Australian Journal of Acupuncture and Chinese Medicine

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Editorial

In this sixth year of production I am very pleased to announce to our readers, authors and reviewers that this journal is now included in Scopus, the world's largest citation database of peer-reviewed articles and high quality web-based publications. This is a great leap forward for us. The Australian Government uses Scopus to track and rank research outputs of Australian researchers in five main subject areas, consisting of Arts & Humanities, Engineering & IT, Life Sciences & BioMedicine, Natural Sciences, and Social Sciences. In the recent years, we have also put the journal on Facebook and Twitter, and our papers are included in two full-text databases, Informit and EBSCOHost. These strategies enhance the visibility of this journal and its publications to the world, and have produced increased submissions from overseas authors. Our ultimate goal is to have this journal included in PubMed. With continuous efforts from the Editorial Board and the Management Committee, I hope this day will not be too far away.

Included in this issue are two important articles. The first one is authored by an experienced acupuncturist and a renowned public health expert. Janz and Adams reviewed and compared education standards and approved training courses set or accredited by the Chinese medicine profession, the medical profession, Medicare, private health insurers, allied or other complementary health professions and the World Health Organization. They found a significant disparity among the standards and accreditation, highlighting the varied training quality of acupuncturists in Australia. Such variations should not and cannot be tolerated by any health profession. With the coming national registration, the paper cannot be timelier. It provides essential background data about standards and accreditation for the future national Chinese Medicine Board of Australia as well as other fully-functioning Boards who have the power to endorse their registered practitioners in relation to the practice of acupuncture. Chinese medicine practitioners in this country will watch the development of national registration and accreditation closely.

The second important paper is written by two psychologists who studied the therapeutic alliance between Chinese medicine practitioners and their patients. In recent years, a number of controlled trials reported no differences between real and sham acupuncture. Some researchers claim that acupuncture is a form of placebo; whereas others think deeply about what else matters in the action of acupuncture. One element is the positive patient-practitioner relationship, also called the therapeutic alliance. In this issue, we publish one of the first empirical examinations of this alliance in acupuncture practice. The study reported on patients and acupuncturists' views of the therapeutic relationship and compared views of student practitioners with those of experienced practitioners. You will find this a fascinating article, and we hope the results will help you re-examine your own practice.

'Acupuncture research protocol' is the first trial protocol we have published in this journal. It describes a randomised controlled trial on the use of acupuncture for chemotherapy-induced arthralgia in women with early breast cancer. We encourage other researchers to do the same by sharing their protocols with our readers.

You will continue to 'listen to' the 2nd part of the interview with Professor Wang Juyi, the famous acupuncturist who brings our attention back to channel theory.

At the 2010 Australasian Acupuncture and Chinese Medicine Annual Conference (AACMAC) in Adelaide, we heard the experience of Dr Gunter Neeb, an experienced German practitioner of Chinese medicine. He described his three-stage journey as 见山就是山, 见山不是山, and 见山又是山. Its English translation is 'one sees a mountain, and it is just a mountain; one sees a mountain, and it is no longer a mountain; and one sees a mountain, and it is a mountain again'. In this issue, he shares with us his reflections after 30 years in Chinese medicine. Taking away the controversial content about using large quantities of poisonous Chinese medicinal herbs, I am sure a number of practitioners will resonate with Dr Neeb's meandering journey, the enlightenment-like feeling of 见山又是山.

Zhen Zheng
Editor-in-Chief

Acupuncture Education Standards in Australia: A Critical Review

Stephen Janz*[1,2] BN, BAc, GCPH
Jon Adams[3] PhD

1. Kenmore Centre for Health, Brisbane, Australia
2. University of Queensland, Brisbane, Australia
3. University of Technology, Sydney, Sydney, Australia

ABSTRACT

The implementation of the National Registration and Accreditation Scheme for the Health Professions incorporates the registration of acupuncturists under the Chinese Medicine Board of Australia from 1 July 2012. Other registered health professionals will still be able to use the title acupuncturist if their board determines that they are suitably qualified to have their registration endorsed for acupuncture. This paper aims to identify the various education and training standards underpinning the practice of acupuncture among the health professions in Australia and create a reference point to determine the impact of registration on future acupuncture education standards. A literature search was conducted to identify scholarly works on acupuncture education standards as well as a search of standard setting bodies and course providers. Results were tabulated for comparison. There is very little literature on acupuncture education standards in Australia despite its practice by a diverse range of health professions. Acupuncture practitioners can be categorised into four groups: Chinese medicine practitioners, medical practitioners, registered allied health practitioners and non-registered health practitioners. The highest education standards are demonstrated by Chinese medicine practitioners who typically complete at least a four year undergraduate degree, whereas the latter two groups appear to favour two or three day continuing professional development courses despite the availability of post-graduate programs. The standards for medical practitioners are obscured by a non-transparent accreditation process. Restriction of title registration in Victoria has coincided with a trend for these short courses to be described as 'dry needling' rather than acupuncture, thus circumventing the education standards, regulatory processes and protection of public health and safety which underpins occupational regulation. National boards will need to collaborate and carefully consider their acupuncture accreditation standards if they are to fulfil the objectives of the National Registration and Accreditation Scheme.

KEYWORDS acupuncture, dry needling, Chinese medicine, education standards, regulation, Australia.

* Correspondent author; e-mail: sjanz@kenmorehealth.com.au

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Introduction

The National Registration and Accreditation Scheme for the Health Professions (NRAS) was established by the Council of Australian Governments (COAG) to create a single scheme to register health professions nationally.[1] From 1 July 2010 chiropractors, dentists, medical practitioners, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists, and psychologists moved from State based registration to the NRAS. Four additional professions will be included from 1 July 2012, namely Chinese medicine practitioners (including acupuncturists); Aboriginal and Torres Strait Islander health workers; medical radiation practitioners; and occupational therapists. The primary objective of the NRAS is to protect public health and safety by ensuring that only ethical, suitably trained and qualified practitioners are registered to practise.[2] A further objective is to foster a high standard of education and training among health practitioners.[2] Under the scheme accreditation authorities recommend accreditation standards to the national boards for approval, and assess education programs against approved accreditation standards.[3] Currently there is no functional national accreditation authority for acupuncture, with acupuncturists registered in only one State, Victoria.

From 1 July 2012 the use of the title acupuncturist will be restricted outside of Victoria for the first time. Restriction of title allows the public to identify practitioners who are qualified to practise safely and competently while prohibiting those who are not registered from using the title.[4,5] Only suitably registered or endorsed practitioners will be able to use the title acupuncturist or hold out to practise acupuncture.[5] Accreditation standards will need to be approved by the Chinese Medicine Board of Australia (CMBA) in order to register practitioners.[5] In addition to the CMBA accreditation standard, each of the other thirteen health boards may also set a standard to endorse their practitioners for the practice of acupuncture.[5] The Health Practitioner Regulation National Law Act 2009 (National Law)[5] requires wide ranging consultation be undertaken in the development of an accreditation standard. Informed consultation is difficult without a review of the similarities and differences in the acupuncture education of the various occupational groups who seek to hold themselves out to the public as safe and competent acupuncturists.

In response, this paper reports the results of a critical review of the education standards underpinning the current practice of acupuncture in Australia. This review aims to identify the range of practitioners currently practising acupuncture in Australia; to identify the education standards underpinning their practice; and to create a reference point against which the success of the NRAS's goal of fostering high education standards can be compared. This review also aims to inform registration boards, accreditation authorities and health policy makers on their deliberations regarding future accreditation standards.

ACUPUNCTURE IN AUSTRALIA

Acupuncture is currently being practised in Australia with varying degrees of education and training by acupuncturists, medical doctors, physiotherapists, chiropractors, osteopaths, podiatrists, nurses, massage therapists and other unregulated health practitioners.[6] Acupuncture is one of the most popular and successful complementary and alternative medicine treatments used in Australia.[7] It is estimated that 10.2 million acupuncture treatments are carried out annually in Australia, the majority of these provided by acupuncturists rather than medical doctors or other health professionals.[8] Acupuncture is the main practice of Chinese medicine used in Australia, rising to prominence with the development of formal training courses in the 1970s.[9] Most practitioners and teachers were non-Chinese,[10] however immigration from Vietnam and China since the 1980s has altered the cultural mix of the profession in Australia.[11-13] The result has been an increase in the popularity of Chinese herbal medicine[13] and an increased proportion of Chinese and Vietnamese migrants comprising the Australian acupuncture and Chinese medicine workforce.[10]

Acupuncture became a registered profession in Australia following the passage of the Chinese Medicine Registration Act 2000 (CMRA) in the State of Victoria. Practitioners in Victoria have been registrable as an acupuncturist, a Chinese herbal medicine practitioner, and/or a Chinese herbal medicine dispenser, depending upon their qualifications.[14] Other registered health professionals in Victoria who also practise acupuncture are not required to register with the Chinese Medicine Registration Board of Victoria (CMRBV), as legislation enables their own board to assess their acupuncture education and instead endorse them as an acupuncturist.[15] Outside Victoria the practice of acupuncture has continued without statutory regulation or any restriction on the use of the title 'acupuncturist'[16]; however this will end on 1 July 2012 when the jurisdiction of the CMBA commences under the NRAS.[17]

Methods

An initial search was conducted of the University of Queensland (UQ) library catalogue and online journals. The keywords 'acupuncture', 'education', 'regulation', and 'Australia' were used to identify relevant literature. Of 258 results only two papers referred to education standards.[7,13] An additional search using the same keywords was conducted using Medline resulting in 28 results. None of these results contained education standards for acupuncture. The same search was repeated on Web of Knowledge with 13 results, none relevant

to education standards. The A+ Education database was searched for 'acupuncture', 'education' and 'Australia' revealing one result which was a phenomenographic study.[18] The search was widened to include the terms 'myofascial', 'dry needling' and 'education'. This combination resulted in 67 results from UQ, none of them referring to education standards and 182 results from Medline, none referring to education standards. No date restriction was applied as historical standards were also of interest. Default search options were used for all databases. Most of the excluded results referred to clinical practice, risks or clinical research.

The lack of literature on acupuncture education standards in Australia led to a search for source documents from standards-setting bodies. The Australian Health Practitioner Regulatory Agency (AHPRA) website was searched for standards and consultations for each of the ten registered professions resulting in one consultation standard.[19] The CMRBV website was searched for content relating to education standards resulting in the identification of another standard[20], and inferences on the standards applying to other registered professions in Victoria. Websites of other health professions in Victoria ceased to be available from 1 July 2010, so the Wayback Machine internet archive (http://www.archive.org/web/web.php) was used to search copies of the chiropractic, medical and physiotherapy registration board websites for annual reports and standards regarding acupuncture endorsement, revealing the chiropractic and medical standards. The websites of peak professional associations representing Chinese medicine practitioners, natural therapists, massage therapists, physiotherapists, chiropractors, osteopaths, nurses and podiatrists were examined for either explicit standards for acupuncture or for advertisements for acupuncture courses. Explicit standards were only identified for the Australian Acupuncture and Chinese Medicine Association (AACMA).[21] The Australian Natural Therapists Association has published a recognised course list and general guidelines on course duration, content and mode of delivery.[22] The Australian Traditional-Medicine Society has a recognised course list[23] but no explicit details on standards. Of the remaining professions searched recommendations for the duration and content of training programs could be identified for The Australian Association of Massage Therapists (AAMT)[24] and the Australian Physiotherapy Association (APA)[25]. Nurse's professional indemnity insurance policies covered acupuncture but no education standards were identified.[26] Advertisements for acupuncture and or dry needling courses were located on the websites of the Australian Osteopathic Association[27] and the Australian Podiatry Association[28] but no explicit standards were identified.

Private health funds and Medicare Australia are third party payers who tie education standards to provider status. Medicare Australia and the three largest private health insurers' web pages were searched to identify standards for provider recognition.[29-32] A Google search for 'acupuncture courses' 'dry needling courses' and 'myofascial dry needling courses' was conducted with results limited to Australia to identify courses and training providers which are offered outside of a regulatory framework. Twelve distinct courses were identified of mainly two or three days duration,[33-41] with one four day course[42] and two five day courses.[43,44] Myotherapy courses at advanced diploma[45-48] and degree leve[49] were also identified.

Standards were collated in a table to allow for comparison by criteria common to each (see Table 1). In addition the *World Health Organization Guidelines for Basic Training and Safety in Acupuncture* (WHO GBT)[50] has been used for comparison to give an external reference point to Australian standards. Courses delivered outside of a statutory regulatory framework provided evidence of the minimum training underpinning acupuncture practice in their target markets (see Tables 2 and 3).

Results

The mixed regulatory environment of acupuncture practice in Australia means that the impact of a given standard varies, depending upon the profession practising it and the jurisdiction in which acupuncture is practised. Results of this review are organised to reflect this mixed environment and presented in the order as follows: the only existing national standard, standards in Victoria where acupuncture is a registered profesison, and education standards developed by professional associations applied in the self-regulatory environment outside of Victoria. Standards developed by private health insurers and Medicare are also reported as they impact both within Victoria and the rest of Australia. Finally, the World Health Organization's standard is presented for comparison.

AUSTRALIAN GUIDELINES FOR TRADITIONAL CHINESE MEDICINE EDUCATION (AGTCME)

In March 1998, the Australian Acupuncture and Chinese Medicine Association convened the National Academic Standards Committee for Traditional Chinese Medicine (NASC).[51] The objective of the NASC was to develop curriculum guidelines for acupuncture and traditional Chinese medicine courses in anticipation of the needs surrounding the imminent passage of the Chinese Medicine Registration Act in Victoria.[51] Prior to this the AACMA had developed the *National Competency Standard for Acupuncture* 1995 (NCS).[52] Although the NCS determined that acupuncture programs should be at Australian Qualifications Framework level 7 (bachelor degree), the NCS was not a curriculum guideline and sought more to identify the scope of practice of acupuncturists in Australia.[53]

TABLE 1 Acupuncture Education Standards in Australia: A Comparison

Standard setting body	Undergraduate level of qualification	Graduate-entry level of qualification where specified	Usual minimum duration	Biomedical Sciences	Acupuncture Theory
National Academic Standards Committee for Traditional Chinese Medicine (NASC)[51]	Bachelor Degree	Must meet undergraduate outcomes	4 academic years; 2500 hours	20–35% 750 hours±	30–35% 750 hours±
Chinese Medicine Registration Board of Victoria[55-57]	Bachelor Degree		4 years full-time (8–10 semesters)	20–35%	30–45%
		Must meet undergraduate outcomes	4–5 semesters full-time equivalent	Should have same proportion as undergraduate course with RPL for content covered in prior health studies.	
Australian Acupuncture and Chinese Medicine Association[21]	Bachelor Degree	Must meet undergraduate outcomes	4 years full-time	Conforms with NASC criteria	
Australian Natural Therapists Association[22]	Advanced Diploma; additional criteria apply for degree programs[22]	Not specified for entry-level qualifying award	3 years full-time; 2600 hours; up to 1200 hours may be off campus.	800 hours	1000–1200 hours
Bupa Australia[30]	Bachelor Degree	No separate standard specified	4 years full-time		
Medibank Private[31]	Not prescribed directly. Under rule 10 of the Private Health Insurance (Accreditation) Rules practitioner must be a member of a specified professional association. Educational standard varies between acceptable associations from Advanced Diploma to Bachelors Degree to graduate entry Masters degree.[21-23]				
Medicare[29]	Item 173. Must be registered Medical Practitioner. No acupuncture education required to claim item 173.				
	Items 193, 195, 197 and 199. No educational standard specified; require a registered medical practitioner to be accredited by the Joint Consultative Committee on Medical Acupuncture (JCCMA) or the RACGP. Either of the two courses below is usually required for JCCMA accreditation.				
	Graduate Certificate in Medical Acupuncture Monash University[65,66,77]		12 months part-time off campus; 640 nominal hours.	25%	25%
	The Australian Medical Acupuncture College (AMAC) Qld & NSW combined course[66,77]		10 months; 40 contact hours.	40 hours formal lectures and teleconference; 180 hours self-directed learning, assignments and case studies; 30 hours mentorship.	
World Health Organization: Guidelines on Basic Training and Safety in Acupuncture[50]	This level is for non-medically trained acupuncturists.		2 years full-time; 2500 hours	500 hours	1000 hours
	This level is a full training course for medical practitioners		1500 hours		500 hours
	This level is for medical practitioners who wish to use acupuncture as a technique in their clinical work		not less than 200 hours		not specified

TABLE 1 CONTINUED Acupuncture Education Standards in Australia: A Comparison

Clinical Theory & Training	Supervised Clinical practicum included	Example of Course which meets criteria	Comments	Standard setting body
25-35% practical studies and clinical practicum; 750 hours±		NASC does not accredit courses.	+250 hours professional issues, et cetera; must be substantially face to face delivery	National Academic Standards Committee for Traditional Chinese Medicine (NASC)[51]
25–35%	500–800 hours (30%)	Bachelor of Health Science (Acupuncture and Chinese Manual Therapy);4 years full-time; RMIT University	+5-15% professional issues Must be substantially face to face delivery.	Chinese Medicine Registration Board of Victoria[55-57]
See previous column	300–640 hours (at least 80% of undergraduate requirements)	Master of Applied Science (Acupuncture) by coursework; 3 years part-time; RMIT University	Must be substantial face to face delivery	
Conforms with NASC criteria		Bachelor of Health Science in Traditional Chinese Medicine; 4 years full-time; University of Technology, Sydney (acupuncture and herbal medicine)	Must be substantially face to face delivery	Australian Acupuncture and Chinese Medicine Association[21]
600 hours	400 hours on campus; 200 hours off campus.	Advanced Diploma of Acupuncture and Oriental Therapies; 3 years; Australian College of Eastern Medicine; Not a VET-accredited program[82]	Must be more than 54% on-campus delivery.	Australian Natural Therapists Association[22]
		Bachelor of Health Science (Acupuncture); 4 years full time; Endeavour College of Natural Medicine, Brisbane	Must be substantially face to face delivery	Bupa Australia[30]
		Advanced Diploma of Acupuncture; 3 year full-time; Australian Institute of Applied Sciences, Brisbane		Medibank Private[31]
25%	25% (1 out of 4 subjects) 30 specified hours. Level of supervision unspecified.		100% of 3 out of 4 subjects assessed by journal keeping.	Medicare[29]
not specified				
500 hours	500 hours			World Health Organization: Guidelines on Basic Training and Safety in Acupuncture[50]
500 hours	500 hours			

TABLE 2 Minimum Level of Training Undertaken for the Practice of Acupuncture by Various Health Professions

Occupation	Course Type	Usual Duration	Comments
Chiropractic	Various CPD* courses[33-35,37-39]	2 or 3 day courses	
Nursing	Various CPD courses[33,41]	2 or 3 days	Only one course markets to nurses by name.[41]
Osteopathy	Various CPD courses[33-35,37-39]	2 or 3 day courses	Gemt course[39] advertised on Australian Osteopathic Association website.
Physiotherapy[25]	Dry needling or western acupuncture (CPD)[34,35,38,39]	2 days 16 contact hours	Courses approved by the Australian Physiotherapy Association
	Traditional acupuncture (CPD)	150 hours	No courses meeting this criterion were identified.
Podiatry	Acupuncture for Podiatrists (CPD)[33,34,36,41]	2 days	Artisan Orthotics course[36] advertised on Australian Podiatry Association website.[28]
Massage Therapy	Various CPD courses[33,40]	2 -3 days	Allied Soft Tissue course[33] advertised in Australian Association of Massage Therapists journal.[70]
Myotherapy	Advanced Diploma Remedial Massage (Myotherapy)[45-47]	2.5 years full-time	Acupuncture content varies with programme. E.g. 2 units out of 49 in one Advanced Diploma.[42] 93 hours (3 units) in 4 year Bachelor degree.[49]
	Bachelor of Health Science Clinical Myotherapy[49]	4 years full-time	
Naturopathy and other unregulated health professions	CPD course[33]	2 days	Not marketed to by name but meet course eligibility criteria.

In 2001, the NASC published AGTCME which determined that the minimum education standard to achieve the necessary graduate outcomes in acupuncture is a bachelor degree in acupuncture-moxibustion, or a combined acupuncture and Chinese herbal medicine degree. A suitable degree in acupuncture alone would nominally be of at least four years duration, consist of approximately 2500 hours of instruction and be delivered substantially in face to face mode. For further details see Table 1. Graduate entry programs which met the guidelines would also be acceptable.[51] A review of the guidelines is currently underway.[54]

VICTORIA

In Victoria first the CMRA and now the Health Professions Registration Act 2005 (HPRA)[15] which succeeded it require the CMRBV to develop and administer standards for course accreditation. A graduate of an approved course is eligible for registration without having to sit an examination.[55] The CMRBV's Guidelines for the Approval of Courses of Study in Chinese Medicine (GAC) set the minimum entry level for undergraduate courses at four years full-time study with at least 500–800 hours of supervised practical clinical training.[20] The recommended breakdown of the program is similar to AGTCME (see Table 1) which informed the development of the GAC.[20] Courses are to be conducted substantially by face to face mode of delivery.[20] Unlike the AGTCME, the CMRBV has developed specific guidelines for graduate entry programs which may be undertaken by a graduate from a health discipline other than Chinese medicine (See Table 1).[56] Flexible delivery may be considered due to the improved learning ability of a graduate compared to an undergraduate.[56] The CMRBV has approved four undergraduate programs and two graduate entry programs (one in acupuncture and one in Chinese herbal medicine) under these criteria.[57] At 30 June 2010, there were 1107 registered Chinese medicine practitioners in Victoria, 97% of which were registered as acupuncturists and 62% registered in both acupuncture and Chinese herbal medicine.[58]

In Victoria it is an offence under section 80(2) of the HPRA to use a registered title or hold out to be a registered practitioner unless registered or endorsed to use that title. Section 28 of the HPRA excludes chiropractors, dentists, medical practitioners, nurses, optometrists, osteopaths, physiotherapists and podiatrists from these provisions if their respective Board is satisfied that the practitioner is qualified in the practice of acupuncture.[15] There is no requirement for these Boards to consult with the CMRBV on education standards. The CMRBV notes that most Boards have undertaken consultation

TABLE 3 Short Courses in Acupuncture & Dry Needling Offered in Australia

Course Provider	Duration	Marketed to (from course webpages)
Allied Soft Tissue[33]	3 days	Massage therapists with HLT50302/HLT50307 & WA0350 or equivalent diplomas. Any other health professionals
Artisan Orthotic Laboratory[36]	2 days	Podiatrists
Australian College of Sports Therapy[42]	4 days	Doctors, chiropractors, physiotherapists, osteopaths, remedial therapists and anyone with a background in health sciences who want to better serve their patients.
Biomedical Acupuncture Institute[37]	100 hours, including pre-reading & 3 day course	Medical doctors, osteopaths, chiropractors, physiotherapsists
Clinical Edge[38]	2 days	Physiotherapist, osteopath, chiropractor or exercise sports scientist. Same trainer as Dry Needling Plus
Combined Health[34]	2 days	Physiotherapy, medical practitioner, osteopathic, chiropractic or podiatry registration
Dry Needling Plus[35]	Pre-reading and 2 day course	Physiotherapy, osteopathy, chiropractic or sports medicine.
Esperance Physiotherapy[41]	2 day course	Participants must have at least a 4 year science degree in a related health profession e.g. physiotherapy, chiropractor, nurse or doctor.
GEMT[39]	3 day course	Physiotherapists, osteopaths, physical therapists, chiropractors and is appropriate for GP's and sports physicians who have an interest in treating musculo-skeletal conditions.
Melbourne Institute of Massage Therapy[44]	40 hours (2x2.5 days)	Must have a diploma of remedial massage qualification
Myofascial Pain Study Centre[43]	5 days	Introduction to Myofascial Pain Management including Dry Needling for Physiotherapists
Subiaco Sports Massage Clinic[40]	2 days	Qualified remedial therapists

anyway and applied a similar standard to the CMRBV's for endorsement in acupuncture.[58,59] A notable exception is the Chiropractors Board of Victoria[59] which reduced its standard between 2007 and 2008 from the Master of Applied Science (Acupuncture) at RMIT University (RMIT) to the Graduate Diploma in Acupuncture at RMIT.[60-63]

The other exception in Victoria is medical practitioners.[59] The Medical Board of Victoria did not set an education standard for acupuncture endorsement directly, rather it accepted either of the courses approved by the Joint Consultative Committee for Medical Acupuncture (JCCMA), or qualifications acceptable to it by a specialist college.[64] The JCCMA courses are an externally delivered Graduate Certificate in Medical Acupuncture from Monash University[65] and a 40 contact hour course over 10 months called the Australian Medical Acupuncture College (AMAC) Qld & NSW combined course[66] (see Table 1). This is the same standard required for Medicare payments for acupuncture items 193–199.[67]

DRY NEEDLING IN VICTORIA

Acupuncture is also practised in Victoria by other occupational groups under the term 'dry needling'.[6] According to the Melbourne Institute of Massage Therapy (MIMT), 'Dry needling focuses on the deactivation of myofascial trigger points (MTrPs). Using single fine needles, the same needles that are used in acupuncture…'.[44] The MIMT offers a 40 hour course on dry needling to students with a Diploma of Remedial Massage.[44] Myotherapists complete either a two and one-half year full-time Advanced Diploma in Remedial Therapies[45-48] or a four year Bachelor of Health Science – Clinical Myotherapy[49], each which entails two or three units[45-47,49] in musculoskeletal acupuncture under the label 'dry needling'[46], 'myofacial needling'[47], or 'myofascial dry needling'[45,49].

Short courses in musculoskeletal acupuncture under the term 'dry needling' are usually of two or three days duration and are also marketed to osteopaths, chiropractors, nurses, physiotherapists, medical practitioners, podiatrists, massage

therapists and other unregulated health professions[33-39]. The term 'dry needling' is not a protected term under section 80(2) of the HPRA, so provided the practitioner is not deemed to be holding out to practise acupuncture the practitioner is exempt from both the punitive and regulatory provisions of the HPRA. A similar paradox will persist under the National Law[5] when Chinese medicine is registered nationally.

STANDARDS OUTSIDE OF VICTORIA

The ten existing nationally registered health professions have the authority to develop criteria and endorse their registrants for acupuncture under section 97 of the National Law.[5] Boards are required to consult widely when developing an accreditation standard under section 40.[5] Only the Medical Board of Australia has commenced consultation on acupuncture endorsement ahead of the appointment of the CMBA.[19] Professional associations, private health insurers, Medicare and course providers are otherwise the standard setters in the remaining States and Territories.

PROFESSIONAL ASSOCIATIONS

The largest acupuncture association is Australia is the AACMA.[7] The AACMA requires a four year bachelor degree as the minimum standard for acupuncture accreditation. In addition the course must substantially be taught in face–to-face mode (not distance or flexible delivery).[21] AACMA has accredited 11 Bachelor degree programs across Australia (some now discontinued) which lead to acupuncture accreditation with the association.[21] AACMA has not accredited any graduate entry programs[2.1] In 2010, it had 1740 accredited members.[68]

The Australian Physiotherapy Association (APA) established the Acupuncture and Dry Needling Group (ADNG) in 2007.[25] The predecessor of ADNG was the Acupuncture Study Group established in 1979 based in NSW. The Acupuncture Study Group…'has successfully trained over a thousand physiotherapists via the APA Level 1 and Level 2 Traditional Acupuncture courses'.[25] The ADNG differentiates training standards for dry needling, western acupuncture and traditional acupuncture.[25] Suggested training varies from two days for dry needling to 150 hours for the level one traditional acupuncture course. Thirty hours of continuing education in acupuncture over three years is recommended following each course to maintain competence.[25]

The AAMT is the peak body representing massage therapists with approximately 6500 members in 2008.[69] AAMT has not prescribed education standards for the practice of acupuncture but has developed a Position Statement and Practice Guideline for Myofascial Dry Needling (PSMDN).[24] The PSMDN identifies that dry needling is outside of the general scope of remedial massage, but can be provided with adequate training. AAMT specifically recommends that members should have at least a diploma of massage, and that training should include infection control, occupational health and safety issues as well as relevant government regulations. A three-day dry needling workshop is advertised on the opposite page to the guidelines.[70]

PRIVATE HEALTH INSURERS

Private health insurers were required to implement Rule 10 of the Private Health Insurance (Accreditation) Rules 2008 (PHIAR)[71] from 1 July 2009. The PHIAR enacted quality and safety requirements for private health fund providers.[71] Rule 10 specifically applies to providers who are not regulated by Medicare or a centralised body and specifically included complementary therapists.[71] Providers now have to be members of a national professional association which: assesses members training and education; administers a compulsory continuing education scheme; maintainsd a code of conduct; and administes a formal disciplinary mechanism.

The standards which individual insurers have applied for compliance with Rule 10 vary between insurers. Bupa Australia (BUPA) and Medibank Private (Medibank) are the largest private health insurers in Australia with a market shares of 27.1% and 31.3% respectively.[72] The next largest insurer is The Hospitals Contribution Fund of Australia Ltd/Manchester Unity (HCF) with a market share of 10.3%.[72] BUPA requires acupuncturists to be a member of one of three specified associations and have a bachelor degree which broadly complies with the AGTCME (see Table 1).[30] Medibank does not prescribe any academic qualifications and requires membership of any one of eight associations.[31] The education standard for membership of these associations varies from an advanced diploma[22,23] to bachelor degree[21] to graduate entry master degree[22] depending on the association. HCF requires the same bachelor degrees as BUPA and membership of one of five associations.[32] The effect of the diverse standards applied between the major insurers means that patients of acupuncturists with qualifications below a bachelor degree have not been eligible for health fund rebates from BUPA Australia or HCF (nearly 40% of the market) unless the acupuncturist was already a provider before the implementation of Rule 10. Graduates of sub-degree programs may be attracted to Medibank's members choice program (a preferred provider scheme)[73] in order to increase the proportion of these clients in their practice.

MEDICARE AND MEDICAL PRACTITIONERS

Medicare payments are available for acupuncture services provided by medical practitioners under Medicare Items 173, 193, 195, 197 and 199.[29] Medicare sets no education requirements for acupuncture training for medical practitioners to be eligible to provide services under item 173. Eighty-one thousand seven hundred and forty-eight (81 748) services at

a cost of $1.9 million were provided nationally by medical practitioners under item 173 in the 2009-2010 financial year.[74] Items 193–199 pay a higher rebate than item 173, with 456 037 services at a cost of $20.9 million provided under these items in the same period.[74] To be eligible for items 193–199 Medicare requires doctors to be accredited by the JCCMA.[29] The JCCMA is a six person committee draw from AMAC, The Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine.[66] The JCCMA recognises the same two courses required for acupuncture endorsement in Victoria. To be accredited by the JCCMA medical practitioners must also pass part one of the Australian Medical Acupuncture College Fellowship exam (FAMAC) conducted by the AMAC.[64] The AMAC was established in 1973, has 600 members and administers its own course and the FAMAC exam.[75]

Accreditation standards must be developed in a transparent, accountable, efficient and fair manner in accordance with section 3(3a) of the National Law.[5] The Medical Board of Australia (MBA) proposes that the interim standard for acupuncture endorsement until review by 1 July 2012 should be the same as that which was used by the Medical Practitioners Board of Victoria.[76] The CMRBV's submission to the MBA[77] makes a number of observations and comments about the MBA's proposed acupuncture endorsement standard: no details are provided on the education standard that underpins the two recommended courses; that the AMAC courses are not conducted by an education institution; while the two courses are very different from each other each has substantial distance learning components and limited clinical training; that the deduced contact hours of 250 reflects very basic training; that there is a lack of transparency in the governance of the proposed course providers. The CMRBV observes that there is no evidence that the proposed standards will produce graduates that meet contemporary Australian entry level standards in acupuncture practice or that the standard is comparable for that of a registered acupuncturist. The CMRBV has offered to assist the MBA in the development of a suitable standard.[77]

Public funds directly subsidise medical practitioners who use an acupuncture Medicare item number so further examination of medical acupuncture standards is warranted. Medical acupuncture education does not appear to have changed dramatically since 1996. In Towards a Safer Choice: The Practice of Traditional Chinese Medicine in Australia (TASC) Fellowship of the Australian Medical Acupuncture Society (AMAS) (renamed AMAC in 1998) was listed as >250 hours with membership set at >50 hours.[78] No other course details are provided. The AMAS recognised that medical acupuncture education was inadequate and was conducting a review at the time.[78] From 1 November 2003 access to the higher paying items 193, 195, 197 and 199 were restricted to medical practitioners who were accredited by the RACGP Joint Working Party (JWP) which entailed: successfully complete a training course recognised by the JWP; complete the FAMAC part 1 exam; ongoing participation in a recognised continuing professional development program in medical acupuncture.[67] Doctors who did not meet these criteria or who had no acupuncture education could continue to claim item 173.[67] The CMRBV sought details from the AMAC of the education standards underpinning a recognised course at the time but the request was denied.[79] The contact hours for fellowship of the AMAS in 1996[78] are similar to those of the currently accepted courses suggesting that they are substantially the same programs.

INTERNATIONAL EDUCATION STANDARDS

The World Health Organization published Guidelines on Basic Training Safety in Acupuncture in 1999[50] (see Table 1). The guidelines comprise education standards for non-medical acupuncturists as well as medical practitioners who wish to use acupuncture clinically. The guidelines were intended to assist national health authorities and training institutions to develop examination standards and training programs respectively.[50] The guidelines recommend that nonmedical acupuncturists complete two years and 2500 hours education with at least 1000 hours of practical and clinical work. A full training course for medical practitioners should comprise 1500 hours with at least 1000 hours of practical and clinical work. The same core syllabus should be followed as for non-medical acupuncture. Limited training in acupuncture for medical practitioners would comprise of at least 200 hours of formal training derived from the core syllabus. Other primary care health personnel are recommended to study acupressure rather than acupuncture as 'Training in acupressure would make no great demands, could be incorporated into the general training of primary health care personnel, and would carry no risk to the patient'.[50]

Discussion

Acupuncture education standards in Australia are diverse and can be grouped into four main categories: standards for Chinese medicine practitioners; standards for medical practitioners; standards for other registered allied health professionals; and standards for non-registered health practitioners. Presently the CMRBV only directly regulates acupuncturists who are eligible for registration under the HPRA. Outside of Victoria acupuncturists are self regulated. Despite this regulatory difference education standards for acupuncturists in Australia generally conform to or exceed the WHO GBT (see Table 1). The regulatory influence of private health insurers such as Bupa Australia and HCF provides a clear financial incentive to graduate from a recognised bachelor degree program which is not conducted substantially by flexible delivery or distance education.

The growth of courses providing 'dry needling' or 'myofascial dry needling' appears to have coincided with the regulation of acupuncture in Victoria.[6] Subjects once taught as 'myofascial acupuncture for myotherapists'[78] are now called 'myofascial dry needling'[80] Courses of two or three days duration are marketed to both registered professions and non-registered practitioners alike. Of the allied health professions only the APA and AAMT have publically identifiable guidelines for acupuncture training for its members. Neither guideline is a standard as there is no compulsion to follow them. Substantive training in acupuncture which does broadly conform to the WHO GBT is available at the post-graduate level[81] for the very health professionals to whom the short 'dry needling' courses are marketed to.

The standards underpinning training in medical acupuncture remain obscured. Despite public funding through Medicare, Medicare does not set an education standard for acupuncture item eligibility. Instead it refers to an external assessment by JCCMA and AMAC which do not publish details of their requirements while also delivering one of the courses. Changes in the course content, delivery and assessment are invisible to public scrutiny making it impossible to definitively determine what changes, if any have occurred over time with medical acupuncture accreditation. This is in stark contrast to the detailed publically available course accreditation standards and procedures developed by the CMRB. The National Law requires transparency in the development of accreditation standards[5] so for the first time details of the medical acupuncture standard may be available to public review. The details that are in the public domain align medical acupuncture accreditation in Australia to the WHO GBT criteria for limited training in medical acupuncture.[50] Medical practitioners would need to complete the current Master of Applied Science (Acupuncture)[81] at RMIT or similar to achieve the WHO GBT standard for medical acupuncture.

Conclusion

Acupuncture education standards for registered acupuncturists are the highest of any health practitioners who practise acupuncture in Australia. The standard of medical acupuncture education is very low in comparison to both registered acupuncturists and international standards. The lack of transparency in medical acupuncture training should change with the requirements of the National Law. Registered allied health practitioners and other non-registered health professionals have access to high quality post graduate acupuncture education; however two or three day courses appear to be preferred.

An objective of the HPRA was to regulate risky health practices to protect public health and safety. The National Law shares the objective of protecting public health and safety and also requires improved education standards. Restriction of title is designed to allow the consumer to identify not only safe practitioners but also competent ones. Victorian registration has led to the highest standards for registered acupuncturists but much lower standards in other parts of the health community. Chiropractors have reduced their education standards for acupuncture and other health practitioners openly practise acupuncture after a two day course under the name of dry needling.

Accreditation bodies and national boards will need to carefully consider the range of education standards underpinning acupuncture practice when developing an accreditation standard for registration or endorsement. The ability of the public to identify both safe and competent acupuncturists will not be served if nine or more different education standards permit the use of the title. The trend of teaching and practising acupuncture under the name dry needling directly challenges the intent of the statutory regulation of acupuncture and may require a legislative solution if the objectives of the NRAS cannot be fulfilled by the development of accreditation standards and enforcement of registration standards. Achieving the objectives of the NRAS to protect public health and safety, provide quality health care, and improve education standards will require a co-operative effort from the respective accreditation authorities and boards.

Clinical Commentary

Practitioners, other than Chinese medicine practitioners, will be able to use the title acupuncturist after 1 July 2012 if their Board endorses them as suitably qualified to practise acupuncture. At the same time both registered and unregulated practitioners are avoiding regulation altogether by completing two or three day courses and calling their practice 'dry needling' rather than acupuncture. This paper identifies the education standards underpinning the acupuncture practice of various health professions with a view to informing regulators of a range of issues to consider when setting an accreditation standard.

TABLE 4 Glossary of Abbreviations and Acronyms

Abbreviation	Meaning
AACMA	Australian Acupuncture and Chinese Medicine Association Ltd
AGTCME	Australian Guidelines for Traditional Chinese Medicine Education
AHPRA	The Australian Health Practitioner Regulatory Agency
AMAC	Australian Medical Acupuncture College
AMAS	Australian Medical Acupuncture Society
APA	Australian Physiotherapy Association
BUPA	BUPA Australia
CMBA	Chinese Medicine Board of Australia
CMRA	Chinese Medicine Registration Act 2000
CMRBV	Chinese Medicine Registration Board of Victoria
COAG	Council of Australian Governments
FAMAC	Fellow of Australian Medical Acupuncture College
GAC	Guidelines for Approval of Courses of Study in Chinese Medicine
HCF	Hospitals Contribution Fund of Australia Ltd /Manchester Unity
HPRA	Health Practitioners Registration Act 2005
JCCMA	Joint Consultative Committee for Medical Acupuncture
JWP	The Royal Australian College of General Practitioners Joint Working Party
MBA	The Medical Board of Australia
MIMT	Melbourne Institute of Massage Therapy
NASC	National Academic Standards Committee for Traditional Chinese Medicine
National Law	The Health Practitioner Regulation National Law Act 2009
NCS	National Competency Standard for Acupuncture
NRAS	National Registration and Accreditation Scheme for the Health Professions
PHIAR	Private Health Insurance (Accreditation) Rules 2008
PSMDN	Position Statement and Practice Guideline for Myofascial Dry Needling
RACGP	The Royal Australian College of General Practitioners
RMIT	RMIT University
TASC	Towards a Safer Choice
UQ	University of Queensland
VET	Vocational Education and Training
WHO GBT	World Health Organization Guidelines on Basic Training Safety in Acupuncture

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An Examination of Therapeutic Alliance in Chinese Medicine

Suzannah Eva Miller Doctoral candidate
Kenneth Mark Greenwood* PhD, DPsych

School of Health Sciences, RMIT University, Melbourne, Australia

ABSTRACT

Background: In psychotherapy, positive client/therapist relationships are often associated with good therapeutic outcomes. However, little research has been conducted in different health professions and the effect of therapist experience on alliance is not clear. Aims: This study aimed to examine therapeutic alliance in experienced and novice Chinese medicine practitioners and to compare these results to those reported for experienced and novice psychologists. Subjects and Settings/Outcome Measures: A total of 27 experienced and student therapists in the field of Chinese medicine and their clients completed the Working Alliance Inventory (WAI). Results: Chinese medicine clients and therapists reported higher scores on the WAI compared to psychology clients and therapists. As expected, experienced therapists scored higher on the WAI than student therapists, both when rated by themselves and by their clients. Discussion and Conclusion: These findings suggest the therapeutic alliance is relevant in the field of Chinese medicine with further research required into other professions with similar dyadic relationships. Levels of experience also appear to be an area requiring further research. The higher alliance scores found in Chinese medicine may reflect differences in the clients of this discipline and not reflect a superior ability to develop an alliance. Therapeutic alliance seems strong in clients of Chinese medicine practitioners. Further work should focus on how client variables may influence the development of the alliance.

KEYWORDS therapeutic alliance, Chinese medicine.

Introduction

The quality of the relationship between the therapist and client in psychotherapy has consistently been shown to be associated with positive therapeutic outcomes.[1-5] Given this, it is generally accepted within the field of psychology that positive relationships between therapists and clients are an essential element to the therapeutic process.[6-8,5,9] Further, the existence and quality of the relationship between therapist and client is thought to have a specific therapeutic effect separate from that associated with the particular treatment administered.[7,10]

Due to the large amount of research conducted on the topic of the therapeutic relationship within psychology, a significant amount of terminology has emerged to encompass this concept. Terms such as working alliance, working relationship, therapeutic relationship and therapeutic alliance have emerged in the literature. These terms broadly refer to the same concepts and are often used interchangeably. While there is little doubt that the presence of a relationship between therapists and clients can have positive effects, there is no commonly-accepted definition of what constitutes this relationship. Perhaps the most commonly-used definition of this relationship is the therapeutic alliance.[6] Based on Bordin's theory, the therapeutic alliance is seen to be collaborative in nature, consisting of three components: the bond between the therapist and client; their agreement on treatment tasks; and, a consensus on goals to be achieved in therapy.[11,5] The Working Alliance Inventory (WAI) was developed to assess the therapeutic alliance as conceptualised by Bordin.[12]

* Correspondent author; e-mail: ken.greenwood@rmit.edu.au

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The importance of therapeutic alliance seems clear in psychological settings, but little research has been conducted in other health fields where similar therapist-client dyads exist. The most common exploration of the therapeutic alliance outside of psychotherapy is in medical settings.[7,13,3,14] This research often focuses on issues such as compliance, provision of positive information and reassurance and less on the outcome of the relationship.[15,7,13,3]

Previous research into other health fields such as chiropractic and Chinese medicine is limited. However, studies conducted have indicated that therapeutic alliance in these areas also promotes positive outcomes.[16-18] Oths[19] studied the relationship between clients and their chiropractor and suggested that an initial 'link' between the chiropractor and the client often led to decreases in termination rates. Further to this, strong relationships between the chiropractor and client were seen to develop through the chiropractor displaying traits such as warmth and caring for the client. Smith[18] examined practitioners in the fields of Chinese medicine, chiropractic and healing touch and their relationships with clients. Results indicated that positive relationships between therapists and clients also predicted positive therapeutic outcomes. The first aim of the present research was to further contribute to the exploration of the presence of therapeutic alliance in other helping professions, specifically Chinese medicine, and to compare these data with the discipline of psychology which has been most studied in this context.

Research conducted to date has used a wide range of therapists, some having extensive experience in therapy whilst others are still in training.[6,1] This inconsistency in experience levels of therapists may have led to the discrepant results between studies, particularly if experienced therapists can form a therapeutic alliance earlier or to a higher level compared to their less experienced counterparts. Mallinckrodt and Nelson[20] investigated experience levels using novice, trainee and experienced therapists and their clients using a measure of therapeutic alliance. As expected, results indicated that clients reported higher ratings of therapeutic alliance with more experienced therapists than with novices and trainee therapists.[20] Dunkle and Friedlander[21], in contrast, found no significant difference on measures of therapeutic alliance using a range of trainee and experienced therapists. Given this discrepancy between studies examining the effect of clinician experience, the second aim of the present research was to examine possible effects associated with therapist experience levels and the development of a therapeutic alliance across dyads.

A number of studies using global alliance measures and outcome measures, such as termination rates and session quality, have reported clients as more accurately predicting the strength of the alliance than their therapists, with client assessment of the alliance more strongly related to outcome.[22,23,5,25] In contrast, other research has found relatively small differences between therapist and client perceptions of the therapeutic alliance.[25,26] Recent research proposes that clients and therapists are reporting on different factors in regards to a therapeutic alliance.[25] Kramer et al.[25] propose that the client measures the alliance in therapy whilst the therapist measures the process in therapy. The final aim of the present research is to explore possible differences in client and therapist perceptions of the therapeutic alliance.

In summary, the three aims of the research are to firstly compare therapeutic alliance within Chinese medicine with that found in the most commonly investigated discipline of psychology. The second research aim was to examine possible effects associated with therapist experience levels. The final aim of the research was to explore client and therapist views of the therapeutic alliance within individual dyads.

It was hypothesised that therapeutic alliance would be similar across the health professions of Chinese medicine and psychology with a small, yet significant, increased alliance in psychology due to training in developing alliance included in psychology. Secondly, it was hypothesised that therapeutic alliance scores would be higher with experienced therapists than with student therapists. Finally, it was hypothesised that the discrepancy between client and therapist views in psychology would be less evident in comparison with Chinese medicine.

Method

PARTICIPANTS

Participants included 27 dyads of clients and Chinese medicine practitioners. Fourteen dyads involved clients seeking treatment from a probationary Chinese medicine practitioner at a university health clinic and 13 dyads involved an experienced practitioner in a private practice and their client. Clients consisted of 17 women and 10 men; six clients were aged 18 to 30 years, four clients were aged 30 to 40, four clients were aged 40 to 50 and thirteen clients were aged over 50 years. Therapist participants consisted of 23 women and 4 males, nine therapists were aged 18 to 30 years, sixteen therapists were 30 to 40 and two therapists were 40 to 50 years old. Student therapists were in their fourth year of training in Chinese medicine and on average saw 7– 8 clients per week, completing approximately 10 hours of clinical work at the university health clinic.

MATERIALS

Participants in the study were required to provide information including gender, age, experience level as a therapist, and were also asked to complete the Working Alliance Inventory[12] (WAI).

The WAI was slightly modified for the profession of Chinese medicine with each item containing the word 'therapist' changed to 'Chinese medicine practitioner'.

The WAI is the most commonly used measure of the therapeutic alliance and was developed for a range of different therapies.[3] The WAI consists of 36 items rated on a 7-point Likert-type scale ranging from 1, 'not at all true', to 7, 'very true' with a possible score range of 36 to 252.[1] Clients are asked to report their perceptions of the relationship with their therapist, whereas therapists respond to the items based on what they believe their client perceives regarding the therapeutic alliance. Previous research conducted into therapeutic alliance has reported either a mean score or aggregate score from the WAI with higher scores indicating stronger alliances between therapists and clients.[27-31] With reports of strong validity and reliability coefficients of .95, the WAI is considered a reliable and valid measurement of therapeutic alliance.[1,32] Data reported in all five studies[28,29,31,30,27] located in the literature which reported average or aggregate WAI scores from the field of psychology were used to compare with the results obtained from Chinese medicine practitioners and their clients.

PROCEDURE

After obtaining ethics approval through the Human Research Ethics Committee (HREC) at RMIT University, dyads asked to take part in the proposed study were provided with a plain language statement (PLS) suitable to their respective role, client or therapist. Included within the PLS was a section informing all participants, both therapists and clients, that at no time would their data be shared with their client/therapist, and that all questionnaires would be coded and therefore unidentifiable to all involved. Therapists and clients were asked to complete the WAI at the end of their fourth session with their therapist-client and place it in an envelope provided. The decision to have participants complete the measure after the fourth session was a design issue; if the measure were completed too early no relationship may have formed with the literature on therapeutic alliance suggesting the fourth session has allowed time for the relationship to develop.[27,29,2,30]

TABLE 1 Means and Standard Deviations for Chinese Medicine Client and Therapist Scores on the WAI

		M	SD	n
Client	Student	6.26	0.53	14
	Experienced	6.44	0.44	13
Therapist	Student	5.92	.055	14
	Experienced	6.51	0.28	13

Results

The average ratings of both experienced and student therapists and their clients are shown in Table 1. A two-factor mixed design analysis of variance was conducted in order to compare the results of experienced and student therapists with repeated measures across client-therapist dyads. Results indicated a significant main effect of experience, $F(1, 25) = 10.82$, $p = .003$, with higher mean WAI scores reported by therapists and clients, on average, for experienced therapists than for student therapists. The effect size for experience was large (Cohen's $d = 0.86$). However, no significant main effect of respondents (therapist versus client) was found on the WAI, $F(1, 25) = 0.96$, $p = .39$. Both the client and the therapist were reporting similar views of the therapeutic alliance within their relationship. Student therapists appeared to report the alliance to be less strong than their clients, underestimating the strength of the alliance. In contrast, experienced therapists reported the strength of the alliance as slightly stronger when compared with their clients' reports. However, the interaction between experience level and source of report (client or therapist) was not significant, $F(1, 25) = 2.15$, $p = .15$.

WAI scores from the field of psychology were used to compare with the results obtained from Chinese medicine practitioners and their clients. The summary results from each comparator paper[28,29,31,30,27] were converted from aggregate scores on the WAI to mean scores if required. A series of t-tests comparing the results obtained in the present research with those reported in the literature were then conducted (Table 2).

Scores on the WAI of clients of experienced Chinese medicine practitioners in the current study were significantly higher than the equivalent scores provided by clients of experienced psychotherapists. It was also evident that therapist's scores on the WAI were significantly higher in the present study than those reported in the literature.

The weighted mean difference between therapist and client scores reported from four of the five studies of psychology discussed above, was 0.45 with each study reporting lower scores by therapists compared to their clients, that is, therapists in psychology tend to underestimate the alliance perceived by their clients. For the experienced Chinese medicine practitioners, the mean difference was only 0.07 with therapists reporting stronger alliance. These results suggest that Chinese medicine practitioners are more accurate in their judgements of the alliance experienced by their clients.

Discussion

The aims of the current study were to firstly explore the levels of therapeutic alliance within Chinese medicine and compare

TABLE 2 Sample size, Mean and Standard Deviation for Psychology Client and Therapist Scores on the WAI reported in the literature and results of t tests comparing the results to those obtained in the present study

Source	Manuscript	Source	n	M	SD	t	df	p	d
Clients	Hersoug et al. (2001)	Clients	65	4.94	1.08	4.93	76	<.0001	1.82
	Mallinckrodt and Nelson (1991)	Clients	50	5.61	0.77	3.72	61	<.0001	1.32
	Cecero et al. (2001)	Clients	52	5.74	0.84	2.93	63	.004	1.04
	Kivlighan (2007)	Clients	53	5.81	0.61	3.44	64	.001	1.18
	Baldwin et al. (2007)	Clients	331	5.88	0.73	2.73	342	<.0001	0.93
	Weighted Mean	Clients	551	5.72					
Therapists	Hersoug et al. (2001)	Therapists	65	4.66	0.82	4.75	71	<.0001	3.02
	Cecero et al. (2001)	Therapists	58	5.13	0.57	9.92	74	<.0001	3.07
	Mallinckrodt and Nelson (1991)	Therapists	50	5.15	0.67	7.20	61	<.0001	2.65
	Kivlighan (2007)	Therapists	53	5.26	0.75	6.02	64	<.0001	2.21
	Weighted Mean	Clients	181	5.03					

these to those found in psychology. The second research aim was to examine the effect of therapist experience levels. The final aim of the research was to explore client and therapist views of the therapeutic alliance within individual dyads.

Therapeutic alliance in the profession of Chinese medicine was found to be higher than that reported in the psychology literature, both when reported by clients and also by therapists. The findings of the present study suggest the relationship between Chinese medicine therapists and their clients is positive with implications of trust and belief in treatment.

Therapeutic alliance scores were significantly higher with experienced therapists in comparison with student therapists with a large effect size. Previous research found similar results in comparisons between novice, advanced trainee and experienced counsellor's scores on the WAI.[20] Mallinckrodt and Nelson[20] suggest that, although trainee therapists may have acquired the skills necessary to facilitate the therapeutic alliance, more advanced skills such as the formulation of therapy goals and case conceptualisation are acquired through experience and training.

There was less discrepancy between client and therapist views of the therapeutic alliance in the profession of Chinese medicine in comparison to previous reported findings within the field of psychology. Further to this, higher ratings were not reported by the psychologists in comparisons to the Chinese medicine practitioners. These results were quite surprising given the training psychologists receive in forming relationships and alliances with clients compared with other health professions such as Chinese medicine. It was also surprising that Chinese medicine practitioners' scores were, on average, closer to those of their clients.

The surprising results in the current study may relate to the nature of the different clientele of the professions and the treatment sought, in particular the differences between physical therapy and psychological therapy. Psychology clients may find it generally harder to form relationships given their mental state at the time of therapy. It may be that physical treatments are more plausible or that agreed treatment outcome goals are easier to form than in psychology. Scores on measures of therapeutic alliance in the field of Chinese medicine may not be as high as psychology if their clients were similar to psychology clients. The results may also relate to the point at which alliance was measured and the outcomes achieved by the clients at that point of time. For example, by the time alliance was assessed, clients receiving Chinese medicine treatment may have already noticed improvement in their health condition and this may be responsible for the higher alliance scores. On the other hand, psychological therapy may take longer for its impact to be realised. Future research should consider also assessing the clients' perceptions of improvement in their condition and use this as a covariate when comparing across different professions and for clients with different conditions.

Limitations of this research include the small sample size and the indisputable differences between receiving treatment for psychological distress and physical conditions. A number

of participants did not complete questions relating to their therapist 'caring' about them and wrote notes suggesting they did not feel this was applicable to the relationship. Further to this, the amount of time spent with a client may only be 15 minutes in Chinese medicine, whereas it is usually around 60 minutes in psychology with regular visits in Chinese medicine being relatively short for routine provision of herbs, massage or acupuncture. In this study, however, we did not measure the duration or frequency of sessions and it would be useful if future research were to do this. Many Chinese medicine clients may come to know what to expect in their treatment, whereas the stigma associated with seeking psychological therapy and the processes involved may be relatively unknown to people seeking psychological treatment. However, we did not assess clients' expectations, or knowledge, of treatment approaches and this may be of value to assess in future work. Client's higher scores on measures of therapeutic alliance may also relate to previous experiences with a Chinese medicine practitioner and strong beliefs in the practice of Chinese medicine itself, rather than their individual relationship with their therapist. Questions relating to participant's previous experiences with a Chinese medicine practitioner should be assessed in future work and may be useful in gauging attitudes towards the profession at the early stages of treatment. The duration of time taken for the different therapies to take effect and the time point at which alliance are measured are also confounds which need to be considered. In addition, not all therapists or clients approached to take part in the study agreed to participate. Unfortunately, data about those who decided to take part and those who declined are not available. Future research should pay attention to the possibility of responder bias influencing the findings.

The experience of the therapist and the impact this may have on therapeutic relationships also needs further exploration. Inconsistencies amongst previous studies using both trainee and highly qualified therapists need to be addressed and examined as contributing to the therapeutic alliance and outcome independently of other associated factors. The issue of whether experience may exert some effects on the formation of therapeutic alliance may aid in informing newly qualified therapists of possible barriers and predictors of the therapeutic alliance with clients. Such research should focus on the age of the practitioner as well as their experience. Future research may wish to consider examining differences in individual item response between experienced and novice practitioners on the WAI to provide a deeper understanding of the effects of experience.

More knowledge regarding the processes involved in forming and maintaining therapeutic alliances may also result in better client outcomes. Due to the large body of evidence surrounding the positive effects a strong therapeutic alliance has in therapist-clients dyads, it seems only logical that this knowledge be applied to a range of health professions and clinical settings to increase client outcomes for a larger population of individuals.

Clinical Commentary

In psychology and other disciplines, positive client/therapist relationships are associated with good therapeutic outcomes and how to develop and maintain such relationships is often a focus of clinical training. There has been little research of this in Chinese medicine. In this study it was found that Chinese medicine clients and therapists reported higher scores on relationships compared to psychology clients and therapists. As expected, experienced therapists scored higher than student therapists. These findings suggest that such relationships (also known as therapeutic alliance) are relevant in the field of Chinese medicine and may have a similar positive relationship to therapeutic outcomes.

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Acupuncture Research Protocol: Feasibility of Use of Acupuncture for Treatment of Arthralgia Secondary to Aromatase Inhibitor Therapy in Women with Early Breast Cancers

Byeongsang Oh*[1,2] PhD
Benjamin Kimble[1] MSc
Anna McLean[2] BSc
Jane Beith[1,2] MBBS, PhD

1. Sydney Cancer Centre, Royal Prince Alfred Hospital, Sydney, Australia
2. Sydney Medical School, University of Sydney, Sydney, Australia

ABSTRACT

Background: Breast cancer is the most common cancer in females in Australia. Aromatase-inhibitors (AIs) are recommended as adjuvant hormone therapy for postmenopausal women with early breast cancer. A substantial proportion of women taking AIs experience joint pain and stiffness. This AI induced arthralgia does not respond to conventional analgesics and can greatly reduce a woman's quality of life. Studies have suggested that acupuncture may be effective in treating osteoarthritis. Method: This is a randomised double blind phase 2 pilot trial. Participants will be randomised to receive sham or electroacupuncture (EA). Participants in the real electroacupuncture group will receive electroacupuncture twice weekly for six weeks. Patients in the placebo group will receive sham electroacupuncture for the same duration of time via specially designed non-skin penetrating needles placed at points close to the real acupuncture points in the study. Outcomes of joint pain and stiffness will be measured with BPI-SF, WOMAC, quality of life and cognitive function with FACT-G, FACT-Cog, hand strength by a grip test, and serum markers of inflammation (CRP) by a blood test. Discussion: In this article, we report the acupuncture pilot study protocol and design of a randomised clinical trial to reduce joint pain caused by chemotherapy. We expect this pilot study will provide information about the potential efficacy of acupuncture on arthralgia caused by aromatase inhibitor chemotherapy for women with breast cancer. Further, if this study's results are positive, the data will be used to support grant applications to conduct a large RCT to provide the scientific evidence of acupuncture on arthralgia. Trial registration: This clinical trial obtained ethics approval from the Royal Prince Alfred Hospital, Sydney and is registered with The Australian New Zealand Clinical Trials Registry (ANZCTR).

KEYWORDS acupuncture, cancer, pain, randomised clinical trial, research protocol.

* Correspondent author; e-mail: byeong.oh@sydney.edu.au

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B Oh, A McLean, B Kimble & J Beith

Introduction

Breast cancer is the most common cancer in women with over 13 000 women being diagnosed each year in Australia.[1] Approximately 75% of patients diagnosed with breast cancer will have hormone-receptor positive breast cancer. Tamoxifen or aromatase-inhibitors (AIs) are currently used as adjuvant hormone therapy for postmenopausal women with endocrine sensitive early breast cancer. While tamoxifen has long been considered to be the gold standard, studies have shown that AIs instead of, or given sequentially to, Tamoxifen have improved disease-free survival. This has led to the American Society of Clinical Oncology (ASCO) guidelines recommending that an AI be included in the management of postmenopausal women with hormone sensitive breast cancer. The use of AIs in the adjuvant setting has increased dramatically worldwide.[2] However, recent large adjuvant trials of AIs for breast cancer treatment, both clinical and community based, have indicated that 20 to >40% of women taking AIs experience joint pain and stiffness.[3]

AI induced arthralgia often does not respond to conventional pain medication and can greatly reduce a patient's quality of life.[4] Also it has the potential to lead to discontinuation of AI treatment. This is of particular concern as the success of AIs as adjuvant treatment depends on a patient's willingness to adhere to long-term treatment.[5] The mechanism of AI-related arthralgia is currently unknown, but may be related to oestrogen deprivation and the release of proinflammatory cytokines. [3]

The use of complementary and alternative medicine (CAM) is increasing, with two-thirds of breast cancer survivors[6] and up to 55% of women undergoing chemotherapy for breast cancer reporting use of CAM.[7] An increasing proportion of the population believes CAM is a safer alternative for non-life threatening conditions even though its mechanisms of action remain inconclusive.[8] Acupuncture is one such alternative technique currently used for treating a variety of conditions, including musculoskeletal pain. The analgesic mechanism of acupuncture is uncertain, but it is speculated that analgesia may be mediated by the release of opioid peptides and serotonin.[9] Previous randomised trials have found that acupuncture can reduce pain in patients with osteoarthritis of the knee.[10] This study will investigate the feasibility of using acupuncture to reduce AI related athralgia in postmenopausal women with early stage breast cancer.

Aim

The primary objective of this study is to evaluate the feasibility and safety of using electroacupuncture to treat AI induced arthralgia. The secondary objective is to assess any benefits from the use of electroacupuncture for reducing AI induced arthralgia.

Hypothesis

We hypothesise that electroacupuncture will be well-tolerated and may reduce AI related joint pain and stiffness, therefore improving the quality of life of the patients.

Study design

This study is a randomised double-blind phase 2 pilot trial. The total study duration for each participant will be 12 weeks. Participants will be randomised to receive either sham or real electroacupunture. Participants will receive treatment twice a week for six weeks. Sham acupuncture will be delivered via specially designed non-skin penetrating devices placed at points close to the real acu-points in the study. Surveys to assess pain, stiffness and physical function, immunological tests for inflammatory cytokines and measurement of grip strength will be performed before and after the six weeks of acupuncture and six weeks after completion of acupuncture.

Study population

Inclusion criteria were:

- women who are postmenopausal with a history of stage I, II or IIIa hormone-receptor positive breast cancer and who have been taking a third generation aromatase inhibitor (anastrozole, letrozole or exemestane) for at least six months.
- women who report ongoing pain and or stiffness in one or more joints, which started or worsened after initiation of AI therapy
- baseline worst pain score on the BPI-SF of ≥3 on a scale of 0–10
- age >18 years
- ability to understand English, and
- willingness to sign a written informed consent document.

Exclusion criteria were:

- previous receipt of acupuncture for AI-induced joint symptoms or receipt of acupuncture in general in the six months prior to study entry
- inflammatory, metabolic or neuropathic arthropathies, bone fracture or surgery of an effected extremity during the previous six months
- currently taking steroids (oral or injected) or narcotics, severe concomitant illness, severe coagulopathy or bleeding disorder or dermatological disease within the acupuncture area, and
- patients with cardiac pacemakers, defibrillator or any other implanted or topical electrical device, active infection and needle phobia rendering patient unable to receive electroacupunture.

Sample size: This study will recruit 15 participants per arm (total $n = 30$).

Research Interventions

Participants in both groups will receive acupuncture consisting of bilateral perpendicular insertion of sterile disposable acupuncture needles (Viva, made in China, gauge and size 0.20mm x 25mm) at various acu-points twice a week (Day One Monday, Day Two Thursday) for six consecutive weeks. During this time patients in both groups will be allowed to take their usual medication, including pain medication as needed and other CAM therapies. The acupuncture protocol and procedures will follow the *Revised STandards for Reporting Interventions in Clinical Trials of Acupuncture* (STRICTA) recommendations and a standardised protocol.[11]

The designation of acu-points will adhere to the *WHO Standard Acupuncture Point Locations in the Western Pacific Region*.[12] The sites will be LI4 *Hegu*, LI 11 *Quchi*, GB 34 *Yanglingquan*, ST 40 *Fenglong*, LR 3 *Taichong*, GV 20 *Baihui*, EX-HN 1 *Shishencong* and EX-UE 9 *Baxie* on Day One and GB 21 *Jianjing*, TE 5 *Waiguan*, ST 6 *Zusanli*, SP 6 *Sanyinjiao*, LR 3 *Taichong*, GV 20 *Baihui*, EX-HN 1 *Shishencong* and EX-UE 9 *Baxie* on Day Two. Acu-points LI 11 *Quchi*, LI 4 *Hegu*, GB 21 *Jianjing*, TE 5 *Waiguan*, EX-UE 9 *Baxie* were chosen to improve pain and stiffness of arm and hand. Acu-points GB 34 *Yanglingquan*, ST 36 *Zusanli*, ST 40 *Fenglong*, SP 6 *Sanyinjiao*, LR 3 *Taichong* were selected to improve pain and stiffness of leg and feet. Acu-points GV 20 *Baihui*, EX-HN 1 *Shishencong* and LR 3 *Taichong* were also selected to reduce stress and improve cognitive function. Research suggests that stimulation of acu-points ST 6 *Zusanli*, LI 4 *Hegu* may improve immune function.

In the treatment group, the needles will be inserted, with bilateral rotation until the *deqi* sensation is elicited. The needling techniques include twirling, thrusting and lifting. After *deqi* is achieved, the needles will be connected through a microalligator clip and an electrode to a battery-operated pulse generator connected to the negative pole on the acu-points LI 4 *Hegu* or TE 5 *Waiguan* and a microalligator clip and an electrode connected to the positive pole on acu-points LI 11 *Quchi* or GB 21 *Jianjing*. Electrical frequency will be delivered over 2–10 Hz, 0.5–0.7 milliseconds duration pulse width for 20 minutes (Electro-Acupuncture Units IC-4107, ITO Co Ltd. Japan). Electroacupuncture methodology was developed based on previous studies conducted with cancer patients.[3,13]

Patients in the non-active group will receive sham electroacupuncture following the same schedule via specially designed non-skin penetrating devices placed at points close to the real acu-points in the study. Treatment will consist of bilateral manipulation using specially designed sham acupuncture needles[14] (Asiamed, Pullach, made in Germany; 0.30mm x 30mm) at five acu-points close to the real acu-points. The sham needle produces a pin-point pressure sensation. It does not penetrate the skin and automatically retracts on contact. Care will be taken to avoid a *deqi* sensation. The electroacupuncture machine will deliver the same audiovisual stimuli as in the electroacupuncture treatment arm, but lead wires will be concealed and disconnected so that no electrical current is passed through to the needles.

Two acupuncturists (OB and KB) who have more than 10 years experience in acupuncture practice will provide acupuncture treatment to the participants. One (OB) is a clinical senior lecturer at the Sydney Medical School and has six years of acupuncture training. The other (KB) is an acupuncture clinician who has had six years of acupuncture training with 10 years of practical acupuncture experience. Before the needle insertion, the acupuncturist will evaluate patients according to traditional Chinese medicine diagnostic procedures. However, the acupuncturists will administer the standard electroacupuncture protocol only. The first treatment will take an average of 60 minutes including the traditional Chinese medicine diagnosis. Follow up treatments will take an average of 40 minutes, including evaluation and treatment. All electroacupuncture will be 20 minutes duration per session.

Outcome measurement

All outcomes will be assessed by a research assistant blinded to the treatment arm. Measurements will be done at baseline and within one week of completion of treatment. To ensure a comprehensive evaluation of the patient's symptoms, both self-report and grip strength tests will be utilised. Baseline self-assessment will involve three short questionnaires: the BPI-SF, WOMAC, FACT-G and FACT-Cog, which collectively assess the severity of pain, evaluate the impact on quality of life and determine social and emotional well being, and cognitive function. Participants will also complete a very brief survey on their use and attitudes towards CAM. Hand grip strength will be assessed using a dynamometer which the participant will squeeze three times with maximal force. The average for each hand will be recorded. Throughout the acupuncture program, participants will document any changes in dosage and/or frequency of analgesic use. At the completion of acupuncture treatment, all baseline measurements will be repeated.

Data analysis

Tolerability to the electroacupuncture treatment will be assessed by level of participant satisfaction including compliance with treatments and side effects. Paired independent t-tests will be used to compare pre- and post-treatment values for each of the outcomes measured. In addition, two-sample t-tests will be used to compare the average change in score for the group randomly assigned to receive electroacupuncture with that for the group assigned to receive sham electroacupuncture. The variables (use of pain medication and CAM therapies) will be controlled by a multiple regression model during the statistical analysis.

Discussion

Recently, our study suggested that the use of acupuncture by cancer patients is growing.[15] This pilot study was designed to test the feasibility and efficacy of electro acupuncture for women with breast cancer prior to designing a large randomised clinical trial (RCT). These study results will provide data to calculate appropriate sample size for RCT.

Further, innovative approaches to acupuncture research design are needed. This acupuncture study design needs improvement before an appropriate RCT is performed. The complexity of acupuncture research design has been recognised, but there are no single agreed approaches to overcoming methodological challenges.[16] Currently, the implications and feasibility of a double-blind RCT methodology for the assessment of acupuncture interventions is under debate. The National Institute of Health (NIH) in the USA recommended a three arm design for CAM studies (intervention arm, placebo control arm and usual care control arm) instead of the two arms used in conventional medicine studies (intervention arm, placebo control arm).[17] The three arm design will improve the evaluation of CAM but add significantly increased financial costs of running research projects. Where blinding of treatments is not possible, this must be acknowledged and the inclusion of an attention-control group (in addition to standard care alone) needs to be considered.

In this study, participants will be randomised to receive two sessions per week for six weeks only with standard acupuncture treatment. This is a strength of the study, in terms of the treatment being controlled, but it can also be considered a limitation. The acupuncture may be more effective if patients are allowed to have additional acupuncture points based on the symptoms of individual patients. The design of the study can also be improved with the addition of long-term follow-ups to determine the duration of the efficacy of the acupuncture treatment.

In conclusion, more acupuncture studies with large RCTs are required to prove the efficacy of acupuncture for controlling the symptoms of cancer treatment. When the evidence is available, it will be possible to develop evidence-based guidelines regarding the appropriate use of acupuncture and integrate this evidence with conventional medicine within the health care system.

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Clinical Commentary

Use of acupuncture by cancer patients in Western countries is increasing, although supporting evidence is limited. Thus, evidence of acupuncture for cancer care is essential for Chinese medicine practitioners, patients and health care professionals. This clinical trial is design to provide evidence of acupuncture for cancer care as well as to encourage Chinese medicine practitioners to engage in scholarly activities.

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Interview with Professor Wang Juyi, World-Renowned Acupuncturist: Part 2 of 2

James X Liu*
RMIT University, Melbourne, Australia

Introduction

Born in 1937, Professor Wang Juyi graduated in 1962 from the first class of the newly established Beijing Institute of Traditional Chinese Medicine (now the Beijing University of Chinese Medicine and Pharmaology). Professor Wang has been practising Chinese medicine for over 48 years. He worked as a doctor of acupuncture at the Beijing Hospital of Chinese Medicine for 22 years, then later served as president of the Beijing Xuanwu Hospital of Chinese Medicine for two years. He also served as professor, dean and chief editor of the China Journal of Acupuncture and Moxibustion (中国针灸) at the China Academy of Chinese Medical Sciences for twelve years. He worked as a doctor and professor in the United States for two years and has been a pioneer in developing a private Chinese medicine practice in the fast changing environment of modern Beijing for the last ten years. Since the late 1970s, he has had many teaching tours in major western countries and some third-world countries.

In 2008, he published *Applied Channel Theory in Chinese Medicine: Wang Juyi's Lectures on Channel Therapeutics* (王居易经络学讲演录 Wang Juyi *jing luo xue jiang yan lu*, referred to below as ACTCM 讲演录), co-authored with Jason D Robertson. This book has received favourable reviews and was awarded the 'Book of the Year 2008' by the German Scientific Society of Traditional Chinese Medicine NPO (DWGTCM).

Professor Wang specialises in applying classical channel theory to both diagnosis and treatment. Not only does he treat difficult and complicated cases effectively, he also treats commonly encountered illnesses with unconventional strategies. Professor Wang graciously agreed to be interviewed which was conducted over several sessions during the month of April earlier this year (2010) in Beijing.

The Questions – Part 2

How would you explain the essence of the channels? First of all, does the channel system change with ageing? Secondly, do occurrences of disease impact the channel system? Finally, from the perspective of channel theory, what role do the channels play in the modern concept of preventative medicine?

I personally believe that an understanding of the channel system should not be divorced from modern anatomical concepts. That is to say, that the channels describe an organic system not dissimilar to the functions of blood vessels, the lymphatic system, the nervous system, the musculoskeletal system, the skin, the internal organs or the body fluids (blood, lymph and interstitial fluid). Now this would of course include other physiological features defined by the most advanced anatomical research. Consequently, we should avoid the temptation to isolate the channels from the human system as a whole. I am personally surprised that, despite advances in modern technology, we are still unable to definitively locate and define the channels. I think that much research in the past has been looking in the wrong places. In ACTCM 讲演录 we attempt to thoroughly describe some of the physiological features of the channel system. Basically, the channels function in between the organs and tissues of the body. They occupy gaps or space just as other physiological systems do. It is simply a fact that the channels *are* the gaps. If you carefully consider it, the acupuncture points are all located in gaps or spaces where connective tissues intersect. This is the core reason why we talk about communication which transmits through the channel system.

Now, because the channels belong to the realm of human physiology, their condition will change along with ageing and will be affected by disease. Regarding the role of the channels in preventative medicine, I would encourage everyone to have proper and sufficient rest on a regular basis. Allow the channels to rest and regenerate. I believe that maintaining both physical and psychological relaxation is vital. One can apply this concept to daily life through meditation, regular and appropriate qigong exercises such as *baduanjin* (八段锦), *taiji*, and even walking.

* Correspondent author; e-mail: wodongacmclinic@gmail.com

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It is equally important to take one's own constitution into consideration when selecting a type of exercise. For instance, the elderly should focus on low-impact exercise, increasing slowly to avoid possible injury. One might also massage the channel pathways or use acupressure on points to ease minor complaints. This approach is often enough for treating a mild illness or improving a serious disease.

Can you discuss how the theoretical concepts from The Classic of Difficulties (Nan Jing) might be incorporated into a modern clinical practice?

The *Classic of Difficulties* (*Nan Jing*) can be viewed as a supplementary text following the Y*ellow Emperor's Canon of Internal Medicine* (*Huang Di Nei Jing*). The text not only explores the meaning of the acupoints in more depth, it also more thoroughly introduces the Eight Extraordinary Vessels and their relationship to the system as a whole. I would encourage students to read and understand the *Yellow Emperor's Canon of Internal Medicine* (*Huang Di Nei Jing*), firstly, because this will help them to understand where The Classic of Difficulties (*Nan Jing*) is coming from.

Since Dr Jiao Shunfa invented scalp acupuncture during the last century, his theories have been accepted widely in acupuncture circles. However, based on classical literature and your own practical experience, you developed some new approaches to scalp acupuncture. For example, I have seen your unique use of BL7 Tongtian, GV21 Qianding and GV19 Houding. The use of these acupoints are different from twentieth-century scalp acupuncture, but nonetheless seem to get some great results. Can you briefly explain the mechanisms behind this and how you arrived at the theory?

While palpating the channels, I sometimes noticed that there would be a soft area around BL7 *Tongtian* that was achy to the patient when pressed. After massaging or needling BL7 *Tongtian*, I discovered that the technique was able to relieve some symptoms. Because of this, I began to rethink the acupoint and its relationship to the organs. I have concluded that BL7 *Tongtian* tonifies deficiency in cases of chronic cough and back pain. Consequently, I often call BL7 *Tongtian* the 'lung point' (feidian 肺点) or 'kidney point' (*shendian* 肾点) and even sometimes 'head lifegate' (*toumingmen* 头命门). Over time I have realised that BL7 *Tongtian* can help with many other types of disorders. So, in the end, I concluded that the original name is best: *Tongtian* means 'heavenly connection' and the acupoint truly does have an ability to broadly reconnect.

The other acupoints you mentioned are also interesting. Once again through palpation, I have found that GV21 *Qianding* helps to ascend clear qi while descending turbid qi. This regulation of qi in the head makes the acupoint an excellent choice for many sensory disorders. GV19 *Houding*, on the other hand, tends to dredge the governing vessel and regulate blood for motor disorders, such as stiffness and soreness of the neck, shoulders and low back.

You often use a 'quick acupuncture' technique (快刺法 kuai ci fa) to treat certain diseases. Would you say a bit about which acupuncture points and disease conditions are most appropriate for this technique?

The acupoints I needle most often with this technique include: GV14 *Dazhui*, GV13 *Taodao*, GV12 *Shenzhu*, CV15 *Jiuwei* and certain back transport acupoints along the bladder channel, such as BL12 *Fengmen*, BL13 *Feishu*, BL17 *Geshu*, BL18 *Ganshu* and BL23 *Shenshu*.

Important considerations for this technique include firstly that one must obtain qi and secondly that the needle is not retained at all. For example, when needling GV14 *Dazhui* one sometimes gets an electrical sensation or instead a sense of heat running up and down the governing vessel. Sometimes needling this acupoint makes the patient feel hot all over the body. If these sensations do not arise, then one can try twirling, lifting and thrusting or even strong techniques such as 'Setting the Mountain on Fire' and 'Green Turtle Searches for the Point'. Usually, one wouldn't stimulate more than two acupoints when using the 'quick acupuncture' method. Again, the needles are withdrawn immediately after obtaining qi and are not retained. After having first used the 'quick acupuncture' technique one might then use other acupoints in a more conventional manner. However, if one first does the 'quick acupuncture' then needles regular acupoints, retaining the needles 30 minutes for each session, the stimulation will be too strong.

Would you mind discussing the concept of 'leading yang to unblock the collaterals' 引阳通络法 and some commonly used acupoints for bleeding technique?

What is termed 'leading yang to unblock the collaterals' is a method which uses filiform needles to prick the Jing-well acupoints. The key to this technique is that the amount of blood removed is slight (just a few drops). The goal of the technique is to remove blood stasis in that crucial junction between yin and yang channels. This moves qi and blood in both channels. I use this technique in situations where yang qi has become stagnated. We might think of this technique as being similar to one used in an old radiator heating system. When these systems are blocked by an air bubble, we open a valve to remove it and the heat comes back on. For this technique, the most commonly used acupoints include SI1 *Shaoze*, LU11 *Quchi*, SP1 *Yinbai* and ST45 *Lidui*. Most often, these are cases where there is a stasis of yang qi. Symptoms will vary but might include tightness in the chest and difficulty breathing due to an obstruction of

lung yang in which case I might prick LI 11 *Shangyang*. If there are tremors, numbness or cold in the fingers because of an obstruction of yang qi in the three hand yang channels, I would prick corresponding *Jing*-well acupoints. If the above conditions are not caused by an obstruction of yang qi, but are instead due to a deficiency of yang qi, moxibustion is used instead.

You once mentioned to me that acupuncture theory and practice should evolve over time. At the moment, we largely utilise acupoints on the surface of the body. However, it isn't impossible to imagine that, with the development of technology, we might discover and stimulate more and more acupoints. That is to say, in the near future, we might even find points on the internal organs for treating disease. If this is the case, what might be the indications for internal organ acupoints? What are some difficulties you might expect in the development of acupoints in and around the organs?

The hypothesis that direct internal organ acupuncture is possible draws from two factors. Firstly, acupuncture has already had some limited use in treating organs directly. For example, some have used hot-needling for lymphomas with a 'fire-needle' technique, while others have needled the thyroid gland and stomach directly for certain conditions. Secondly, we have relatively recently developed extremely fine-gauge needles, which could enable the stimulation of organs (including even the brain) with much less fear of causing trauma. In some cases, direct needling of the internal organs might be useful for regulating collaterals. Chinese medicine holds that chronic diseases can cause disorders of the organ collaterals. It is therefore possible to consider that direct organ needling may be more helpful for many chronic and complicated conditions.

For now, this technique has not been explored largely because of cost and complexity. Nevertheless, it is now commonplace for surgeons to use laparoscopic techniques. It is not so hard to imagine that similar technology might be used for inserting acupuncture needles very precisely into the spaces in and around the organs themselves.

Question: It has been 36 years since I became your student. I have noticed that your clinics are nearly always full of patients and that you always seem to be busier than other doctors. Why is this? Is it because of your theoretical foundation, unique experiences, effective business strategies or personal charisma? Or is there something else that attracts patients?

In order to attract patients to your clinic, you must firstly have confidence in yourself. Believe in your own ability and have faith that acupuncture cannot only treat simple diseases, but also much more complicated conditions. One of the biggest obstacles to confidence is an over-reliance on western medical examinations and diagnostic results. This over-reliance causes some to limit their scope of possible syndrome patterns and thus narrow their treatment options. *Divine Pivot*, Chapter 1, asserts that 'even though a disease is longstanding, it can be stopped. Those who say [these conditions] cannot be treated have not yet realised their skill.' When you have confidence in yourself, you will try everything to cure the condition. This kind of self-confidence will have a positive effect on your patient's confidence in you and their faith in the treatment.

Secondly, you must constantly broaden your knowledge and improve your skills in order to raise your success rate. If you do this, people will speak highly of you. There is an old Chinese saying: 'Faraway people can still smell good wine'. In other words, some patients will follow you wherever you go. In fact, some may even introduce you to their next generation and even the generation after that!

Thirdly, it is important to have a good reputation among your patients. Some practitioners, in order to seek financial gain, engage in false and exaggerated advertising. These people may make some short-term financial gains but, in the long term, patients will not have faith in them and will not speak highly of them. Contemporary consumers have faith in those practitioners who have maintained a good name rather than those with the most colourful advertising.

Since ACTCM 讲演录 was published in 2008, the book has received quite a bit of positive and encouraging feedback from acupuncture circles in the West. It has been singled out as an outstanding publication. It seems to not only benefit relative beginners in our field but also experienced practitioners with its ideas and philosophical discussions. Can you highlight the outstanding features of the book in your mind and how to apply the text in the clinic?

There are three unique themes which we tried to emphasise in the text: tradition, reality and practical application.

All of the theoretical discussions and practical applications described in this publication are drawn from the core texts of the *Yellow Emperor's Canon of Internal Medicine* (*Huang Di Nei Jing*), *The Classic of Difficulties* (*Nan Jing*) and the *Systematic Classic of Acupuncture and Moxibustion* (*Zhenjiu Jiayi Jing*). I also sometimes borrowed contemporary medical terminology in order to illustrate and expand upon our discussions of acupuncture. Nevertheless, I have never deviated from the basic theories and practice of traditional Chinese medicine. The contents of this book all come from my own understanding and interpretations of the classical texts in combination with practice. The work is a true record of my own work as a doctor of Chinese medicine for the past 48 years. It may have errors here and there, but it is a true record and there is no falsification.

The important contents of the book include channel and acupoint theory, channel examination, differentiation and selection of channels, case studies and acupuncture acupoint pairs. We explore these concepts in detail with an overarching goal of helping readers to develop their own understanding, which can then be applied in practice. There are two indexes included in the book, which list all of the acupoints discussed, the case studies, theoretical discussions and fundamental concepts. These indexes make the text easier to use as a reference book as well.

I have heard that there are many overseas students who practise in your clinic. In your opinion, what are the most prominent problems for these students in their studies? How can they overcome these problems?

There are three main problems with overseas students' learning. Firstly, they do not understand the Chinese language very well. Secondly, they sometimes have a lack of understanding of Chinese culture. Thirdly, many may have very limited learning opportunities in their home countries.

The Chinese language is the medium for transferring knowledge in Chinese medical education. There is a very rich body of knowledge in the classical Chinese texts and studying hard is the way to build up a knowledge foundation. These days there are some excellent new texts in Chinese. Thus, not being able to understand the Chinese language constitutes a major stumbling block for learning Chinese medicine. Nevertheless, it does not mean that one cannot study acupuncture. I have some very good overseas students. One is Jason D Robertson, who is a co-author of ACTCM 讲演录 and speaks fluent Chinese. Another is Yefim Gamgoneshvilli. Although he does not understand Chinese, he is very smart and works extremely hard. Yefim now has a very busy clinic. He works much harder than those students who already understand the Chinese language. Nyssa Tang in New York is another of my excellent Chinese-speaking students.

Acupuncture is rooted in Chinese culture. A lack of understanding of Chinese culture makes the process of studying acupuncture much more difficult. In the long journey of studying Chinese medicine (including acupuncture) a basic cultural understanding should actually precede the study of medicine. In order to understand Chinese culture, one needs to learn about Chinese history, particularly the history of Chinese medicine and how it draws from Chinese philosophy. Following and learning from more experienced Chinese medicine practitioners is important. It also helps of course to interact with Chinese people and, if possible, to visit China as often as possible.

I know that acupuncture enjoys a much lower social status in western countries and that it is seen as somehow inferior to western medicine, chiropractic, osteopathy and naturopathy. Chinese medicine does not have hospitals and even well-equipped clinics are few and far between. Such an environment contributes to some of the great difficulties for those trying to learn and develop a career in Chinese medicine in the West. The best way to overcome such a problem is to visit and work in China. The rich soil of an old acupuncture culture in China can enhance and nurture students in their learning and development. For example, I have heard from you that undergraduate students studying Chinese medicine at the Royal Melbourne Institute of Technology (RMIT University) in Australia spend a few months in China before they graduate.

The last advice I would like to offer to overseas students studying Chinese medicine is to keep a diary at all times for self-directed study. Record all of the valuable knowledge you encounter. This will not only help you to share your experience, it can also help you to consolidate it for yourself. By consolidating your insights, you can better remember them and thus understand, analyse, be creative and move the field forward. My diary keeping for the last few decades has benefited me quite a bit. I still look back over my diaries to enrich my body of knowledge and wisdom. Much of my advanced acupuncture thinking is the result of diary keeping and revisiting the ideas within.

Thank you very much Dr Wang for your time and your honest answers.

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Personal Reflections: What Changed for Me After 30 Years in Chinese Medicine

Gunter Neeb* PhD
Idstein, Germany

Translated by Hamish Brown
Walcha, Australia

见山就是山 *Jian Shan Jiu Shi Shan* (One sees a mountain, and it is just a mountain)
见山不是山 *Jian Shan Bu Shi Shan* (One sees a mountain, and it is no longer a mountain)
见山又是山 *Jian Shan You Shi Shan* (One sees a mountain, and it is a mountain again)
Old saying from Chan-Buddhism

The Mountain

A few hundred years ago, travellers from the West brought a message from the middle kingdom. This message sparked the imagination of artists and scholars who drew paintings and made porcelain ware about China, from how they imagined it to be in that day. This meant that all the Chinese had slanty eyes, hair braids, flat round farmer's hats, dragons soaring through the air, scrolls with unintelligible markings, and lots of bamboo. This menagerie, which only vaguely corresponded to the truth and was later termed *chinoiserie* in German, originated from the French words for China and phantasy.

When I first read the philosophies of Lao-Zi and Zhuang-Zi.i, I would have been around 16 years old. The first translation was in German by Richard Wilhelm, then in English by John Blofeld, and lastly in French by Marcel Granet. The more I read, the more differences I discovered, and as a typical westerner I thought only one version could be right. It would take another twenty years until I was able to read the original and learn that they, like the Chinese themselves being pluralistic, were not all false, and neither were my ideas about them.

With similar *chinoiseries* in my head, and perhaps some naïve notions, I went to Taiwan in 1988. Meanwhile, I had read translations of the *Huang Di Nei Jing*, different versions of *The Book of Changes* (*Yi Jing*) and had also studied some acupuncture during and after my degree. In 1978, inspired by Porkert's *Clinical Chinese Pharmacology*, I conducted my own field study about the availability of Chinese medicines and their possible exchangeability with Western plants.

So I arrived in Taiwan and saw the mountain. As expected, it was a mountain. Taiwan had still kept a lot of the old traditions of Chinese culture and medicine, which for me was closer to what I had read on paper. I studied tea ceremonies and *Qi Gong* with a Daoist master, to whom, when I asked to become a disciple, I had to be initiated with kowtowing and incense like they did hundreds of years ago. At university I studied acupuncture with a patient teacher, traditional Chinese language, and literature including *Dao De Jing*, by old Lao-Zi. In addition, I was still able to see ceremonies of the triads of the underworld Gods and met scholars with long beards and Chang Pao who gathered to play the board game *Wei-Qi*. Despite the environmental pollution and scraps in parliament, and despite the coffee shops and hi-tech, I got to meet a China which seemed to correspond to my previous ideas. Although the majority of the youth were more interested in *Gong Fu* movies, there were still many old teachers who taught and had really mastered the *Wu Shu* techniques.

A highlight was a long conversation with Chen Li-Fu, the figurehead of the Chinese medicine society in Taiwan who had come over from the mainland with Chiang Kai-Shek (Jiang Jie-Shi). By founding and supporting the China Medical College of Chinese Medicine in Taizhong, and the Yi-Jing Research Society in Taibei, he had made sure that the traditional medicine would not disappear, despite the Western orientated direction of the Government. My most important question to him was 'What would be the best approach to study Chinese medicine?' He advised me to start with the very early philosophy of the *Yi Jing*, the *Nei Jing*, and the *Shang Han Lun*.

* Correspondent author; e-mail: dr.neeb@me.com

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I started eagerly and was soon a little discouraged again, since the ambiguous philosophical books escaped application in clinical practice. Everything could be put in one way, but also in a totally different way again. Frustratingly, I didn't have the experience to know when to apply which interpretation. Acupuncture and *Qi Gong* worked quite well without the philosophical background but the depth of medicinal therapy, which in Taiwan was based on the six-level model of *Shang Han*, evaded me still.

The Non-Mountain

In 1994, I finally started a degree at a university on the mainland and was quite glad that everything was suddenly more logical, orderly and well presented for anyone's academic expectations. The pharmacology of the medicines explained a lot, but not everything. The experiments and research on people and animals, which I was part of, convinced me that there was nothing mystical about the medicines that could not be scientifically researched. I did have to study the four classics (*Nei Jing*, *Shang Han*, *Jin Gui*, and *Wen Bing*) during my degree but learned that in practice most of the doctors cared less about the old books the younger they were. The frustrations of practically applying the myriad of interpretations of the old texts was being satisfactorily replaced with modern science. And suddenly…there was no longer a mountain (of old mysterious books) anymore.

I began to demystify the last mysteries and successfully developed a logical, scientific way of interpreting pulse diagnosis. I wrote down the first pharmacological actions of the medicines in German and, with a razor (maybe Occam's), cut through the jumble of philosophy and superstitions. But my scepticism occasionally got thrown back at me when I thought that the following 'medicine' could surely have no provable effect – burnt human hair, children's urine, flying squirrel's droppings and other unusual medicines being described in the old books. To my surprise, the pharmacological and technical examinations resulted in positive proof of action over and over again and delivered a model to explain the use of these strange ingredients.

I could only shrug my shoulders and admit that the oldies knew what they did. But, it still worked quite well without them. The more I stormed up the academic ranks, the more scientific and western my studies became. I worked as a doctor in a research centre, had my own patients and students and, by the time I graduated, had begun to treat patients in my own clinic. I was rather satisfied with my knowledge and found it worked quite well in the clinic. I mostly worked with the *zangfu* model, qi and *xue*, differentiating through yin-yang, full-empty, hot-cold, exterior-interior—and it worked very well.

In about 20% of the patients though there were problems – either they were too weak and the medicine didn't go down well, or the illness was too strong and they did not react (or only slowly) to my prescriptions. In addition, there were the ones who had already healed and returned with a relapse after a few years where, here too, the body did not respond well to the renewed treatment. Was there a common pattern present?

My inner 'white-coated inspector' tried to find the smallest common factor, but in vain.

Well, my results were presentable—patients with peripheral artery occlusive disease of the third class going on mountain tours, again thanks to blood stasis therapy; children and adults experiencing complete convalescence from asthma, restitution of hypertension, gynaecology, dermatology and even cancer therapy.

Pretty reputable, isn't it?

But, perhaps something was still missing?

There were the classics, some only 200 years old, others 2000 years old, which were recommended by all the older teachers. Reading about their cases and descriptions of illnesses, I was regularly startled at how great the successes of the elders were. One prescription and everything was rosy? They either only recorded their successes, exaggerated tremendously, knew something that I didn't, or something was different with their patients. I postponed the pending question and kept on doing things as always.

By chance I bumped into a book in Yunnan where I had done my clinical placement many years ago. Back then, all the doctors had taught me something – Dr Su Lian about hepatitis, Dr Wang about stomach disorders, and so on. However, one of them was only showing me his successes with his patients and, when I wanted to record his prescriptions, he became obscure. He enciphered his prescriptions along the lines of 'WenLi-prescription 12, plus x, minus y', and the students would not let me copy. 'Typical for a practitioner with a family tradition', I thought, 'always this secretiveness with their prescriptions'. He was the son of one of the four most famous doctors in Yunnan, Wu Pei-Heng. This man had been known to everyone as 'Dr Fuzi', because he prescribed such high doses of aconite.

So I had found a book in Yunnan named 'An expedition through Fire school therapy'. First, my wife read it and was completely enthusiastic about it. Because she has the same education as I have, and in addition is a Taiwanese Chinese, she read through the book more quickly than I did and daily showed me parts of the book which sounded plainly unbelievable. I had seldom seen her so excited, and had to repeatedly calm her down by

reminding her that 'paper is patient'. She answered, 'But there are cases from 20 different doctors of the fire school, and not all of them could be exaggerated', and so I finally looked at it as well.

I was flabbergasted – restore yang to nourish yin, warm internally to lower fever instead of giving cold medicines, formulas with only three ingredients for 30 indications, initial worsening of symptoms through yin-fire, and over and over again high doses of *Fuzi*, *Rougui*, *Ganjiang*, *Mahuang* and *Xixin*. It turned everything I had learned so far on its head. Yet the explanations were conclusive, the differentiation almost simple, and the results in the practice unbelievable.

There was only one option to test or to refute these ideas—in the practice!

While I continued to treat my patients in an orthodox manner, we took *Si Ni Tang* and *Fuzi* at ever-increasing dosages at home, which caused my old toothache return. According to the Fire school, this is typical for yin-fire, and by taking more *Fuzi* and Rougui and the inflammation will disappear. So, I took more *Fuzi* and *Rougui* and the inflammation disappeared. Waves of infections began to spread around me, but we were all spared.

After I had carefully applied Fire school principles, mixed with conventional TCM, the first patients returned with results. This encouraged me to finally increase the dosages. Meanwhile I was taking 90g of *Fuzi* as raw medicine, and trying different effects, and side-effects on myself. My parents-in-law had been at 180g *Fuzi* per day for a long time and hardly felt a thing, and likewise with my father taking 60g of *Wutou*. Of course, says the Fire school, they are older and their yang is weaker.

And then, the second round of patients were treated with pure Fire school prescriptions. Day after day I sat behind my desk and heard of miracles; After five years of loss of hearing a complete recovery; macular degeneration with 10% vision to 45% with increased retina growth; after eight years of hemiplegia a man rises from his wheelchair and now practices daily with a walker; a woman who came to see me because of infertility falls pregnant after only four weeks, and, and, and….

And again: The Mountain

I had received a fairytale book, where the elves and salamanders inside had jumped out, and now lived in my clinic as pets. The results were as unbelievable as in the cases that were described in the book. Yet the daily successes were a lot more convincing than anything printed. I started reading more literature on the Fire school. My brother-in-law was in China and he sent them to me. He wrote that in China and Taiwan the Fire school had recently risen to extreme popularity, especially amongst the younger students.

I finally received the books of Zheng Qin-An, Wu Pei-Heng and other Fire school doctors. I wanted to know why it worked so well, yet the answers to it weren't to be found in pharmacology books. You guessed it—they were recorded in the *Yi Jing*, the *Huang Di Nei Jing* and the *Shang Han Lun*!

And now after all these years of clinical experience I understand how to put the classics into the right context. I also became clear on why the Fire school is getting so popular everywhere; it developed at a time when, due to the euphoria over the successful prevention of epidemics by using cold *Wen Bing* medicines, more and more cold was promoted. The thermal equivalent to them, though, is antibiotics which are mostly cooling and at times randomly prescribed for 50–60% of all colds, even in modern China. What does this mean? It means that warmth generating processes through active gut flora in the intestines are being minimised. The patients then often suffer from a weakness of endocrine gland secretions, lack of enzymes or simply dysbiosis, and produce soft and at times undigested stools. This is interpreted according to TCM as iatrogenic cold or spleen yang emptiness of the digestive organs. But that's not all:

- During my time in hot Taiwan working in Dr Zhang's clinic, I was wondering why most of the patients with colds came in the summertime. At this time there were no air-conditioners in the cars at home in Germany. Later in Europe, a patient needing knee cartilage replacement therapy, made me realize that it had been caused by air-conditioning, whereby he had been driving for 16 hours with the cold stream of it blowing at his right knee. Here was my answer to the colds I saw in summertime at Taiwan.

- A short while ago, I had a patient whose temperature was permanently measured in hospital because of an infection. With relief they found out that his temperature did not rise to a fever at all, and therefore no fever-decreasing drugs had to be prescribed. His body temperature was not exactly in the physiological area with 34–35 degrees, but this was dismissed as harmless and with a shrug of the shoulders. They also said there is not a drug existing which could raise his temperature either.

- When antibiotics are not a help because no antibiogram was done, or because they were even given against viral infections, or if there is already an immune disease present, then usually corticoids will be used. Their catabolic effects are originally a relic from a time where the body needed to free up reserves when danger was present (e.g. mobilising blood sugar for muscles). This means they

are not being produced over longer periods of time. Externally administered cortisone therefore interferes with the function of the sensitive hypothalamic-pituitary-adrenal axis, which finally causes atrophy of the adrenals, but also promotes the decompositions of bone tissue and other tissues.

- An example in the extreme manifests in the area of oncological chemotherapy, whereby the administered mitosis-poisoning drugs slow down cell division and the resulting thermal oxidation. Besides the often-occurring Cachexia, the patient also gets cold from the poisons released from the cell. In the statistics of the Chinese doctor Sun Geng-Chan on 1000 of his cancer patients, over 80% showed a cold syndrome according to TCM. It has already been mentioned, what the reason for this is historically. Here, the tendency is also to encourage catabolic processes and to minimize warmth, but on the other side, not to see cold as evil.

But not only is the trend in Western medicine decreasing the yang, or warmth of life, in addition our modern society is getting colder in and around us as well:

- Because we constantly have less time, food consumption has become faster and faster. It is now common practice to consume sandwiches, cold convenient products, meals scantily warmed up in the microwave, or even to eat cold food straight out of the refrigerator. The body then has to warm this food to 37 degrees centigrade with its own warmth instead of a warm meal supplying thermal calories. This means it loses physical calories from the thermal unit. Cold drinks, ice cream and other foods below room temperature account for the same problem. On top of this, it is the ideal for women to be as slender as possible and therefore consume ‘calorie conscious’, ‘low-calorie’, and ‘light’ foods like salads and raw food, or for us non-ruminants, indigestible foods like raw grains (muesli etc.). Interestingly, the biggest epidemiological study on nutrition and disease does not confirm this ‘fear of calories’ but shows that not the amount of calories, but the type of foodstuffs ingested plays a far bigger role in weight gain. These are only weak, but consistent influences.

- In a recently published Canadian study, they asked the participants to remember a socially cold situation like bullying and then to estimate the room temperature. The control group on the other hand was asked to think of a situation of human warmth and sympathy and estimate the room temperature. The results showed that even social coolness made the subjective feeling of the room temperature drop a few degrees.

In another study the participants were asked to judge a potential applicant. While doing so, one of the groups drank ice coffee, while the other drank hot coffee. The warmer the beverage, the more positive the judgments were.

The next question now would be how ‘cool’ our society really is, and what it means for us? Maybe the next ice age has already started within us.

At least for me a new era has begun. I can not read the old classics quickly enough for the theory, and to put the prescriptions of the Fire school into practice and spread their ideas. This treasure of Chinese medicine is perhaps the most valuable I have learnt in the past 20 years. Not that the logical and pharmacological approach is bad, but it is just a part of the whole.

In the west we have changed the old Chan saying to this one:

First there is a mountain
Then there is no mountain
Then is

That is fine as well. But actually, it goes like this:

One sees a mountain, and it is a mountain
One sees a mountain, and it is no longer a mountain
One sees a mountain, and it is a mountain again

For me, Chinese medicine has become a mountain again. And, it is a beautiful and climbable one.

Editor's disclaimer

According to ‘Standard for the Uniform Scheduling of Drugs and Poisons (SUSDUP)’ produced by the Therapeutic Goods Administration, Australia, some medicinal herbs used by the author are prohibited scheduled substances in Australia and should not be supplied by Chinese medicine practitioners or herbal dispensers to patients for treatment use in Australia. The relevant herbs are *Mahuang* 麻黄 (Schedule 4, prescription only medicine), *Xixin* 细辛 (Appendix C, prohibited substance), *Fuzi* 附子 (Schedule 4) and *Wutou* 乌头 (Schedule 4). Supply of prohibited substances is a prosecutable offence. For further information, visit the website of the CMRBV <http://www.cmrb.vic.gov.au/information/schedherbs.html>.

In addition, the dosages used by the author are far beyond the recommended dosages listed in all the standard textbooks. The opinions expressed in the article are those of the author, and do not represent those of this journal or the publisher, Australian Acupuncture and Chinese Medicine Association Ltd.

Research Snapshots

Johanna Shergis BAppSc(HumBiol/ChinMed)
RMIT University, Melbourne, Australia

Tsiewe Ying (Amy) Tan BAppSc(HumBiol/ChinMed)
RMIT University, Melbourne, Australia

CHINESE HERBS IN THE TREATMENT OF INFLUENZA

OBJECTIVE: This study was designed to investigate the efficacy and safety of *Antiwei* granule, a traditional Chinese prescription, in the treatment of influenza.

METHODS: This study was designed as a multi-centre, randomised, double-blind, placebo-controlled trial. Subjects were randomised within 36 hours of onset of influenza-like symptoms; that is, fever over 37.4°C, at least one respiratory symptom (cough, sore throat, or nasal symptoms), and at least one other symptom (headache, fatigue, myalgia, thirst, chills). Subjects received 6g *Antiwei* granule or matching placebo twice daily for three days.

Antiwei granule contained: *Ma Huang* (~11%), *Bai Mao Gen* (~33%), *Ge Gen* (~17%), *Gui Zhi* (~11%), *Gan Jiang* (~6%), *Ku Xing Ren* (~11%), *Gan Cao* (~11%).

OUTCOMES: Primary outcomes were percentage of participants who recovered after 3 days' treatment and mean symptom scores. Secondary outcomes included length of time to alleviate fever and severity of each symptom after the first 24 hours of treatment. Immunofluorescent antibody assays confirmed influenza A and B virus infection, with analysis of influenza-like and influenza-confirmed populations performed separately.

RESULTS: Four hundred and eighty adults were recruited from eight emergency departments in China. Three hundred and sixty individuals were randomised to Antiwei granule and 120 to placebo. No significant differences were observed between the two groups at baseline. Thirty-four participants withdrew, but none were due to adverse events. Influenza infection was confirmed in (50.1% in the Antiwei group and 42.1% placebo subjects. In influenza confirmed subjects (n = 225) *Antiwei* granule resulted in 23.2% recovery after 3 days (p = 0.009), compared to 6.25% in the placebo group. Similar recovery was seen in the influenza-like group (24% (*Antiwei*), 8.8% (placebo), $p < 0.001$). Compared with baseline, fever, cough and expectoration reduction improved after one-day treatmen. Other domains including chills, headache, nasal obstruction, rhinorrhoea, sore throat, fatigue and thirst were not significantly improved after one day. One adverse event was recorded with mild paroxysmal palpitations, which resolved within two days without additional treatment and the participant continued in the study.

CONCLUSION: Oral administration of 6g *Antiwei* granules twice daily for three days was associated with improvement in total symptom scores and patient recovery from influenza-like and influenza-confirmed populations. Generally *Antiwei* granule was well tolerated by participants with only one adverse event.

COMMENT: Overall, the reporting for this trial complies with the CONSORT statement. However, some parameters were not elaborated, including characteristics of the herbal products (methods for authentication, analysis, purity, standardisation and heavy metal testing). The authors acknowledge the limitations in design, including no follow-up and short duration of observation. The positive results should be interpreted with some caution.

Wang L, Zhang RM, Liu GY, Wei BL, Wang Y, Cai HY, et al. Chinese herbs in treatment of influenza: A randomized, double-blind, placebo-controlled trial. Respiratory Medicine. 2010;104(9):1362–9.

GINSENG FORMULAE FOR CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD): A SYSTEMATIC REVIEW

OBJECTIVE: This review focuses on evaluating Ginseng formulae for stable COPD.

METHODS: The authors searched four English and three Chinese databases to identify randomised control trials (RCTs). Methodological quality of studies was assessed using Jadad's scale and Cochrane risk of bias. COPD, ginseng and their related synonyms were searched and details extracted. Selected studies met pre-specified criteria, including; RCTs (with or without blinding); participants with stable COPD; and studies administering oral formulae with ginseng being one ingredient compared to a control group. Included studies also needed to report at least one of four primary outcome

measures: (1) Spirometric parameters; (2) Percentage of effectiveness of symptom changes; (3) Quality of life; or (4) Frequency of COPD exacerbations.

RESULTS: Twelve studies with a total of 1560 stable COPD patients met the selection criteria for this review. Eleven studies were published in Chinese and one in English. Duration of intervention ranged from one month to six months, with three studies using a follow-up period (six months). All studies used different ginseng formulae, containing between one and 12 Chinese herbal ingredients. Methodological weakness was observed in the majority of studies, with only one study being considered as of low risk of bias. Results differed throughout the studies, yet encouraging evidence of some effect in improving lung function (FEV1), respiratory symptoms and quality of life was reported.

CONCLUSION: The authors observed some benefit of ginseng formulae for stable COPD. Due to methodological weaknesses in the included studies, further trials are needed to address the identified problems in this review.

COMMENTS: The data from this review suggest some effect of ginseng formulae stable COPD. However, poor methodologies need to be addressed in further studies to confirm ginseng formulae's true effect on this population.

An X, Zhang AL, Yang AW, Lin L, Wu D, Guo X, et al. Oral ginseng formulae for stable chronic obstructive pulmonary disease: A systematic review. Respiratory Medicine. 2011;105(2):165–76.

Johanna Shergis

BU ZHONG YI QI TANG FOR LONG-TERM MANAGEMENT OF QI DEFICIENT ATOPIC DERMATITIS PATIENTS

OBJECTIVES: To evaluate the efficacy and safety of *Hochu-ekki-to* (*Bu Zhong Yi Qi Tang*) in the long-term management of *Kikyo* (qi deficient) patients with atopic dermatitis (AD) via a multicentre, double-blind, randomised, placebo-controlled trial.

METHODS: *Kikyo* condition was assessed using a questionnaire scoring system. Ninety-one AD patients aged 20–40 were enrolled. Patients who were using weak topical steroids, strongest topical steroids, systemic steroids, oral suplatast tosilate, allergen desensitisation therapy or other herbal medicines for less than four weeks before the study were excluded. An independent investigator randomly assigned patients to the *Hochu-ekki-to* treatment or placebo group. Patients received twice daily of either *Hochu-ekki-to* fine granules or placebo granules for 24 weeks, while continuing their usual treatment regime of topical steroids/tacrolimus, emollients or oral antihistamines.

OUTCOME MEASURES: Skin severity scores, total equivalent amount (TEA) of topical agents used, adverse effects and laboratory examinations were examined at pre- (0-week), mid- (12-week) and post- (24-week) treatment. Prominent efficacy rate and aggravated rate were also evaluated.

RESULTS: Seventy-seven patients completed the trial (Hochu-ekki-to: $n = 37$; placebo: $n = 40$). There was no significant difference in overall skin severity score. The use of TEA of topical agents and aggravated rate (ratio of patients whose TEA had increased over 50% at 24 weeks) were significantly ($P < 0.05$) lower in the *Hochu-ekki-to* group. Prominent efficacy rate (rate of patients whose severity score became 0 at the end of study) was 19% in the *Hochu-ekki-to* group and 5% in the placebo group ($P = 0.06$). Mild adverse events (53 events in total) were reported; however there were no significant differences in adverse events and laboratory examination (serum IgE, lactate dehydrogenase (LDH) and eosinophil counts) results between both groups.

CONCLUSION: The authors concluded that *Hochu-ekki-to* could reduce the usage of topical steroids/tacrolimus without aggravating AD and be a useful adjunct to conventional treatments for *Kikyo* patients with AD.

COMMENTS: The questionnaire scoring system was not explained in depth and there was no indication that the reliability and validity of the scoring system was tested, therefore it is difficult to determine if the questionnaire scoring system was sufficient for the diagnosis of *Kikyo* condition.

Kobayashi H, Ishii M, Takeuchi S, Tanaka Y, Shintani T, Yamatodani A, Kusunoki T, Furue M. Efficacy and Safety of a Traditional Herbal Medicine, Hochu-ekki-to in the Long-term Management of Kikyo (Delicate Constitution) Patients with Atopic Dermatitis: A 6-month, Multicenter, Double-blind, Randomized, Placebo-controlled Study. Evidence-based Complementary and Alternative Medicine 2010;7(3):367–73.

ACUPUNCTURE CAN REDUCE TYPE I HYPERSENSITIVITY ITCH IN ATOPIC ECZEMA PATIENTS

OBJECTIVES: To evaluate the effects of acupuncture on type I hypersensitivity itch and on the wheal and flare formation in atopic eczema (AE) patients in a double-blinded, randomised, placebo-controlled, crossover trial.

METHODS: An allergen stimulus (grass pollen or house dust mite) was applied to 30 AE patients. To test the direct

effect of acupuncture, the patients were randomised to receive verum acupuncture (VA) on LI 11 *Quchi* and SP 10 *Xuehai*, 'placebo-point' acupuncture (PA), or no acupuncture (NA) four minutes after stimulus application. Those in the VA and PA group received one session of acupuncture for 11 minutes. To assess the preventative effect, the allergen stimulus was applied again after a resting period of 15 minutes. A visual analogue scale (VAS) was used to measure the severity of itch after each application of the allergen stimulus. Ten minutes after each allergen application, wheal and flare sizes and skin perfusion were measured. The Eppendorf Itch Questionnaire (EIQ) was answered by patients 15 minutes after intervention and also after the second allergen stimulus was applied. The study was designed as a three-arm crossover trial where each patient was subjected to all three groups and each served as its own control.

RESULTS: Direct effect: Compared with PA and NA, VA had mean VAS-ratings and mean descriptive ratings of EIQ which were significantly lower; mean wheal sizes were significantly smaller in VA than NA while mean flare sizes were significantly smaller in VA than PA; mean perfusion units were significantly lower in VA than NA. Preventative effect: Compared to PA and NA, VA had mean VAS-ratings, mean wheal and flare sizes and mean EIQ ratings which were significantly lower; mean perfusion units were significantly lower in VA than NA.

CONCLUSION: It was concluded that type I hypersensitivity experience by AE patients could be effectively reduced with verum acupuncture treatment when compared with placebo-point treatment or no treatment.

COMMENTS: The design of the study as a three-arm crossover trial was not explained in depth. It was stated that patients were subjected to all groups but it was not stated how this was carried out. There was no mention of the intervals between each intervention during the crossover and whether precautions were taken to prevent influence from the effects of the previous intervention on the results of the next intervention applied to patients. Furthermore, this study reflected mainly on the immediate result of a single acupuncture treatment and did not mention the extent/duration of the effects and if it could be applied for long-term management.

Pfab F, Huss-Marp J, Gatii A, Fuqin J, Athanasiadis I, Irnich D, Raap U, Schober W, Behrendt H, Ring J, Darsow U. Influence of acupuncture on type I hypersensitivity itch and the wheal and flare response in adults with atopic eczema – a blinded, randomized, placebo-controlled, crossover trial. Allergy 2010;65(7):903–10.

Hsiewe Yin (Amy) Tan

Book Reviews

Yamamoto New Scalp Acupuncture: Principles and Practice

By Richard A. Feely
Thieme, 2011
ISBN: 9783131418326

This book systematically described the Yamamoto New Scalp Acupuncture (YNSA) from fundamental theory, diagnosis methods, and treatment principles to case reports of clinical application.

For most of traditional Chinese medicine (TCM) practitioners, Yamamoto New Scalp Acupuncture is not a familiar acupuncture modality, although we probably know conventional Chinese scalp acupuncture and utilise it in our daily clinical work. YNSA however is a unique scalp acupuncture system which is very different from TCM and the classical acupuncture system, both theoretically and practically.

YNSA was discovered and developed during the 1970s by Toshikatsu Yamamoto, MD and PhD, of Japan. Previously published in 2003 was a book entitled 'Yamamoto New Scalp Acupuncture:YSNA' by Toshikatsu Yamamoto and Helene Yamamoto. In this previous book, the YNSA was introduced from basic concepts to practical procedures. This new book by Richard A Feely combines both Dr Yamamoto's pioneering work and the author's diagnostic and treatment points identified in his YNSA practice.

Traditional Chinese acupuncture is based on the systematic theories of TCM including Yin-Yang, Zangfu, Qi-blood-body fluids substances, and especially the channel and point theory. Treatment is applied following TCM-style diagnosis. YNSA is a scalp acupuncture system very different from conventional Chinese scalp acupuncture, especially regarding point location, diagnosis, or treatment applications.

YNSA is an acupuncture microsystem, like conventional Chinese scalp acupuncture and auricular acupuncture. It uses a somatic representation on the scalp to reflect the different parts of the whole body and internal organs. Its treatment approach is to insert an acupuncture needle in a scalp acupuncture point. The scalp acupuncture points are classified as mainly the Basic points and Ysplion points (to be explained later). The treatment is based on the unique neck palpation diagnosis and abdominal palpation diagnosis, although clinical history and sometimes pulse diagnosis are also used. YNSA is mainly used to treat musculoskeletal and neurological pain, as well as some other disorders.

Compared with the previous book on YNSA, this book tries to integrate YNSA with TCM. The author gives a brief introduction of fundamental TCM theories, including Yin-Yang, Wu Xing, Qi-blood-spirit, diagnostic principles, and acupuncture channel theory. The author also tries to explain the mechanisms of how traditional acupuncture and YNSA by referring to scientific physiological research evidence. Obviously YNSA is not based on TCM theory. and it would be a difficult and complicated task to formulate YNSA into TCM.

The most valuable part of this book, I believe, is that it presents the details in YNSA diagnosis and treatment. YNSA uses unique diagnostic methods, i.e. neck diagnosis and abdominal diagnosis. The neck diagnosis is a palpatory examination of the neck soft tissue structure to identify which Basic points and Ypsilon points are to be selected for treatment. YNSA abdominal diagnosis also involves the palpation of different abdominal areas to help determine which Ypsilon points to use. A detailed description of the procedure, purpose, and methods for neck diagnosis and abdominal diagnosis are presented. As these methods are very different from TCM diagnosis, I feel that a lot of effort is needed to understand and master YNSA diagnostic methods.

Another core aspect of YNSA is point classification and location because diagnosis and treatment are ultimately to identify which point to be treated. YNSA points are classified as Basic points and Ypsilon points. The Basic points are the scalp points most frequently used to treat pain in an anatomical area, or disease and dysfunction associated with particular body part. There are 23 points in each Yin and Yang area (anterior and posterior half of the scalp). The point location, anatomical correlate, needling technique, and clinical use are described for each of the points. Ypsilon points are named after the 12 major channels and are located on the temporal region of the head which is divided into the four quadrants each side. There are 12 Ypsilon points representing 12 TCM channels. Ypsilon points are used to treat pain or other symptoms after treating with the Basic points.

This book tends to focus on the practical aspects. Treatment protocols and needling techniques (needling insertion and needling manipulation) are presented. YNSA indications, contraindications and possible side effects are also described. Practice guidelines summarise the step by step procedures in clinical application of YNSA. A list of anatomical sites and common disorders are also listed with the corresponding Basic points and Ypsilon points for clinical reference. Furthermore, 18 case reports are presented and most of them are commonly seen clinical conditions such as migraine headaches, herniated lunbar disk, and sciatica.

The YNSA system, especially the diagnostic points in the neck and abdomen, and the treatment points (Basic points and Ypsilon points) were discovered by Dr Yamamoto using trial and error during clinical practice. I was really amazed by the fact that one practitioner could develop such a unique acupuncture system through his practice. As mentioned by the author, finding the Basic and Ypsilon points is difficult at first. This skill, as well as YNSA needling techniques, is best learned one-on-one with an expert instructor. The companion DVD included with this book is helpful for learning, modeling, and practising.

As a practitioner of TCM acupuncture, I believe the theory and techniques presented in this book will expand our theoretical base and permit a wider perspective in clinical practice. The combination of TCM theory, scalp acupuncture which is taught in most acupuncture educational institutes, and the YSNA, will surely improve our clinical results and benefit the patients. For those who want to further expand their knowledge and upgrade their scalp acupuncture technique, this book is highly recommended..

Reviewed by Yun-Fei Lu

Ear Acupuncture: A Precise Pocket Atlas Based on the Works of Nogier/Bahr

By Beate Strittmatter
Thieme, 2011.
ISBN 9783131319623

Although titled a pocket atlas the second English edition of Ear Acupuncture is 424 pages and is a useful and comprehensive source of auricular points and their location. Ear acupuncture is increasing practised around the world, and this text will be useful to those new to this application, as well as the more experienced acupuncturist.

The content of the book is based on the teachings of Paul Nogier and Frank R. Bahr, MD. The second English edition consists of nine chapters. Chapter 2 describes the Projection of the Locomotor System which establishes the foundation for understanding the auricular map. Chapters 3, 4 and 5 provide an overview of the Internal Organs, head and nervous system, and their location on the auricular surface. Each structure is spaciously laid out with text describing the location, a facing page with a diagrammatical presentation of the ear and illustration of the location of the relevant structure. In addition, Chapter 5 relating to the nervous system presents a case for indication of use. The remaining half of the book (Chapters 6 and 7) is dedicated to functional points. The same format as earlier chapters is applied, with the point location clearly described, and a succinct description of the application of each point given. Chapter 8 describes the projection of the body jing-luo channel system onto the ear surface. The value of this application is to enhance treatment when using standard body acupoints. For each channel, a selection of four points were selected and their location described. In the last chapter (Chapter 9), specific disorders are selected and a brief treatment plan for each disorder is presented.

My only minor concern with this book would be with this chapter. Overall Chapter 9, presents a plan of the points that would be selected for a particular condition, mentioning the side of needling and the use of gold or metal needles. This chapter is too brief and is limited to comments relating to the method of locating a point using electrical resistance/conductance, the only points to be needles are those found to be active, which pain points to be needled with gold needles and what other sites to consider needling with stubborn cases. Given the broad and diverse audience this book attempts to target this chapter is too simplistic or insufficient and readers could have been referred to more appropriate texts.

To conclude, this book is easy to read, well laid out and is a useful and extremely handy resource to have at hand in the clinic.

Reviewed by Caroline Smith

Jing Jin: Acupuncture Treatment of the Muscular System Using the Meridian Sinews

By David Legge
Sydney College Press, 2010
ISBN: 97809577392

Musculoskeletal pain is a prevalent condition that does not respond to pain medications very well. It is also the main reason why two-thirds of patients seek acupuncture treatment. The ability to produce consistent and effective results with acupuncture for those patients is the goal of every acupuncturist.

This 166 page book by David Legge seems to promise that. I have been looking forward to reading the book. A few weeks ago, I saw with my own eyes the great improvement that a patient experienced after being treated with Legge's methods.

In this book, Legge takes us back to the basics of the meridian system, the *Jing Jin*, i.e. the muscular-tendon meridian. This aspect of the meridian system and its clinical implication are rarely discussed in modern acupuncture texts. Through his clinical experience and examination of the *Jing Jin*, Legge integrates his anatomic knowledge of the musculoskeletal system, trigger points and Jing Jin, and proposes a revised version of the system replacing acupuncture points and plain language description of the body with anatomic terms. He then uses this system to give practical guidance on how to diagnose and treat different painful conditions.

For example, according to *Ling Shu*, the foot *Taiyang* (Bladder) *Jing Jin* 'begins in the little toe of the foot, goes up to connect with the ankle bone, then goes diagonally up to connect to the knee. A lower branch follows the lateral side of the foot to connect at the ankle bones, then mounts and follows the heel to connect in the crease of the knee' (p32). After examining the muscles in the region and pathways of other meridians, Legge decided the pathway described in the first sentence fitted in with the *Jing Jin* of the Gall Bladder meridian but not that of the Bladder; his proposed revision reads that the foot *Taiyang Jing Jin* 'begins over the heads of the metatarsals with the plantar fascia which travels over the sole of the foot to bind on the calcaneus. It travels up over the heel to the Achilles tendon, through its muscles – gastrocnemius, soleus and plantaris, and joining popliteus' (p36).

This revision serves at least two purposes. Firstly, it replaces plain language with anatomical terms, which allows acupuncturists to communicate with other health professions more effectively. Secondly, it rationalises the use of points in the calf and hamstring muscles to treat plantar fasciitis although the pain is in the sole. Such knowledge provides a framework for health professions, such as chiropractors, osteopaths, and physiotherapists, who use trigger points distal to the pain sites without a theoretical system.

For clinicians, this book is practical and full of advice on how to diagnose and treat different painful conditions with acupuncture. The treatment parts include selection of *Ashi*, trigger and classical points; and more importantly have detailed description on needling techniques, duration of needle retention and posture of the patients. The latter is often neglected by many acupuncture texts. I consider this is a trigger-point needling book for acupuncturists.

The proposed pathways give us a fresh look at the *Jing Jin*; but at the same time also challenge our thought and belief systems. Those who love the classics and the complexity of acupuncture might ask 'What is the consequence of altering the first stem of the Bladder *Jing Jin*? Would it limit the clinical implications? For instance, to treat plantar fasciitis, one could also use the points along the Bladder Jing Jin on the lateral aspect of the foot'. Others might say that needling multiple *Ashi* points along the *Jing Jin* seems to be rather rudimentary and neglects the holistic feature of Chinese medicine, such as five element theory and *zangfu* theory.

Are challenges and simplification damaging to acupuncture? Each reader will have their own answer. Legge's proposal here is not based just on his belief, but based on his years of clinical experience and knowledge. Being an osteopath and acupuncturist, Legge is in a unique position to examine the *Jing Jin*. As he states on the back cover of the book, he has attempted to 'make sense of Chinese medicine' for 30 years. The book is a fine example of integration of knowledge.

The only drawback of the book is its illustrations. Not all muscles mentioned are included in the diagrams, making it harder to comprehend the information. Most readers will need an anatomy book beside them to assist the reading.

This is a book that every acupuncturist should have. The methods offered will not cure all patients with musculoskeletal pain, but it will likely improve their conditions significantly. Combining the methods proposed by Legge with the holistic view and practice of Chinese medicine, acupuncturists will see more and more satisfied patients.

Reviewed by Zhen Zheng

The Complete Stems and Branches: Time and Space in Traditional Acupuncture

Roisin Golding

Churchill Livingstone, 2008
ISBN 9780443068690

In *Stems and Branches* Roisin Golding provides a clinically practical 320 page text packed with theory to guide the practitioner of Chinese medicine in applying the study of this neglected field. This is the art of awareness of how qi is influenced by the external environment at a much deeper level than just the weather. The dedicated practitioner, upon studying this easy to read text, and with the aid of the energy calculator disc, may immediately diversify his or her practice of acupuncture by complementing diagnosis and acupuncture treatment with knowledge that was very much a part of the repertoire of physicians of Chinese medicine up until the twentieth century.

Golding brings to us, in the English language in an accessible form, ideas that were very much embedded in the practice of Chinese medicine until the exigencies of modernity saw more emphasis placed on tangible areas of medicine which may be subject to physical verification. This idea is that our bodies and our minds are influenced to a significant degree by our place in the universe. The position and the movement of the moon, the planets and the stars were believed to affect our qi so much that an awareness and understanding of this must influence how we treat our patients. The qi of every person on earth, including both patients and practitioners, is subject to constant change, and never in a fixed state. It is affected by time and space and is in a constant state of motion as we hurtle through space at speed. We are not static or still even if we perceive ourselves to be. We have no choice in the matter. In other words, the time of treatment matters because our position, both temporal and spatial, is subject to rapid change. Golding provides a reference book to enable practitioners to calculate the best times for treatment acknowledging that each patient will be different in a deeper sense than just their presenting symptoms.

The book is divided into three parts: Time, Space and the *Dao*; Heavenly Stems and Earthly Branches; and The Inner Core of Acupuncture. Practical book as it is, Golding has combined her research of the area of study with discussions on her own clinical practice. Rendering the study to be of practical use for the clinician, interspersed throughout the book are relevant case studies.

The first part is an introduction to the genre, combining a discussion of the theory of time and its relation to clinical treatment. Ranging through aspects of time such as day and night, the four seasons and the moon cycles Golding then reflects on the life and death cycle. Significant in this part of the book is a chapter on the relevant calendars including the farmer's calendar and the lunar-solar calendar. Central to this study of Stems and Branches is a longer chapter on Heaven, Earth and Humankind (*Tian*, *Di*, *Ren*). Golding shows that this method enables us to more effectively treat mental and emotional disorders. The reasoning behind this is that time and space and our relationship with the universe influences our emotional and psychological state. Part two, Heavenly Stems and Earthly Branches (*Tian Gan Zhi Di*) is a detailed discussion of how it all works. This can be summarised by this quote from the *Su Wen*:

> *The celestial stems and the terrestrial branches should be established first… and then the change (in climates) may be identified. Consequently, the way of Heaven may become visible, the energy of the people may be regulated, yin and yang may become intelligible, with the result that the whole theory will become something close to us.*

With the liberal inclusion of charts we see how the stems and branches work in acupuncture treatment. If one is so inclined, you may also make use of the exercises provided in implementation of the stems and branches system.

The final part of the book, the Inner Core of Acupuncture, is essentially an examination of the relationship between astronomy and Chinese medicine. This part will appeal to those interested in understanding the underlying theory of stems and branches. Golding argues that 'for those who want to…unravel several of the mysterious and frankly esoteric passages in the *Nei Jing*, an understanding of astronomy is essential'. Golding complements her discussion on astronomy with a look at psychological profiles and how consideration of the emotional state of a patient cannot be divorced from an awareness of stems and branches, or in lay terms, our relationship with the universe in all its leviathan manifestations. The book concludes with chapters on numerology and symbolism, and examines such concepts as the trigrams. Replete with maps and charts, a further quote from the *Su Wen* shows that this is the source of inspiration for Golding to research and write this book.

> *A physician should know something about the upper region, which is astronomy, something about the lower*

region, which is geography, and should know something about the middle region, which is human affairs; and it is only with such knowledge that the physician will be able to make medical theory long lasting to teach it to the people…

How many of us can claim to have such knowledge? Whether one is attracted to this book depends on whether one believes that this quote from the *Su Wen* is applicable in the twenty first century. Golding argues passionately that it is as applicable as it ever was. Arguably, the *Nei Jing* was the most influential single text in shaping not only Chinese medical thought but also Chinese cosmological thinking and doing the most to shape how Chinese people understood the world. If we concur, it behooves us to study the area in question. Golding is reminding us of the value of such considerations and their very practical nature. Difficult as it is to validate in Evidence Based Medicine systems and even harder to standardise, stems and branches often gets ignored and considered as being in the too difficult basket.

An advantage of this work is that Golding is herself a busy practitioner running a clinic in London, UK. She speaks from experience and not from simply transcribing various textbooks from China. With an obvious love of the Chinese medical classics Golding urges us to consider a return to values and conceptual treatment approaches central to physicians in China prior to modernity. Other authors have written about Stems and Branches but I believe this text to be of interest as it features a deep reverence for the classics from a practitioner in the field combined with a more esoteric discussion on astronomy. This makes the book unique.

This book is worth reading for those who wish to get closer to the essential roots of classical acupuncture. Speaking from my own experience, it was my fascination for the kind of material presented in this book that initially attracted me to study Chinese medicine. With all due respect to my teachers, as a new student, I soon lost interest in stems and branches as I found it to be taught superficially and mechanically, absent of any real theoretical explanation, let alone astronomy. Later, as I delved more into the world of Chinese medical culture, it was reinforced to me time and time again the importance of the above quotes from the *Su Wen*. Even if Stems and Branches receives only superficial attention in modern day courses of education, these ideas are embedded in Chinese, Korean and Japanese cosmological thinking. If one spends any time in these countries one is struck by the constant and obsessive attention to the calendrical cycles and issues of time and space and the stars in general. Indeed, study of the *bazi*, related to astrology, little known by many contemporary physicians, was an every day part of medical culture in East Asia up until the twentieth century.

This should be a book to whet your interest in an area of much fascination and of considerable clinical significance. I look forward to more scholarly work in this area. It can make clinical practice that much richer.

Reviewed by James Flowers

UPCOMING INTERNATIONAL CONFERENCES

2011

20–22 May	Perth, Australia AACMAC 2011 (Australasian Acupuncture and Chinese Medicine Annual Conference) Visit http://www.acupuncture.org.au
31 May–5 June	Rothenburg, Germany 42nd TCM Kongress (Arbeitsgemeinschaft für Klassische Akupunktur und TCM e. V) Visit http://www.tcm-kongress.de
24–26 June	Wellington, New Zealand NZRA Annual Conference (New Zealand Register of Acupuncturists) Visit http://acupuncture.org.nz
1–4 September	Slettestrand, Denmark 3rd Scandinavian TCM Kongress Visit http://www.tcm-kongres.dk
2–3 September	London, United Kingdom WFCMS 8th World Congress on Chinese Medicine (World Federation of Chinese Medicine Societies) Visit http://www.2011wccm.com
5–6 November	Sao Paulo, Brazil WFAS International Symposium on Acupuncture 2011 (World Federation of Acupuncture-Moxibustion Societies) Visit http://wfas2011saopaulo.com or http://www.wfas.org.cn/en/

2012

15–20 May	Rothenburg, Germany 43rd TCM Kongress (Arbeitsgemeinschaft für Klassische Akupunktur und TCM e. V) Visit http://www.tcm-kongress.de
25–27 May	Brisbane, Australia AACMAC 2012 (Australasian Acupuncture and Chinese Medicine Annual Conference) Visit http://www.acupuncture.org.au