM career hoping for traditional employment that would give her more time for spiritual practice, but she found instead that "jobs were nonexistent in 2008." She moved at least six times in 5 years trying to find a situation in which she fit. Eventually, she entered a doctoral program and started a practice in her current location in a middle-sized western city. As a result of reflection, she eventually decided that she must "sink or swim" with regard to her practice, so she has recently begun to actively work at patient recruitment strategies. She reports encouraging results in that area but also suggests indirectly that she would love to eventually not be a business owner.

4. Carla is in her 40s and single without children. She wants to project a slightly alternative persona to her patients and has located in a "quirky" part of a large city near similar businesses. She came to AOM from her experience being severely injured in an auto accident and living in pain for several years. Told she would never walk again or be without pain, she nevertheless sought AOM and had a nearly miraculous recovery. Active in sports and the "kinky

community," she finds provides understanding care to other community members and is trusted in treating them. She has worked as a personal trainer and specializes in difficult cases of bodywork and physical rehabilitation. She pours herself into her practice and remains highly energetic. She's optimistic, outgoing and "loves her work."

5. Ann is also in her early 40s, reserved, professional in demeanor and articulate in describing her passion for seeing AOM accepted in the mainstream. She is married and practices in a mid-sized urban area where AOM is gaining acceptance. To further that goal, she spends time working as an activist for AOM in the state legislature. She has a partner in her practice whose practice focus is different from hers but compatible in philosophy and way of conceptualizing the business. She believes in collaboration instead of competition, and she has worked to establish her practice reputation as connected with socially responsible, sustainable business in her area.

6. April is in her late 30s, energetic and creative. She is single and content with her life, but she would like to have a child when she can afford to take the necessary time off. Along with building her own practice, she is experimenting with a co-op form of practice providing space and services to other practitioners who "aren't good at or even interested in business." By making use of her organizational abilities and business skills, she hopes to provide another steady revenue stream that will enable her to realize her personal ambitions. She works long hours, but feels "energized instead of exhausted, even when [she is] tired."

7. Ignacio is in his late 60s, and AOM is his third career, after applied arts and teaching careers. He came to AOM through martial arts practice and massage study in Thailand. He practices in a mid-sized city on the west coast. He is active in providing sports medicine to the

running community and desires to move his practice to a cancer treatment hospital in Thailand after his doctoral program ends. He believes in lifelong learning and expresses a deep love for the principles and philosophy underlying the medicine. As he was taught, he must "treat someone every single day" if he is ever going to master the skills and knowledge of the medicine. While he identifies with Chinese medicine and philosophy, he takes patient care and service to community seriously, so he takes extra care to reach out to western medical caregivers of his patients in order to try to attain coordinated care in spite of the divide between ways of seeing in the two medicines.

8. Madison is the youngest participant at age 32. She grew up in a conservative area of the country where her interest in Chinese philosophy ran extremely counter to the norm. She maintained an expectation that she would become "a highly-paid professional, like a nurse practitioner" upon graduation. She moved across the country to work for an MD in her state, but the offer fell through, and she had no contract upon which to gain recourse. She has moved several more times since graduation, unsuccessfully seeking a job as a practitioner in someone's clinic. She eventually returned to her home town and founded her own practice, but she has struggled due to the very hostile environment toward AOM where she lives. Nevertheless, she has lately discovered a niche in which she can serve people in her remote area and introduce them slowly to AOM.

9. Jane is in her early 50s. She lives in a small resort town where AOM is well-accepted and she has practiced for over a decade. She has a business partner, her son, who just graduated and joined her this year. She is very proud that he has aspired to the same profession and very glad he has more of a bent toward business than she does. Her major challenge is from

competition from other acupuncturists which has become intense in her area in recent years. She has been successful in creating a networking group among local acupuncturists that she feels is very beneficial for everyone's professional development. Privately, she worries that there may not be enough patients in the area to support everyone.

10. Howard is divorced and in his mid-30s. He lives in a remote small town that he chose for the natural beauty and "spiritual resonance." AOM is not well-known and accepted where he lives. His self-identity centers on being authentic as to who he is and how he sees the world, and Eastern spiritual practice is an integral part of his life and medicine. He does not enjoy the business aspects of practice or feel comfortable asking for payment for his services. He experiences ongoing financial pressure due to a large debt load that is not completely due to student loans. His low-volume practice, "sliding scale" fee scheme and aversion to advertising his services contribute to professional isolation as he cannot afford to attend professional development events.

11. Bruce is in his early 50s and practices in a larger urban area that is not accustomed to Chinese medicine or culture. He came to AOM as a professional in another allied health field as a result of observing acupuncture treatment results in China. He is anxious for AOM to be accepted within mainstream medicine for the potential of shifting healthcare from fixing problems to preventing them. He is a systems thinker in designing business processes and who is self-disciplined and focused on his goals. He challenges the conventional wisdom whenever possible in order to gain better results. He sees more patients than anyone else in this study each week in order to both make a decent living and to advance knowledge of the practice in his area.

12. Warren is 40 and came to AOM as a result of involvement with martial arts and experience being treated with acupuncture for pain from wounds received in military service. He was a top sales person after he left the military, but he ultimately wanted to do more to help people. In AOM, he sees a way to help people experience wellness, no matter what they may think about the Chinese systems, culture and philosophy that is often attached to it. He takes pains to be sure that he communicates so his patients understand and feel comfortable connecting with him. He was originally practicing (and struggling) in a large urban area but eventually moved his practice to a small town where he is very successful.

Findings from the Narratives Collected

The participant narratives collected in the course of this study provided important insights into the experience of transition from graduate school to a private professional practice not studied before in this profession. Some of those narratives provided insight into the research themes and their interactions on the individual, profession level and larger general society level. The themes and findings are summarized and discussed by major category (C, S and L.)

Findings Relating to Cognition/Perception (C) Themes

Participants addressed their perceptions and cognitive processes (C) on three levels: individual, professional community and the larger society. This category was the one where evidence of changing entrepreneurial cognition patterns as theorized by Hofer and Sandberg (1987) was most

striking, often as a result of entrepreneurial learning processes (L). While it is important to note that all the factors considered (C, S, and L) interact with one another in ways that are hard to separate at times, the focus at this point is on the role of entrepreneurial cognition/perception.

There were a few points upon which all participants held similar perceptions, and, except for personal financial worries, these were seen largely at the larger society and profession levels of socialization:

1. Transformative potential of the profession. The participants feel that the profession in this country is in an infant stage but capable of being a transformative agent within the larger society for good. Within this view, practitioners took pains to describe AOM as a healthcare profession fundamentally different from western medicine in its philosophical and spiritual component. It is the wellness emphasis and holistic approach to treating the whole person that they feel is most needed to combat the impersonality of western medicine today.

2. Dysfunction in the profession. All participants seemed to agree that the current public bickering and in-fighting on the national professional stage is very toxic to the cohesion and progress of whole profession. They similarly held low expectations and varying degrees of resentment toward their AOM colleges for failing to provide practical and relevant training in how to deliver the medicine, for failing to provide mentors and for generally not caring about them after graduation. As one participant commented, "they taught us the medicine, not how to *deliver* the medicine…and there's no one to teach you when you get out" (John, p. 20-21).

3. Financial worries. All participants seemed worried about the impact of student loan and other debt to the growth and viability of practices, even if they were not themselves in an unmanageable debt situation. Some also expressed concern that in very competitive markets,

acupuncturists are undercutting each other in fees charged in order to gain patient volume (Warren, p. 2).

4. Optimism for the profession's future. In spite of some areas of negative professional perceptions, all participants, no matter their degree of enthusiasm for starting a private practice, seemed fully committed to the ideals of the profession and optimistic that the general society will grow to accept them as familiarity increases with who acupuncturists are and what they have to offer. They also agree with Madison's assessment (p. 3), "I really do feel optimistic about the future. It's just we're not quite there yet."

Beyond these points of agreement about the profession and its potential within society, perceptions of the individual's experience transitioning from graduate to professional and business owner diverged markedly. These perception patterns generally followed either of two tracks based upon whether the participant perceived the role of entrepreneurship positively or negatively. This underlying attitude toward the necessity of entrepreneurship provided a useful lens with which to analyze the participants' perceptions and cognitive processes. Those who tended toward either end of the continuum of perception about this entrepreneurship role are referred to as "embracers" or "resistors". In addition, participants whose experience was closer to their expectation about what practice would be like seemed to experience less distress and be more likely to persist in a given practice setting until she/he found some level of success. At the professional community level, the impact of his/her individual perception of professional support and collegiality of other practitioners (or lack of it) served to reinforce individual-level perceptions either positively or negatively as well. At the larger society level, both resistors and embracers acknowledge that their profession stands apart culturally and perhaps spiritually from

the mainstream of American culture and healthcare. The primary difference is how they perceive the divide and adapt socially.

The following sections outline the findings related to the resistors and embracers categories of participants' perceptions of their experiences on the three levels of interactions.

The resistors

Resistors' Cognition/Perception at the individual level

Three of the study participants, Joanne, Howard and Madison, could be classified as strongly resisting the idea of having to start their own businesses in order to practice as a professional. To quote Joanne:

> No one told me I would have to start my own business in order to work [in my field]. I tried really hard to find a job, but nobody was hiring in 2009. I tried six jobs in four years, all in different places. When I left school, I was burnt out, exhausted. I needed to rest…I thought [in] working for someone else I wouldn't have those responsibilities (p. 3).

Her experience was similar to the expressed expectations of the other two participants in this group, both of whom held onto the idea that employment by another acupuncturist was the right goal for themselves, even in a severely recessionary environment. Their perception of the choice they had to make was where to relocate in order to find employment, not whether to embrace starting their own practice. Building a private practice was a last resort after several relocations and years of job searches failed. Two of these three relocated up to 6 times in 3 years in search of jobs, and when the opportunity failed to meet their previous expectation for what the

employment should be like, they looked elsewhere. Joanne best described what they ultimately wanted—rest from the rigors of graduate school, an income, an opportunity to practice their chosen profession without having to "sell themselves," e.g., engage in patient recruitment activities.

In spite of the difficulties these encountered and the very large gap between the expectations for professional life and practice held as a student and the realities of the market after graduation, these participants endured. Eventually, all but one made a conscious decision to engage in business development activities to some degree in spite of their cognitive discomfort with the idea. As Joanne explained, "Individuals were sinking or swimming…I was going to *swim*. I'm a swimmer; I'm swimming as fast as I can." (Joanne, p. 8) She is now feeling more confident in her ability to build a practice. It still may be that she will decide that she would rather eventually be an employee than a business owner, but her change of perception has at last set her on a trajectory toward success in her present situation.

Resistors' Cognition/Perception at the profession level

The resistors seemed to experience deep disappointment and a high degree of resentment toward their professional schools and the profession itself for their unsatisfying situations during their transition. This discontent came largely from a disconnect between what they thought the profession and professional relationships would be like and what they actually experienced. For example, they related how they had no mentors and no support in starting their careers. For two of three resistors, AOM schools did not sufficiently temper their expectations of finding regular employment after graduation. Though most schools probably attempt to communicate the

realities after graduation, few students have enough experience to understand the information's implications, or enthusiasm for the career overshadows future possible challenges. As a result, many students maintain dreams of regular employment as a highly-compensated professional. Madison explained,

> I thought I would get a job with an acupuncturist and work in a clinic, as an employee with a well-paid salary…maybe someday get my own practice, but start out as an employee…I wanted to get more experience, to learn how the 'behind the scenes' thing of running a clinic, the business aspect, works…I wasn't thinking that I'm going to get out of [graduate] school and get a job making eight dollars an hour as an acupuncture employee. I was thinking to be well paid as a professional, like a nurse-practitioner would (p. 6-7).

For all three in this group, mental models developed in school also emphasized professional collaboration and professional community connection that they found missing once they left school. Joanne described herself as "scrambling, isolated… a little disappointed that none of the acupuncturists I tried to work with were willing to help me [learn how to practice]. It wasn't at all how I thought working for another acupuncturist would be like" (p. 5). Madison remarked,

> "I suspect that graduates [in other professions] get more support after school than we do. It's irritating. It makes me think I should have gone to naturopathic school instead. I mean, we learned how to be really good health practitioners. We did not learn anything about how to be business owners or even how to get a job." (p. 13)

These participants' expectations for the employment setting went beyond merely having a job, including collegial interactions, mentoring and connection. However, in practice, most "employed" acupuncturists are in fact independent contractors working in a business but not part of it, and there is often no reciprocal expectation of mentorship and collegiality on the part of the established practitioner (who is often very busy attending to his/her own practice.) In addition, many established acupuncturists have not provided a path to full partnership in these arrangements. Joanne described one such situation in which she was briefly associated as a contractor. In addition to the perception of lack of mentoring support, she also resented being asked to "go out and market for her [the owner's] practice. The whole reason I didn't start my own practice was that I didn't want to go out and market…If I'm going to have to do that, I should be the one benefitting, not her." (p. 5)

The three participants in this group also spoke of a sense of isolation and "being on my own" in relation to their profession and other practitioner colleagues. They expressed the feeling that once they were graduated, their schools did not care about them anymore: "I feel I got a really good education at [institution]. I loved the program…but once you're gone, you're gone" (Madison, p.9). These participants had the strongest sense of resentment toward their AOM schools and the profession for not providing a path to regular employment opportunities, a lack of preparation for post-graduate realities, a lack of mentoring and their enduring debt load.

Researcher's note: I was struck by the level of passion, anger and frustration that several participants expressed toward their AOM institutions for perceived lack of preparation and support in the early period after graduation. As previously noted, a significant percentage of the participants wished to express their frustration beyond the narrative, taking advantage of my

offer to go "off the record" so that their most unveiled feelings would be registered by someone they considered an insider but not be fodder for quotation (presumably identifying the specific participant) in this research study. It is therefore significant to note that the comments included in the narratives in this area are but the tip of the proverbial iceberg, and further research should specifically address these concerns.

Resistors' Cognition/Perception at the larger society level

A commonality of this subset of participants occurs within their interactions on the larger society level. These are mostly seen in the way they differentiate Chinese medicine from western medicine, the language they use to describe their work and the role of spiritual practice in their lives at work.

1. View of mainstream medicine and AOM**.** They are enthusiastic, even evangelistic, about Chinese medicine's superiority over mainstream medicine. These practitioners expressed their appreciation for principles of Chinese philosophy, describing it as an entire way of life. As a group, they perceive that they are counter to the main currents of culture, but they are unapologetic for it and expect others to accept them on their own terms. Howard gave the example of ordering a sign for his office:

> "The people who made my sign said it wasn't eye-catching. I said, 'the people that need to see me will see me'... I don't want to grab anyone's attention. That's not my goal [to be engaged in marketing]. I want to be part of the counter-culture that Chinese medicine represents." (p. 7)

2. Use of language in describing their work. These participants use language that reflects deep appreciation for an East Asian world view. They speak of "energy work," "moving or cultivating qi," "meridians" and "caring for the chakra." Two of the three seemed to use eastern terminology intentionally to differentiate what they are doing from western medicine. For example, Howard described how he interacts with patients:

> My western mind has shifted so much, to where somebody has a cold and they think it's a virus. I say, no it's actually 'cold'. And you see the weather patterns…[when it's cold,] you see people come in. Throw out the whole viral bacterial thing as much as you can, and start seeing with the eyes of the masters that started this medicine…they knew some stuff we have forgotten...It amazes me what I can do with [this knowledge.] I've reached into people and pulled out traumas…I can grab people's meridians and shift them from left to right…I've stuck in a needle and felt their emotions, I can feel if they are blocked. I can open those channels and it's great. It's the stillness practice, the qi gong. (p.16)

3. Role of spirituality in practice. Most took pains to describe how the spiritual element of the medicine is unique to AOM and an aspect that western medicine does not possess. In line with their philosophy of life, financial considerations seem to play a much smaller part in their decision-making than making time for family relationships, spiritual practice and other quality of life considerations, such as living in an area of natural beauty and working fewer days of the week. For Howard, spiritual practice guides design of his acupuncture practice. He described deciding not to try to treat multiple patients simultaneously in spite of the financial advantages because he realized that his holistic approach of giving spiritual guidance as well as physical

healing required his undivided attention to one patient at a time for an extended time period (p. 9).

Joanne described her path to AOM from a hard science background this way:

> "I had a great career, but I think I had personal discontent. I went on a spiritual journey, started looking into Chinese philosophy, Chinese medicine and herbs. I was really taken with the balance and the beauty…and somehow, I thought, I needed to change professions." (p. 1)

Because these three participants avoided entrepreneurial learning behaviors early on (especially marketing their practices), they often remained in the novice stage of development in both professional and business domains for several years. All three experienced a very low volume of patients and financial difficulty so that they lacked patient treatment experience and reported an inability to afford professional development opportunities (CEU events) that would move them beyond novice level. Eventually, two of the three chose to engage with business development activities, specifically building patient volume and beginning to conceive of a unique market niche or practice specialty. Joanne explained the decision to engage with "marketing" and "figuring it out" this way:

> It looked like everyone was scattered; individuals were sinking or swimming …Everyone was, 'now what do we do?' That's how I felt. I decided I was tired of being frustrated and "stuck", and terrified that I would sink. I am a swimmer. I was going to *swim.* (p.8)

While Howard emphasized his intention to stay in his chosen location and continue his chosen type of practice without regard to financial success, both of the other participants in the resistor group characterized themselves as "not business people" and spoke of their hope that an

improving economy and developing profession will eventually provide the employment opportunities that they really want. While engaging in entrepreneurial learning activities to some degree, their future vision seems to be about enduring in practice until the day that they can be employees without business responsibilities.

The embracers

As there were three participants whose narratives strongly described the experience of resisting entrepreneurial behaviors in order to practice their profession, there were four participants representing the other end of the spectrum, who embraced the notion early on that they would be business owners as well as professionals in Chinese medicine. Their stories had several important themes in common and mirrored the major success factors that Kessler and Frank (2009) and others have found in successful small businesses. These are discussed in the next sections.

Embracers' Cognition/Perception at the individual level

Common themes among the embracers group included: early realization of the need to prepare; a humble "beginner's mind" attitude; embracing business learning; energy and endurance; total commitment; and persistence.

1. Early realization of need to prepare. The first common theme among those who embraced the dual track of professional development is their early realization and preparation for the business founding process, often in spite of a lack of formal training opportunities in their AOM institutions. These practitioners often worked on their business plans, intentionally

developed good credit histories over several years and fleshed out their long-term vision long before graduation with the objective of being able to open the doors of their practice as soon as they achieved licensure. They were not shy about engaging with a range of experts in various fields, from accounting, law, real estate, banking, insurance and computer technology to learn what they felt they needed to know to be a successful business owner (Beresford & Saunders, 2005; Dyer & Ross, 2008). They all spoke of the realization that they had much to learn: "When I started, I knew Chinese medicine but nothing about business. I knew I was ignorant; I just kept asking people until I found out what I needed to know" (John, p. 13). These practitioners were proactive and motivated learners, actively seeking out individual counsel, taking classes, receiving coaching by business people and reading many books in order to obtain the knowledge resources they needed.

2. Beginner's mind attitude. As John exemplified, one particularly striking aspect of the practitioners' perceptions of their novice entrepreneurial status was their adoption of the "beginner's mind" in that realm, the humble realization that there is always more to learn, and one must first accept that he/she doesn't know everything in order to truly learn. No matter how expert these successful practitioners became, they still expressed the expectation that they would need to continually learn more in order to progress, both as professional practitioners *and* as business persons. As Ignacio noted,

> When I started, I was a little older than most of my classmates, so my patients tended to think I was wise. By contrast, my partner looks like a surfer kid, and his patients were skeptical that he knew anything at the beginning. We both know that we have to keep

> learning—both business and the medicine—if we are going to ever be any good at this. I owe it to my patients to have my act together in my business, too. (p.4)

3. Embracing business learning. While the resistors tended to express a lack of interest in learning about business, even if it might help them in practicing their professions, one of the embracer's group described being so inspired at the benefit of learning his accounting software that he offered to do a continuing education seminar to teach others how to do it easily, but only a handful of practitioners took the course (John, p. 13). One successful practitioner noted that her skills in business organization and willingness to engage with business development created an opportunity for her to provide shelter of a sort for practitioners less business savvy:

> I went to school with a lot of these people. A lot of them don't have the skills to build a business or the interest to do so…My idea was [to set up a practice setting] where practitioners have room to focus on their strengths instead of their weaknesses. (April, p. 6)

4. Energy and endurance**.** Another theme among the embracers was that they exhibited high energy, determination and endurance in pursuing business development (Kessler & Frank, 2009) and professional growth simultaneously. They agreed that starting a practice involved much more time involvement and hard work than any employment, but they all expressed the expectation that enthusiasm, long hours and hard work are normal and necessary in the course of founding a successful practice. Warren commented this way:

> My advice for new graduates is, they have to know that it's a lot of hard work! This whole notion that 'I don't have to work hard' to make it happen, just spend hours meditating, is a load of sh*t, pardon my language…if you want to work for yourself, you

> have to work 12 hours a day. You have to always be on call, and it's friggin' hard…A lot of people think it will just show up, and it won't. I know school is hard, marriage is hard, raising a son is hard, but that's the way it is. *Everything* is hard; it's called life, so just shut up and do it—or don't. Make up your mind. Be passionate about something! (p. 6)

In order to maintain this level of energy, participants in this group emphasized the importance of having a strategy for conserving personal energy in order to endure for the long haul. Robert (p. 11-12) relayed an account of how he overcame a habit of overwork followed by illness and burnout after he realized that he could not do everything he felt needed to be done by himself. By enlisting his spouse in his business and entrusting her with setting boundaries for him, he was able to live a more balanced life and avoid patterns of behavior destructive to his health while growing his practice.

5. Total commitment. The fifth common theme among the embracers was the agreement that founding a private practice requires total commitment, as Kessler and Frank (2009) also found. John and Robert took out substantial loans to realize their business plans (Petrova, 2012); Robert, Bruce and Warren all consciously decided not to take part-time work when actively starting their practices so that they could devote themselves fully to the demands of the nascent practice. They could do so because they had partners or spouses with employment to provide moral and financial support during the early months and years (Kessler & Frank, 2009). Even those who did not have spouses or partners to enable the financial luxury of full-time involvement from the start exhibited extraordinary commitment and focus. For example, April worked two part-time jobs for a time in addition to starting her practice and by having a detailed action plan that she worked on daily until she was able to transition to the practice full-time.

6. Persistence. Embracers are willing to exhibit hard work, persistence and determination because they have confidence in their abilities and maintain optimism and faith that they will eventually succeed, even when difficult times made it look as if they might fail. John recalled one point where he had nearly run out of capital and considered closing his practice:

> My father said…Business is hard, but just keep it up and see what happens. I've failed many things in my life, but I keep going. It's the ethic and fundamental moral concept of the indomitable spirit, of trying to do your best, and eventually you will succeed. (p. 15)

When asked if there was any decision he would like to have changed in hindsight, John noted that all the mistakes and difficulties contributed to his success, so he would not want to change anything (p. 16). This ability to see a larger purpose in one's difficulties, as a part of the learning process, seems to be a critical perceptual resource of the embracers, imparting resilience to weather hard times.

Embracers' Cognition/Perception at the profession level

Common perceptions of the embracers seen toward the profession and its institutions included the following areas: attitudes toward professional business preparation as it is currently done in most AOM schools, lack of collegiality among practitioners, profession in-fighting and assumptions regarding its proper role, and engagement with the western medicine system.

1. AOM schools' role in business preparation. The positive attitude toward entrepreneurship exhibited in this group seemed to produce a common impatience with the profession's lack of sophistication and effort in providing practice development training. One stark difference in perception between the embracers and the resistors in relation to what they

expected from AOM schools' business preparation training was in the level of sophistication of the curriculum. As noted in a study of business curriculum across AOM colleges (Stein & Sloan, 2011), novice-level training needs such as patient recruitment techniques are emphasized to the exclusion of other topics needed by new professionals, particularly accounting skills. One participant noted that the business class seemed to focus on marketing techniques, and her classmates seemed unaware that there were other things they needed know (April, p. 8-9). To a person, this very successful group expressed strong disappointment with AOM schools for "dumbing down" (Bruce, p.16) business and practice management curriculum and for the lack of time and emphasis on practical skills in this area that are commonly needed for building a successful practice. They also criticized the schools for not demanding enough of students in the business classes given the value of these skills to long-term success. All but the most resistant new professionals mentioned QuickBooks accounting software and insurance billing systems as training they wish they had received in school. Embracers also noted the need for more advanced-level training, including financial planning and management, contracting, engaging with the insurance system and understanding the legal and tax aspects of small business.

2. Lack of collegiality. Though embracers reported their efforts to be a positive role model to other practitioners, they expressed disappointment with the profession for a lack of transparency and collegiality, especially when it works to harm some members:

> This profession has a problem, ultimately that causes financial and practice failure, and that is in-fighting…schools fight with each other; practitioners don't share information…they don't work together at all…it's more about their own agenda, and it robs the entire profession. (John, p. 8)

3. Dysfunctional professional societies. All agreed that the primary national professional societies are highly dysfunctional in the way they act at present, but there was a significant divide as to the perceived role of the professional society. While resistors seemed to assume that the profession (AOM schools and professional organizations) should be involved in providing support to individual graduates through mentorship and employment opportunities (Joanne and Madison, for example), the embracers took the view that the professional organizations exist to advance the profession instead of individuals. Because of this contrast in viewpoints, the embracers see the goal of involvement in professional networking very differently from resistors. Embracers expect individual level professional relationships to be highly reciprocal (Pirolo & Presutti, 2010) and judge the quality based on a sense of equal exchange in value, as Ignacio commented:

> I tried to be a loyal member when I first came [to his state], but they do nothing for me, no referrals, no advocacy, no nothing…when I would go to a meeting, it was all about what someone could get from me, not equal at all. (p. 5)

As a result, the embracers tended to frame their professional interactions as a few individuals with whom they could truly collaborate as colleagues and eschewed professional "networking groups" as being "too many people trying to get business from other people instead of going out to get their own" (Warren, p. 4). They often expressed disappointment with the AOM profession for its lack of helpful networking groups, except for the few informal collegial relationships that they developed in a doctoral program (Ignacio, John, Bruce and Warren). Ignacio in particular felt that his "interdisciplinary" cross-profession network was the best way for him to get and give professional advice and support.

4. Engagement with western medicine. As well as selective engagement with their own profession, the embracers tended to be the group that made the most effort to engage western practitioners. From having a practice location within the local hospital (John) to be seen by western medical practitioners to configuring their office layout so that it mirrors a western doctor's office in décor and systems (Bruce), the embracers are creative and determined to make connections with the dominant medical establishment. Ignacio (a moderately successful practitioner) relayed the story of one fibromyalgia patient he treated, whose symptoms were, he believed, being magnified by her pharmaceutical prescriptions. After researching all the drug interactions and reconstructing her whole drug regimen, he repeatedly called her physician to offer his consultation:

> I said, I want to consult with him about his patient (I could have said '*our* patient')… Anyway, I kept calling this guy until he agreed to see me. I brought my medical records and the list of her prescriptions. At first he was the typical MD attitude, stands for Minor Deity…But he was blown away—he didn't realize she was taking half of them! I said I was worried that she might be getting worse due to drug interactions, and what did he think he wanted to do about it. I told him exactly what I was doing to help her, in western terms, and gave him a copy of the chart notes. I emphasized that her improved health was my only goal, and I wanted to work with him to do that. (Ignacio, p. 5)

Embracers' Cognition/Perception at the larger society level

Themes relating to the embracers' view of the larger society included their perception of how they are perceived in the eyes of western medicine and patients, bridging strategies for crossing the east-west divide culturally and having a global vision for the profession.

1. Validation by western medicine and patients. As well as having deep passion for Chinese medicine and a belief in its superiority, these practitioners also expressed deep satisfaction especially when validated by receiving referrals from mainstream medicine (John, p. 17) or when they are able to help patients overcome health issues that have not been helped by other kinds of medical practice—"Patients limp in and dance out. To me, that's success." (Carla, p. 18) To them, this is evidence that there is hope of eventual acceptance by mainstream medicine and of respect for them as a healthcare provider.

2. Bridging strategies crossing the east-west divide. As a group, the embracers are careful to consider the need for their practices and their individual manner to appear welcoming to those who are not familiar with Chinese medicine. As a result, they spoke of being careful with the use of terminology in communicating with patients, society and mainstream medicine. The three most successful participants spoke of the need to "speak English, not qi" to be understood, and framed their approach as "making gateways instead of barriers" for westerners to become familiar with Chinese medicine, e.g., refraining from making the patient enter a "foreign" psychic or social space to receive treatment. This also means creating some inviting point of entry for the uninitiated, such as tai chi or yoga classes, before offering acupuncture or unfamiliar herbal concoctions, a strategy effectively employed by John and Jane.

As they are careful about use of language as a gateway factor that can either make entry into the world of AOM easier or harder for American patients, the embracers also made careful use of western medical conventions in the practical office environment in order to meet the expectations of patients, sometimes in spite of their own personal preference. There were several strategies mentioned to create this kind of familiar space for patients, such as obtaining a doctoral credential, hiring office managers early to separate the financial transaction from treatment, wearing white lab coats, taking blood pressure of patients, keeping Asian influences in décor to a comfortable level for their patient base (including removing a Buddha statue in a Bible Belt location), using standard weekday business hours at a minimum, providing insurance billing services, providing convenient telephone and/or online scheduling access and location in buildings with professional offices.

3. Global vision for the profession**.** Though the recent recession made persistence difficult for embracers as well as the resistors, embracers each recounted instances of how they hung onto the belief that what they were doing was important for the good of the entire society. Having a wider vision of their role in improving society seemed to provide important impetus for continuing to overcome ignorance of AOM and to persist in building their practices. John framed it this way: "For me, it is that I had the opportunity to help people change their minds about medicine and health." Warren added, "Everyone is sick in America; we have a powerful way to help them get well. We need to go out and find them and do it." Bruce expressed the most global vision of the group:

> I don't want to be a relief care physician. Yes, I want to help patients get well and have their symptoms go away, but I'm more interested in that patient never having that

> symptom come back again. I wanted more for them to…journey through the entire health correction and end up in maintenance care, the philosophy that patients should be coached on habits of wellness. I really want to change the whole [healthcare] conversation. (p. 2-3)

Findings Relating to Social Capital Themes

The literature indicates that entrepreneurs are either helped or hindered by their ability to use social capital in founding their businesses (Baron & Markman, 2000, among others). Social capital has four components: social perception (how adept a person is at reading others' perceptions), impression management (how adept a person is at making himself/herself appear in a positive light to others), persuasion/influence (the ability to change other's ways of thinking), and social adaptability (how well a person can adapt to different social situations). In this study, participants' use of social capital in founding their practices were examined in these four areas on individual, professional community and larger society levels.

Social Capital on the individual level

On the individual level, the study showed that AOM practitioners must actively manage all social capital components in order to grow their practices, but at the individual level, social capital was most actively seen in five areas: support networks, resource acquisition, patient recruitment, patient retention and perception of care.

1. Social capital in support networks. In this study, most of the practitioners used their individual social capital to gain needed financial and outsourced business services as well as to gain patient referrals and keep current patients. On the individual level, participants expressed reliance upon family and friends as the primary sources of support, resources and skills in the early days. Those with supportive spouses and partners to provide moral support (and secondary income streams) seemed to report the least amount of stress in the founding process, even if the spouse or partner was not directly involved with the business. Ways participants noted that social capital networks benefited them included: encouragement and moral support when hard times threatened survival, counsel in making business decisions involving areas where the practitioner did not have a strength, accountability for the level of energy put into the practice (including limits on what qualifies as an emergency) and "grounding" perspective, defined as providing a sense of balance (Robert, p. 14). The most successful practitioners in the study consciously made time to nurture personal social connections, particularly outside the profession where they engaged in another "community of interest" for hobbies or service. By contrast, all the struggling practitioners lacked close personal supporters while all the very successful practitioners had strong, positive family support structures.

2. Social capital in resource acquisition. In the realm of resource access, close family members and friends provided most of the financial resources for startup (with the exception of John, who took out a substantial SBA loan co-signed by his father). Other participants received help with converting office space (Madison) or free use of space for a time (Jane) to help keep costs down. Robert entered into a cooperative arrangement to share janitorial services with other professionals in his office building as a result of organizing them for that purpose. April's co-

operative experiment showed how a socially-adaptable and business savvy professional can build a second source of income while providing a valuable service to others by handling business functions for those who do not see themselves as "good at business."

3. Patient recruitment**.** The narratives of the study participants contained recurring themes of leveraging close personal relationships for patient referrals as well as gaining needed resources. Often, the first patients a new practitioner treats are family and friends who are more likely to stay with a new practitioner learning how to interact with and treat patients because of the preexisting relationship. The practitioners in this study who returned after school to their home towns found an embedded base of social contacts that often provided a noticeable boost to the new practice (John, Robert and Jane). Further, those returning home were less likely to relocate again due to deeper community connections. Several participants' narratives included episodes of interruption in their progress due to relocating their practices, even short distances. Carla observed that, while it was ultimately beneficial for her to move her practice to a more visible location, in the short term, a move of four blocks was nearly disastrous. In hindsight, she would have planned the move more carefully and started much earlier to prepare her patients for the transition.

One important role for social capital in founding private practices echoed across all the successful practitioners interviewed was their involvement and service within a community of interest outside AOM. For example, Ignacio is active in the running sports community and volunteers treatments for marathon runners. Carla's involvement in the leather community gave her almost exclusive access to "kinky" enthusiasts and their specific health needs. In these cases and others, involvement in some local community of shared interest allowed the AOM

practitioner to use persuasion and influence to extend awareness of AOM into other corners of their local community and build patient referrals from them.

Every participant in the study underscored the satisfied patient referral as the primary way practices grow, but not all referrals come from patients who have seen extremely positive clinical results. Robert recounted how patients he has had little clinical success with have nevertheless recommended him to others because of his willingness to show interest in his patient's entire person. Warren told of a patient with a very challenging neuromuscular degenerative disease who came to him and asked if AOM could help. He was honest with the patient that he had never personally treated someone with this condition and offered to treat the patient for free if the patient wanted to try. The deal was that he would not charge the patient for the learning experience, and the patient "might get lucky" and improve (p. 7). Warren told me that the patient had seen only a small amount of improvement, but he had referred other patients on the strength of his perceived caring and integrity in not overselling the medicine's benefits.

4. Patient retention. A new practice may benefit from a base of family and friends' support in the early days, but it quickly requires more patients to survive and grow. Since AOM businesses seem to grow primarily through word of mouth, maintaining and growing social capital is critical to survival. An acupuncture practitioner may join insurance panels, but if he/she is unable to form a positive impression with the patient socially as well as technically, the patient is not likely to return. All the very successful participants made patient retention efforts a priority, primarily emphasizing the value of the medicine for keeping well, ensuring clear and effective communications and providing a positive patient treatment experience. According to

Bruce and Robert, as patients become accustomed to a regular treatment rhythm, their tendency to drift away decreases and their tendency to refer their practitioner to others increases.

5. Perception of care. Western medicine is commonly accused of feeling impersonal and uncaring in patient's eyes, while "compassionate care" is a core value of Chinese medicine. While most of the participants indicated that taking time to express care and concern for the whole person is a critical piece of their treatment approach, Bruce took issue with the idea that being a caring healer means taking a lot of time with each patient. For him, a short period of time can be effective if he is "intentional" in whatever amount of time the interaction takes. He works to be completely focused on the patient, listening intently, answering questions and communicating clearly while sticking to the point of the visit. Together with his efforts to make sure "I don't waste the patient's time or mine" by running a very efficient office, Bruce is able to see many patients who feel that he is providing very high quality care. Warren is also emphatic that intentional focus on the patient is more important than time spent, but he feels that patients ultimately want healing most of all, so he has focused on gaining a lot of treatment experience to hone his craft.

Social Capital on the professional community level

Social capital findings on the professional community level were primarily centered on how the practitioner related to the professional organizations at state and national level and their AOM schools. In general, both successful and less successful practitioners expressed annoyance with the national professional organization for its "constant bickering about the little stuff instead

of working on the big stuff, that advances the whole profession" (John, p. 4, 8). Few of the participants reported supporting this group by membership or donation. Support of state professional organizations was mixed, with a few practitioners in states with active associations being enthusiastic supporters (e.g., Robert, p. 17). Others reported professional landscapes in states where other professions are making inroads into acupuncturists' scope of practice with impunity and no response from the acupuncturists' professional organizations. In the cases where new practitioners felt that the profession owed them support and help with the transition into practice (notably Joanne, Madison and Howard), they felt disappointed and angry, disinclined to support the profession. However, those who did not expect direct benefits from professional membership seemed to feel that it was the professional's *duty* to support the larger professional organizations even if they seemed dysfunctional, in order to attain the larger goal of acceptance by the larger society. Robert put it this way:

> I think it's really important that we have a good professional organization to represent us as a profession. You know, as a group of people, we are really anarchistic, tend to go against the grain just by choosing this profession, so we tend to argue a lot and not communicate well at a group level. We need to get across the word to people that what we're doing is not quackery...we need to focus on that. (p.17)

All the practitioners participating in this study noted that mentors for new graduates are nonexistent, and those who could provide good mentorship for new entrants into the field are either too busy or not interested in sharing how they learned what works (John, p. 8). As a result, those participants who were not already adept or interested in business felt disadvantaged and adrift in figuring out how to go about starting their practices. In view of this deficiency,

practitioners have developed several coping strategies to fill the gap that a mentor from the profession would normally fill. Among the approaches used by participants are:

a. Selective network-building among AOM school classmates, particularly in doctoral programs. Practitioners involved in advanced programs such as doctoral studies (five in this study) indicated that they chose to build a consultative network among certain classmates, even if those persons were scattered around the globe. They used technology to keep in touch socially as well as to discuss cases and share potential treatment options as well as to "bounce ideas off each other [about business]" (Ignacio, p. 5). This type of professional networking was highly satisfying to all participants who engaged in it. By contrast, participants generally described their AOM master's program classmates as not being much help in networking, because "the people I graduated with were also struggling, were like, 'what do we do now?'" (Joanne, p. 8)

b. Maintaining connection with AOM schools and faculty. Several participants (e.g., Howard and Madison, for example) indicated that they felt the AOM school faculty members were the most logical source of mentoring, but neither of them had been successful in gaining a mentor from their AOM school in spite of their attempts. They attributed this to faculty being too busy to respond to communications, schools' focus on current students rather than graduates and lack of career focus within the institution, especially in business skills development. Robert expressed appreciation that his AOM school had one faculty member specially tasked with professional (business) development but questioned whether the faculty member had time to really mentor anyone. Two participants who lived near another AOM college (Ann and Jane) reported doing clinical supervision of student interns primarily to support their income, but also

so they could meet other faculty who might be helpful to know if they needed to consult with someone on a difficult case.

c. Engagement with AOM and healthcare networking groups. For professional growth in the AOM and other allied medical specialties realm, participants found general "wellness" networking groups somewhat beneficial for building awareness of new treatment approaches and being known in the community. For learning how to build a practice and gain patient referrals, most found them of little use. One participant expressed the opinion that they might have a negative effect on building a practice in that they could be an excuse for a practitioner to avoid patient recruitment activities (Warren, p. 4).

d. Online community involvement. As the national professional organizations and AOM schools have lost relevance in the eyes of many practitioners as sources of help and advice for new professionals, the online community has arisen to potentially take their places. Carla, who practices in a large urban area, noted that "nobody really gets an acupuncturist until they need one" (p. 2-3). As a result, she spends a larger amount of time than she would like on her practice's FaceBook page interacting with her "friends" and posting information designed to catch the attention of people who have recently been in auto accidents or know someone who has. Her goal is to be noticed at the point of need, but she admitted that "I resent the fact that I use FaceBook, but I kind of feel like I have to" (p. 9).

The youngest participant in this study, Madison, lives in a part of the country where there are few acupuncturists and the medicine is largely unknown among the public. She reported that her major source of professional networking involvement and connection is the 8,500 member Acupuncturists on FaceBook group. She also subscribes to the Acupuncturist Business

Academy, another online FaceBook group "dedicated to helping acupuncturists figure it out," according to Lisa Hanfileti, the group's founder and moderator. In both these online groups, acupuncturists can discuss treatment approaches, professional insurance options, get advice on a range of practice-building topics, pose questions to the group and occasionally give and get referrals. Given the convenience and immediacy of access, the online social media community is Madison's primary means of connecting with and interacting with the profession.

Social Capital on the larger society level

All the participants in this study recognized that they are in a counter-culture field that is still outside the mainstream of the western medical system. It seemed that each individual developed his/her own strategy for managing others' perceptions based on his/her objectives and values. For example, Warren's colleagues located in an area known to be accepting of AOM practice cautioned him against moving his practice to a small town where AOM wasn't well known or widely accepted. Warren is high in social adaptability and impression management. He decided to position himself in the smaller community first as "the pain guy" (p. 7) with the confidence that his ability to treat pain successfully would open further doors for treatment based on results instead of philosophy. He further chose to use terminology familiar to mainstream Americans and to provide a treatment setting with the look and feel of a familiar doctor's office. By making his first patients comfortable with him and treating their "gateway symptoms" successfully, he was able to leverage the social capital made among the first patients to a steady stream of referrals. By contrast, Howard chose to position himself as the "alternative"

practitioner in a socially conservative area where most of the population has no familiarity with AOM or is skeptical of it. His addition of Eastern spiritual aspects to practice, avoidance of what he sees as immoral "manipulation" in normal patient recruitment methods and his decision to limit his patient flow to one patient per hour all worked against growth and left him socially marginalized in his community.

Findings Relating to Entrepreneurial Learning Themes

This study sought to explore participants' learning patterns, including use of reflective practice and elements of discontinuous events and epiphany as described by Cope and Watts (2000), McDonald (2008) and others. During the analysis of the narratives, it became clear that the participants also were progressing along a continuum of novice-to-expert (Dreyfus & Dreyfus, 1980; Daley, 1999) in the business realm at the same time as they were progressing from novice-to-expert in their professional development. Entrepreneurial learning in this study seems to be tied to experimentation, reflection and epiphany in relation to a particular issue or problem, usually involving a change of viewpoint or reframing of the issue, resulting in a positive turning point in the business trajectory. McDonald (2008) describes various kinds of sudden, dramatic epiphanic experience, but while these participants often described their epiphanies as being quiet and gradual realizations, they were still powerful and intensely meaningful. In this study, they often produced a marked turning point that moved the practice forward in both business and professional development. These occurred in relation to all three levels of interactions: individual, profession and larger society.

Entrepreneurial learning on the individual level

Practitioners' learning in the business domain covered a wide range of insights gained through trial-and-error experimentation, observation and reflection. As previously noted, mentorship and extensive formal business training are not usually part of the acupuncturist's preparation, so learning is varied and organic. Significant epiphanies, realizations and turning points realized by the participants covered aspects of practical business formation as well as aspects of individual level, professional level and society level interactions. A list of significant realizations reported by the study's participants in their own words is included in Appendix E.

At the individual level, there were six major recurring entrepreneurial learning themes:

a. Discontinuous events. Most of the participants' narratives included instances of discontinuous events as described by Cope (2005), jarring and unexpected events that challenged the practitioner to consider his/her business approach in a new way. Besides the experience of being thrown into an entrepreneurial role without a mentor or training, the most common impetus reported ultimately grew out of the recent severe economic recession that began in 2008. Five of the twelve participants in this study obtained licensure during the period 2008-2010, and all of these cited the general economic climate as a primary challenge in building a stable patient base, especially as patients gained and lost insurance coverage. Those who did not involve themselves in the insurance system (e.g., completely cash-based practices) found their patient flow even more dependent upon the patients' economic well-being. To cope with this turbulent circumstance, participants tried a variety of strategies to keep patients on their treatment schedules. One participant (Howard) described charging patients on a 'sliding scale' based upon what the patient thought they could afford, essentially a donation-for-service model based on his

values of "integrity and compassion". He found, however, that the local cultural norm of "not wanting to accept charity" hampered his good intention to help people dealing with economic distress, and he had to start charging a set fee again, based on time spent with the patient rather than the number of services provided, in accordance with his moral view of exchange.

During the economic downturn, other practitioners, like Ann and Warren, also experienced wild fluctuations in patients' ability to pay and financial threats to the continued survival of their practices. Being concerned about the professional ethics of appearing to prescribe treatment based on ability to pay, Ann wrestled with her own economic well-being as well as her patients'. Warren "knew from experience what it was like to not have money for lunch" and promised himself he would never turn away a patient for lack of ability to pay. Both chose to create funds within their practices from which they subsidized patients' payments for short periods of time so that the standard billing fee remained the same but patients in difficult economic straits received a "discount" from the fund. Both found this strategy more socially acceptable than the "sliding scale" approach. Ann noted that "it is important for long-term relationships to be built upon equal exchange, and a discount is a way to offer help without the patient losing face in the process." Warren reflected on his need to be known and build awareness in the community, so he purposed to treat anyone who entered his office without charge for the first month. He learned that most initial visits were from those who were merely curious, but many of those "liked him" and eventually referred friends and family members for his services.

Madison, another practitioner in a particularly challenging economic environment where acupuncture is not well known suddenly found her business environment surrounded by

chiropractors doing "dry needling" and advertising it as acupuncture. Reflecting on their relative market power versus hers, she decided she must reinvent herself to provide a different set of services that people wanted. Her solution was to build upon her interest in nutritional counseling and functional medical testing and interpretation as a way to attract patients with acupuncture treatments provided as a secondary service. Madison charged standard lab test rates for the testing and discounted her acupuncture treatments. In addition, she created a mobile service in order to reach remote underserved locations. To make this strategy viable, she provided a 'superbill' with the necessary information so that the patient pays up front and then can submit the charge to insurance for reimbursement. One unexpected epiphany from this experience is that she reported much higher patient interest in and compliance with treatment plans. As she said,

> When they see the [test] result, that number, on a piece of paper, it suddenly becomes real, like, 'oh, I have to do something about this result.' Then they will listen and are more likely to do what I recommend…I try not to make them make big changes all at once, too. It seems to work a lot better that way. (Madison, p. 11)

Also coming into the profession during the recent economic downturn, Robert decided to return to his small hometown primarily because he was fatigued, ill and burned out after AOM school (p.7). His parents lived in that area, and he thought he could use the moral (and perhaps financial) support of his extended family. Once he returned to the area, however, he spent time "being seen" in local coffee shops and other locations where he renewed connections with old friends and acquaintances. This group of people became the core of his new practice and brought their friends as well. Reflecting on the value of deep community roots and fearful of being spread too thin, he decided to stop commuting to his other practice location and concentrate on

building a single practice where he was best known. In making this decision, he discovered his energy was better conserved, and he has been able to maintain his own health and model healthy behavior to his patients.

Other practitioners related accounts of sudden change that threatened their professional careers, especially divorce, that left them financially and spiritually damaged for a period of time. In general, the practitioners who were engaged in regular reflective practice of some kind were able to shift focus from their own pain to problem-solving or achieve clarity as to what is really important to them. As Jane noted when she suddenly divorced 6 months into founding her practice,

> I was running around [between two practice locations] where I was only seeing 4-6 patients a week tops, and I wasn't getting any support from my ex. I said, 'how am I going to eat doing [acupuncture]?...I thought I would have to take a regular job 20 hours a week, but then I thought, 'how's that going to work if I do that?' For a while I thought I would have to leave [the profession]…Later when I was meditating, I realized I was surprisingly sad at the thought of leaving my practice. Then it hit me: Acupuncture is what I love. *That's* what I'm going to do! (p.6)

b. Sustaining energy. Another area in which the individual's learning processes were seen in the narratives was in the way they described efforts to sustain their mental, emotional and physical stamina during the founding process. While several of the practitioners (John, Jane and Robert especially) tried to have two locations at one time or another, all of them eventually gave up all but one due to a sense of being spread too thin. More than one participant described instances of illness or extreme fatigue at some point in the founding process, prompting them to

learn how to balance the necessity of intense business focus and long work hours with needed rest and replenishment. Robert related that the main reason for considering bringing his wife into the practice as business manager was so that he would not have to be physically present for every activity of the business but still know that all would be well taken care of. His goal was to conserve his energy, but as he reflected upon the benefits of not holding every detail of his practice in his mind at all times, he noted that

> It made space for me to be a better practitioner, more present and focused with each patient…if my wife hadn't said that thing about my need to control everything, I would not have even considered that I was holding progress [of my practice] back. As it was, that freed me up to treat a lot more people, and they came… (p.8)

All participants described attempts to place reasonable boundaries around work and life, and those who enjoyed the business founding process more seemed to have less of a problem with boundaries and perceived fatigue, even over the long term. Carla commented on her continuing procrastination at doing her paperwork as being a drag on her energy just from feeling pressure that she "should be" on top of it. The more pressure she put on herself, the more she resented doing the actual work and the more she procrastinated. When she decided to implement online patient scheduling, she realized that her schedule would always fill in at the last minute, so if she waited for a break to do paperwork, the break would never come. As she said,

> It's Tuesday. I say, 'I've got a big gap [in my schedule] on Thursday; I'll do [insurance billings] then', and then Thursday fills in. So it's not so good. I realized that I have to

schedule in time for my paperwork or it doesn't get done. And if it doesn't get done, I don't get paid. (p. 14)

All participants in the study had passed the initial startup process in their practices, and all but the least successful and least invested in starting a private practice described making "necessary sacrifices" to make their practices successful. This most often was reported as working longer hours than they desired, but it also included a measure of self-denial for those motivated to grow their practice to achieve their goals. For example, April commented that during the startup phase, she not only worked three jobs to get by but also lived a "no frills" lifestyle in which every dime of profit was reinvested in her practice (p. 2). She commented later that the vision of a satisfying, functional practice kept her going while she was sacrificing to get there, and she found large and small ways to reward herself for doing so. In her case, it was hiring someone to clean house for her each week (p. 10).

c. Gateways rather than barriers focus. A third significant individual level learning process finding was that the more a practitioner learned to create gateways to the medicine (bridging strategies) rather than barriers for those unfamiliar with AOM, the greater the practice success in patient outreach and financial results. As previously noted, AOM comes with a significant philosophical and spiritual component that western medicine lacks. Many practitioners have found that they must deemphasize these in order to create an inviting point of entry to AOM for those unfamiliar or skeptical of the technique or underlying spirituality. Some in this study framed this conscious attitude shift as a public service mentality (as in Carla and Ann, for example), and others framed it as "effective communication" (John and Bruce) or even "ethical sales communication" (Warren). Those participants who took time to reflect on how

they were perceived from the uninitiated public's point of view and were willing to take steps to make the patient's comfort paramount found acceptance in a community much easier to achieve than those whose self-image saw this kind of compromise as unauthentic or antithetical to their worldview. For example, Bruce practices in the Bible Belt where AOM is not well-known and where the spirituality associated with the medicine can alienate the public. He related how he had to remove a Buddha statue that was part of his décor when two patients were offended and left his office:

> To me, it was just part of the décor; I have a [prayer] on the wall too. But it was an offensive distraction to those patients, and I'll never get to talk with them again to see if there is a way I can help them. That makes me sad. Mr. Buddha had to go." (p.15)

The conscious effort to make AOM accessible for the mainstream patient tended to improve a practitioner's opportunities for treating patients, but that attitude did not extend to the treatment itself. Bruce, for example, further described an instance when a patient told him he would receive acupuncture but not herbs (p.13). He explained that he had to tell his patient that, as a professional, only he has the right to determine the appropriate treatment protocol, not the patient. Ignacio described a similar viewpoint, observing that "people don't tell MDs what to prescribe or what surgery to do" (p.5). Both of these participants framed this unwillingness to yield to the patient's sensibilities in this area as a concern for the patient's best interest and as a professional and ethical responsibility. "If we don't respect the medicine, who will?" said Ignacio (p.3). While these professionals reserved the right to exercise professional judgment in their treatment of patients, they were confident that the improved outcome would eventually build trust in the patient's mind and improve practitioner-patient relations long-term.

d. Business model considerations. A fourth significant learning process concerned the way the expert practitioner learned to configure their business model and interact with their patients. This has special significance due to the commonly-held assumption that quality care and "compassion" can only happen if the practitioner takes more time with the patient (resulting in fewer patients seen). Most AOM schools and many AOM practitioners in the USA have adopted a model of one hour per patient visit, in part due to this assumption. (It is however more correct to say that AOM schools use the hour treatment format because neophyte student interns take longer to accomplish diagnosis and treatment, a distinction that seems lost in the controversy on the subject.) Conventional wisdom also holds that American patients will not come to appointments more often than once a week. Most of the practitioners in the study seemed to have configured their practices on these assumptions and were limited in earnings potential to a rate per hour per week. Those doing some form of bodywork were the most certain that they must treat only one patient per hour due to the nature of their work (e.g., Howard and Carla), and they found it challenging to increase earnings unless they chose a specialty, such as worker's compensation injuries, and provided treatments that could be paid by insurance. However, a few extremely successful participants, such as Bruce and Warren, spoke of "challenging fixed assumptions" so that they were able to provide quality care and see enough patients to make a good living.

Bruce related how he wrestled with his value of providing excellent care and his belief that the profession will only come into the mainstream when most practitioners see *many* patients every week. When he visited hospitals in China, he was struck with the differences in clinical practice, especially the large numbers of patients being seen, especially in groups. When he saw

what he considered excellent care done efficiently on a much larger scale, an epiphany occurred for him:

An experienced acupuncturist there treated 140 patients in one day. And maybe I'm seeing 30 or 40. He's seeing 140! …I asked the resident intern how often the patients would come in, and he said, 'every day in most cases.' We as American physicians have a fixed idea that patients won't come in that often. Who says…? (p.4)

He challenged himself to "try breaking all the rules and fixed ideas [of AOM practice] that limit the potential of an acupuncturist" (p. 4). He saw three major requirements for achieving this: First, patients will transition from 'relief of symptoms' care to 'maintenance of wellness' care; second, he will provide quality care, including listening to patients; and third, he will ask the patient to do what is necessary to achieve the first goal, in this case, possibly come more often than once a week if indicated. He then described a process of analyzing how his practice worked from a systemic viewpoint, planning and designing efficient subsystems that together reach the ultimate 'output goals' of the practice (making a good living, giving quality care and advancing the profession). Easily the most sophisticated practitioner from a business standpoint, Bruce transitioned his management to a goal-oriented metrics-based system that provides a short but extremely focused time with his patients.

He described this connection style as "intentional," meaning he avoids extraneous chit chat but focuses all his energy on each patient for the time he sees him or her. To him, he can "listen to patients" and communicate effectively in a short period of time if his intention level is high with each one, so he delegates effectively and makes efforts to manage a minimum of business information during treatment hours in order to achieve that goal. With his very efficient

and focused practice system, he is able to regularly see more than 150 patients per week, ten times what some of the less successful participants reported.

e. Shifting emphasis. The fifth individual level entrepreneurial learning finding relates to the shifting emphasis between professional and business focus that occurs as a practice develops. One important observation about managing the dual progression tracks business owners and practitioners must manage was made by John, who reflected on the tension in his own practice and came to the realization that one or the other role must be primary at different times, and this is not part of the preparation AOM schools provide:

> You learn the medicine, but not how to *provide* the medicine. You have to learn how to actually get it out there and provide the medicine. That, at the beginning of practice, is about 90% of your work. The 10% of how to treat someone, you've learned in the AOM master's program. You need to learn the 90% [the business emphasis] that's going to get you to the place where you can do 90% of treating people and only 10% of running a business. (p. 21)

John's point was that both sets of competencies are important, as is emphasizing the right competency set at the right time. While it may be that entrepreneurs do more of the back office work at the beginning due to economic necessity and lower patient volume, he emphasized the need to do these activities is primarily in order to really understand how the business works. As he further explained,

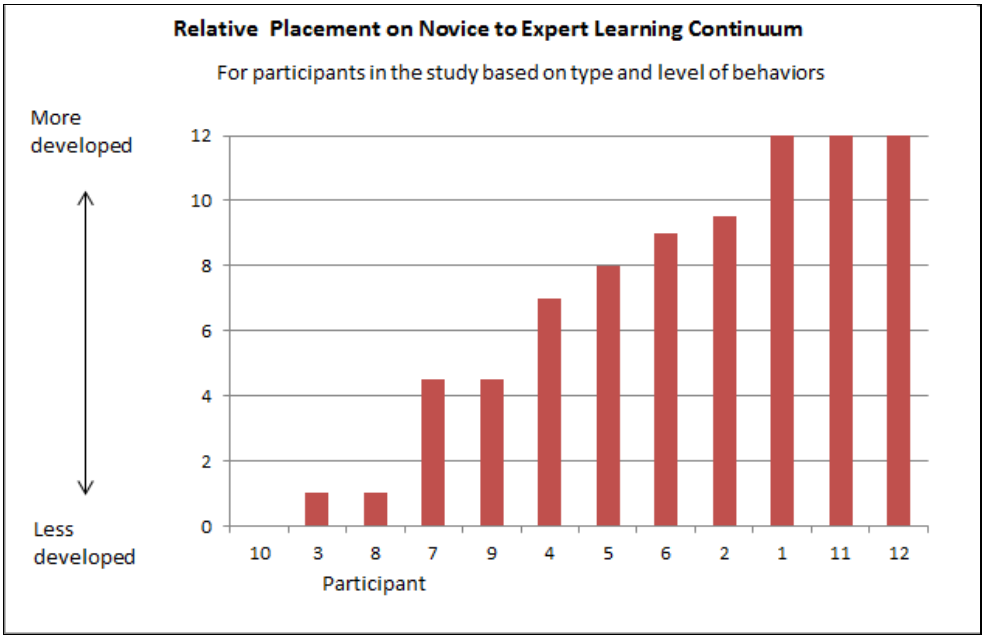
> 90% [of my time] was business at the beginning and 10% practice and actual treatment, but now my 90% is treatment, and I spend about 10% on business stuff like writing

checks, paying bills. You have to know these things, so you do them at the beginning. Now I have office managers and things like that to do it and report to me. (p. 21)

f. Progression from novice to expert. One surprising finding that occurred during the data analysis was that each study participant could be seen progressing along a business development continuum as well as a professional development continuum as described by Dreyfus and Dreyfus (1980), Benner (1984) and Daley (1999). Their description of "novice to expert" progression has been validated across several professions as applicable to continuing professional development, and it is easy to apply those to a range of business development activities and levels of expertise as described earlier. In this study, participants were observed progressing from novice to expert in both business and professional learning, and the dual progressions seemed to be interactive with each other to the point where failure to progress in one stunted progression in the other. For example, those who resisted the idea of having to start a private practice business (e.g., Howard, Joanne and Madison) seemed to be stuck at the novice level in both domains until their perception and willingness to engage in business development changed, as Joanne's and Madison's did. All the study participants could be placed on the business development continuum according to specific sets of behaviors and skills learned (see Figure 4 below), and progression from one stage to another seemed to be moderated by entrepreneurial learning activities, epiphanies and turning point events. For example, Bruce's observation of how patients are treated in Chinese clinics caused him to challenge the assumptions that only one patient must be treated each hour and patients will only come for treatment once a week. His realization that the important ingredient is intention level with each

patient allowed him to configure his practice to serve many more efficiently and to become an expert in both the professional and business domains.

Figure 4. Relative placement of study participants on the novice to expert continuum for business development progress.



Entrepreneurial learning on the profession level

The most painful learning experiences the participants expressed was in their professional community interactions. Because AOM schools do not provide in-depth business skills training, and mentors are few and difficult to find, there is perhaps a greater gulf between the expectation of what being in the profession will be like and the lived experience. Most AOM schools do not have cooperative education structures in place that reliably give the student much experience

with practitioners in their practice context. As a result, new professionals must learn quickly how to navigate the environment on their own after graduation or drift. In this study, profession-level learning occurred in three major ways:

a. Working with other AOM practitioners. As a result of little exposure to the profession before joining it, those who entertained the idea of continuing professional education through employment in a practice setting often learned painful lessons. First, those who entered the profession between 2008 and 2010 had little chance of being hired as an employee anywhere in the country. Being "hired" as an independent contractor quickly introduced them to the significant status differences, and one participant, Joanne, noted this gap in expectations produced the first wedge between her and the employer. Perceived disorganization in work habits and unwillingness to mentor further separated the two until the arrangement failed. A lack of understanding of the common practices used with independent contractors seems to fuel much resentment between practitioners, especially the idea that "someone else is taking a huge chunk of their money" (April, p. 6), when the independent contractor's share of patient revenue going to the practice pays for things like rent, utilities, supplies and other necessary costs of practice.

The second area within professional working relationships concerned learning who is perceived to be valuable for connection and who is truly valuable for a network. New professionals learned that subject matter knowledge in AOM field did not automatically translate to the ability to start a practice. As John found, business skills must be emphasized to a greater degree in the startup phase of practice, and many who are skilled at acupuncture know little about business. Warren observed, "The worst acupuncturist who is good with business will outlast the best acupuncturist who is bad at business" (p. 2). He then went on to note that most of

his classmates wanted to network with those good at acupuncture or herbs, not with those who are smart about or at least interested in business. One participant observed that

> "There is a reason that CEU courses for Dr. Tan or [Giovanni] Macciocia are sold out and you can't get anyone to come to one on QuickBooks. For people in our profession, learning about the medicine is always more exciting than finances, but you need to know [accounting], too, you just do." (John, p. 13)

The third area of learning in professional work relationships concerned how practices are structured. John learned that when "partners" put up unequal amounts of startup capital, unequal commitment to the practice group results. When partners in a practice are unequally committed to building it, the partnership won't last (p. 10). By contrast, Ann described a coordinated effort she and her business partner made to make sure that they did not compete against each other (by cultivating different markets and developing different specialties). In addition, they intentionally collaborated where possible. Three participants noted that, from their experience, it was important to them as independent contractors that the practice owner offer reciprocity in the form of fair compensation and a path to true partnership (ownership) in return for the expectation that they build the practice's patient base. April observed a need for practice structures that would accommodate single mothers who need to work less than full-time for a number of years, as she desires to have a child in the near future but feels she cannot under the common employment and partnership structures she finds today (p.6).

<u>b. Collegiality in the larger profession</u>. The second community level learning area for participants was in how the profession works and collegiality of AOM practitioners. While AOM schools promote the values of group harmony and collegiality, participants found that "AOM

practitioners do not easily share information or cooperate with each other" (John), and professional associations have often eroded their own legitimacy through dysfunction and "constant arguing over fine points of philosophy instead of moving the profession forward" (Ignacio).

A second issue relating to collegiality of AOM professionals has to do with the uneven distribution of acupuncturists across the country and resultant pockets of intense competition. While AOM is becoming more familiar to Americans, it is far from the mainstream of healthcare, and as discussed previously, this dynamic has led both to oversaturated markets and acupuncture "deserts". One of the participants, Warren, echoed a common sentiment that in cities where there are many acupuncturists, "everyone is cutting each other's throats" (p. 2) in competition, so all are suffering. Whereas there is potential in an area with many practitioners to experience positive, helpful collegial relationships among the professionals, in actuality, the environment has become so competitive as to be toxic to professional relationships. Warren solved this issue for himself by living in the metropolitan area and moving his practice to the small town where competition was not an issue. As he explained,

> All the acupuncturists I know think they have to have a practice in the big city. What matters is ratio. You have to have 8,000 to 10,000 people to support an acupuncture practice. I don't think [big city] can support all the LAcs that that want to live there. It doesn't matter where you are if you have the ratio [of population to acupuncturists]. I think I'm not that good; I just win by default [laughs]." (p.2)

c. Professional relationships across professions. In this study, entrepreneurial learning among new professionals on the professional level included the need to broaden relationship

networks from purely AOM professionals to a much wider web of allied healthcare and other kinds of professionals. While the subset of participants who resisted entrepreneurship seemed to resist expansion of their networking group beyond similar-thinking AOM practitioners, those who embraced building a practice seemed to quickly learn the value of expanding their network. In fact, those in all but the novice group of business development described helpful contributions from professionals with a range of knowledge and skills from allied health to banking and insurance to accounting and real estate. To John, "you need a good accountant more than you need an attorney," and April found her banker's critique of her business plan immensely helpful. While many of these outside experts did not become patients, some did, and reciprocity within cross-professional networks included client/patient referrals both ways.

Even cross-professional networking and collaboration within allied healthcare professions were seen by the more successful participants as more useful than participation within the AOM professional organizations. As Ignacio observed, "one great collaboration [between compatible professions] is worth many fruitless and selfish 'networking' groups where all people want is for you to give them your patients" (p. 5). He went on to explain that he derived more practical benefit as a practitioner and a business person by building an interdisciplinary resource network that included a bodywork specialist, herbalist, nutritionist, kinesiologist, etc., supplemented by a strong personal and consultative network of AOM doctoral program classmates.

Entrepreneurial learning at the larger society level

As alternative practitioners outside the mainstream of American healthcare, AOM practitioners are very aware of the need to build legitimacy with the larger society if they are to advance the profession and gain increased acceptance. Participants described learning that legitimacy for AOM with the larger society must nevertheless be built on two levels: the individual practitioner and the profession as a whole. There is a high degree of agreement among participants in this study that individual-level legitimacy is built in the eyes of the larger society when a practitioner is able to provide effective treatment (Carla, Ann and Warren), when he/she runs his/her business in an ethical and responsible way (Robert, Ignacio and Ann), and when he/she is able to bridge preconception barriers keeping the public from trying the medicine (John, Warren, and Bruce). As referred to earlier, Warren knowingly relocated his practice to a smaller town where AOM was not yet widely accepted because he was confident that he would be able to effectively treat "gateway" issues such as pain effectively, that he would run his business respectably and honestly, and because he would design his practice to interact with patients in the way *they* expected it to occur, that is, like an American medical office. He described use of language ("English, not qi"), office protocols (the office manager bills and accepts payments), décor (standard medical/professional office) and his personal involvement in the community as all contributing to raising the comfort level of the public with his business. Bruce learned that he cannot have many Asian influences in his office décor, especially a Buddha statue in the Bible belt, but he can emphasize wellness medicine and build a thriving practice. John, Robert and Carla emphasized the importance of putting down roots in a community and "being known" as key to acceptance and persistence.

All the participants agreed that community acceptance comes with "being known," and familiarity with AOM is slowly growing in this country. The profession, the participants agreed, is more interested in fighting among itself than in making AOM known in the larger society. They see this as the major threat to their profession and to their individual livelihoods--"If they look bad, they make us look bad," as John put it. Robert observed that the profession is made up of independent "anarchistic" thinkers, so squabbling among themselves is probably to be expected. He expressed optimism that as more young acupuncturists join the professional organizations at both state and national levels, priorities can be ordered more positively, especially the priority of making AOM part of the accepted mainstream healthcare system. He cites a growing body of clinical research studies as evidence that "we have medicine that works" (p. 18) and he feels it is each practitioner's duty to help advance the profession for the benefit of all. Bruce and Warren further add that the only way for a change (e.g., acceptance of AOM into the mainstream system) to occur at the larger society level is for far more patients to experience the medicine's benefits. In their view, more practitioners must adopt business models that allow for many more patients to be treated before grass roots support is sufficient for full acceptance of their profession in society.

Summary of the Research Findings

This research study sought to explore a largely unknown aspect of entrepreneurship in the professions, particularly the transition experiences of new professional graduates who must start private practices. Its goal was to examine the role of cognition/perception, social capital and

entrepreneurial learning across the three levels of social interactions described by Salzer (1998), the individual, professional community and the larger society in the context of founding a private practice.

During the course of the project, there were findings arising from synthesis of the literature, from observations regarding interactions between the researcher and participants and from the narratives collected in the areas of the research themes under consideration. By synthesizing the entrepreneurship literature since Chrisman, Bauerschmidt and Hofer's (1998) new venture performance framework, there may be an opportunity to reconceptualize the model to recognize its dynamic character and add cognition/perception, social capital and entrepreneurial learning as significant constructs. In addition, the professional development continuum described by Daley (1999) and others can also be used to chart the progression of professionals in the business development domain as they engage in entrepreneurial learning activities.

In the area of methodology, this study provided the context to learn more about the narrative method itself, as the researcher's interaction with participants took unexpected turns and resulted in participants' desire to convey strongly-held opinions but to give them off the record due to the perception of being an insider. While being a professional near to the industry provided levels of understanding beneficial to the project and opened communication with the participants, it also meant that they expected more confidentiality in sensitive comments than normally expected in a research project.

Summary of findings related to Cognition/Perception

In this project, findings relating to Cognition/Perception were found at the individual, profession and larger society levels. At the individual level, participants all agreed that the AOM profession has the potential to be a transformative force for good in the larger society, but it is being hampered at present by dysfunction at the profession level, particularly in its lack of support for new practitioners, lack of mentorship, and lack of relevant business skills training within the AOM colleges. They further agree that the turbulence in the healthcare system and the private practice model (with or without insurance participation) together with large levels of remaining student debt are potentially ruinous to some practitioners. Nevertheless, they see this situation as "growing pains" of a new profession that will, ultimately, become accepted within the mainstream healthcare system.

Beyond these points of agreement in perception, participants were divided into those who embraced their business role and those who resisted it. At the individual level, the strength of the participant's resistance or welcome of the business role seemed to be connected to the degree of gap between what the participant thought private practice would be like and the lived reality. Those who did not want to be an entrepreneur and held strongly to the expectation of regular employment in a practice seemed to be more disappointed and less willing to engage in business development activities or entrepreneurial learning. Conversely, those who realized and accepted the role early on tended to prepare more thoroughly, seek out learning opportunities in a wide range of business topics, progress in the business development continuum faster and enjoy the experience of starting and building a practice more than others.

Overall, resistors experienced a larger expectations gap between hope and reality, in large part due to the lack of paid employment, lack of mentors, and lack of support or induction from the profession. Several reported disappointment in the lack of collegiality, useful networks among AOM professionals and lack of connection they felt while trying to find out where they fit. They generally are enthusiastic supporters of Chinese philosophy and medicine and not interested in engaging with western medicine. They use Eastern terminology to differentiate their medicine from the mainstream. Spiritual aspects of the medicine hold special attractiveness to this group of participants. Due to their hesitancy to engage with business development, they are stuck in the novice level of both professional and business development progressions. However, the shifts in perception observed in the narratives of some resistors provided indication that by changing attitudes and perceptions, novices can advance in their business development (Hofer & Sandberg, 1987).

Embracers, on the other hand, exhibited a pragmatic willingness to engage with business skills development and entrepreneurial learning. They began preparation for their private practice businesses early and diligently sought knowledge from a variety of sources. They show a "beginner's mind" in learning, a humble recognition that they don't know everything and a willingness to ask questions in order to learn. They therefore embrace the practice development process with total commitment and persistence, being careful to maintain their energy and endurance for the long haul. They show confidence and faith that even if they fail, they may still succeed if they keep trying. Embracers are eager to learn, so they are impatient with the dumbed down business curriculum as taught in most AOM colleges. Because they maintain a larger vision of the good the profession could do, they are annoyed by the current lack of transparency,

in-fighting and dysfunction of the primary professional organizations, but they still seek to advance the profession, especially by engaging members of the western medical professions. Finally, they are creative and thoughtful about finding ways to bridge the east-west divide for their patients and the larger public that is unfamiliar with AOM as yet, in hopes of changing the larger healthcare conversation to one of maintaining wellness instead of curing disease.

Summary of findings related to Social Capital

While the study reinforced other studies contentions (particularly Baron & Markman, 2000) that social capital is an important contributor to founding a new venture, the usual professional support structures for new members (mentors, active professional societies, linkages to AOM schools) are almost totally lacking, leading these professionals necessarily to create their own personal and interdisciplinary support networks across professions other than their own. Participants found social capital to be especially helpful in the areas of personal support, acquiring resources and patients, retaining patients and creating a perception of care wherein the patient feels that the practitioner is not only competent but caring and compassionate in delivering healthcare.

On the profession level, AOM seems to have a vacuum where there should be a network of support and mentorship for new members. As these professionals feel that the schools and the profession are failing them both in preparation for "delivering the medicine" and through a lack of mentors and other support, "the profession" (the AOM colleges and the professional organizations) is largely without legitimacy in their eyes. The one group of participants who see the advancement of the profession as a duty of its members support the profession's

organizations in spite of their dysfunction. On an individual level, the lack of valuable professional networking opportunities within the profession has led participants to try various workarounds to fill the need: selective networking among doctoral program classmates, attempts to engage AOM school faculty, participation in AOM networking for AOM-specific development and general wellness promotion groups for cross-profession networking. Of particular interest is the rise of social media forums that provide immediate access and connection at no cost.

While social capital is recognized as important to new venture survival and success, this group fully recognizes that they are outside the mainstream. For some, that is intentional and is connected with a spiritual and social philosophy. For others, the bigger question is how to bridge the differences between two fundamentally different systems so that the profession can advance, find acceptance and make a contribution to the larger society.

Summary of findings related to Entrepreneurial Learning

Entrepreneurial learning is connected to social capital and cognition/perception in ways that are difficult to separate at times. In the course of this study, participants have shown that their perceptions change as a result of learning activities, as advanced by Cope and Watts (2000), among others. Learning activities can occur as a result of formal education, interacting with mentors, peers and other experts, reflective practice and discontinuous events—those jarring, unexpected events described by McDonald (2008) and Cope (2005), among others, that lead to seeing situations from other viewpoints, considering different alternatives, challenging

assumptions or being struck by a sudden and unexpected realization (epiphany, as described by McDonald, 2008).

Participants' narratives all included many instances of learning and epiphanic realization as they went about founding their practices, some small and some very significant. These included realizations about individual values, insights into making a business model work, which domain (business or professional) must be emphasized at various points in the founding process and realizations that spur turning points, e.g., move the entrepreneur to a new level of business development. A list of these significant realizations relayed by the participants in this study is included as Appendix E.

At the profession level, the lack of available support structures within the AOM profession has led the more successful participants to build cross-profession networks that address the particular needs of the professional and his/her practice. For example, Ignacio does not engage with AOM organizations, but he has built an interdisciplinary network of doctoral classmates and professionals in allied health fields that overlap or are helpful to his specialty.

At the larger society level, the findings of this study indicate that the profession is advanced in the mainstream when both individual practitioners and the profession gain legitimacy. Participants described these in three major areas: the ability to treat patients effectively and compassionately (Warren, Bruce, Robert, Jane), running the practice business ethically and responsibly (Ignacio, Howard, Ann and Warren), and the ability to effectively bridge the east-west divide for those unfamiliar with or skeptical of AOM due to its cultural and spiritual components (John, Bruce and Warren).

CHAPTER 5: DISCUSSION, RECOMMENDATIONS AND LIMITATIONS

Discussion of the findings

As an exploratory study in an under-researched area, this study has the potential to contribute to the professional literature in several ways. Because little is known to date about the experience of transitioning from being a graduate student to an AOM professional, the study gives insight into the challenges and rewards, expectations and realities, fears and joys of this group of healthcare professionals. In addition, because the participants involved in this study are professionals who must build private practice businesses in order to practice their profession, this research can shed light upon the dynamics at work in those who seem to accomplish this easily and those who struggle. The discussion of the findings includes analysis of the contributions to the literature and the research themes arising in each of the levels of socialization considered in the study.

Reconceptualization of the NVP model

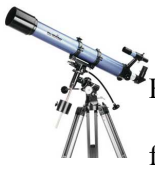
As previously shown, the thinking about which factors contribute to new venture survival and performance has evolved largely over the past thirty years. The dominant paradigm, described by Chrisman, Bauerschmidt and Hofer (1998), includes five major factors: Entrepreneur, Industry structure, Strategy of the business, Organization structure and culture and Resources needed and available. Four of those factors have been readily accepted, but the Entrepreneur has been much more difficult to define and is less understood. Most of the research to date centers on start-up businesses with a founding team, investor capital and a desire to grow

into large businesses. Perhaps when there is a founding team of entrepreneurs (as is common in tech start-ups, for example), it is less important to understand the internal drivers within the people. However, in a professional private practice, the Entrepreneur is of perhaps the greatest importance in survival and growth. Therefore the model might be of more use to practitioners and scholars if this "preeminent" factor (Herron, 1990) was better understood. In this research, the entrepreneurs were professionals starting private practices and principals in very small businesses in which their cognition/perception, social capital and entrepreneurial learning processes were vital to survival and growth.

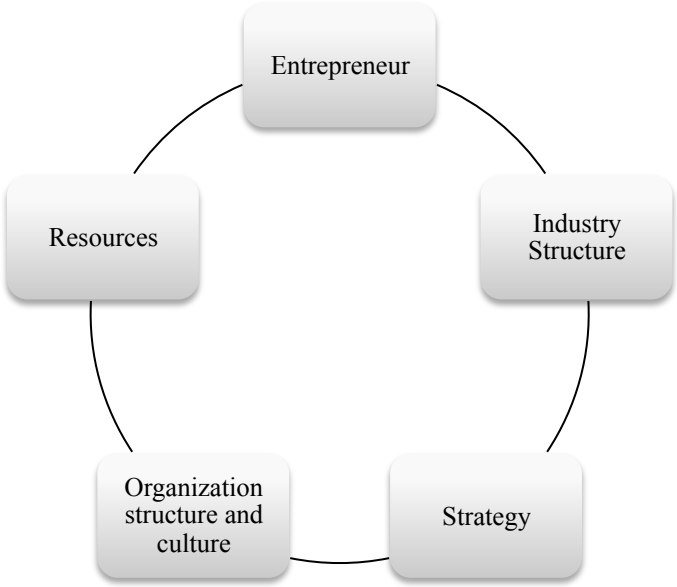
Because different lines of scholarly inquiry in this domain have different emphases, it might be most helpful to adopt a flexible and contingent model that follows Chrisman, *et. al*., (1998), but uses different lenses of analysis according to the need of the research. This contingent model of the Entrepreneur, for example, includes the original embedded static qualities, values, education and experience the entrepreneur brings to the start-up process as the base out of which the three additional active constructs used in this study (cognition/perception processes, social capital and entrepreneurial learning processes) interact. Through interaction of cognitive processes, social interaction and learning processes, the entrepreneur's "behaviors and decisions" gain more clarity.

For research questions focused at the macro level of the new venture, a telescopic lens could be used in which the Entrepreneur is but one system variable (with Industry, Strategy, Resources and Organization). Because there is less emphasis on the motivations and processes within the founder, the Entrepreneur can be managed as one construct within a larger system:

Figure 5. Chrisman, Bauerschmidt & Hofer's (1998) original model of New Venture Performance



Telescopic (Macro) View of NVP = *f* [E, I, S, O, R], where the Entrepreneur is one of several system factors and the inner drivers of the founder is not relevant to the research

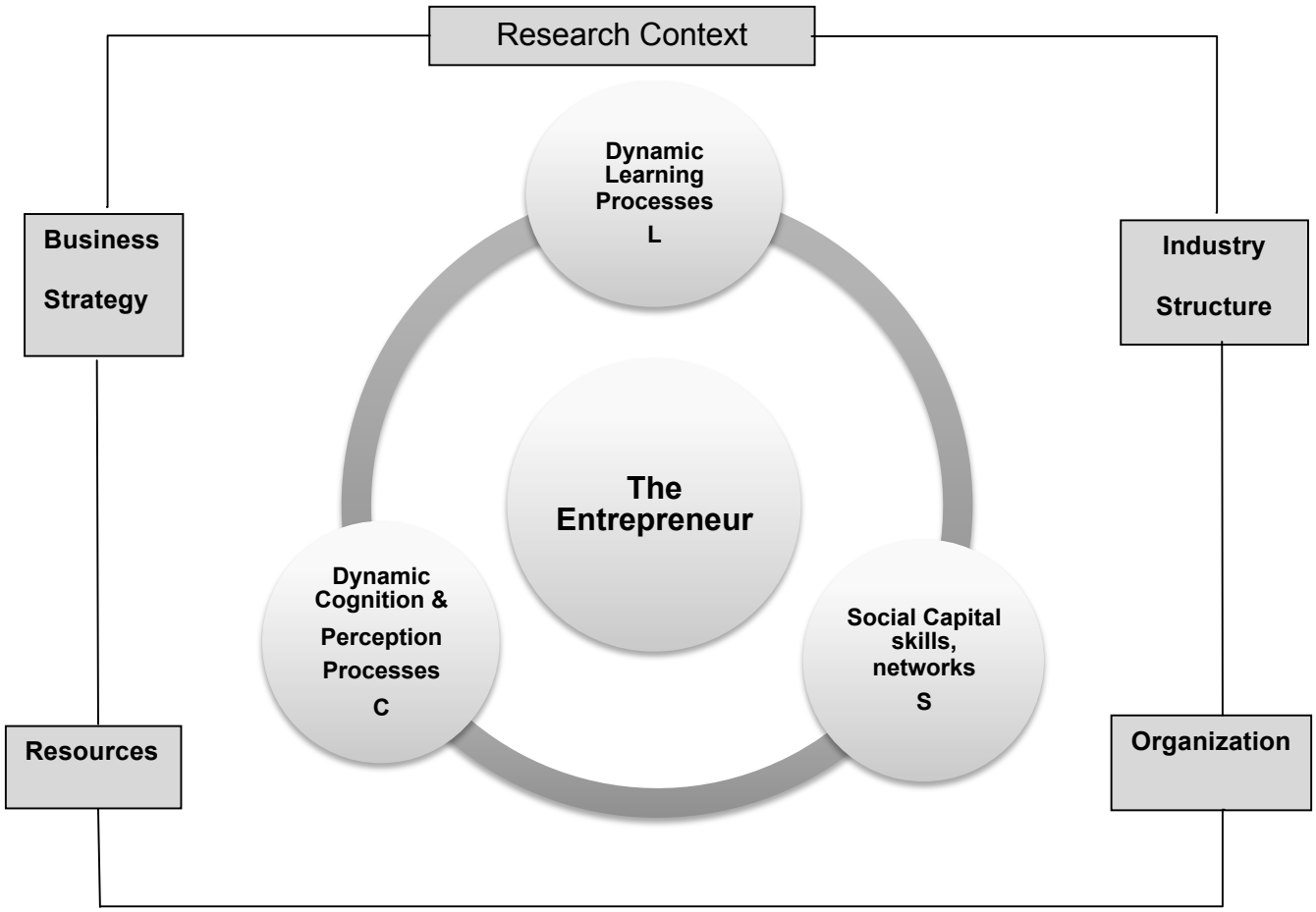


When the research is concerned with the drivers of the Entrepreneur in which the other NVP constructs provide context but are not directly under examination, I propose a modified, microscopic view that includes Chrisman, Bauerschmidt and Hofer's model factors and dynamic

cognition/perception processes, social capital and experiential entrepreneurial learning processes. The reconceptualized microscopic view of the Entrepreneur construct might be presented thus:

Figure 6. Reconceptualization of the NVP Model of Chrisman, Bauerschmidt & Hofer (1998)

Microscopic View of NVP = *f* [E, I, S, O, R], where emphasis is on the Entrepreneur within the context of the new venture and where other NVP factors are not of primary importance to the research



In this conception, embedded characteristics from the original model are part of the Entrepreneur's basic human capital, including personality, values, skills, formal education and experience brought to the start-up, as well as "behaviors and decisions" (1998, p. 11) which are made in the process of entrepreneurship. Factors C, S and L are recognized to dynamically moderate the decisions and behaviors expressed by the Entrepreneur based on multiple levels of interactions. Conceptualized this way, the Entrepreneur can be seen as dynamic and complex, and the model increases its usefulness to entrepreneurship researchers.

Cognition/Perception themes

This study confirmed the body of earlier research showing that cognition/perception within the entrepreneur is an important factor in building a new business venture, particularly in the areas of confidence in ability (Gatewood, Shaver, Powers & Gartner, 2002), attitudes toward being in business (Block & Koellinger, 2009), perception of risk (Caliendo, Fossen & Kritikos, 2009), and attitudes toward work effort, potential failure and perseverance in difficult circumstances (Foo, Uy & Baron, 2009; Van Gelderen, Thurik & Patel, 2011). Further, I observed that cognition/perception is not a static condition within the participant, but changes as the person interacts with the self, the profession and the larger society, engaging in experiential learning. This observation also lends additional credence to the notion that entrepreneurial cognition processes and perceptions about business and the self are malleable and dynamic—that as Hofer and Sandberg (1987) theorized, entrepreneurship can be learned.

For example, one of the resistors, Joanne, told of how the financial pressure and sense of risk in being single and alone caused her to reflect and clarify her values and intentions for her career. Though she still does not see herself as a "business person," she is willing to engage in practice development activities, particularly patient recruitment and retention, in order to be able to live in this world that feeds her spiritual hunger. After years of drifting, she is finally emerging from the novice stage of both business and professional development and is beginning to find enjoyment in her chosen career. Whether she will remain in private practice if a suitable job opens for her is unknown.

Resistors to embracers

Perhaps the most important question raised in the course of this study concerns how to change the perceptions that resistors harbor that keep them in unsatisfying, unsuccessful career situations. We do not know how many who resist the idea of starting their own practice might have a different attitude if exposed early to successful practitioners through cooperative education opportunities or if they felt they had received the tools necessary to succeed. It may be that there are those who lack interest in business and would resist entrepreneurship in any case. However, in this profession at this point in its development, resistors are much more exposed to risk in taking that position. Up until now, the profession has either ignored this situation or assumed that there is nothing more it can do to assist them. From a moral standpoint, this is an untenable position. From the research there seem to be a few areas where changing perceptions could help improve the resistor's professional and business outlook:

1. Competing world view paradigms. It has been previously discussed how the medicine has an innate spiritual component lacking in western medicine that is very attractive to its practitioners, providing "beauty and balance," as Joanne says. Further, in Howard's repudiation of the moral bankruptcy and emphasis on profit found in the western healthcare system, there is repeated a common criticism of the AOM practitioners who structure their practices after that model. This is a source of much of the rancor and factionalism in the profession, and while some may attribute that viewpoint to jealousy, it is perhaps more productive to frame this divide as two competing paradigms in need of synthesis. Embracers may benefit by keeping spiritual values in mind while profiting from practice, particularly offering to mentor new members. Resistors might consider how to strengthen their social capital components (particularly impression management and social adaptability) in order to present an attractive alternative to the public. Educators might point to the positive aspects of both approaches to practice in order to help students synthesize a new paradigm focused on a set of professional values before facing the situation, including compassionate care, collegiality, service to the public, spiritual growth, engagement with the public and humility in interactions.

2. Expectations about practice. AOM schools must clearly set expectations for entrepreneurship after graduation, being clear to communicate the realities of practice life, including expectations to be an independent contractor and the expectation to recruit and retain patients for the practice. These must be communicated and repeated throughout the program. However, a vision of expecting to be a business owner does not mean that the vision cast is without values. For example, students encouraged to reflect upon their own core values can decide how to incorporate those into the business model they will someday put into operation.

Emerging social business and nonprofit models may provide attractive alternatives to those who wish to focus on the spiritual aspects of practice while ensuring practice success in both financial and patient recruitment measures. These sorts of people-focused business models might provide positive alternatives to merely opting out of the current healthcare system. In any case, however, it is important for educators to clearly emphasize the realities of the profession, even those that may not resonate with new members. As our research shows, the sooner the reality sinks in, the sooner the professional begins to cope.

3. Business skills training. While focus on the reality of entrepreneurship and provision of mentors are two areas where cognitive and perceptual interventions can be aimed, those who prepare graduate students for professional practice must also address the "dumbed down" business skills curriculum taught in most AOM colleges. No longer can the schools allocate only 1.5% of total hours to such an important area. It is incumbent upon the accrediting agency for AOM, the ACAOM, to mandate sufficient focus in the curriculum, extending to hours provided and subjects covered. The specifics are addressed in the recommendations.

4. Recognizing spirituality and public service calling**.** In the findings regarding perceptions, the spiritual dimension of the medicine is apparent. While it is important to note that AOM practitioners embrace a wide range of belief systems, it is also important to note that the medicine itself is an outgrowth of East Asian philosophical and religious thought. This spiritual dimension underlying the medicine is very different from the rational, functional approach of western medicine in which a practitioner's personal spirituality plays little role. For some participants in the study, spiritual aspects of the medicine are some of the most attractive aspects and tend to pull the focus of the practice inward toward the individual rather than outward to the

public. Even in some of the outwardly-focused participants, the sense that practicing the medicine is a "calling" plays a very large role in the entrepreneurial cognition/perception realm. Ignacio recalled a situation in his practice where he was performing a lucrative service to health insurance providers by evaluating credentials and billings of other providers, but it was taking up all his time. "My own practice could not grow. I felt like I was making money but not doing what I was called to do." (p.3) He decided to give up the revenue stream in favor of seeing more patients, pulling his practice back in line with his "calling" and values. As he finishes his doctoral program, he looks forward to moving to Thailand to treat cancer patients in order to fully realize that calling.

5. Cultivating maturity and humility. One observation about the differences in groups of participants lies in the relative degree of maturity with regard to their world view. Clearly all the participants in this research felt strongly that AOM was a superior system of healthcare over western medicine, especially as practiced in this country. However, that sense of superiority expresses itself in two different ways, seen in how the resistors and embracers interact with the concept. (Note that holding either viewpoint is not necessarily related to being a resistor or embracer in entrepreneurship terms, but in this case, it refers to resisting assimilation or embracing society. In this research project, the different views happened to coincide with either group.)

Resistors hold a view that they have a superior medicine, and that knowledge tends to make them more focused on AOM as self-expression and spiritual development on the individual level. This group made little attempt to bridge the east-west philosophical divide in order to make Chinese medicine accessible to those unfamiliar with it. They seem to desire to emphasize

the differences from the western healthcare system, and they often expect the public to adapt to their world view. By contrast, the embracers seemed, as a group, to interact with the idea of having a superior medicine more on the profession and larger society levels, that is, the knowledge imparted to them a responsibility to have an outward-facing service focus. Because they want to see the superior medicine become widely accepted by society, they approach the unfamiliar public with humility, making room for the initiated to become comfortable with the foreign aspects of the medicine. They embraced the spirituality as well, but they used creative bridging strategies in order to help people outside the AOM world become willing to try the medicine and often downplayed their own personal preferences for décor, means of interaction and language choices in communication in order to serve the public.

As John, Bruce and Warren noted, this willingness to engage the larger society (including western medicine) is necessary in order for the profession to advance toward acceptance in the mainstream. Practitioners must adopt the very Confucian value of humility, not just toward teachers but toward all people in order to extend their effectiveness. For example, Ignacio related an instance in which he interacted with a patient's MD caregiver in which the MD had made a mistake in prescribing pharmaceuticals. As an ethical caregiver interested in his patient's welfare, he approached the MD to point out the error. He indicated that the MD's initial response was to deny making a mistake and suggest that Ignacio had no standing to make such a suggestion. Instead of being offended or "sticking the PDR under his nose so he could see that I was right," (p.5) Ignacio humbly provided the evidence and asked him what he thought the best course of treatment would be for the patient, thereby making room for the MD to discover the error on his own, saving face. While one cannot legislate morality or humility in another, it could

be very important for student curriculum to include consideration of these two basic world views (professional practice as self-expression or service to others) so that students can be socialized toward values supporting the larger, long-term professional and social good rather than mere personal satisfaction.

6. Realities of starting a practice business. The findings support previous entrepreneurship research (such as Kessler & Frank, 2009) in confirming that starting a private practice business is hard work, requiring total commitment, hard work, high energy and persistence over an extended period of time. It may be that those who resist the idea of entrepreneurship or have a strongly-embedded expectation of regular employment after graduation experience a greater shock than those who accustomed themselves and prepared for the experience for years before doing it. In an unsupported environment, sudden realization of all that is required to build a successful practice might undermine confidence and reinforce feelings of inadequacy and isolation, as reported in this study. While no two practices may be exactly alike, student exposure to a variety of practice types and hearing the stories of transition emphasizing how others like them overcame obstacles and endured might have a powerful effect. While it is only human nature to want to emphasize the successful aspects in the telling, it could be more helpful to those facing the process to know what to expect, particularly the pitfalls and mistakes. As Madison remarked, "No one told me I would have to fail 10,000 times before I succeeded." Knowing that would be a reality might have allowed her to take her missteps in stride. John also expressed appreciation for his father's "permission" to fail if he had to in order to exhibit the "indomitable spirit" that would eventually succeed if he persevered.

Social capital themes

The participants in this study used their social capital at the individual level in several ways as they started their private practice businesses, primarily in the areas of building support networks, acquiring resources, recruiting and retaining patients and maintaining a perception of care. These findings support findings of previous studies of social capital's impact, particularly as explained by Baron and Markman (2000). However, the participants found little positive networking 'infrastructure' at the profession or larger society level, contributing to a general sense of isolation and being on one's own. According to the participants, mentors are generally unavailable in this profession, and there is a sense the profession's institutional organizations are more interested in fighting one another than assisting new members. In society, AOM is outside the mainstream of healthcare, with a long road toward acceptance of its potential.

1. Social networking. Perhaps due to the lack of support offered by the profession and the mainstream medical system to these new professionals, personal social capital used to build a network of support and encouragement was critical to persistence in the profession. Those with a cohabiting partner (Kessler & Frank, 2009) or close friends at the individual level were clearly at an advantage in overcoming a potential sense of loneliness and isolation as they enter what is essentially a hostile environment.

The only AOM-related networking group mentioned positively by the participants was the network several created from interactions with a few classmates in advanced study (doctoral) programs. The participants did not, as a rule, continue to network with their master's classmates, carrying the perception that they were also struggling and knew as little as the participant did (Joanne). Ignacio is representative in being highly selective about his social networking, holding

the opinion that most of his colleagues are only interested in what they get out of networking while he expects equal exchange. As with most of the participants, he reported less interest in networking with AOM colleagues than in an "interdisciplinary" group of professionals that he indicated covered all the allied specialties overlapping with his practice focus.

As previously noted, these professionals were creative in creating cross-profession and surrogate networks in ways that supported their particular specialty areas and drew patients from communities of interest other than AOM in which the professional engaged for recreation, social interaction or service. Since patient referrals are few in this profession due to competition, there is a need for each professional to widen his/her circle of interaction in the community in order to be known and available when someone needs an acupuncturist or wants to know about AOM. It is unknown if there are some communities of interest or professional relationships that are more fruitful than others in yielding patients for a new professional's base. Ignacio's involvement in service to the running community has worked well for him, for example, because he is himself a running enthusiast, and he is authentic in that role as well. More research is needed to ascertain what types of social networks are most advantageous in which professional contexts.

One emerging direction for professional networking in the profession is the use of online social media such as Acupuncturists on FaceBook and the Acupuncture Business Academy, also on FaceBook. With a worldwide reach of over 8,500 members and 3,100 respectively, these provide immediacy and connection for acupuncturists in both urban and remote areas who otherwise lack connection with others in the profession. As earlier noted, these online forums provide the bulk of Madison's professional network. Madison is young and tech savvy, at ease in online interaction. For her, this is the future of professional networking because it is free to

participate, it is immediate when she wants it, she can either "lurk" or participate as she wishes, and she can usually find a conversation thread about any issue she might encounter and see a wide variety of opinions. If she does not find the information or advice she wants in previous posts, she can always post a question herself. She is enthusiastic about the democratic character of the forum and thinks it is good for the profession. The forum is moderated aggressively to ensure politeness, on-topic posts and adherence to the "no sales" rule. In Madison's opinion, the Acupuncturists on FaceBook forum is gaining in legitimacy among practitioners at the same time the national professional society is losing its legitimacy, but she is not sure an online social media forum will ever replace the AAAOM.

2. Mentorship. John's observation about the need to put 90% of his time into business development activities in the early days of founding his practice provides another insight into use of social capital, networking and the mentorship problem. John and April both reported reaching out to accountants and bankers for help in honing their business plans and learning record keeping skills as they began efforts to start their practices. John and Robert both had relatives who were successful business people and who provided surrogate mentorship in the business development domain in the early days. Bruce engaged a business coach when he realized he needed to reconceptualize his practice from the ground up, "not to give me the answers but to challenge my assumptions, to give me an ear" (p. 10). All these found the practical guidance and expertise most useful to them for the need of the moment in mentors from business, not AOM. It may be that there are a few established, successful professionals in AOM able to mentor new members in both domains, but the need certainly outstrips the available number of mentors.

If the findings of these participants are any indication, any effective mentor for an acupuncturist must emphasize business development first—almost to the exclusion of AOM at the beginning. The reason for this is that new professionals must first create a context for continuing their professional development, and that means recruiting patients to treat. This in turn creates a need for patient management systems, financial and billing, office location and the usual trappings that characterize a real business. The participants' narratives indicated that the optimal time to do these steps is when patient volume is still low. According to John, this creates an environment in which patient volume can grow, and when it does, focus can shift back again to treatment and other professional skills.

This idea of essential early mentorship in the business domain is certainly heresy to the profession, and more research will be necessary to validate it. This is not to say that mentorship in the professional domain is unnecessary. However, the need for a mentor in the business realm is a profession-wide blind spot, as is the idea that lack of business acumen can hold back professional development. If emphasizing business mentorship first turns out to be the most effective way to make any professional entering private practice successful in both domains, it may have the potential to significantly impact the way educators approach professional and career education.

3. Perception of care. One of the points of controversy in the profession is how patient care should best be delivered. In most acupuncturists' minds, patients expect "compassionate care," meaning unrushed and empathetic, treating the patient as a whole person and spending time talking with and listening to the patient. To them, this is a strong point of AOM treatment, socialized within them since they were students treating one patient per hour within a school

clinic. Many have, therefore, carried this vision of "compassionate care" into their professional setting and experienced the limitations of this model on their incomes. As explored previously, at least two very successful practitioners in the study were seeing many more patients (one was seeing 110 and the other 150 per week) and delivering quality care. Bruce explained his breakthrough as treating patients with intention in the short, focused time he spends with each one. He listens intently, but he does not engage in general conversation or waste time. He expects patients to do the health questionnaire before the interview and does not ask questions that are obviously not relevant to the patient's condition. His focused attention and outcome results are the measure of his patient care, not how long he spends with each patient.

Bruce, Warren and others point to the mass treatment approach of the medicine as practiced in Asia as evidence that spending a long period of time with the patient is not originally a part of the Chinese medical tradition. Rather, they point out, it is a reaction against the impersonal North American approach to healthcare. They also point out that the highest compassion is to alleviate suffering (through effective treatment). In the context of practitioner-patient relationship, it might well be best for a practitioner to ask what factors involved in patient care (level of social connection, effective treatment, communication skills, listening, etc.) are most important to his/her patients and what individual weaknesses in this area of social perception need to be strengthened before assuming that the need is more time spent with a patient.

4. Professionalism in the profession. As previously discussed, the profession is still in an infant stage, and the counter-culture founders have instilled values of protest and questioning authority which is sometimes expressed as factionalism, unprofessional communications and a

tendency to attack one another over differences in opinion or ideology (see Rohleder, 2012). Lack of agreement on basic issues of professional direction have also stymied efforts to raise professional standards such as a first professional doctoral level requirement for licensure in spite of wide agreement that it is the wave of the future. It is clear from the research that all the participants see the public in-fighting and lack of cooperation, collegiality and transparency as toxic to the profession. Perhaps the best way for new professionals to learn to engage each other and the public positively is for the profession to adopt codes of professionalism and professional courtesy that are taught to students in school and modeled on the local and national profession stage, as described by Garman (2006), among others. This is at its core a leadership issue that cannot be ignored if the profession is to develop and be accepted in mainstream society.

There is perhaps hope that as a generation of new leaders emerge who are not steeped in a counter-culture movement in opposition to something, there can be less emphasis on ideology and more emphasis on advancing the profession in a way that maximizes its social capital. Robert, for example, is an enthusiastic member of the state association where he lives, not for what it does to support him, but for the purpose of advancing the whole profession. He sees it as his duty, a way of serving all his colleagues. Being younger (age 33), he is not invested in maintaining old ideologies. He is interested in advancing the medicine for the sake of his patients' wellness and he wants all other acupuncturists to be successful, even if they do not practice the way he does (p.17). In short, Robert exemplifies a new breed of AOM professional that may yet overcome the weaknesses of the current profession.

Entrepreneurial learning themes

As previously mentioned in the findings, entrepreneurial learning was in evidence on all three levels of interactions. Two key aspects of the entrepreneurial learning process bear further discussion. First, the role of discontinuous events, reflection and epiphany in spurring learning is examined. This area concerns largely what professionals learn in the process of developing a practice business and how they learn. Second, application of Daley's (1999), et. al., professional development continuum to the business development process that occurs simultaneously with professional development for professionals in private practice is explored further. This dimension provides a framework for charting a larger progression in which learning events serve to propel the professional forward in business development.

1. Discontinuous events, epiphany, reflection and learning. The major learning processes involving individual professionals in this study often involved a sudden or gradual but meaningful realization about an issue or problem area for which there was no preexisting guidance. This kind of realization may involve seeing an issue from another perspective, challenging assumptions or taking notice of a detail previously thought to be insignificant, similar to McDonald's (2008) description of epiphanic experience. While the realization may or may not be emotional, it is meaningful in that it leads to changes in direction that can significantly improve the trajectory of the business. One example cited earlier, in which Warren realized that he could move his practice and not uproot his family, fits the description in that the problem was solved by shifting his viewpoint and challenging the assumption that all the successful practitioners are located in large urban areas. This realization created a turning point for his practice in both financial and satisfaction terms. Jane faced her fear of financial risk of

staying in the profession and clarified her personal values when she realized that another job would not make her happy. Joanne began to engage in business development and moved out of the novice level of development once she decided that, if the choice was to sink or swim, she would swim. All the large and small epiphanies related in the narratives of the participants worked to solve difficult problems, clarify values and direction, and to move the individual forward in business development. A collection of the significant realizations and epiphanies related from the narratives is found in Appendix E. They each represent an instance of entrepreneurial learning that the participant found significant and transformative in his/her business development process.

a. Learning how to learn. Since most of the professionals starting private practices in this field have little business background and there is very little support available for them, there is a great need among new graduates to "learn how to learn" –both how to access the most relevant information and training for the situations they face and how to apply the information in a way that propels their practices forward. Fortunately, there are many general small business resources available online and in most communities for formal and informal learning when a need is identified. Jane reported that she learned how to do basic bookkeeping in a small business development center at a local community college. Through her class, she was able to find several other business people who were facing similar business issues and questions as she, and these became good network resources outside class. Jane also reported that she learned that online tutorials were not effective means for her when she attempted to learn how to submit her insurance billings. She reported that she felt deeply frustrated and made many mistakes until she was able to call the insurance company and find a person willing to teach her over the phone.

She was happy she learned how to do this task efficiently and gained a personal contact in case she had further questions. Madison, by contrast, is happy to access Acupuncturists Business Academy for suggestions from other practitioners in the specific areas of business she needs when she needs them.

b. Bridging the focus domains. Since they are very busy people, likely to be deeply immersed in either business or patient treatment at any given moment in the day, there is also a need to learn how to bridge the two very different cognitive and skills domains easily. Bruce realized that constantly shifting focus was draining his energy level, and with it, his intention level with patients. His strategy was three-fold: to minimize the number of items of business management that he watches, to minimize shifts between professional and business domains occurring in a day and to plan business focus times in advance. He delegates specific metrics to staff to monitor so that he does not spend much time managing staff or business processes, except when they are scheduled. Of course, emergencies arise and plans change from time to time. However, he feels that this approach allows him to manage his business well, to "stay sane" and to keep his intention level high for each patient. Other practitioners may not be as systematic as Bruce or may be naturally able to easily shift from business to treatment and back without experiencing a cognitive energy drain. It seems important, however, for each practitioner to examine this aspect of being a professional in private practice and create his/her unique strategy for combating inattention or overload as a response to this balancing act.

c. Reflective practice. Finally, as is currently being undertaken in the nursing profession, there is a move to teach novices reflective practice, a discipline in which the professional is taught to hold an ongoing reflection conversation with himself/herself in the moment, testing

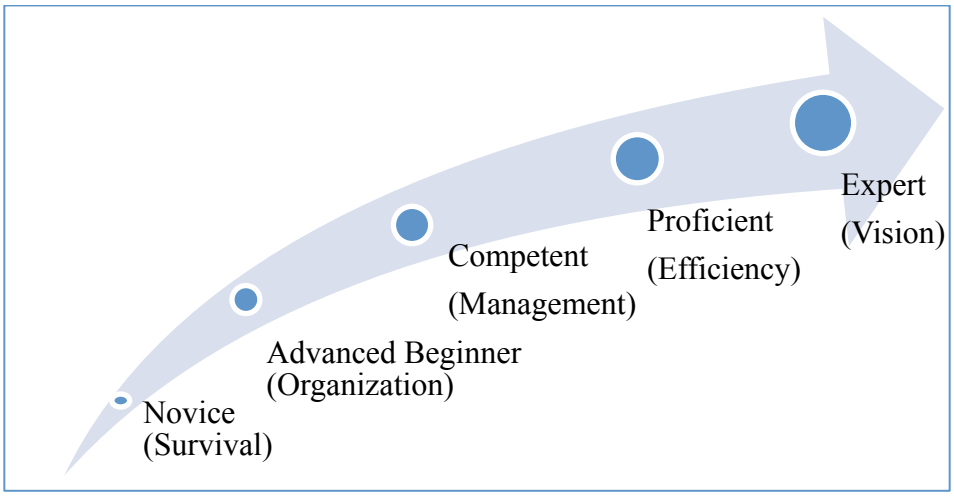
intuitive understanding, shifting viewpoints and creating higher levels of situational awareness as means to learning, as described in Daley, (2001), Daudelin, (1996) and Matsuo (2012) among others. While this body of scholarship is aimed at professional domain learning and may be useful in generating a form of insight or epiphany in relation to a practice issue under consideration, it may also be employed as the professional moves through the business domain issues and experiences of the day (Cope, 2005; Corlett, 2012; Issitt, 2003). Since this body of techniques is useful for professional practice, it can and should be taught to AOM students and honed well before graduation. As the new graduate enters the business development domain, these habits of mind can then be employed to spur ongoing learning and insight at the individual level.

It is the heightened awareness and learning at the profession and larger society levels that may ultimately save the profession, as members become aware of the connection between the power of the medicine and their service to the larger society. Those who were more successful in their practices were also those who were socially mature, outward-focused (at least behaviorally) and humble in reaching out to society. Their narratives show that they have a much larger vision for their practices than merely self-expression. In order to achieve their goal of making AOM accepted in the mainstream healthcare system, they are willing to employ bridging strategies ("gateways instead of barriers") to close the philosophical and cultural east-west divide that still keeps many Americans skeptical or unfamiliar with acupuncture. The professionals in this study all had passion for the transformative power of their medicine for society, but some framed it in opposition to the prevailing system. As a result, their practices overall remain small and unlikely to gain many converts. Those who described themselves, like Bruce, as a "wellness physician,"

have an attractive message that the profession must also adopt in order to change attitudes at the societal level.

2. Business development progression model. As described previously, this research adapted Dreyfus and Dreyfus' (1980), Benner's (1984) and Daley's (1999) novice-to-expert professional development continuum for describing the larger progression that professionals building a private practice business must also navigate. The 12 participants in this study fit the five major proposed steps well, and the focus of activities at each level seem to parallel findings of Lichtenstein, et al. (Lichtenstein, B., Carter, N., Dooley, K. & Gartner, W., 2007) and Scott and Bruce (1987), though these earlier models are mostly focused on very early start-up activities of larger, more complex businesses. The model stage descriptions resulting are intended to be a combination of those described in the literature, the observations of over 25 years' experience working with start-up businesses and the activities and awarenesses described by the study participants. These are not absolute, but they are general descriptions of competency and growing awareness as learning progresses. The proposed model steps build upon one another as the professional engages in entrepreneurial learning activities and professional development.

Figure 7. Daley's (1999) novice to expert continuum for professional development applied to business development progression model



a. Novice level. In the business development model continuum, the application of Daley's (1999) professional development continuum indicates a professional who does not yet know what the relevant questions are in the business development domain. A novice relies upon theory if it has been taught to him/her in school, but he/she has little experience applying it to messy real-life situations. As a result, a novice can be overwhelmed, afraid to make decisions, and unsure of direction, so the safest business strategy is to do what others are doing. The primary business awareness at this point is survival, gathering start-up resources (including licensure), the need to gain patients and awareness of the need for a desirable location for the practice. Participants described choosing a location intuitively—for "spiritual resonance" or for traffic flow or for the "quirkiness" of the neighborhood, for example, instead of based on data. Novices usually advertise but may not know the best way to approach this, so trial and error in

advertising is common. Novices generally see the business needs of the practice (besides location and recruiting) as getting a business and professional license and a tax ID. At the novice level, financial, operations and human resource areas are generally ad hoc or disorganized due to the large numbers of things competing for the founder's focus. In general, an analysis of AOM college business training (Stein & Sloan, 2011) indicated that most business training was aimed at novice level concerns.

b. Advanced beginner**.** At this point, the novice is starting to think about getting organized and developing a way to differentiate himself/herself from other practitioners in the market by developing a specialty based on his/her strengths. However he/she is usually is forced to be a generalist and take any patient to grow the necessary patient base. The advanced beginner may start to reach out in efforts to "network" with other business owners, generally in efforts to gain more patient referrals. Patient retention is beginning to surface as a concern. The advanced beginner notices that he/she is generating financial and operational data and begins to arrange to collect it and process it through billing and data entry. Record keeping may be hit and miss as patient volume grows, creating financial and operational blind spots. Benner's observation about advanced beginners starting to recognize "recurrent meaningful situational components" (Benner, 1982, p. 403) comes into play as the professional starts to notice patterns in patients' treatment visit routines (e.g., everyone leaves town in the summer months), but he/she may not understand the full importance of the pattern or how to manage it.

c. Competent practitioner. The competent-level practitioner has enough experience in the business to plan and organize business activities so that work flow is becoming efficient and he/she has a plan for each day. The business emphasis is on good management of resources.

Interruptions and unexpected developments do not completely derail the progress of the work, as the practitioner may use scheduling flexibility to deal with contingencies. Online systems including financial accounting, billing and patient scheduling produce advantages sufficient to warrant investment of time and attention to learn them. Because the patient volume level has stabilized to some degree, the practitioner can revisit the notion of a well-defined niche that includes both a treatment specialty and fit within the local market ecosystem of other practitioners. Efficiency and discipline emerge in carrying out business processes so that the business is well-managed and operating smoothly.

d. Proficient practitioner. A proficient practitioner from a business standpoint takes a holistic view of the business and uses information generated by his/her operational systems to ascertain its condition for the purpose of making it run as efficiently and profitably as possible. He/she uses a financial diagnostic approach to find and fix business problems, bases decisions upon data instead of intuition and is able to discern which business priorities are most important. Planning more than a month or two in advance is becoming a habit, and the business owner is engaging with tax strategy and considering the best returns on investments of capital in the business, particularly in adding staff positions, such as business management staff. In the marketing realm, the proficient practitioner is beginning to develop a "second generation" of patient referrals—those in which established patients are regularly referring other patients to him/her and the established patient base is retained. The practitioner may be experiencing a second growth spurt in the business, caused by a developing an effective market niche. The additional volume may cause him/her to consider acquiring more space or relocation. Before

making that decision, the proficient practitioner will analyze financial, patient and larger market data to determine the wisest course of action.

e. Expert. The expert business practitioner knows and understands the dynamics of the business intimately so that he/she is able to quickly diagnose emerging problems from a reading of the key metrics used to manage the business. Because the practitioner is responsible for two busy domains of management by this point in development, he/she has learned to bridge quickly and easily from one to the other and creates strategies to conserve cognitive energy while doing both. Through key metrics, the expert is able to manage the business from a systems perspective, including activities delegated to staff. He/she builds a brand identity that cohesively pulls the practice together. The optimized systems at this level allow the expert to focus on attaining his/her larger goals and vision for the practice.

In addition to the progression through distinct levels of business development in addition to professional development, the study participants reported similar issues and focus concerns for each level of development. These are summarized in Table 2.

Table 2. Activities and concern focus observed at the levels of business development for new professionals starting acupuncture practices

Area of focus	Novice	Advanced beginner	Competent practitioner	Proficient practitioner	Expert practitioner
Marketing	Recruiting volume, location	Recruiting volume, Specialty development	Patient retention Specialty niche	2nd generation referrals, location/space expansion	Branding, recruiting quality vs quantity
Financial	Gathering	Monitoring	Organizing	Analyzing	Strategizing
Strategy	Focus on immediate needs and survival	Doing what works for other similar businesses	Building a specialty Patient focus	Niche within market, goals and planning Patient focus	Larger vision of Patient within Society
Operations	Overload and disorganization	Emerging organization	Disciplined processes	Efficiency profitability	Optimization Mission attainment

Recommendations

Recommendations based upon this study's indications fall in categories corresponding to the major players affecting the process of creating new professionals that are ready to found successful and satisfying practices: the aspiring acupuncturist/student, the new professional, the professional organizations making up the practicing acupuncturist's professional community and the preparatory institutions of higher education serving them.

Recommendations for aspiring acupuncturist/students

1. Awareness and 'fit testing'. Recommendations in this area concern prospective students' awareness of the realities of the profession and "fit testing" of their own mindset, values and expectations. The participants in this study expressed strong agreement with the idea that the prospective acupuncture student must do more personal self-exploration and research into the profession before enrolling in graduate school, including gaining an understanding of their reasons for choosing this career. Several of the participants described how they had not had an acupuncture treatment until they had decided to enroll or had already enrolled in AOM school, and for at least two participants, enrollment in AOM college seemed to be an impulsive choice. All participants expressed this concern in one way or another. As one participant noted, "you might like to *get* acupuncture, but you may not like *being* [an acupuncturist,] especially all the other stuff you have to do to make a living." (Jane, p. 8)

All participants were in agreement that prospective acupuncturists need to have a better understanding of the actual profession and themselves prior to entering the profession in order to

assess level of fit between the individual and the job requirements itself. This can happen three ways:

a. Cooperative education opportunities. AOM schools must enhance their cooperative education arrangements both in quality and quantity so that students can observe a variety of practices, including discussion of the business side, in order to narrow the gap between students' expectations and reality.

b. Caveat emptor. AOM schools need to assist students in making better sense of the ability to make a living and repay student loans in the profession. One communication designed to help prospective students evaluate "career training program" outcomes may actually downplay the challenges and overstate graduate outcomes, even when used in compliance with federal regulations. While the US Department of Education requires institutions of higher learning with "career programs" to disclose rates of employment upon graduation, the existing rules governing disclosure does not serve prospective students well in a profession where 90% of graduates must be self-employed. Many institutional sites rather disclose percentages "in practice" 6 months after graduation as a proxy for employment. In addition, the criteria for what qualifies as "in practice" are unspecified or vary so much that comparisons by consumers are impossible. Where consistent measures of outcomes do not exist across the community of acupuncture schools, students cannot but make important school decisions based on factors other than graduate financial success, practice viability over time, or professional satisfaction. Prospective acupuncture students must be educated as to the characteristics of the profession, including the need to build a private practice and lack of employment options, but AOM colleges can help by taking time to help students interpret statistics and making graduate surveys readily available.

c. Annual check-in**.** As well as providing better information, as Jane suggested, it may be helpful for educational institutions to do an annual "check-in" with students to help them ascertain whether they should continue pursuing this profession. With better disclosure, more cooperative experience and more open communication (including students' responsibility to ask questions), there is no reason prospective students cannot make good decisions about their career path.

2. Reality of entrepreneurship. As shown in this study, entrepreneurship is based on dynamic cognition/perception, social capital and learning patterns in a social context rather than an innate condition within personality. That is, it is a set of perceptive, social and learning processes than can be taught to some degree. Aspiring acupuncturists starting private practices must adjust their mindsets to embrace entrepreneurial behaviors, whether or not they see themselves ideally as entrepreneurs. As Chrisman, Bauerschmidt and Hofer (1998) emphasize, entrepreneurial performance is based on "decisions and behaviors." According to Hofer and Sandberg (1987) and this research study, the majority of acupuncture students may be able to learn how to be successful business owners to some degree if that is the reality they face in order to practice their profession. It is therefore important for this aspect of professional self-image to be developed in graduate school alongside the self-image of healer and medical professional. If students are socialized to see business aspects of professional practice in a positive light and taught how to enhance their own social capital to advance their practices, they may be more ready to embrace learning the second set of necessary competencies.

Recommendations for the new professional

Cognition/Perception related recommendations.

To combat the situation where a heavily-indebted new graduate finds him/herself in the position of realizing that there is very little in the way of traditional employment available but resisting starting one's own practice, it is critical for graduates to carefully examine their perceptions and motivations and adjust their mindsets in such a way as to create cognitive room for adaptation to the realities. While some practitioners may eventually be happier as employees, most will have to accept that they will always be in the patient recruitment business, either for themselves or someone else. That realization was a powerful motivator for at least one struggling study participant, providing the catalyst for changing her attitude about embracing and making her practice successful, even though she suggested that her long-term goal is to be an employee. Several of the participants spoke of the enjoyment they found in having ownership, control and flexibility in their work to a much greater degree than if employed by someone else.

> Kessler and Frank (2009) found that new venture survival and success are enhanced
>
> …when the venture is planned and realized with determination, as if the business is expected to be full-time, to provide financial security for the founder and to present itself as a legitimate business... (p.736)

New acupuncturists must also adjust to the reality that starting a professional practice business will most likely take more time and effort than imagined, certainly more than a regular job. Carla summed up most of the participants' comments on the amount of work:

> I think it's important that new graduates recognize that they are going to work their asses off to make a business happen. It's not just going to magically appear…You can't sit in

> your office and wait for [patients] to show up…There are no 30-hour weeks in the first two years. (p.19)

New professionals face a big task in starting their own businesses, but they need not be stopped by fear of what they do not know (Arenius & Minniti, 2005). Each participant in the study endured difficult times, especially those who were founding their practices during the recent severe recession. Everyone who had achieved some measure of success had also endured hardship and self-doubt but persisted until they succeeded. John's observation about the indomitable spirit and the moral and ethical obligation to keep trying in spite of failure is especially applicable. Successful practitioners are successful only because they never gave up.

Social capital-related recommendations.

1. Find a *business* coach or mentor. The literature (notably Sullivan, 2000, and Tolar, 2012) underscore the power a mentor can bring to a novice starting the process of business development. While the study participants found AOM colleges to be disappointing sources for mentors, the most successful ones found mentors outside the profession, particularly in the business domain (business coach in the family, a mother or father with his/her own business, a professional in another field with a private practice, a friend who is steadfast in support and wise in business, for example) to be the most helpful in the early years of founding a practice. As John reminds us, in the early years, the most advantageous emphasis is on business development; later, the competency emphasis flips to professional knowledge.

2. Inventory personal social capital strengths and weaknesses. As discussed previously, some participants seem to be overly focused on their own self-expression to the detriment of

their practice outreach and impacting the larger society. Certainly, students entering a graduate school program come at all levels of personal maturity, but the importance of one's awareness of his/her own strengths and weaknesses in social capital components cannot be ignored. It could be beneficial to examine these in a professionalism context and to offer exercises to strengthen the individual's weak areas in order to improve both professional and business outcomes, as suggested by Baron and Markman, (2000); Kessler and Frank (2009) and others. This is an area where advances in the field of Social Cognitive Theory (Bandura & Schunk, 1981) might be applied to professional education to improve entrepreneurship outcomes as well as professional efficacy and satisfaction. For example, students might practice reading and interpreting body language to improve their innate social perception skills or receive coaching to improve their interpersonal communication and impression management skills.

Entrepreneurial Learning-related recommendations.

Resources are available to those who seek them, and advice abounds. From the study, the participants' advice can be summarized:

1. Get business skills training in key areas, such as small business accounting and marketing first (Chrisman, McMullan & Hall, 2005; Dimov, 2010; Gartner, 1985). Most community colleges have small business development centers where short courses are offered very cheaply and other small business owners are also learning. At least one study participant mentioned this resource as very important to her early establishment.

2. Detail the business plan**.** A business plan is useful primarily because it forces an entrepreneur to think in detail about his/her strategy and because it causes him/her to consider all

the major areas of the business, not just marketing. For example, April related how she worked on her plan immediately prior to startup (Dimov, 2010; Liao & Gartner, 2006) and sought advice and critique from her banker (Dyer & Ross, 2008).

3. Act on the plan**.** Study participants observed that most AOM schools do not require much effort from students in passing the rudimentary business course which is supposed to prepare students for founding a practice. In my own experience, a practice development course lays out the format for a business plan, but it does not require much detail or deep thought to complete the "plan" or pass the class. This does not mean business planning can be neglected without consequence. April found that detailing her plan and asking her banker to critique it was extremely helpful. John and Ann put extra effort into detailing theirs in order to be ready to open their doors as soon as they were licensed. John's business plan alerted him that he needed to develop a good credit history in preparation for obtaining a startup loan (see Petrova, 2012). Second to creating a plan, finding a good accountant is probably the most important professional ally for who are not trained in financial management (Chrisman, McMullan & Hall, 2005). Accountants can holistically model the entire business, assess strengths and weaknesses and evaluate capital needed to succeed. In spite of the wealth of experts that can give advice, the most important piece echoed by participants is for the professional to hold him/herself accountable for acting on the plan in a deliberate and committed fashion (Kessler & Frank, 2009). The participants agree that making a small business successful takes long hours, hard work and commitment.

4. Reflective practice. Daley (1999, 2001) and Corlett (2012) emphasize the power that disciplined reflective practice can have in the realm of professional development. As a form of

experiential learning advocated by Cope (2005) and others, reflective practice can spur better decision making, heightened awareness and insight into the issues facing the business as well as professional side of the practice.

5. Learn from others. Participants in this study provided a wealth of advice and wisdom in a variety of areas based on their epiphanies and realizations in the course of learning how to found a private practice. These are found in Appendix E.

Recommendations for acupuncture's professional organizations

The AOM profession is a profession experiencing a great deal of turbulence internally and externally at the present time. As a result, it faces significant challenges in providing support to its newest members and a unified positive message to the public. One brighter spot in the way the profession is evolving is the robust participation of acupuncturists in online and social media venues. FaceBook has several online social communities listed for practitioners of AOM, one having over 8,500 members worldwide. The Acupuncture Business Academy, another FaceBook forum limited to business issues of acupuncturists, has some 3,100 members. For practitioners located in areas of the country with few other available practitioners, the online community is a primary means of professional consultation, support and encouragement. While the official professional organizations purporting to represent acupuncturists' interests on the national (and sometimes even the state level) were often dismissed as irrelevant, unhelpful and "just want my money" by participants, attitudes toward the online community groups were just as often seen as helpful or potentially helpful and supportive. Several participants mentioned the active moderation of the forum and enforcement of community standards of "respectful interaction" as

a key component of their satisfaction with the FaceBook group. Most important to the participants, these groups do not charge admission.

With the recognition that most professional organizations run on a business model that emphasizes streams of dues and fees primarily from members, the acupuncture professional organizations are not unique. However, if members feel they are economically stressed, the experience of participation is not pleasant and affirming, and the individual is not able to identify a tangible benefit from membership, that organization will lose its legitimacy to those that provide a better value proposition. Of course, questions remain as to whether the online community groups can effectively sponsor research or advance the profession's social and legislative goals the way a national organization usually does.

In view of these factors, recommendations for the profession are:

1. Adopt a code of professional behavior that is socialized to all members beginning in graduate school that emphasizes respectful communication, collegiality and public service. Agree to focus on a few issues of national, profession-wide importance that will improve the *economic* situations of the members, such as gaining reimbursement under Medicare. Adopt a professional identity based on humility, service, engagement with the larger society (including mainstream medicine) and the transformational aspects of the medicine. Based on Garman (2006), participants' descriptions and my own observations, a general model of professional conduct might include the following four major descriptive areas:

Figure 8. Recommended model of professional conduct (Garman, 2006 and various sources).

Understanding Professional Roles & Norms	**Managing Yourself**
Joining in the professional community, engaging in professional development, continuing to learn about the profession, modeling "professional" values and behaviors (collegiality, transparency, cooperation and courtesy)	Work/life sustainability, aspiring to excellence in everything, actively managing my career, seeking those who can cause me to grow in expertise and as a whole person, engaging in my work with intention, humility and a good attitude
Working with Others	**Public Service**
Communicating effectively and constructively, respecting others, creating strategic networks across professions and organizations, encouraging others in professional growth, being a contributor to team efforts, being a mentor, creating a climate that allows others to develop	Generously and directly contributing time and resources to serve others, actively seeking the betterment of society, engaging in writing, presenting or advocacy, being a good role model in the community, encouraging others to serve and helping others to find areas where they can be effective in service

2. Combine resources and enhance cooperation across the professional landscape to spur rigorous research into a few strategic chronic medical conditions for which acupuncture is

uniquely indicated and for which Medicare can judge acupuncture as a cost-effective therapy, such as osteoarthritis of the knee and pain management.

3. Pursue avenues now opening in the US Military hospitals to trial acupuncture with other therapies for wounded personnel returning from theaters of battle.

4. Pursue uniform scope of practice legislation in all 50 states so the public knows what acupuncture is and isn't. Use targeted messaging campaigns to educate the public and discourage pushes by chiropractors and physical therapists to do "dry needling" without proper and adequate training.

5. Engage the public and the western medical establishment with a positive message of what AOM can contribute to national wellness. Make efforts to inform the public what acupuncture is and isn't. As Bruce urged, "change the conversation" about healthcare from an impersonal "relief care" model to a "wellness maintenance" model.

Recommendations for institutions of higher education preparing acupuncturists

1. Improve business skills training. As reported earlier, new student surveys at one leading acupuncture school showed a repeating pattern of the large gap between business knowledge and experience of new students and new students' confidence in the ability to start and run and practice (New Student Survey, 2011, 2012, and 2013, for examples.) According to the participants, the lack of business skills training in the backgrounds of new students is overwhelmingly insufficient in the curriculum of AOM schools prior to graduation (Stein & Sloan, 2011.) The participants in this study suggested more than once that schools hire instructors proven successful in developing a private practice (Warren, John and Madison, for

example). Further, the literature indicates (Chrisman, McMullan & Hall, 2005) that entrepreneurial knowledge and outcomes are improved when guided preparation is offered. This usually is best provided in the form of guided detailed business planning supplemented by courses in the areas of finance and accounting, management, marketing, industry-specific legal and contract issues and business strategy. (Human resource management may or may not be included as hiring employees is most often delayed in small business, whereas planning for skills and human capital needed should be included.)

2. Inform students of the realities of practice. Schools already disclose post-graduate "employment" based on U.S. Department of Education regulations, but as previously mentioned, the method of reporting could actually mislead students into believing there is abundant regular employment after graduation as some of the participants indicated. It could also be that the enthusiasm and optimism of the new student overshadows all other considerations at the point of entrance into graduate school, so that average debt statistics and warnings about the lack of paid employment positions after graduation merely goes unheard or unconsidered. While many AOM institutions are aware of this phenomenon, they have largely been unable to ensure that students engage in proper self-examination about the dual roles they must fill competently or that students realize that entrepreneurship (and all it entails) is an expectation of the graduate. They must communicate more clearly and forcefully.

3. Make room for enough business skills training. As the entity that is responsible for setting expectations of students and new graduates in starting their careers, AOM institutions cannot ignore entrepreneurship and business literacy as they have to date. While most take the approach that it is beyond the scope of the program, that it is not within their core competencies,

or that it will not fit in the hours allotted to an accredited master's program, the massive rise in student loan debt has re-opened the debate in the minds of graduates and the public. It seems that there is a moral imperative to address this neglected need, and if moral suasion is not enough, the federal government's increasing interest in the whole of career education's promises versus outcomes may provide the impetus for serious consideration.

It is unlikely that AOM institutions themselves may be able to effectively address the curriculum gap issue, especially when the accrediting body (ACAOM) and licensing body (NCCAOM) have so much control over the curriculum and program requirements. These bodies must use their power and central coordination role within the profession to redesign preparatory program expectations and licensure in such a way as to allow for room to business curriculum to be provided to a greater degree and at a higher quality than is currently common. For example, an entry-level doctoral program and phase-out of the master's program will go a long way toward providing a better value proposition for the cost of education in terms of the credential gained and will expand the hours enough to add at least the core of the entrepreneurship skills needs. However, the AOM accrediting and licensure bodies must mandate that the institutions add this set of competencies in sufficient hours and provide skilled faculty to teach it.

4. Consider a specialized post-graduate business transition program. While some MD programs have been combined with MBA programs in order to address a perceived need for business competency as well as technical competency, most acupuncturists do not need a traditional MBA degree to run a small business and would be hesitant to underwrite the cost based on future earnings. The unique nature of the AOM profession and general structure of

AOM colleges provides a possible opportunity for consideration if an institution truly wishes to build a competency in the business skills education area and assist its graduates in transition.

At the present time, graduates are students one day and entrepreneurs the next. The sudden change can be jarring, especially without mentors or other professional support. An institution could create a three-part transition program over 6 months or a year in which master's program graduates could undertake business skills and planning, receive mentorship and peer-coaching and improve their treatment skills while in close proximity to faculty and other experts in the field. While no AOM institution has undertaken a comprehensive program like this, parts have shown promise in a pilot program at one institution. Early evidence from the pilot program (confirming the literature) indicates that all three parts are required for optimal results. Simply granting treatment privileges in the clinic setting will not address the business skills and mentorship gaps. If the institution offers a first professional doctoral program, it may be easier to design such a transition program into the structure of that program. Either way, the curriculum committees and accrediting bodies must begin to discuss and address the issue.

Limitations of the Study

This is an exploratory study in a discipline which is in its infancy as regards rigorous research. Preliminary studies of acupuncturists' success in founding viable practices have been few to date, and rumor and speculation abounds still. This study will not remedy this entirely due to its small size and lack of generalizable findings. Though efforts were made to include a variety of participants, research was conducted on a very tiny slice of the acupuncturist

community. Specifically, participants did not include acupuncturists practicing in California or the "community acupuncture" practice model, one predicated upon offering a few basic services to a large volume of patients paying low fees, without insurance system involvement.

Community acupuncture proponents might offer the criticism of this study that by omitting them, I have left out evidence of the financial stress reported by these practitioners. The limitations of that model, primarily its need for a never-ending high volume of patients to compensate for low fees, should be obvious, given the early state of AOM adoption in the United States at present. This is a model driven by passion and dogma (see Rohleder, February, 2012), not economics, and it is reasonable to assume that this very small slice of the profession will be more prone to financial difficulties. In doing this study, I was more interested in those who were in the mainstream of the profession, founding private practices with the expectation of making a decent living and repaying their student loan debt. There may be value in a future study considering experiences of community acupuncture practitioners, especially in determining how they overcome the inherent economic obstacles and find professional satisfaction, especially compared to those using other business models.

Another limitation of the study is that none of the participants represented the "new face" of the emerging AOM profession, younger females managing families and building practices at the same time. April, for example, had delayed having a child specifically because she felt that there are no business model options compatible with that life choice at present. Her work establishing what may eventually become a professional co-op practice is an attempt to create a new structure that better fits what she wants her life to be like at this point. Further research could assist in this effort.

This study seeks to add to the body of knowledge in the field of entrepreneurship, particularly entrepreneurship in the professions. This is a special case of small business with specific constraints and dynamics that are not found in all cases of entrepreneurship. Nevertheless, professionals in private practice are *de facto* entrepreneurs, and the study emphasizes the difficulties of building a practice without attention to the dynamics of starting and running a small business. However, one limitation of the study in this area is its focus on one profession. Though the small amount of literature in relation to some other professions where private practice is the norm (veterinary medicine, for example) seem to indicate similar issues exist within those professions, not enough research has been done to date that would allow definitive pronouncements. Though the AOM profession is perhaps a very "pure" example of professionals engaging in entrepreneurship (without the moderating effect of profession support or alternative employment opportunities), we do not as yet understand the extent to which the findings of this study might be applicable to those other professions.

This study is the first time adaptation of the Dreyfus and Dreyfus (1980) and Daley (1999) novice to expert model has been applied to entrepreneurial development of professionals. Therefore, the category descriptions, specific skills, behaviors and attitudes rely upon intuitively-derived (but informed) judgments of the researcher based on years of working in and with entrepreneurs in a variety of settings. As this model has not been tested empirically, caution should be exercised in extending it beyond the present situation.

Another limitation is the qualitative method itself. While using the story method allows us to go deep in understanding the constructed reality of an acupuncturist's experience, the very small sample size and lack of randomness preclude generalization of the findings. However,

where the described experience repeats themes across most or all participants, a certain level of trustworthiness might be inferred on those points. These provide strong areas of indication for future exploration and research among many more participants, rather than indicating definitive pronouncements. As discussed earlier, the qualitative method's primary value is in understanding the experience so that we can ask the right questions in future research projects.

APPENDICES

APPENDIX A

Human Subjects Research Committee Approval for this Project

GEORGE FOX
SCHOOL OF MANAGEMENT

GEORGE FOX UNIVERSITY
IISRC INITIAL REVIEW QUESTIONNAIRE
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Title: **Acupuncturists as Entrepreneurs: Experiences of New Professionals Founding Private Practices**

Principal Researcher(s): Susan A Sloan

Date application completed: 9.29.2014

COMMITTEE FINDING:

X 1) The proposed research makes adequate provision for safeguarding the health and dignity of the subjects and is therefore approved.

____ 2) Due to the assessment of risk being questionable or being subject to change, the research must be periodically reviewed by the HRSC on a _____ basis throughout the course of the research or until otherwise notified. This requires resubmission of this form, with updated information, for each periodic review.

____ 3) The proposed research evidences some unnecessary risk to participants and therefore must be revised to remedy the following specific area(s) of non-compliance:

_____

_____

_____

_____

____ 4) The proposed research contains serious and potentially damaging risks to subjects and is therefore not approved.

Chair or designated member _____ Date 11/11/14

APPENDIX B

Acupuncturists Experiences Project
Screening Survey Instrument

Acupuncturist Experiences Project

The Acupuncturist Experiences Project is a scholarly research project investigating the process of transition from graduate school to private professional practice, emphasizing especially the experience of starting one's own acupuncture practice. In doing this research, I am trying to better understand the particular needs and challenges facing acupuncture graduates from a business perspective and to gain insights into the practice development process. I hope this research will be helpful to practitioners and AOM institutions in their efforts to better focus professional development curriculum on the areas that will prepare graduates for building more successful, satisfying professional practices.

Participant Survey
The purpose of the survey is to capture some basic information that will help me get to know you and put your story in context. Please provide the requested information and return to me prior to your interview. **Please return the survey with the Participant Acknowledgement and Informed Consent to Participate**. If you prefer, I will provide a self-addressed, stamped envelope for that purpose. Thank you for participating!

DISCLOSURE: *This is a scholarly research project. Your participation is completely voluntary; you may withdraw at any point in the process. The information you provide to assist in this research, both in this survey and in your interview, will be used solely for the purpose of the Acupuncturist Experiences Project. Every effort will be made to keep all personal information confidential, and any references to information you provide will be disguised to protect your privacy in any scholarly works produced. Following the survey and interview, you will be given an opportunity to review, correct and if necessary, elaborate on the data gathered to ensure a faithful and accurate record.*

Identifying Information (will be masked in any published work)

Name:	City:
Email:	Telephone:
Gender:	Current Age:
# People in my household:	
Where I practice:	____Large Urban, upscale
	____ Large Urban, economically-challenged
	____ Mid-sized city
	____ Small town or rural

	____ Combination (check all that apply)
How long in this practice setting:	____ years
Approx. average hours/week	____ hours
Type of practice setting: (check as many as may apply)	____ single practitioner, space not shared
	____ single practitioner in integrated practice
	____ group of practitioners sharing space
	____ employee in someone else's practice
	____ "Community Acupuncture" or nonprofit
	Other:_____
Describe your average patient demographic:	_____% female, _____% male Age: Ethnicitie(s):
Approx % with health insurance coverage:	____%
I accept insurance reimbursement:	Yes ____ No____
Comments on patients' economic means:	
Does your practice include Chinese herbs, body work or other modalities? If so, which?	
If other modalities, what approx total % of practice revenue?	
Graduated from which AOM institution:	
Most advanced AOM degree attained:	
Licensed since:	
Other advanced degrees held (MD, BSN, etc.)	
Total student loan debt at graduation:	
Approximate monthly payment:	
What other information about your practice would help in understanding you and your practice better?	

*Thank you for completing this survey! Please return it with the signed **Participant Acknowledgement and Informed Consent to Participate form** to the Investigator. Please keep a copy for yourself.*

APPENDIX C

Acupuncturist Experiences Project

INTERVIEW GUIDE

Please read the Ground Rules to the Participant:

- Interviews are supposed to be fun. If you aren't comfortable, please say so.
- Please forget that you are being recorded. However, you are being recorded.
- Please give the Informed Consent to Participate to the Researcher prior to starting the interview.
- Please give verbal permission to record the interview. You have the right to go "off the record" with a hand signal if you feel you want to say something that you don't want recorded. We will hit the Pause button immediately.
- We may ask clarifying or exploratory questions when the opportunity arises. The objective is to gain deep understanding of your experience, to know what it felt like and how you understand it now.
- You will have an opportunity to review and approve the transcript. If there is something you want to add or delete, it's your decision. Once it's final, it becomes my "data set".
- Your privacy matters. We won't use your "data" in any way that is easy to identify you personally.
- Thanks for participating!

Interview Format
Introduction:

"The Acupuncturists' Experiences project is about finding out what really happens between graduation and having a fully-functional, satisfying practice. To do that, we need to hear your voice, your experience. We would like for you to tell your story—past, present, turning points, vision for the future—"

Past

"Tell me a bit about yourself and your background. What or who made you want to be an acupuncturist?"

Probe C, S- early socialization from family, education, personal interests favoring alternative medicine or Chinese culture
Probe S – Wider social influences, professional networks, key people
Probe L – Was there a significant event or epiphany that directed your path toward an AOM career?

"Can you tell me the story of how you got from graduation to where you are today?"

Probe C - What did you expect being an acupuncturist to be like?
Probe C – What were your strengths and weaknesses as you started a practice? Did you feel prepared? Did it feel risky?
Probe S – When you realized a need for some kind of help, how did you go about accessing it?
Probe S –Do you have a support and accountability network? How did you go about building it?
Probe S - What role did the AOM profession or AOM community play in launching your practice, maintaining it, and growing it?
Probe L - How has the changing environment influenced you and your practice? (Wider social influences context, larger economic, macro environment, regulations, political, attitudes toward Chinese medicine)
Probe L – Were there unexpected events that disrupted your progress in some way?

Events, Epiphanies and Turning Points [L]

"Can you tell me about a key moment or turning point that changed you, your practice, outlook etc.? What happened, how did it change you, your outlook, the trajectory of the business?"

Probe L - Do any other key moments or events stand out?

Present

"How would you describe your practice at the present time in terms of your success and satisfaction with your career?"

Probe C –What parts are most satisfying? Dissatisfying? What is most surprising to you about the way your practice turned out?
Probe C – If you could go back to the beginning and change one thing you did in starting your practice, what would that be? Why?
Probe S – Are you involved in the larger professional community? How? Why or why not?

Future

"Where do you anticipate your practice will go?"

Probe C - Your long-term goals?

Probe C - How you will know you are "successful"?

Probe C, S - Advice for new grads?

Conclusion

"Thank you for sharing your story. Is there anything else I haven't asked that you would like to add?"

[End of interview]

"Thank you for participating in the Acupuncturist Experiences Project! Your interview will now be transcribed, and you will receive a copy to review via email. You can add additional thoughts, edit or delete whatever you like in order to create the account that accurately and completely tells your story. It is important that you review your transcript and send it back to me as you would like it to read. Please feel free to contact me with any questions you may have about this research. My contact information is below. I might contact you with one or two clarifying questions as I study your story. If so, I will contact you by email or phone as you prefer. Again, thank you for participation in this project."

Preferred contact for follow-up questions:

Phone _____ Email _____@_____

APPENDIX D

Acupuncturist Experiences Project
Disclosures and Informed Consent

(Please return the last page to Researcher)

Purpose of the Project

The Acupuncturist Experiences Project is a scholarly research project investigating the process of transition from graduate school to private professional practice, emphasizing especially the experience of starting one's own acupuncture practice. In doing this research, I am trying to better understand the particular needs and challenges facing acupuncture graduates as they start their practices. I hope this research will be helpful to AOM institutions in their efforts to better focus professional development curriculum on the areas that will prepare graduates for building more successful, satisfying professional practices.

Risk Disclosure and Steps to Protect Participants

Because the research involves human participants, it is designed with extra safeguards. The research data I am collecting is personal stories. As such, I will potentially use quotations from your story in the thesis document and in scholarly works. The main risk to a participant in this interview-based research is potentially to have disclosed some personal information or feeling that the participant wishes he/she had not disclosed later. To protect all research participants participating in the project, the following protections will be incorporated:

1. Participation is completely voluntary; you may withdraw at any time without penalty.
2. The personal identity of all participants will be masked at transcription. All participants chosen will be given an alias sufficiently different from his/her name and location as to make identification by peers or others extremely

difficult in the final document. All documents and recordings referring to the participant will be labeled by the alias. If video is used, it will be reduced to a transcript and the original file deleted to prevent identification of the participant. Reference to a specific participant in any report, article, study or other published work will use the alias to maintain the privacy of the individual.

3. All participants will sign an acknowledgement of disclosures statement indicating they understand the proper and intended uses of their information, the steps to safeguard their privacy that will be taken, and the expectations for their participation.
4. All participants will be given the opportunity to read, add to, comment further, correct and approve survey forms and transcripts prior to use. While the participant has control over the creation of the interview data, the researcher will retain the right to interpret and to use quotations as needed in the research reports, including the thesis and journal articles related to the research.
5. Original data will be securely stored in accordance with the institution's retention policies and then destroyed per schedule. Personal data that might lead to any kind of identity theft or misuse or harm to an individual will be destroyed as soon as the need for it is passed. It will be securely stored until that time.

Expectations for Participants

This research relies upon narrative disclosure of stories, perceptions, feelings and events that are personal and participative in nature. Participation is completely voluntary, and participants may withdraw if they so desire at any point in the process without repercussion.

The successful co-creation of your narrative requires partnership and engagement with the researcher throughout the process. The participant relies upon the researcher to be non-judgmental, unbiased and interested in a deep understanding of the experience

related. To provide the greatest benefit from this research project, the researcher relies upon the participant to:

1. Be open, reflective and willing to share the experiences as honestly as he/she is able,
2. To be willing to review and edit the transcript of the interview in a timely manner and to return it to the researcher for study and analysis,
3. To give permission to the researcher to contact the participant for follow-up questions, and
4. To respond to clarifying questions after the interview is completed.

Please sign the **Participant Acknowledgement and Informed Consent to Participate** on the following page. Please return it by mail or bring it to your interview. If you have any questions, please contact me by phone at 503.706.6045, or email me at ssloan07@georgefox.edu.

With my deepest thanks,

Susan Sloan,
Researcher

Acupuncturist Experiences Project

Participant Acknowledgement and Informed Consent to Participate

(Return this page to Researcher)

I, _____, have read, understand and accept the protections provided to me as a participant in the Acupuncturist Experiences Project as appropriate and sufficient as stated. I understand that participation is completely voluntary, and I may withdraw from the study at any time without penalty of any kind. I agree to participate in the project as described and agree to permit the researcher to use the data collected for scholarly research, including completion of a doctoral thesis, scholarly publication or curriculum development efforts related to this project. I further agree to abide by the expectations for participants as outlined in this Disclosure statement.

_____ _____

Participant signature Date

Please bring this form to the interview, or, if you are being interviewed by telephone or video, please return it by mail in the stamped envelope provided. Please contact me with any questions.

Susan Sloan

Researcher

APPENDIX E: ACUPUNCTURISTS' REALIZATIONS AND EPIPHANIES IN THE COURSE OF ENTRPRENEURIAL LEARNING

Following are some of the realizations and lessons in quotes and paraphrases reported by participants during the course of founding their private practices, organized by general topic on the Individual, Profession and Larger Society levels:

Realizations at the Individual Level

Expectations: "Expect to be a business owner. Even if you are an employee in someone else's practice, you still have to bring in patients. You have to think like a business person, at least about that."

Expectations: "The biggest shock I had after school was that not everyone wants your help, and you can't help everyone. If the patient doesn't care or can't accept the care you offer, you just have to respect that. All you can do is give your intention and do the best you can where they let you."

Accessibility: "So we hired an answering service to make sure somebody always answers the phone and sets up [the patient's] appointment. We also get a text right then (so we can be there)"

Accessibility: "The first thing I learned is that you have to stay by the phone that you're there when patients want to walk in."

Ego: "When I came to this profession, I think I had entitlement issues. When I had to do 'grunt work' when I was licensed to heal people, it wasn't what I wanted. Eventually I realized that my attitude was my ego getting in the way. Getting knocked down a few pegs taught me that I was very much a baby in this profession."

Effort: "I think it's important that new graduates recognize that they are going to work their asses off to make a business happen. It's not just going to magically appear, no matter how many people you know. You can't sit in your office and wait for them to show up. You have to have a strategy, a marketing plan, you have to brand yourself and make it happen...There are no 30-hour weeks in the first two years."

Effort: "I worked seven days a week when I first started and I did everything. And I learned everything…I have employees now, but at the beginning, I did everything…learned from scratch."

Commitment: "Tell students they must completely commit to building a practice, not dabble part-time."

Commitment: "You have to commit, jump in with both feet, be challenged and under the gun if you are going to make it. Yes, it will hurt for a while, but that's the only way to make your practice work."

Commitment: "If you really want a business, you have to put yourself in a position where you have a real business for people to come to. That means put yourself into it more."

Perseverance: "It's the ethic and the fundamental moral concept of the indomitable spirit, of continually trying to do your best. Eventually you will succeed."

Perseverance: "I didn't realize that to succeed you have to fail 10,000 times."

Perseverance: Participant thought about leaving profession during downturn, but realized, "This career makes me happy. That's what I am going to do."

Perseverance: "I don't think I would have changed the struggling I did. It's been a learning process, and the struggles made me who I am today. It's all good."

Perseverance: "There was once when I was about to leave it all and go back to being [in another career]. I was on a plane to [the big city] with a job waiting for me. I was trying to convince myself that I could still help people. I was unsettled. Then, it occurred to me that I have always changed course just before a situation turned around. I didn't want to miss a good opportunity by doing that again, so I said, "I'll stick it out just a little longer; if I'm going down, I'm going down good." So I stayed with it and it turned around. It worked out, really well in fact."

Attitude: "I have something of great value to offer, and I deserve to be paid. I'm not shy about asking to be paid."

Attitude: "When I started, I knew I was ignorant [of business]. I just kept asking people—insurance people, my accountant—until I found out what I needed to know"

Business Emphasis: "At the beginning of practice, [how to provide the medicine to the patient] is 90% of your work. The 10% of how to treat someone, you've learned…in the master's program. You need to learn the 90% that's going to get you to a place where you can do 90% of treating people and 10% of the business. Eventually the emphasis flips." (You have to have both competencies and emphasize them at the right point in the practice's growth.)

Preparation: "You need to start preparing [for business] when you are a student. It takes years to make a good credit history. Most of my classmates didn't realize this until they started and needed [loans and trade credit.]"

Business Emphasis: "The best acupuncturist and the worst business person will be out of business long before the worst acupuncturist and best business person will. You have to pay your bills [in order to keep offering your services]. That's just fact."

Business Emphasis: "Nobody ever feels they have time to set up systems, but when you have things that work, office processes that work, well that is worth the investment. Everyone is more efficient."

Motivation: "Know what motivates you: I thought working in [a risk-free practice structure] would take the pressure off me, but if I'm truthful, I was kind of lazy for a while. I needed the challenge of paying rent every month to motivate me to build the practice I knew I wanted."

Motivation: "I wanted, *needed*, to be pushed to succeed; I needed to light a fire under me [by having to see enough patients to pay the rent each month]."

Fear: "When you are feeling trepidation about your business, it's impossible to grow."

Risk: "I was terrified that I wouldn't be able to pay my family back for loaning me money for my herbal dispensary, so I made sure I lived on practically nothing, no frills in my life at all at first. And I worked two other part-time jobs while starting my practice."

Risk and values: "When I decided to stop doing the insurance thing, I didn't know if anyone would be left [on my patient list]…I just knew I couldn't play that game any longer and be an ethical practitioner. It worked out."

Communication: "Don't try to be interesting and tell every patient how much you know. Be interested in the patient but don't waste their or your time. Stay focused on why they are there, show care but don't feel you have to share everything you know with your patient."

Communication: "We DO medicine, but really, we are in sales. As long as people are communicating and have a choice about what medicine to use, we are in sales…a lot of sales is educating, and that is the core of what we do. Doctors are in sales in so many ways, so I am in sales even as an acupuncturist. I think that realization was what helped me move my practice forward."

Communication: "Building a good relationship with your patient doesn't have to take lots of time. You have to come with intention--the patient is all that you care about when you are with them. It's quality, not quantity of time."

Communication: "When you walk into the treatment room, the *only* person you care about is the patient. That's the only thing that matters. You have to clear your mind of other things when you are with a patient so you can truly take them in for care."

Finance: "For the first three years, every dime I made went into my business."

Finance: "I spent time planning for my clinic with five classmates, who all were willing to move across the country to start it. When it fell apart was when I said, 'I need $20,000 from everyone to do this plan.' None of them were willing or able, I don't really know, to contribute. Don't people know that starting a business takes investment?"

Finance: "QuickBooks is easy; insurance billing is easy. People only say they are hard because they haven't tried doing it. Once I had these under control, everything was easier [on the business side.]"

Finance: "When I learned how to do QuickBooks for my practice, I wanted to do a CPE course to help others see [that's it's really easy], but only about 4 people signed up. The thing is, you need to know accounting, you need to know profit and loss, you need to know how to manage your business. You *need* to know these things.

Getting Advice: "A good accountant is more important than a good attorney [for business success]."

Getting Advice: "The best thing I did was to have my banker critique my business plan. That was really helpful in so many ways."

Getting Advice: "My [relative] was a business coach. He loves to help me think through my ideas and crunch numbers to see if it makes sense."

Location: "After graduation, I moved back to my hometown. People know me, and I had a small group of patients all ready to go, a base to grow on. Even when I was just starting out, I didn't feel isolated."

Location: "Pick a location in a professional building if you want people to see you as a healthcare professional."

Location: "My colleagues think that they have to practice where acupuncture is widely accepted, where the other acupuncturists are. They are wrong; you need to go where the acupuncturists *aren't*. I do well where I am because people just need to be helped, and second, they don't care what I do to heal them as long as I can communicate with them and make a difference in their health."

Location: "I had patients who said, I can't come to your city office anymore because it's just too far…it turned out they all lived in the same small town about 30 miles away from the city where I was. Later, I was having coffee at a local café thinking about how I was struggling due to competitive environment, and my wife didn't want to move. It suddenly hit me that I didn't need to move my family, just my practice. You have to put yourself where the ratio (LAcs per 1,000 people) is favorable."

Location: "All the acupuncturists I know think you have to practice in a big city [to make a good living.]. What matters is the *ratio*: You have to have 8-10,000 people to support an acupuncture practice. The big city I was in isn't big enough for all the acupuncturists who want to live there. It doesn't matter where you are as long as you have the ratio in your favor. I think I'm not that good; I just win by default [laughs]."

Patient Recruitment: "You have to be visible in the community, out and around where you run into people. Then they see you, they say, 'oh, I have to make an appointment.'"

Patient Recruitment: "It's really important to be out in the community treating people (for cheap or for free) at the beginning. It only costs you in time, and your patients only come because of you."

Patient Recruitment: "The only way you get really good at this medicine is by treating a lot of patients, so I did whatever was necessary to treat patients, even for free. I still benefitted."

Patient Recruitment: "I gave open houses with free treatments, participated in community events, just basically, got involved in the community. In a small town, that's how you get people who don't know you or AOM to talk to you about it."

Patient Recruitment: "I didn't start thinking I needed to specialize, but I soon realized that you naturally are drawn to one or two areas in which you are really good, really effective. You get really good in one thing, then move out from there."

Challenging Assumptions: "It all comes down to vision for the practice. If you think all you can see is 15 patients a day, that's all you will. If you are willing to rethink some of your assumptions and intentions--really examine why you think what you do--then possibilities emerge. From there, you have to list all the steps it takes to get to the fulfillment of the vision you want, the tactics. Ask, how do I measure what's enough? That's the statistic, the doing-ness."

Challenging Assumptions: "AOM schools reinforce the idea that you need an hour exclusively with one patient, but that's not what they do in China. Instead of one hour once a week, they do 10 minutes every day. We just naturally assume Americans won't do that, but we don't ask them either. So I am seeing upward of 165 patients a week... Time does not equal quality of care. I am intentional, caring, but I don't waste my time or the patient's time on chatting about other things."

Challenging Assumptions: "What I really needed was a business coach, not to give me answers, but to help me question my assumptions and expand my vision beyond what I thought I could do. In that process, I found lots of little things that add to efficiency that can make or break a practice--like having the patient come in 15 minutes early and fill out the health assessment form instead of having me do it. I also don't do every [diagnostic] step with every patient every time. That's good use of professional judgment."

Strategy: "I have to stop practicing as a 'relief care' physician. I am more interested in preventing recurrence of symptoms…I want more for them to journey with me through the entire health correction, and eventually end up in maintenance care. Maintenance care is the philosophy that patients should be coached on habits of wellness and educated about nutrition and lifestyle. The patient should receive acupuncture not because they are sick, but to maintain their health…This is opposite of the western approach that starts with the assumption of disease. My clinic is about wellness."

Business metrics: "Measure what makes a difference--those things that provide your final product that gets you your final valuable product. If what you are doing doesn't fulfill your purpose, throw it away."

Preparedness: "If I hadn't been thinking and planning about this [kind of opportunity] for years, it would have passed me by. It was a combination of luck and preparedness."

Growth: "Business growth has to happen at a sustainable pace from a personal standpoint, not just financially…Somebody gave me the advice recently that I need to be running the practice, not letting it run me. The entrepreneurial spirit in me is great because I love what I do, but it gets out of hand really fast...I can forget that I need to be balanced in everything...the business will grow at its own rate. If I push it, I'll burn out again."

Growth: "Be careful to not expand too fast. Solid growth takes time."

Goal Attainment: "Stay on track by regular reflection on how present you were that day and by being accountable to someone. I have goals and if I don't reach my goals, I fine myself. I run my practice by statistics."

Goal Attainment: "Have someone hold you accountable for your own balance in life, your own health, for your goals and purpose, for your intention level…That's how you make progress."

Realizations at the Profession Level

Employment: "Even if you are an employee, you still have to be bringing in patients for the good of the business. It's expected."

Employment: "I don't want somebody who's going to come in and not be committed to working here. I want their spirit to be in it as much as mine is. A long-term goal I have is that an associate, after they have worked here for a year or two years, we know we work well together, and the treatment and business philosophies are the same, they buy into the practice and become a partner."

Business Model Development: Participant is experimenting with forming a co-op practice: "What I do is allow other practitioners to play to their strengths, not their weaknesses…and eventually, I might be able to have enough of a revenue stream to take time off. I'd need that if I was going to have a child."

Networking: "One small, really collaborative social network--where everyone gives as well as gets something--is worth all the big networking events or organizations where everyone is struggling and just trying to get you to refer your patients to them"

Networking: "Except for a very few trusted classmates from my DAOM program, that I know well, I don't network with acupuncturists. My network is interdisciplinary--bodywork, kinesiology, nutritionists, herbalists of all traditions, people like that."

Collaboration: "My partner and I set up our practice so as to not compete with each other, but to collaborate where we could. The idea for both of us was not to build our individual practices, but to build the practice."

Mentors: "Mentors seem to be hard to find in this profession. Since the important thing for me in the beginning was building my business, I got advice and help from wise business people, like my father who had his own business. Once you have been around for a few years, then it's good to choose a few other [AOM] practitioners for your network."

Competition: "Some areas of the country have far too many acupuncturists for anyone to do well. There should be an expectation for students coming out of [AOM] school that

you move to an underserved area, at least for a while. That would be your public service…That would do a lot to help the public become aware of us, and new practitioners would find it so much easier to get their practices going."

Professional Organizations: "The profession has a problem that ultimately causes financial and practice failure, and that is the infighting. Schools fight with each other; practitioners don't share information…they don't work together at all, and a lot of the time, it's about semantics...these associations are more about themselves and their own agendas than [raising] public awareness. "

Professional Organizations: "I don't belong to AOM professional organizations. It helps my practice more to belong to the Rotary. Oh, you have to have a social network, to be sure. I have a few doctoral program classmates I consult with, but I'm picky because I don't have time to waste."

Credentials: "All the allied health professions are moving to first professional doctorates. I think that it's expected in America, that when you go for treatment, you expect to be treated by someone called 'doctor,' so the profession should stop arguing about it and figure out how to help everybody get there."

Realizations at the Larger Society Level

Western Medicine: "Every few months…a physician will walk in the door [at the hospital clinic]. It's convenient for them there. And I think they walk in because I don't talk qi--I talk western, how the body works, the way that they would understand…so I get a lot of physicians, and they are amazed at what can happen."

Western Medicine: "I'm not about just my practice; I'm about the profession. I did a doctoral program, not because I want to teach in an AOM school. I want to teach western med what we do."

Communication: "I think it confuses people…the explanation that they need to know is something that they can grasp…They need help and you're literally speaking Chinese to them. If they don't understand it, what are they going to do? Most likely, they are going to walk out the door and you will never see them again."

Communication: "Patients expect you to speak English, so I speak English, not qi. I can't treat them effectively if they think I am speaking a foreign language to them."

Communication: "It really helped my practice to lift off when I hired an office person who did the money for me. What western doctor talks to their patients about money? No, the doctor treats you, and the office person does the money part. That's what people

expect, are comfortable with. It freed me to focus on patient care and gave me more time to see more patients. It more than paid for the hire."

Communication (The "two hat" issue:) "We found that separation between the person prescribing treatment and the person billing/collecting payment is necessary for us as an ethical principle. I don't want to have any connection, even subconsciously, between what a patient can pay and what I charge."

Branding: "We decided to brand everything intentionally to focus on the practice as a whole. We did different [specialties], but we had unity in the higher goals and look of the practice."

Public Outreach: "I'm planning to offer tai chi and perhaps yoga classes to the public. I don't make any money from the classes, but people who take the classes ask about acupuncture, and some eventually get services. It creates a community, a gateway [for people to get used to Asian medicine before trying acupuncture]."

Public Outreach: "Everyone in this country seems to be sick, therefore everyone needs my services. Like Starbucks, Walmart and Kinkos, I have to go where the customers are and be sure there are enough of them to support my business. In [the town where I practice], I am one of two. They need me there."

Public Outreach: "I'm more likely to change a paradigm in the US about how people view Chinese medicine if I see a hundred patients a week. It won't happen if I only see ten. It just doesn't work that way."

Public Outreach: "A lot of it [persistence] is just being known…being there for three to five years, when people just know you for being there…After a while my practice started picking up just because I was being known and known and known…"

Public Outreach: "In my state, [AOM] is a little like 'voodoo'. There is a lot of skepticism. Often, patients won't come unless their western doc gives them permission. Nobody here seems to know what acupuncture is or what we do. They have a fixed idea, a preconceived idea, good or bad. You have to educate your patients."

Public Outreach: "I think patients respect the medicine if I do. I don't over-promise, but I do make sure I do my best for each one. People respond to [practitioners] who have integrity and know what they are doing [in treatment]. They don't care that I don't bill their insurance for them; they came for medicine that works."

Cultural Sensitivity: "One thing I learned was that, in this [socially] conservative area, I should have sold myself primarily as a Shiatsu or Asian massage therapist and slowly integrated acupuncture and Chinese medicine into my practice as people became more comfortable with the idea. You don't want to freak people out."

Cultural Sensitivity: "One important thing is that you have to be there when patients call. You can't leave the office just because you aren't seeing a patient at the moment. You need to be there in case somebody shows up or pops in."

Cultural Sensitivity: Participant sensed that her practice needed to appeal to middle-class people comfortable with the mainstream in order to grow: "I need to remove barriers for patients and to make gateways instead to find out what acupuncture is and how it can help them."

Being an Example: "To be effective as a healthcare practitioner, you have to be healthy. That takes investment in yourself."

Being an Example: "The acupuncture physician should be the healthiest person in the room…and how can a sick physician ever take care of sick patients? The first rule is: Make yourself well. Be sure you are doing what you are telling your patients to do."

Patient Education: "Patients think they can pick and choose therapies. You have to tell them it's a package. You don't tell your MD what drugs or procedures to do. Have a little self-respect and your patients will respect you, too."

Patient Education: "When you can give [the patient] a piece of paper with an objective measurement on it, like the lab test, then you can tell them what is wrong and what they need to do to feel better. People are given diagnoses for their whole lives and they don't want to be sick. You help them see on paper what is the problem [from a functional viewpoint], then they are willing to work with you on the therapy. They can make the connection. They appreciate that you really working on getting to the root of why they feel bad and know how to turn it around."

Patient Education: "I am not an acupuncturist or any technique; I am a wellness physician, a health coach, a patient advocate. I'm a traditional practitioner that uses techniques and arts developed in East Asia."

Patient Education: "If I don't respect my medicine, who will?"

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