A PEER-REVIEWED JOURNAL

Australian Journal of Acupuncture and Chinese Medicine

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Australian Journal of Acupuncture and Chinese Medicine

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The Australian Journal of Acupuncture and Chinese Medicine (AJACM) is the official journal of the Australian Acupuncture and Chinese Medicine Association Ltd (AACMA). It is Australia's only peer-reviewed journal for the acupuncture and Chinese medicine profession. All articles, other than Current Research and Clinical Applications, Research Snapshots, Book Reviews, Conference Reports, Standards and Guidelines, and National and International News, have undergone the peer-review process. AJACM is indexed in the EBSCO, Informit and Scopus databases.

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Australian Journal of Acupuncture and Chinese Medicine

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The Australian Journal of Acupuncture and Chinese Medicine is the official journal of the Australian Acupuncture and Chinese Medicine Association Ltd. It seeks to foster intellectual endeavour and academic exchange about the research and clinical practice of acupuncture and Chinese medicine and to promote quality in the provision of acupuncture and Chinese medicine clinical services.

The primary focus of the Journal is publishing peer-reviewed articles that will enhance quality and diversity in acupuncture and Chinese medicine clinical practice and/or research and stimulate the exchange of ideas about clinical practice and the role of acupuncture and Chinese medicine in contemporary health care.

Peer-reviewed papers include research articles, clinical trials, systematic reviews, case reports and case series, as well as general and theoretical papers. The Journal also publishes brief reports on current research, book reviews, conference reports and other articles relevant to the Journal's objectives.

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Editorial

In the last three months, acupuncture in Australia has attracted much media attention nationally and internationally, mainly due to two studies[1,2] published by RMIT researchers. One study examined the quality of two brands of commonly used acupuncture needles, and the other evaluated the feasibility of providing acupuncture service to patients attending the Emergency Department in a public hospital. These two studies are completely different, but have touched two core aspects of our practice: how good our tools are and how acupuncture could be integrated into the current health system. The public does pay attention to media reports of those studies and you might find your patients asking you about them. Both studies are reviewed in this issue.

Closely linked to the quality of acupuncture needles and quality standards is an article by Dr David Graham, Chair of the International Organization for Standardization (ISO) Technical Committee 249. The committee's main responsibility is to develop standards for Chinese medicine. This article introduces to you the role of the ISO Technical Committee 249.

The Australasian Acupuncture and Chinese Medicine Annual Conference (AACMAC Melbourne 2014) was recently held in Melbourne. Being so soon after the WFAS Sydney 2013 8th World Conference on Acupuncture in November, AACMAC Melbourne 2014 was on a small scale. The quality, however, was not compromised. One of the highlights of the conference was the Victorian Health Minister Hon David Davis MP's speech at the opening ceremony. In his speech, Hon David Davis reviewed Chinese medicine registration in Victoria and then Australia, and outlined six key characteristics of a strong and mature profession. He encouraged Chinese medicine practitioners, and any other health practitioners, to present a united front to governments, regulatory bodies and the public; to work collaboratively with other health professionals; and to always place patients' care at the centre of our practice. His speech was inspiring, and was like giving this profession a formula of tonics to strengthen our righteous Qi so that we have the strengths to deal with our own deficiencies and any other 'invading' Qi.

It is becoming a common practice that acupuncture is used to assist in in vitro fertilisation (IVF). The recent debate looks at how effective acupuncture is in this area and whether it is better than placebo.[3–4] In a comprehensive review published in this issue, the authors look at this question from a different angle. The paper outlines the benefit of a healthier mental status to enhance the success of IVF, and examines if acupuncture improves the mental status of women who undergo IVF, therefore contributing to the positive outcome of this therapy. This review draws our attention to a key aspect of acupuncture practice, which is to calm the Shen.

The second paper in this issue is a member survey of the Australian Acupuncture and Chinese Medicine Association (AACMA). The study was conducted in 2006, and eight years have since passed. We decided to publish this paper because the result provided a snapshot of characteristics of members and their practice at that time. It is an important reference point for future studies of members of Chinese medicine associations.

In this issue, Professor George Lewith, a professor of integrative medicine from London, United Kingdom, was interviewed. This refreshing interview provides us with a strategy for dealing with media about complementary and alternative medicine. Professor Lewith's message is not dissimilar to Hon David Davis': we have to do our groundwork to make Chinese medicine or any other CAM a mature and strong profession.

We encourage readers to write to us about your thoughts. One paper in the last issue, entitled 'Does Chinese Medicine Consultation Share Features and Effects of Cognitive Behavioural Therapy? Using Traditional Acupuncture as an Example' has raised some discussion among our readers. We publish two letters to the Editor in response to this paper in this issue.

Zhen Zheng
Editor-in-Chief

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Letters to the Editor

I would like to comment on the article titled 'Does Chinese Medicine Consultation Share Features and Effects of Cognitive Behavioural Therapy? Using Traditional Acupuncture as an Example', which appeared in Volume 8, Issue 2. This article compares the Chinese Medicine consultation process with CBT. It discusses the similarities and differences of both and the specific and non specific features that induce behavioural change in the patient.

I agree with the authors regarding the similarities of the TCM consultation process and CBT. Both processes allow the patient to slow down, gather and express their thoughts. The TCM consultation process also allows the patient to connect their thoughts to their bodily aches, pains and functions.

I believe the consultation process does a number of things.

1. Allowing the patient to talk uninterrupted provides the clinician with an insight into the thought processes of the patient – what it is that is important to them.

If handled well, this free talk can be gently guided to provide the clinician with the majority of information needed regarding the presenting condition and the overall state of mind of the patient. Of course follow up questions will fill in any gaps.

2. The consultation process also provides the patient with a sense that someone is listening to them. This I feel is import, not just for building a rapport with the patient, but also is the first step in the healing process.

3. Also by going back over key signs and symptoms and asking clarifying questions, you are telling the patient that you have listened and are interested in not just the presenting condition, but also their entire person.

In some ways our fast paced modern lifestyle has lost some of its connectedness – when catching up with friends and family moves to a finely tuned schedule and the art of face to face conversation has declined.

The consultation process is a way for people to slow down, air their thoughts and allow the clinician to gain a deeper insight into the emotional links to their presenting condition to provide a holistic, effective treatment, allowing the patient to be the centre of that treatment, thus increasing compliance.

The consultation process is a way for the patient to regain some connectedness with themselves and the clinician is the facilitator of this process.

This, I believe, is the essence of CBT.

Dr Tracey Byrne
Melbourne

I enjoyed reading 'Does Chinese Medicine Consultation Share Features and Effects of Cognitive-Behavioural Therapy? Using Traditional Acupuncture as an Example' in the last issue. I found it was informative and enlightening for me to think about the Chinese medicine consultation from this new perspective.

As a recent graduate, I am always interested in any aspects of practising Chinese medicine that may be associated with better outcomes. There is already so much to think about with acupuncture and herbs that I had never considered this key component of our standard treatment package, except for in the general sense that a medical consultation can be therapeutic.

We devote a lot of time to trying to distinguish the specific from the non specific effects of other aspects of Chinese medicine, and I agree that we should also consider the specific effects of the Chinese medicine consultation. I can now appreciate that our consultations are potentially more than just data collection and may have specific psychological benefits for the patient.

Anna Hyde
Thornbury, Victoria

Interview With Professor George Lewith, Professor of Health Research at University of Southampton, UK

Lily Lai* MATCM, MRCHM, NIHR Research Training Fellow in Primary Medical Care
University of Southampton, United Kingdom

Introduction

I knew from the age of seven that I wanted to become a doctor, a vocation about which I have never had any regrets. Later, when I considered which medical school I should apply to, I became fascinated by molecular biology, and so deliberately applied to Cambridge to allow me complete a Part II in Natural Sciences.

I am a qualified GP and physician with clinical skills in a variety of different CAM therapies, but I retired from clinical practice in 2010. My career has allowed me to combine my scientific interests, including over 300 peer-reviewed papers, and a busy clinical practice in integrated medicine over the last 35 years.

I now work at the University of Southampton, where I lead an internationally respected Integrated Medicine research group within the medical school's department of Primary Care. The department is part of the NIHR national school for primary care research. My research is focused on differentiating the specific from the non-specific effects of treatment and developing models that will help to explain the patient perceived benefits of a variety of complementary medical interventions. I am currently interested in Pain, Arthritis and Cancer as illness models investigating the effects of acupuncture, healing, homeopathy and herbal medicines.

George Lewith MA MD FRCP MRCGP

The Questions

LL: What are your views on the recent international wave against complementary medicine?

GL: There have been consistent attacks against complementary medicine, particularly in the last 10–15 years. These have been largely from people who misunderstand science and have a rather crazy interpretation of what complementary medicine is and, in particular, what researchers in complementary medicine are trying to achieve. My approach is to remain firmly evidence-based, largely not respond to the direct personal attacks and to keep plodding on. It seems to have been a very effective approach as I've survived the slings and arrows and have an increasingly productive research group. The advantage of being in the midst of controversy is that you tighten up your science and in a sense, the anti-CAM brigade has been a great help in progressing the development of CAM at a faster rate.

LL: What is your strategy when it comes to researching integrative medicine?

GL: My strategy on delivering integrative medicine clinically is very simple. Integrative medicine needs to be patient-led, safe and, where possible, evidence-based. It needs to be patient-centred and this means that the patient choice should be important. Diagnosis is paramount so that patients can be given thoughtful options about how they can best choose treatment. This means informing them regarding the evidence that exists for each of those treatments, either singly or combined. In essence, this is all about patients making informed choices with skilled, broad, open clinical teams, and it seems to be very much what patients want. Patients want to know how they can help to self-manage their condition, particularly chronic, long-term

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problems. Integrative medicine in this context is probably best defined as the best of both worlds.

Research in integrative medicine requires a detailed understanding of what you have available to you in terms of grant-giving bodies. Your strategy is governed by the money you have available to do your research and I would particularly point you towards the CAMbrella report (www.cambrella.eu), which explores this diversity in a very thoughtful and considered way. Certain charities may have a particular interest in cancer or arthritis and if they have a patient-centred approach to funding, they will almost always support complementary medical interventions. Government funding agencies may or may not be much more conservative depending on locality. My approach has been to be politically opportunist in terms of funding, while asking fundamental questions around mostly chronic conditions regarding the evidence-based integration and safe use of CAM and conventional medicine together.

Acupuncture for the Mental and Emotional Health of Women Undergoing IVF Treatment: A Comprehensive Review

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ABSTRACT

One in six Australian couples currently struggle with impaired fertility. In vitro fertilisation (IVF) has become the assisted reproductive technology (ART) of choice. The IVF process has inherent stresses: the invasive procedures; medication; knowledge that it might be the last possibility for pregnancy; and the high cost. Both authors have observed in different settings (one clinical and the other during a clinical trial) that women often reported an improved sense of wellbeing and emotional health due to the acupuncture intervention. This paper summarises the reported benefits of acupuncture treatment for mental and emotional health during IVF identified in published peer-reviewed research papers – both theoretically (pathogenesis and physiology) and clinically (with reference to acupuncture treatment and the therapeutic encounter). The trials reviewed, investigating mental and emotional health during IVF treatment, indicate acupuncture had positive outcomes including: reduced anxiety; reduced stress; less social and relationship concern and improved psychological coping. This paper suggests that reflecting on and valuing the therapeutic alliance, including its collaborative nature, the patient feeling cared for and a perception that practitioners are empathetic, could improve fertility outcomes and the emotional health of infertile women through the process of IVF treatment.

KEYWORDS acupuncture, traditional Chinese medicine, in vitro fertilisation, IVF, fertility, stress, anxiety

In Vitro Fertilisation (IVF)

IVF is one form of Assisted Reproductive Technology (ART) and estimates show that 3.6% of women in Australia who gave birth received some form of ART treatment. With just over 60 000 ART treatment cycles, there was a clinical pregnancy rate of 23.9% and a live delivery rate of 18.1%.[1]

One in six Australian couples 'are currently struggling with impaired fertility'.[2] Infertility as defined by the World Health Organization (WHO) is the 'failure to conceive after twelve months of unprotected intercourse'.[3] The causes of infertility in Australia and New Zealand as documented by the Australian government[1] in 2010 are: 'Of the 60 687 initiated autologous and recipient cycles, 21.7% reported male infertility factors as the only cause of infertility; 38.6% reported only female infertility factors; 13.8% reported combined male–female factors; 25.2% reported unexplained infertility; and 0.7% were not stated.' Marriage and childbirth occurring later in life is a main social cause of infertility.[4] The prognosis of ART outcomes are affected by maternal age and the type of infertility experienced.[4,5]

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For the women undergoing treatment, the nature of IVF, the invasive procedures, medication, knowledge that it is often the last possibility and the high cost, all lead to a degree of mental and emotional ill-health.[6] Biomedical research shows pregnancy outcomes were reduced and miscarriage increased in women who worried about financial or medical concerns;[7] had high levels of distress (Hjollund et al.),[11] depression or anxiety during their IVF cycle[8] and had a history of depression earlier in life (Lapane et al.).[11] Greater than average fertility rates were predicted with low psychosomatic symptoms.[9]

Infertile women undergoing IVF who also entered a behavioural study reported similar psychological stress to people with cancer.[10] Two pathways, the hypothalamic-pituitary-adrenal (HPA) axis and the sympathetic-adrenal-medulla (SAM) axis, are described as mediating the effects of psychological factors (stress, depression) on the reproductive system. This could affect gonadotropins in synthesising sex steroids and oxytocin (Cwikel).[11] Changes in heart rate and cortisol caused by stress, anxiety and depression is considered predictive of a decreased probability of achieving a viable pregnancy[12] and research has shown that stress, anxiety, and depression all contribute to a lower pregnancy rate among women undergoing IVF.[8,11–13] Whether the cycle was the first treatment or a subsequent cycle also has a significant difference in the depressive symptoms reported, with 15% of women in the first cycle and 25% in subsequent cycles reporting feeling depressed.[10] A vicious cycle of 'social stigmatization, decreased self-esteem, unmet reproductive potential of sexual relationship, physical and mental burden of treatment, lack of control on the treatment outcome' are identified by Chang et al. as factors leading to psychological stress, which in turn could influence the ability to conceive.[14,15] Furthermore, adverse effects associated with IVF medications could contribute to the mental and emotional status of women undergoing IVF. Those adverse effects include hot flushes, abdominal pain and distention, headaches, emotional lability, insomnia, nausea, dizziness and induction of a menopause state.[16]

There is a relatively low uptake for psychological counselling services of between 5–15% of couples undergoing fertility treatment[17] even though counselling is often recommended for all causes of infertility.[18] Women with a lack of social support and those appraised as having high levels of helplessness dealing with infertility had an increased risk factor of developing emotional problems.[19] Women who worried about financial concerns or medication interventions had worse pregnancy outcomes and those who were very concerned about cost were more likely to miscarry.[7] The emotional stress of IVF also increased the rate of absence from work with women considering the emotional impact to be 'more strenuous' than the physical impact.[19]

Women may not recognise the importance of 'emotional support' during IVF treatment. Patients have reported that they were not adequately informed about medical procedures as well as psychological needs during IVF[20] and that support from family and friends was low due to inadequate information about what IVF entails.[21]

Acupuncture

In Australia complementary and alternative medicine (CAM) is used by 52–69% of the population.[22] Users, as identified by Australian and international literature are 'more likely to be women, well-educated, employed on higher than average wages and with private health insurance'.[4] A study of focus groups of infertile women in Melbourne found the key themes in the use of CAM was 'a woman's strong desire for motherhood; women's negative experiences of ART; and women's positive experience of CAM practitioners'.[4] CAM practitioners reported that their fertility practice was predominantly with women also using ART.[4]

The intention behind acupuncture during IVF thus far has been to improve pregnancy and live birth rates and this has been mostly studied at the time of embryo transfer (ET) and as an anaesthetic during oocyte retrieval. Five recent systematic reviews are not in agreement regarding acupuncture as an adjunct treatment to increase pregnancy rates during IVF treatment. Two reviews found insufficient evidence,[13,23] two reviewed cautiously and found limited but supportive evidence to suggest that acupuncture improved IVF success rates,[6,12] and one found that acupuncture improved rates of pregnancy and live birth rates during IVF treatment at the time of embryo transfer.[24] Only one review mentioned mental and emotional health as possibly contributing to the positive effect acupuncture had on the IVF outcome.[6] Previous research found that acupuncture induced a series of physiological changes which may contribute to reduction in stress and anxiety. Evidence indicates that the calming effect of acupuncture involves inhibition on the sympathetic nervous system, enhanced the release of ß-endorphin, serotonin and dopamine.[33]

- Acupuncture could improve fertility outcomes by increasing uterine blood flow, affecting neuroendocrinological factors and by reducing stress, anxiety and depression.[14,34,35]
- Acupuncture is also thought to demonstrate effects on the HPA axis.[33,35,36]
- Acupuncture influenced cortisol and prolactin levels which could lead to increased rates of pregnancy.[37]

This current comprehensive review aims to explore the effect of acupuncture on mental and emotional health (stress, anxiety and depression) for women undergoing IVF.

Search Strategy

To find all available evidence on the link between IVF treatment and mental and emotional health, an electronic database search was conducted in October 2012 and June 2013 in the following databases: CINAHL, Cochrane library, Medline, PubMed, ScienceDirect, and Google Scholar. Information was obtained from clinical guidelines, including Best Practice and National Health and Medical Research Council (NHMRC). Individual Chinese medicine journals were also searched. The search terms used were: acupuncture, in vitro fertilisation, IVF, embryo transfer, transplantation, assisted reproductive technology, ART, embryo, pregnancy, stress, depression, anxiety and emotion. The inclusion criteria were trials published in English, acupuncture trials of infertile women involving the IVF process, with outcome measures of stress, anxiety or depression and with no limit to the date of publication. Exclusion criteria were all trials not in English, trials about other ART or stages of fertility treatment, and trials about male- or couple-related mental and emotional health.

Sixty-six records were found, including 11 systematic reviews, 17 randomised controlled trials, one case series, 28 qualitative studies and nine opinion papers. Of these, six trials were identified to meet the inclusion criteria.

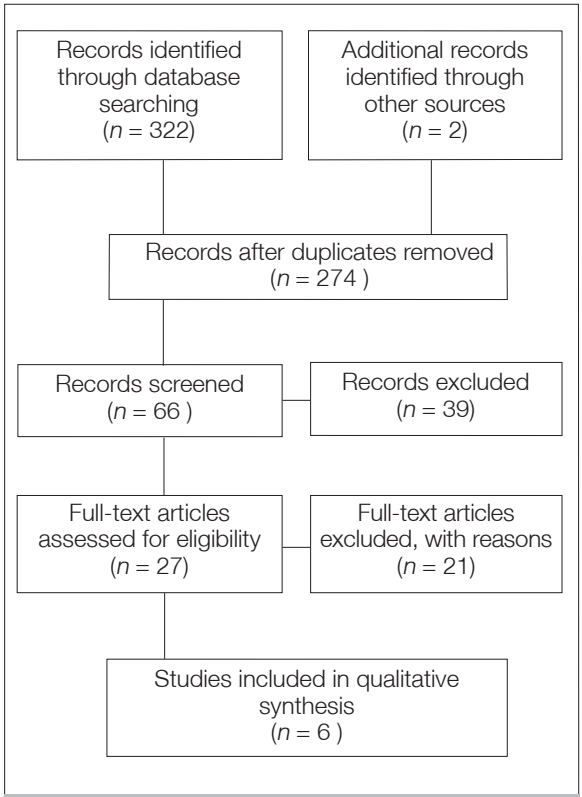

FIGURE 1 PRISMA flow chart

Acupuncture Literature Review Results

For the purpose of this paper, acupuncture as one pillar of traditional Chinese medicine is reviewed. The findings are explained firstly via pathogenesis and physiology and secondly in regards to women and mental and emotional health outcomes.

When reviewing acupuncture trials involving women and mental and emotional health outcomes, five studies reported improvements[25–29] and one did not report any benefit.[30] In the trials there were different outcome measures, acupuncture protocols, controls and treatment that occurred at different times. Refer to Table 1 for trial details.

Acupuncture was found to reduce anxiety symptoms as recorded with the Hamilton Anxiety Rating Scale (HAS) in women (n=43) undergoing IVF treatment, yet there was no difference in the pregnancy rates between the groups.[25] Sham acupuncture was used as the control. In a small study (n = 13) including women that were undergoing ART or natural fertility and receiving acupuncture treatment, the responses suggested that acupuncture may improve self-efficacy and psychological coping for women experiencing delays falling pregnant.[29] Women undergoing IVF or IVF/IUI (n = 57) received acupuncture pre-ET and post-ET reported lower perceived stress scores than those who did not receive acupuncture.[27] The pregnancy rate in the acupuncture group was 64.7% versus 42.5% in the non-acupuncture group. The authors concluded that acupuncture lowered perceived stress at the time of embryo transfer and possibly improved the pregnancy rate. In an acupuncture trial (n = 32) with infertile women who had all had IVF, with some planning more IVF treatment, the outcomes aimed to address self-efficacy, anxiety and infertility-related stress administering treatment over eight weeks compared to a wait list control.[28] Significant changes were noticed regarding less 'social concern' and 'relationship concern' with a trend toward stress reduction on other infertility related domains. There was no comparison to pregnancy rates, yet four women became pregnant during the trial. Correlation was made between the hormones prolactin and cortisol, and their regulation by acupuncture during gonadotropins stimulation in the IVF treatment cycle.[26] They observed the acupuncture group as 'less stressed' and the maintenance of prolactin levels could 'produce better reproductive outcomes'.

So, Ng, Yeuk, Yeung, and Chung[35] investigated the effect of acupuncture after embryo transfer only on anxiety levels and found no difference in anxiety or pregnancy rates in the acupuncture or placebo acupuncture group.

In the reviewed trials, the acupuncture frameworks used were described as Five-element and traditional Chinese medicine

TABLE 1 Characteristics of included studies

Study & Design	Participants	Acupuncture Treatment and Practitioner	Acupuncture Points Used
Isoyama, 2012 Prospective Randomised Controlled Trial	43	4 weekly sessions throughout the IVF treatment; Professional acupuncturist	n = 22 HT 7 Shenmen, PC 6 Neiguan, CV 17 Shanzhong, GV 20 Baihui, Yintang
Kovarova, 2010 Prospective observational uncontrolled study design	17	Individualised treatment based on differential diagnosis and treatment protocols outlines by Lyttleton; Qualified acupuncturists trained in TCM; IVF or natural cycle	Example: Kidney chest points, Yintang, HT 7 Shenmen, HT 5 Tongli, PC 6 Neiguan. Minimum of 4 treatments
Balk, 2010 Pilot study Observational prospective cohort study	57	Paulus Protocol used IVF; Physician acupuncturist	n = 20
Margarelli, 2008 Prospective cohort clinical study	67	Infertile undergoing IVF. Modifided protocols of Paulus and Stener-Victorin = "Cridennda/Magarelli protocol". Nine electrostimulation acupuncture treatments before egg retrieval and one pre and post ET, 11 treatments in total; Certified and licensed acupuncturists were used	IVF with acupuncture
Smith, 2011 Pilot Randomised Controlled Trial	32	Six sessions of acupuncture over 8 weeks; IVF history in all subjects. Some planning IVF; Licensed acupuncturist with 14 years experience	Five-element (causative factor) and TCM style (syndrome pattern). Individualised protocol. Common points: Kidney chest points, PC 6 Neiguan, PC 5 Jianshi, HT 5 Tongli, HT 7 Shenmen
So, 2010 Randomised Controlled Trial Frozen-thawed embryo transfer	226	Patients were diagnosed using the four observations into related syndromes including: Kidney yang/yin deficiency, Liver qi stagnation with blood stasis, Spleen qi deficiency with phlegm and combination of those syndromes; Registered traditional Chinese medicine practitioner	A single session of acupuncture for 25 min immediately after the ET ST 36 Zusanli, SP 6 Sanyinjiao, SP 10 Xuehai, LI 4 Hegu

TABLE 1 Characteristics of included studies, cont.

Study & Design	Control Method	Outcomes	Results of Study
Isoyama, 2012 Prospective Randomised Controlled Trial	n = 21 Needles inserted into areas near yet not corresponding to acupuncture points	Hamilton Anxiety Rating Scale	Mean HAS score was significantly lower in the test group than the control (p = 0.0008)
Kovarova, 2010 Prospective observational uncontrolled study design	No control used	Infertility self-efficacy (ISE) scale	Significant increase in total ISE scores from baseline and after four acupuncture treatments (p = 0.008) n=13 (completed both questionnaires)
Balk, 2010 Pilot study Observational prospective cohort study	n = 37 Completed perceived stress scale and rested for 25 min	Perceived stress level scores Pregnancy rates	Acupuncture 64.7% Without 42.5% Lower stress scores both pre-ET and post-ET than those without. Decreased stress correlated with increased pregnancy rates
Margarelli, 2008 Prospective cohort clinical study	IVF without acupuncture	Testing serum CORT (cortisol) and serum PRL (prolactin)	Beneficial regulation of CORT and PRL during the medication phase (gonadotropin stimulation) of the IVF treatment
Smith, 2011 Pilot Randomised Controlled Trial	Waitlist. Did not receive acupuncture during the trial. Offered it afterwards.	The primary outcomes were infertility self-efficacy, anxiety, and infertility-related stress	Less social concern (mean difference [MD] -3.75, 95% confidence interval [CI] -7.58 to 0.84, p=0.05), and less relationship concern (MD -3.66, 95% CI -6.80 to -0.052, p = 0.02). There were also trends toward a reduction of infertility stress on other domains, and a trend toward improved self-efficacy (MD 11.9, 95% CI -2.20 to 26.0, p = 0.09) and less anxiety (MD -2.54, 95% CI -5.95 to 0.86, p = 0.08) in the acupuncture group compared with the waitlist control.
So, 2010 Randomised Controlled Trial Frozen-thawed embryo transfer	A single session of placebo acupuncture for 25 min immediately after the ET using the Streitberger's control. The same acupoints and procedure was used	Pregnancy and live birth rates Anxiety evaluated using the State-Trait Anxiety Questionnaire before and after the acupuncture treatment	No significant difference found between the groups

syndrome pattern,[33,34] traditional acupuncture,[25] traditional Chinese medicine using four observations,[35] and according to the principles of TCM.[32] Two trials used individualised treatment,[33,34] three used point prescriptions[27,32,35] with one of those trials[35] individually diagnosing while still using a point prescription.

Some of the common points used in the trials included HT 7 Shenmen, PC 6 Neiguan, CV 17 Shanzhong, MHN 3 Yintang, GV 20 Baihui[27,32–34] which calm the spirit and regulate and tonify the heart.[31] When Isoyama et al.[27] used these points anxiety reduced, yet pregnancy was the same in both groups. Balk used the Paulus protocol[32] before and after the embryo transfer and also reported on perceived stress finding that stress reduced and pregnancy may be improved (the pregnancy results were not statistically significant with $p = 0.13$). The Paulus protocol includes PC 6 Neiguan, GV 20 Baihui and the Shenmen ear point, all of which could affect mental and emotional wellbeing.

Discussion

The six acupuncture trials that met the inclusion criteria have a degree of heterogeneity yet indicate predominantly positive outcomes for mental and emotional wellbeing of the women participants. They were randomised controlled trials which included a total of 442 women and the results were reported in peer-reviewed journals. Limitations, however, exist in relation to the small number of trials, the small number of participants, the control variation from study to study, and differing acupuncture treatment protocols. Acupuncture, for example, was performed at different times in the IVF cycle and there were a variety of outcome measures not consistently interpreted across the studies. The one trial that reported no significant difference in the groups involved a frozen-thawed embryo transfer, administered an acupuncture protocol only once after the ET and used a Streitberger control.[27] The use of placebo, sham or Streitberger control has been questioned regarding whether it is an inert control or not.[30,32,33]

When addressing mental and emotional health for IVF women, the emphasis of acupuncture treatment is above and beyond the pregnancy or live birth outcome. The intention is to assist women to remain balanced at all times and provide therapeutic support to increase resilience to the inevitable stresses of the process of IVF. It has been reported that women may not recognise the importance of emotional support during IVF treatment.[20] Acupuncture, based on Chinese medicine theory, is a complex whole system encompassing physical, mental, and emotional elements of health.[34,35] Cochrane, Smith, and Possamai-Inesedy[36] have collated information regarding the best approach for fertility treatment from experienced practitioners. The consultation with ten experienced practitioners found all placed high value on the importance of the practitioner–patient relationship for the therapeutic outcome. Bovey, Lorenc and Robinson[5] interviewed practitioners regarding their IVF perceptions and they felt that the benefits of treatment included stress reduction, relaxation and emotional support. When the author of this paper (LG) visited her local fertility clinic (Fertility Associates, Christchurch, NZ), she found from consulting with fifteen of the IVF team members (nurses, counsellors and doctors) that the resounding association with acupuncture was its 'relaxing' ability. Nurses verbalised that women who had been for acupuncture were more relaxed during their IVF treatment.

Women dealing with fertility challenges have stated that CAM practitioners gave them a positive experience which was different to their biomedical experience.[4] De Lacey and Smith describe acupuncture treatment as empowering women through taking a more 'active' role in their fertility.[37] The value in the therapeutic alliance has been described to include its collaborative nature, the patient feeling cared for and a perception that practitioners are empathetic.[38] A major strength of acupuncture treatment is its ability to individually diagnose patients. Within the six trials found, two used individualised methods[33,34] and four used standardised approaches. All trials used qualified acupuncturists, with one using a 'physician acupuncturist'.[32] It is important to consider that not all practitioners are equal; nor will they provide the same therapeutic encounter.[39] Differing effectiveness has been reported even when applying a standardised intervention.[43] Practitioners have been found to make decisions regarding diagnosis and treatment based on their training and personal preference as well as the individual case.[40]

Acupuncture has a variety of theoretical frameworks. It is possible that five element constitutional acupuncture treatment, with its psycho-emotional focus integrated with TCM theory, could be beneficial as a method in fertility treatment.[28,41] The integration of the two styles is described as 'effective for the treatment of physical illnesses and also enables practitioners to practise a person-centred style of acupuncture, which holds that the health of the spirit is essential to a person's well-being'.[33]

IVF treatment happens over time with different stages, from making the decision to getting the result. It is feasible to consider acupuncture has a role in the management of mental and emotional health throughout IVF. Currently there is a clinical pregnancy rate of 23.9% and a live delivery rate of 18.1%,[42] meaning that initially 76.1% of women are not pregnant, and during pregnancy, a further 5.8% will miscarry. Kowalcek, Kasimzade and Huber[43] found that 57% of women thought that they would be successful when asked about their expectations. Marcus, Marcus, Johnson and Marcus[44] found in a survey of reasons people stop IVF treatment that 35%

cited emotional reasons. This is supported by Verhaak et al.[45] documenting that when treatment is not successful, negative emotions in women increase. Clinically, experience shows that treatment is more effective overtime. This might be explained by consistent improvements in reproductive outcomes of women treated with the Cridennda/Magarelli protocol of 11 acupuncture treatments – nine before hCG is used to induce the maturation of eggs and pre/post embryo transfer.[26]

Conclusion

This comprehensive review indicates that the benefits of the acupuncture intervention during IVF treatment are: reduced anxiety; reduced stress; less social and relationship concern and improved psychological coping. These benefits encourage practitioners to consider addressing mental and emotional health as a part of their fertility practices. If this were the case, this could lead to clinical changes in treatment plans and in the choice of points used. Acupuncture may provide women an experience of support and a framework to help cope and develop resilience to manage the terrain of IVF treatment and the inevitable mental and emotional distress that occurs. It is possible that pregnancy and live birth outcomes may improve as a result.

Clinical Commentary

The positive mental and emotional impacts of a course of acupuncture are apparent to clinicians. Every day people emerge more relaxed from an acupuncture session. Women undertaking ART therapies to assist their fertility report the experience as stressful in itself and a burden above and beyond their emotional response to fertility challenges. This article explores the evidence that connects using acupuncture to better manage the ART/IVF process and whether it is acupuncture's effect on mental and emotional health which impacts on fertility outcomes.

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A survey of the socio-demographics and practice characteristics of members of the Australian Acupuncture and Chinese Medicine Association Ltd

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ABSTRACT

Background: The Australian Acupuncture and Chinese Medicine Association Ltd (AACMA) is the largest national professional body for Chinese medicine practitioners in Australia yet little is known about specific practice characteristics of its members. Method: In December 2006, a four-page questionnaire was mailed to all association members listed on the AACMA database for that year. The questionnaire sought to obtain information on the demographics and practice characteristics of the AACMA members. In total 1 520 questionnaires were mailed out to the AACMA members, of which 386 were returned. Results: The age distribution for respondents was bimodal, with those in the 46–50 and 31–35 brackets being the highest reported ranges. With regard to education, most respondents stated they had obtained their practice qualifications in Australia (n = 279; 73%), while 46 (12%) replied they had received their qualification from overseas. Most respondents replied that they had obtained a Bachelor degree (n = 207; 54%) while 58 (15%) reported having a Diploma and 37 an Advanced Diploma (9%). Concerning practice characteristics, nearly 70% (n = 268) reported that they practised more than 20 hours per week, with significantly more females working fewer than 20 hours compared to males (p = 0.006). When a breakdown of the pattern of modality use was undertaken, approximately 31% (n = 121) of respondents reported using a combination of both acupuncture and Chinese herbal medicine, while 20% (n = 77) stated they used acupuncture solely while only 0.5% (n = 2) used herbal medicine alone. The remainder used various combinations involving acupuncture, Chinese herbal medicine, Chinese remedial massage (Tuina) and/or Western remedial massage. Conclusion: This is the first time a survey of members of a particular Chinese medicine (CM) association has been undertaken in Australia. To further develop CM, a large scale survey needs to be undertaken to further define and establish the social demographics and practices of the newly nationally registered CM profession.

KEYWORDS survey, socio-demographic, practice characteristic, professional association, Chinese medicine, acupuncture

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Introduction

With the recent regulation of Chinese medicine (CM) in Australia the need to understand the characteristics of the emerging CM profession will be central for its future development. Several studies have been undertaken in the past to evaluate the demographics and practice characteristics of both unregulated,[1] and regulated practitioners[2] of CM as well as CM students.[3] More recently the Chinese Medicine Board of Australia (CMBA) has been publishing registrant data concerning registration type, principal place of practice as well as registrant age and gender.[4]

Furthermore, several previous studies have highlighted the increased use by Australians of services offered by the acupuncture and Chinese herbal medicine practitioners, and this is continuing to grow.[5,6] Xue and colleagues[7] have estimated that 94% of all annual acupuncture services administered in Australia during 2005/6 were by acupuncture and Chinese herbal medicine practitioners, with only 6% of these services supplied by general practitioners (GPs). This has been reflected in the growth of the number of CM practitioners. For example, in the period from 1996 to 2006, the Australian Bureau of Statistics reported a 106% increase in the number of acupuncture and Chinese medicine practitioners.[8]

In spite of the evidence supporting the changing social trends in health care, with the population seeking out acupuncture and Chinese medicine as part of a normal healthcare regimen, there is minimal information on the socio-demographic and practice characteristics of practitioners who identify themselves specifically as CM practitioners by seeking out membership of a reputable discipline-specific professional association. While the CMBA releases regular updates on particular characteristics of registrants' data, certain fields such as educational qualifications, length of practice, number of patients seen and practice characteristics are not collected. A survey was therefore conducted to evaluate the demographics and practice characteristics of practitioner members of a large professional association, the Australia Acupuncture and Chinese Medicine Association Ltd (AACMA). While the survey was undertaken several years ago (2006) the results are relevant as a record of the profession at the time, and may assist to inform forward planning for the CM profession.

Methods

A four-page questionnaire was developed and mailed to all members listed on the AACMA database. The questionnaire sought to obtain information on the demographics of AACMA respondent members, how they deliver CM services, their educational background and practice characteristics. The questionnaire was in English and no identifying information was sought. A reply paid envelope was distributed with the questionnaire to assist return.

Following completion of the questionnaire respondents were asked to mail it back to the research team. In total 1520 questionnaires were mailed out to the AACMA members during December 2006 of which 386 were returned. This represents a 25% response rate. Any missing data were not identified in the frequency or percentage counts.

Prior to commencing the research, ethical clearance was obtained from the University of Technology, Sydney Human Research Ethics Committee (UTS HREC-2006-248A).

Results

RESPONDENT CHARACTERISTICS

Figure 1 shows that the age distribution for respondents was bimodal with the 46–50 and 31–35 years of age range being the most reported ranges. With respect to gender, more than half

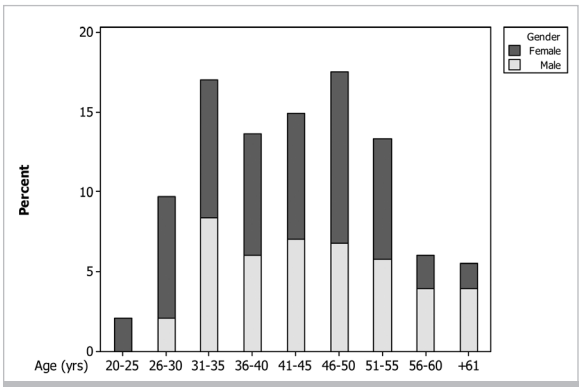


FIGURE 1 Percentage of respondents for each age range (stacked by gender)

TABLE 1 Practice location of respondents by State

State	NSW/ACT	QLD	VIC	SA	WA	TAS	NT
N	144	122	88	8	9	6	3
%	37.9%	32.1%	23.1%	2.1%	2.4%	1.6%	0.8%

of the respondents were female (n = 213, 56%). Interestingly, the female gender was over represented in the younger age brackets (20–25 and 26–30) while the male gender was over represented in the older age ranges (56–60 and +61). In relation to location, Table 1 shows that most respondents resided in New South Wales (NSW) (n = 144, 37.9%), Queensland (n = 122, 32.1%) or Victoria (n = 88, 23.1%).

EDUCATION

When asked where they had received their education, most respondents stated Australia (n = 279; 73%), while a smaller number reported an overseas institute (n = 46; 12%) or from both Australia and overseas (n = 58; 15%). For those who had completed training (whole or part) in Australia, most responded that it had occurred in NSW (n = 122), followed by Queensland (n = 106) and then Victoria (n = 82). The remainder reported that they had received their education in either Western Australia, South Australia or in the Australian Capital Territory (see Table 2).

TABLE 2 Location of Australian education by State

NSW	VIC	QLD	WA	SA	ACT
122	82	106	3	2	2

Table 3 shows that for those who stated they had received their education overseas, the most frequently reported country was the People's Republic of China (PRC) (n = 77) followed by Japan (n = 6), and then Hong Kong (SAR) and Republic of China (Taiwan) (both n = 5).

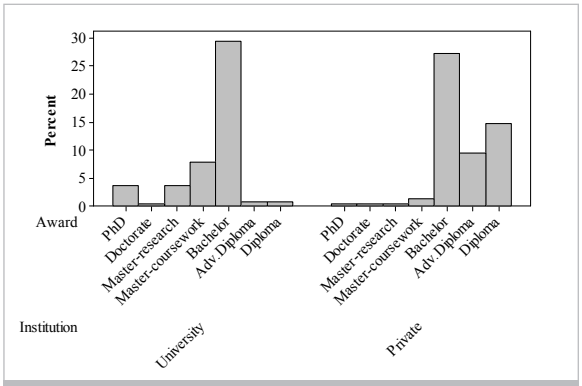


FIGURE 2 Awards being issued from the university and private education sectors (percentage)

When asked what qualification they had obtained, most replied that they held a Bachelor degree (n = 207; 54%) while 15% (n = 58) reported having a Diploma and 10% (n = 37) an Advanced Diploma. Most surprising was the number of respondents reporting they had obtained a postgraduate award. Sixteen respondents reported they had obtained a Doctor of Philosophy (4%) and three a Professional Doctorate (1%). Master coursework degrees were the most common postgraduate qualification reported, (n = 41; 10.7%), while Masters by thesis (research) accounted for approximately 4% of reported post graduate qualifications (n = 15) (see Table 4).

Most respondents reported that the type of institute where they had received their education was a private college (n = 168; 48%) followed closely by a university (n = 145; 41%) and 36 (10%) having both a university and private college training.

TABLE 3 Location of international education by country

Country	China	USA	Canada	UK	HK	Taiwan	India	Japan	South Korea	Austria, France, Germany, Phillippines
Number	77	4	2	4	5	5	2	6	3	1 each

TABLE 4 Highest qualification obtained

Qualification	Diploma	Advanced Diploma	Bachelor	Grad Diploma	Master (Coursework)	Master (Research)	Prof Doc	PhD
Number	58	37	207	6	41	15	3	16

In addition, four (1%) respondents reported having received their education at a TAFE and one by apprenticeship. When the level of qualification was cross tabulated with the educational institute (university or private college), and as would be expected, the Bachelor level and above qualifications were primarily related to the university system. While Bachelor level courses are offered by private providers, private providers were also reported as having conferred qualifications below the Bachelor degree level, primarily the Diploma and Advanced Diploma qualifications. Figure 2 shows that similar percentages were issued from both the university and private education system for the Bachelor degree.

When asked about the primary field of qualification the majority of respondents replied that it was in acupuncture (n = 130; 59%) followed by traditional Chinese medicine – presumed to be a combination of acupuncture and herbal medicine – (n = 70; 32%) and Chinese herbal medicine alone (n = 10; 5%) (see Table 5).

PRACTICE CHARACTERISTICS

Nearly 70% (n = 268) reported that they practised more than 20 hours per week. Significantly more females worked fewer than 20 hours compared to males (p = 0.006) (see Figure 3). No significant association was found for the three major states (NSW, Vic and Qld) between practice location and whether they practised full or part-time (p = 0.09) (see Figure 4).

Respondents were asked to indicate which modalities they practised, either standalone or in combination. Approximately 98% (n = 375) of all respondents used acupuncture, either as a standalone treatment or in combination with another modalities, while herbal medicine was used alone or in combination by 65% (n = 246) of respondents. When a further breakdown of the pattern of actual modality use was undertaken, approximately 31% (n = 121) of respondents reported using a combination of both acupuncture and Chinese herbal medicine, while 20% (n = 77) stated they used acupuncture alone and only 0.5% (n = 2) used herbal medicine alone (Figure 5).

The remaining 49% of the AACMA respondents used various combinations involving acupuncture, Chinese herbal medicine, Chinese remedial massage (Tuina) and/or Western remedial massage. To some degree, the therapeutic scope of practice of the respondent was reflected strongly in their tendency to use multiple modalities, with 34% (n = 130) replying that they 'always' combined different modalities in treatment, with a further 47% (n = 180) stating that they 'usually' combined modalities (see Figure 6). Together, the results indicated that just over 80% of all respondents use multiple modalities during

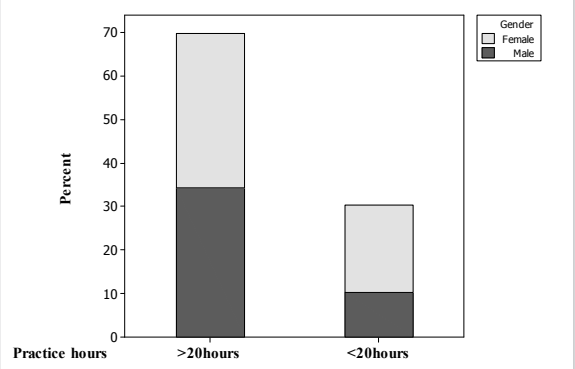


FIGURE 3 Percentage of respondents who worked 20 hours or less and greater than 20 hours (stacked by gender)

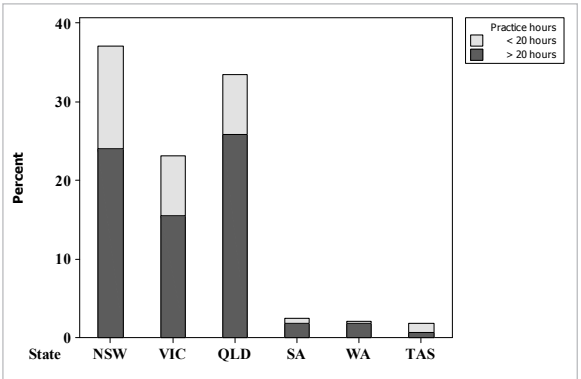
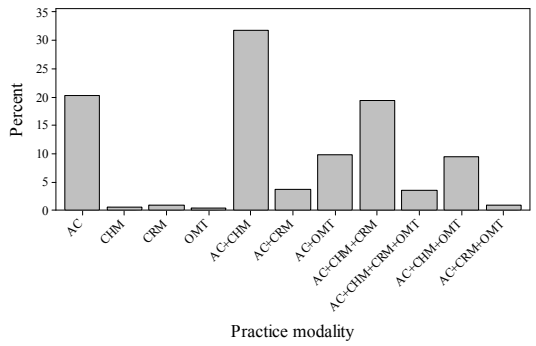


FIGURE 4 Status of practice (greater than 20 hours/week or 20 hours or less per week) by state of location

TABLE 5 Area of primary qualification

AC	AC + CRM	Ayurvedic medicine	CHM	Human Biology and TCM	Medicine	Radiography	Science	TCM
130	2	1	10	1	1	1	1	70

AC = Acupuncture, CHM = Chinese herbal medicine, CRM = Chinese remedial massage, TCM = Traditional Chinese medicine



AC = Acupuncture, CHM = Chinese herbal medicine, CRM = Chinese remedial massage, OMT = Other massage therapy

FIGURE 5 Treatment modalities and their combination

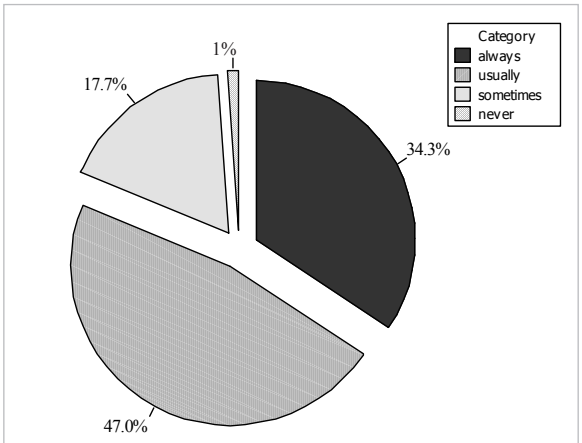


FIGURE 6 Occurrence of treatment combination

their treatment sessions, reflecting the diversity of techniques employed within the acupuncture and Chinese herbal medicine practitioner's therapeutic armoury. As expected, acupuncture was clearly the most often used modality in clinical practice by members of the association. Just over 80% of all respondents additionally indicated they used other modalities in their practice, with Chinese herbal medicine, Tuina and/or remedial massage being the more frequent modalities used with acupuncture.

The mean duration that respondents (n = 337) had practised acupuncture was 11.2 years (SD 8.2, range 0.5–36 years), while for Chinese herbal medicine (n = 246) it was 10.4 years (SD 7.8, range 0.5–36) and for Chinese massage (n = 136) 11.5 years (SD 8.1, range 1–36). One person reported the practice of all three modalities for the duration of 36 years.

When asked whether they worked alone or with other practitioners, nearly half (n = 190; 49.7%) reported that they worked as a sole practitioner while the remainder (n = 192; 50.3%) stated that they worked in a group practice. Table 6 shows that the largest group that worked in conjunction with the respondents were other complementary and alternative medicine (CAM) practitioners (n = 109, 54%) followed by other Chinese medicine practitioners (n = 83; 41%). Surprisingly, nearly half of all responders work with the established health system providers, with respondents respectively in practice with either medical and/or allied health practitioners (medical [16.9%; n = 34] and allied health [29.3%; n = 59]).

TABLE 6 Multi modality clinic colleagues

Practice with other practitioners	N	%
CAM	60	29.7
TCM	49	24.3
AH	21	10.4
TCM + CAM	16	7.9
GP	13	6.4
CAM + AH	12	5.9
TCM + CAM + AH	7	3.5
CAM + AH + GP	7	3.5
AH + GP	5	2.5
TCM + CAM + AH + GP	4	2.0
TCM + AH	3	1.5
TCM + GP	2	1.0
TCM + CAM + GP	2	1.0
CAM + GP	1	0.5

AH: Allied health practitioner, GP: General medical practitioner, CAM: complementary and alternative medicine, TCM: traditional Chinese medicine

PATIENT CONSULTATIONS

Figure 7 shows that only 22% of respondents consulted fewer than 15 patients a week while 25% reported seeing between 15–24 patients per week. Of note is that 81% reported treatment of 44 or fewer patients per week.

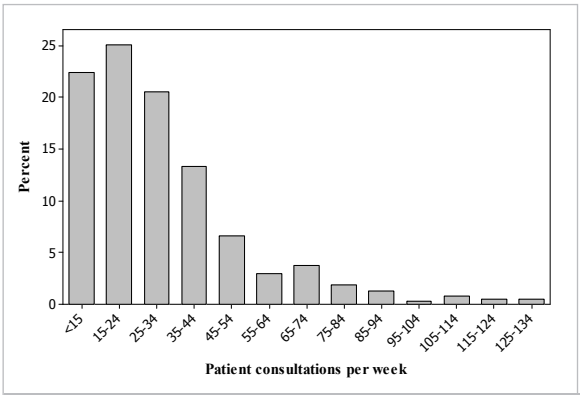


FIGURE 7 Number of patients consulted per week

Discussion

RESPONSE RATE

While this was not an extensive survey involving other primary CM practitioners who were not accredited with AACMA, it does permit some interesting observations. In 2008 the Australian Bureau of Statistics[8] (ABS) reported on the number of people employed as either an acupuncturist or a Chinese herbalist using data drawn from the 2006 Australia census. It was reported that 948 individuals identified themselves as acupuncturists and 480 as traditional Chinese medicine practitioners giving a total of 1 428 practitioners. Thus our respondent sample of 386 represents approximately 27% of the national Australian TCM cohort at that time.

RESPONDENT CHARACTERISTICS

With respect to age, our study showed a small number of practitioner numbers (n = 11, 2.8%) for the over-55-year-old practitioner age brackets compared to the other age brackets. This is in stark contrast to the current CMBA data which shows approximately 31% of those registered were aged 55 or above.[4]

The higher number reported in our study for the 31–35 year bracket compared to the two younger age brackets (20–25, 26–30 years) may suggest that practitioners are being educated in their late twenties rather than proceeding straight from secondary school to a university or college, or possibly completing another professional qualification before entering the acupuncture and Chinese medicine profession as a change of career. The latest data from the CMBA also shows a bimodal peak with respect to age, with the 35–44 brackets (27.6%) and 50–54 age bracket (14.4%) being most populous and only 15% of the national registrants being aged less than 35 years.[4] Further research is needed to determine whether mature aged student enrolment in CM courses is more frequent than direct entry from high school.

The current survey found that males only comprised 44% of our sample. This is similar to the current CMBA data, whereby males constituted approximately 46.6% of registrants.[4] With respect to the present study, when the gender balance across the age brackets was analysed it was observed that there was a larger percentage of females in the younger age groupings (20–30), suggesting a recent shift of females into the TCM workforce. The middle age brackets (31–50) have very similar gender balance, but the gender ratio in the 56-plus age ranges indicates more males than females.

The state of NSW had the highest number of respondents (37.9%) compared with the other two Eastern states, with a significant percentage of respondents from Queensland (32.1%) and a smaller number from Victoria (23.1%). The remaining states reported very low numbers, which may be the result of the majority of educational institutes being in the three Eastern states. This bears some similarity to the data recently reported by the CMBA, in that NSW (40.5%) had the largest practitioner base followed by Vic (27.9%) and then Qld (19%).[4]

EDUCATION

The results indicate that the overwhelming majority of practitioners were initially trained in the Eastern states, with NSW having the highest number of respondents followed by Queensland and Victoria. Interestingly there appears to have been a small drift to NSW in terms of practice location, with both the two other Eastern states reporting a small decrease in practitioner numbers when location of educational institute is compared to practice location.

Not surprisingly, a sizeable percentage also reported People's Republic of China (China) as their primary site of training (n = 46; 12%). This probably reflects the ongoing migration of Chinese practitioners to Australia and, indeed, part of an overall movement of Chinese-born and -trained practitioners to the West. Other Asian educational sites were also reported including Japan, Republic of China (Taiwan), Hong Kong (SAR) and Republic of Korea (South Korea). However, these represented fewer respondents than those reporting China as a country of study. This could reflect the smaller population base in each country when compared to China; a proportionally smaller immigration group when compared to those from China; or the popularity of China as an educational site for international students originating from Australia.

Another 58 respondents (15%) reported receiving education in both China and Australia. This may be due to the common practice of many Australian CM education providers (both Universities and private providers) embedding a student clinical placement in China within their CM programs.

Since the commencement of tertiary training in CM in the early 1990s[9] just over 75% reported they had obtained a tertiary qualification, with the majority a Bachelor degree. This is likely to represent the

ongoing development of CM education since then, with Bachelor degrees being offered in several states. Even more surprising is the percentage of respondents (9%) who had obtained post graduate qualifications in the form of a research degree, either a Masters or Doctorate qualification. While many other Western countries are still trying to acculturate CM education with a critical research focus, Australia is one of very few Western countries that have a research culture embedded within the tertiary-level CM programs.

PRACTICE CHARACTERISTICS

One surprising finding was that 30% of practitioners reported working fewer than 20 hours per week. This suggests that part-time practice remains a prominent feature of CM practice and that there is scope for increased client patronage or, conversely, a desire for practitioners to maintain a healthy lifestyle balance between work and rest. Other possible reasons could be there is little scope to increase client patronage or, alternatively, that some CM practitioners have a second job. Further research is needed to clarify the reasons for this low level of work engagement by a segment of the respondents.

It is of note that a large percentage of respondents practise a variety of modalities with only 22% of the respondents reporting the use of a single modality (either acupuncture, Chinese herbal medicine or Chinese massage). This is not surprising given that different modalities have different therapeutic effects and that the combination of modalities may augment the therapeutic outcome.

Furthermore, acupuncture was reported to be used solely by 20% of respondents while another 78.2% of the respondents used it in combination with another modality. Chinese herbal medicine was used (alone or in combination) by only 64.4% of respondents. Interestingly, the percentage of practitioners practising predominantly Chinese herbal medicine was low, with a small percentage of practitioners practising herbal medicine only (0.5%). In comparison, the CMBA data showed similar percentages with approximately 96.5% (n=4105) of registrants in one of the four fields that include acupuncture, with only 38% (n = 1615) registered in the division of acupuncture solely and 1.3% (n = 59) registered in the Chinese herbal medicine division only.[4] One possible reason for this could be the additional therapeutic effects obtained when different modalities are administered in conjunction or possibly the need to diversify practice for economic reasons. Whatever the reason, this practice of combining modalities is supported by the 79% of respondents in our study who reported this activity.

Finally a sizeable proportion (n = 202, 52%) reported working in a multi-modality clinic. Interestingly, approximately 17% of respondents reported working with a medical practitioner supporting the idea of integration and acceptance by mainstream medicine. In a national survey of the acupuncture/CM workforce and their perceptions of the various workers compensation systems, Choy reported 1.4% of CM practitioners were working in situ in medical practices.[10] This suggests an acceptance of CAM practice by medical practitioners and the likelihood of a closer working relationship that necessitates increasing trust and understanding by both parties.

Conclusion

This is the first time an evaluation of the socio-demographics and practice characteristics of members of a CM association has been undertaken. Future studies are needed to further define and establish the social demographics and practices of the newly registered CM profession.

Acknowledgements

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AACMAC Melbourne 2014: Opening Speech by The Hon David Davis MP

EDITOR'S NOTE: The Australasian Acupuncture and Chinese Medicine Annual Conference (AACMAC Melbourne 2014) was held on 2 to 4 May 2014. A highlight of the opening ceremony on 3 May was a speech by The Hon. David Davis MP, Victoria Minister for Health. Here we publish the full text of the speech.

Thank you and can I begin by acknowledging a number of people: Richard Li, the President of the Australian Acupuncture and Chinese Medicine Association and indeed your conference President; Professor Charlie Xue, Chair of the Chinese Medicine Board of Australia and Head of the School of Health Sciences, RMIT University; Hoc Ku Huynh, Executive Committee of the World Federation of Chinese Medicine Societies; other representatives and in particular the President of the New Zealand Register of Acupuncturists, Ms Paddy McBride and other international guests.

Welcome to Victoria, I hope you have a great conference. I'm sure you will enjoy your stay, your visit and the hospitality that is available.

The program provides, I believe, an excellent opportunity for the profession to gather together, share their practice experience and understand the latest research in Chinese medicine.

This is a time for you to take stock, to sharpen your clinical practice, share insights and collaborate with your colleagues.

I am pleased to see a significant number of international guests on the program who I am sure also will add additional weight and insight for you as clinicians.

I'd like to make a few observations about the role and importance of history.

In Victoria we are privileged to be the beneficiaries of several thousand years of clinical experience that underpins the practice of Chinese medicine.

As Chinese medicine practitioners, you have always known the importance of this history. It provides a very strong, solid foundation and guides your professional practice.

In the 150 or so years of Chinese medicine practice in Australia, the profession has made very big strides on its professionalisation journey.

The State of Victoria has been prominent in that history. As you are aware, Victoria was the first jurisdiction to register and regulate the profession of Chinese medicine outside of China.

It was the Liberal National Government led by Jeff Kennett that initiated those legislative reforms. First under Marie Tehan, then in 1999, under the leadership of my predecessor, The Honourable Rob Knowles as Health Minister, Mr Robert Doyle as Parliamentary Secretary, the then first Chinese Medicine Registration Bill was introduced into the Victorian Parliament. Mr Robert Doyle now of course is Lord Mayor in Melbourne.

Along with the first Chinese Medicine Registration Board Victoria, these pioneers laid the groundwork for Chinese medicine to become a nationally registered health profession, alongside other professions such as medicine, nursing, dental and pharmacy.

Since then, Chinese medicine has been growing in strength and popularity.

It is now almost two years since the registration of the Chinese medicine profession was extended across the country, based largely on the Victorian model. While the profession has come a long way, there are significant challenges.

As you engage this weekend with your colleagues, I encourage you to keep at the forefront of your minds the characteristics of a strong and mature profession.

Obviously there are different views on this and you will have your own ideas. I propose to mention those characteristics that I consider to be important to your, or indeed, any profession.

First, a strong and mature profession is one where members have a commitment

to the highest standards of ethical and professional conduct.

Every patient has the right:

- to be given accurate and reliable information about their treatment options;
- to know exactly what is in any herbal formulae they have been prescribed;
- to have all those involved in their care collaborate and communicate effectively;
- to have a prompt and appropriate response if any adverse event occurs, and open disclosure when a mistake has been made;
- to be referred on to other practitioners where appropriate.

All these are important steps, important prerequisites for professional practice.

All practitioners need to engage actively in self-reflection and to challenge any colleague who is at risk of stepping over a line.

Practitioners also need strong commitment to continuing professional development. Your presence here today is just one very strong indication that you value highly the sharing of professional knowledge and the engagement with your colleagues.

Second, a strong and mature profession is one that recognises the importance of research, and strong research that supports clinical practice. While the evidence base for Chinese medicine is growing progressively, there is certainly significant room for further effort.

I encourage those of you who are not engaged currently in research to think about how you might contribute to the body of knowledge about Chinese medicine.

You can do this through formal and informal collaborations with your research colleagues within universities and other research centres. A strong research community means, in my view, a strong and vibrant profession and a profession committed to its future and the future of its patients.

Third, a strong and mature profession is one that presents a unified and authoritative voice to governments, educators, regulators and the community.

When there are multiple professional associations that claim to represent the views of the profession, this can dilute your voice and the profession's capacity to represent its members' interests effectively.

A united front is not only the most effective way to pursue your profession's objectives; it is also the best defence against the slings and arrows that may come in the profession's direction from time to time.

I would urge you to regularly refresh your efforts to explore common ground with other professional associations and to continue to seek out opportunities for collaboration.

Fourth, a strong and mature profession understands and respects the authority of its registration board. It values the difficult job that Board members do on behalf of the government and the community.

It is not the job of the registration Board to promote the interests of the profession – that is the role of the AACMA. The Board is there to protect the community, and every member of the Board has committed to this objective above all others.

At times Board members have to make very difficult decisions, decisions which must fairly balance the rights and interests of the community and those of an individual practitioner.

There will always be some who think the Board has got it wrong, that's natural. Even so, it is important to maintain a respectful debate, and to use the various avenues that are available to you under the law to review Board decisions.

Fifth, a strong and mature profession has respectful and collaborative relationships with other professions. I understand that strong inter-professional links are not always easy to achieve or maintain.

This is especially so when the paradigm that underpins Chinese medicine practice is not generally well understood, that is a challenge for the profession. You may also be aggrieved when you see other professions increasingly moving into what you might consider to be areas of knowledge and specialty that you have worked in.

To deal with these challenges constructively and professionally, my final ingredient of a mature profession is one whose members place the patient at the centre of each and every decision.

If you focus on your own practice and always place your patients' interests above your own, you will continue to build a strong and very respected place for Chinese medicine care within the Australian health care system.

To finish, I trust that you are all aware that Health Ministers have initiated the first full review of the National Registration and Accreditation Scheme. This includes a review of the National Boards including Chinese medicine, so the 14 professional groups that are registered of which Chinese medicine is one.

The terms of reference for the Review have been published and are available on the Australian Health Ministers Advisory Council's website. The Australian Health Workforce Ministerial Council of which I am a member has appointed Mr Kim Snowball as the Independent Reviewer.

Victoria is well-placed to respond to the national review. This is because,

during 2012–13, at the behest of this Government, the Victorian Parliament's Legislative Council Committee chaired by my colleague and Parliamentary Secretary for Health, Georgie Crozier, conducted its own Inquiry into the performance of AHPRA.

The Parliamentary Committee held public hearings and took submissions. It provided an opportunity for those with an interest to have their say about how AHPRA and the National Boards are working.

On the issue of national registration and accreditation, I have placed on the public record on a number of occasions my reservations towards the idea that national approaches are necessarily always better. As I alluded to earlier, Victoria has a proud history of maturity and sophistication when it comes to health professions and practice. And so, it is critical that any national arrangements do not result in a diminution of Victorian standards but rather, are implemented in a manner that recognises and supports state-specific contexts.

The Parliamentary Committee's report was published recently and is available on the Victorian Parliament's website. I am currently considering the Government's response to its recommendations.

I urge your organisation to take a lead role in the national review, to strongly represent the views of the Chinese medicine profession and its patients and to use this opportunity to have your say about how you think the scheme is performing, and how it may be improved to benefit both the Victorian and broader Australian community and importantly, to your valued and respected profession.

Thank you.

The Importance of International Standards and the Role of ISO/TC 249

David Graham, Chair, ISO/TC 249

It is very impressive when a traditional medicine (TM) system transcends its cultural boundaries and becomes an accepted health modality in other countries. Where this uptake is sustained and increases, it suggests that the system is offering more than simply a response to smart marketing or an interest in a fad but is seen by the society as providing true benefits. This is the case with traditional medicine systems derived from ancient Chinese medicine, namely traditional Chinese medicine (TCM), Korean medicine and Kampo, as their use extends internationally.

However, this wider use also brings risks and challenges, as the traditional medicine system moves away from the environment of its cultural heritage with its inherent checks and balances and, as a complementary medical system in another country, is exposed to many commercial and competing pressures. These risks include a lack of quality control and distortion of the traditional medicine system, with consequent damage to its reputation, public safety and trade.

For a medical system to become an integral part of a country's health system, it requires a number of elements to be in place:

- Informatics – there is the need for a common language and understanding of the terminology, classification and coding of relevant information to support the sharing of research, clinical practice etc.
- Quality education and training for health practitioners.
- Research, innovation and an evidence base to support practice and products. It is a difficult transition to move the evidence base from experiential to scientific; however, this is being increasingly required by regulators and others. The modernisation of traditional medicine – which includes new methods of manufacture, pre-packaged dosage forms and new formulations and methods of delivery – will increase the demands for appropriate levels of scientific evidence that should be commensurate with the risk represented by the product or practice.
- Clinical guidelines and other documentation.
- Means to establish the quality, safety and efficacy (or effectiveness) of treatments, many of which are complex mixtures of natural materials.
- Appropriate use of the treatments by the consumer, including such aspects as product labelling and product information.

When these elements are firmly in place, they provide the basis for appropriate regulation of products and registration of practitioners, which benefits consumers, the profession and industry. These elements protect the reputation of the health modality and support its wider acceptance and integration into the national healthcare and funding systems, while also supporting international trade and commerce associated with the health modality.

Defining standards or benchmarks for each of these elements is a priority. While national standards often suffice, they can vary markedly between countries in their quality, and these differences can undermine public safety, the reputation of the modality and trade. In some cases where standards are most needed, the country may not have the resources or skills to develop the standards.

The International Organization for Standardization (ISO) provides a structure for developing international standards. ISO defines a standard as 'a document that provides requirements, specifications, guidelines or characteristics that can be used consistently to ensure that materials, products, processes and services are fit for their purpose'.

Important benefits of the ISO approach are:

- The consultative and consensus-based processes, where the standards are developed by experts nominated by member bodies and organisations and the standards evolve through rigorous consultative processes. The standards represent global expert opinion drawing on the knowledge of consumers, practitioners, industry and government.
- Defining an expected set of specifications for a product or service which are harmonised across countries and markets. The role of ISO is not to duplicate existing national or regional standards, many of which are already adequate, but to provide a means of harmonising expectations across markets or to provide access to standards where none exist.
- The standards are provided by ISO as an international resource to be used on a voluntary basis and, where deemed necessary, can be adjusted by a country to meet its particular national needs and also mandated in its legislation.

- Providing review processes for keeping ISO standards up to date.

Through these processes, ISO standards can assist in putting into place internationally agreed specifications which protect users and assist commerce.

ISO is well aware of the risks inherent in defining expectations through developing standards and has defined criteria for the global relevance of standards. These are that a standard:

- meets regulatory and market need i.e. the need for a standard must be carefully assessed and prioritised
- does not distort the market nor impair fair competition; for example, by guarding against a proposal for a standard where the motivation is to create a barrier to competitors
- does not stifle innovation and technological development – in fact, a standard should encourage innovation by establishing an environment of confidence
- where possible, is performance-based and not design prescriptive i.e. it should define the outcomes sought rather than the processes for getting there, thus encouraging innovation.

Countries can become members of ISO, usually through their principal national standards organisation. At this time, 111 countries are full ISO members with additional correspondent (observer) members. Australia is a full member represented by Standards Australia. If ISO accepts a proposal from a member showing a need to develop standards in a new work area (such as an industry sector not previously covered by ISO) then ISO establishes a Technical Committee (TC) to perform that work. At present there are 224 Technical Committees.

Both South Korea and China were concerned that as the international use of their traditional medicine systems expanded, they should be underpinned by access to appropriate standards. Proposals were made to ISO and ISO established a Technical Committee (ISO/TC 249) in 2009 to oversee the development of international standards in traditional Chinese medicine. However, ISO also asked the committee to consider whether it could cover other TM systems as well. While the committee still operates under a provisional title of TCM, it was agreed in May 2013 that its scope includes TM systems derived from ancient Chinese medicine, which brings Kampo and Korean medicine within its purview.

Twenty-one national members have chosen to be active in the work of ISO/TC 249 and can vote on outcomes, and 12 national members have chosen to be kept informed of the work but do not vote (Table 1).

Each national body establishes a national mirror committee to the ISO Technical Committee. The role of the mirror committee is to consult nationally and bring that country's input to the discussions and work of the ISO Technical Committee. The shadow committee supported by Standards Australia brings the Australian input to the work of ISO/TC 249, and is very capably chaired by Associate Professor Chris Zaslawski, University of Technology, Sydney.

In addition, certain international, not-for-profit organisations can be accepted as Liaison members of Technical

TABLE 1 National Members participating in ISO/TC 249

Australia	Israel	South Africa
Austria	Italy	Spain
Canada	Japan	Switzerland
China	Korea, Republic of	Thailand
Germany	Mongolia	Tunisia
Ghana	Netherlands	United States of America
India	Singapore	Vietnam
National members with the status of observers		
Barbados	Ireland	Seychelles
Finland	Lithuania	Sweden
France	New Zealand	United Kingdom
Hong Kong	Poland	Zimbabwe

Committees. The World Federation of Acupuncture-Moxibustion Societies (WFAS) and the World Federation of Chinese Medicine Societies (WFCMS) have made valuable contributions to the work of ISO/TC 249. The World Health Organization (WHO) (particularly the area dealing with the International Classification of Traditional Medicine) is also an alliance member. Liaison members do not have a vote on the work outcomes.

There are also a range of other Technical Committees within ISO dealing with health and related sectors. Important to the work of ISO/TC 249 are ISO/TC 34, which deals with food products, ISO/TC 210 which deals with quality management and corresponding general aspects for medical devices, and ISO/TC 215 which deals with health informatics. We aim to ensure that we coordinate our work with their activities.

The Committee is fortunate to have a very strong secretariat headed by Prof Yuandong Shen, Professor of the Shanghai University of TCM, which is financially supported by China and located in Shanghai. The Technical Committee provides the governance of the work, while the technical work is largely carried out by experts operating within Working Groups (WG) that report to the Committee. ISO/TC 249 holds an annual meeting hosted by one of its member countries while the Working Groups meet as needed. Much of the work is done electronically in between face-to-face meetings.

At this stage, the work priorities for the Committee have been to develop standards in the areas of

- Informatics
- Quality and safety of treatments

The Committee has established five Working Groups which have responsibilities as follows:

- WG1: quality and safety of raw materials and traditional processing
- WG2: quality and safety of manufactured products
- WG3: quality and safety of acupuncture needles
- WG4: quality and safety of other medical devices
- WG5: terminology and informatics. There is also a Joint Working Group with the technical committee which deals with Health Informatics (ISO/TC 215).

In a relatively short period, the outcomes of the work of the committee are becoming apparent. Table 2 lists the current projects, covering both traditional aspects and the modernisation processes of these traditional medicine systems with their common origins in ancient Chinese medicine. The objective of each project is an international standard, the development of which follows a process defined in detail by ISO and generally takes three years to complete.

A range of other projects are progressing through the initial approval stages.

The work of ISO/TC 249 has made, and will continue to make a very important contribution to supporting the appropriate international use of TM systems derived from ancient Chinese medicine. The Committee is very appreciative of the strong contribution of Australian experts to its work. The Committee publishes a periodic newsletter of its activities, which people can receive by contacting the committee secretariat on email: mscsh2009@gmail.com.

TABLE 2 Current approved projects of ISO/TC 249, indicating the relevant Working Group.

Ginseng seeds and seedlings – Part 1: Panax ginseng CA Meyer	WG1
Sterile acupuncture needles for single use (now ISO standard 17218: 2014)	WG3
Requirements for basic safety for electroacupuncture stimulator	WG4
General requirements of electrical radial pulse tonometric devices	WG4
TCM Vocabulary Part 1: Chinese Materia Medica	WG5
Electroacupuncture stimulator device for quality	WG4
Heavy metals in natural materials used in traditional Chinese medicine	WG1
Herbal decoction apparatus	WG4
Moxibustion devices – general requirements	WG4
Coding system of Chinese medicines – Part 1: Coding rules for decoction pieces	WG5
Intradermal acupuncture needles	WG3

Book Reviews

Unlocking the Mysteries of Chinese Medicine – A Reference Manual for Consumers

By Karen Pohlner and Russell Shaw
Bamboo Spirit Publishing, 2013
ISBN 9780646904368

This text on Chinese medicine, written for the consumer, begins by providing a brief overview of the increasing use and recognition of complementary and alternative medicine (CAM), including Chinese medicine, both internationally and in Australia.

Perhaps the word 'simple' could have been left out of the statement 'Chinese medicine is a simple, low-technology medicine', as some in the profession will take exception to the suggestion that Chinese medicine is 'simple' – though agreeing that it certainly is 'low-tech' compared to modern 'high-tech' biomedicine.

The statement 'Chinese medicine is essentially a preventative medicine' may also be misunderstood by the reader, as Chinese medicine has both preventative and disease resolution components. The emphasis given to the preventative component early on in the text, without similar attention being given to the disease resolving component, may lead the reader to believe that if they are already unwell, Chinese medicine has little to offer them.

The sections on 'treating the person as a whole' and 'the root and branch approach' are well presented, giving the reader a sense of the therapeutic intent behind Chinese medicine.

The emphasis on holism – the inseparability of everything in the environment – together with the unique nature of each person, gives a clear picture of how Chinese medicine sees the individual in relation to their personal and shared environment.

The difference between Chinese medicine and naturopathy is clarified, and a useful distinction is also made between the superficial way in which dry needling may be practised compared to the in-depth way traditional Chinese acupuncture is practised.

Readers are given a glimpse of what to expect from a course of Chinese medicine therapy, emphasising the ever-changing nature of this therapy as it is applied to the journey of recovery.

Chinese medical theory is introduced with the help of appropriate analogies, giving the reader a sense of the dynamics of the system and the way in which Chinese medicine ties together the various aspects that make up the person.

The text offers informative chapters on Women's, Children's and Men's health, and the broader topics of general and family medicine. These sections are complemented by some dietary recipes and other *yǎngshēng* measures to prevent and ward off illness and to improve one's health.

This publication makes a valuable contribution to the literature and especially so, as it aims to inform the consumer and potential consumer of the perspective of Chinese medicine and the possible benefits of undertaking a course of therapy.

Reviewed by Kerry Watson

Deadly Medicines and Organised Crime: How Big Pharma Has Corrupted Healthcare

By Peter Gøtzche
Radcliffe Publishing, 2013
ISBN 9781846198847

The story of thalidomide will be familiar to most of us, especially those who grew up in the 50s and 60s. The drug was first marketed in West Germany under the name Contergan by Chemie Grünenthal in 1957. Although initially prescribed as a sedative-hypnotic, it was soon found to be effective for nausea and morning sickness in pregnant women and was aggressively marketed for this use. We should remember that at this time there was little regulatory control over the use of medications during pregnancy and drugs were not routinely tested for potential harms to the foetus.

Unfortunately, as it turned out, thalidomide became one of the most successful prescription drugs in the history of medicine. In the UK, Australia and New Zealand it was marketed by The Distillers Company (Biochemicals) Ltd, under the brand name Distavel as a remedy for morning sickness. The advertising literature claimed that Distavel was 'outstandingly safe' for pregnant women and nursing mothers. By the end of the 1950s, 14 pharmaceutical companies were marketing thalidomide in 46 countries under at least 37 different trade names.

As a result of this drug, around 5 000 infants were born with malformation of the limbs (phocomelia) in Germany alone, and only about 40% of these children survived. Throughout the world more than 10 000 cases were reported of infants with phocomelia due to thalidomide, with around 50% survival rate. In addition to limb malformations the adverse effects of thalidomide included deformed eyes, hearts, alimentary and urinary tracts, blindness and deafness.

In November 1961, thalidomide was taken off the market, mainly due to pressure from the press and the general public. Although most victims of thalidomide in Europe received compensation in the aftermath of this tragedy, it was not until December 2013 that a class action filed by over 100 survivors in Australia and New Zealand was settled.

The thalidomide tragedy led to the development worldwide of more structured regulations and control over drug use and development, and many countries, including the US, EU, Australia and Canada introduced much more stringent rules for the testing and marketing of pharmaceutical drugs. In the US, which had never granted approval for thalidomide, President Kennedy honored the FDA pharmacologist, Frances Kelsey, with the President's Award for Distinguished Federal Civilian Service for her key role in denying Richardson-Merrell approval to market thalidomide (despite intimidation from company representatives). The well-publicised 1962 ceremony provided a powerful symbol of the resolute will of governments and their agencies to protect the general public from the profit motivated malevolence of pharmaceutical companies.

To most people, these regulatory changes, which ushered in the 'enlightened' age of evidence-based medicine, were enough to restore trust in doctors and the drugs they prescribed. However, the alarming stories around such drugs as the COX-2 inhibitors (e.g. Vioxx), the SSRIs (e.g. Prozac), and more recently the statins (as exposed on ABC television) show us that these tough new regulations and the institutions charged with enforcing them may not be up to the task. In fact, prescription drugs are currently the third major killer after heart disease and cancer. In the introductory chapter, the author of this book notes that if this were a new type of disease, a cancer or some sort of epidemic, killing people in such large numbers, surely there would be a great deal of media attention focused upon it, with patient groups raising money and lobbying governments to act urgently to eradicate this scourge. Why is there such silence and resigned acceptance when it comes to the widespread harms caused by pharmaceutical drugs?

In this landmark publication, researcher and physician Dr Peter Gøtzsche traces the sorry history of deception, bribery and corruption that has allowed this extraordinary situation to develop. Dr Gøtzsche is co-founder of the Cochrane Collaboration, of which he is still a director, and also founding director of the Nordic Cochrane Centre. Since 2010 he has been Professor of Clinical Research Design and Analysis at the University of Copenhagen. He has published over 50 papers in the major peer reviewed medical journals and participated in 40 meta-analyses and systematic reviews published in the Cochrane Database of Systematic Reviews.[1] Moreover, judging by the way he writes, the man is a true scientist with an innate respect, indeed love, for truth and distain for falsehood in all its forms.

As the title of the book suggests, Dr Gøtzsche draws a parallel between the drug industry and the mafia. In examining the world's 10 largest drug companies he has exposed activities generally associated with

organised crime, such as fraud, federal drug offences, bribery, obstruction of justice, obstruction of law enforcement, tampering with witnesses and political corruption. However, in addition to finding the law to be a major impediment to their pursuit of unlimited profits, the pharmaceutical industry has also faced another annoying obstacle that the mob doesn't need to negotiate: scientific integrity.

Also unfolding within these pages is the story of the artful seduction of medical professionals by the industry: how legitimate payments for representing their interests at live events and in print gradually, almost imperceptibly, morph into frank bribery, stripping these so-called 'industry whores' of their professional integrity and reducing them to the level of circus animals. The numbers of such paid professional spokespersons for Big Pharma is both staggering and alarming!

Dr Gøtzsche describes the lengths to which one has to go in order to retrieve scientific information, which should be freely accessible, both to the profession and to the public. These data remain the commercial-in-confidence 'property' of the drug company that sponsored the clinical trial of their drug – while enlisting the help of medical staff and volunteer patients who believe they are contributing towards scientific advancement for the benefit of humanity. We are also shown how such trials are in most instances improperly conducted in order to minimise or hide harms and exaggerate clinical efficacy. As Dr Gøtzsche explains in a recent interview:

'There are very little high-quality published data. Neither the drug industry nor publicly employed researchers are particularly willing to share their data with others, which essentially means that science ceases to exist. Scrutiny of data by others is a fundamental aspect of science that moves science forward, but that's not how it works in healthcare. Most doctors are willing to add their names to articles produced by drug companies, although they are being denied access to the data they and their patients have produced and without which the articles cannot be written. (This is called 'ghost writing' and is usually denoted as 'editorial assistance' in the list of authors for a trial or review paper.) This is corruption of academic integrity and betrayal of the trust patients have in the research enterprise. No self-respecting scientists should publish findings based on data to which they do not have free and full access.' After elaborating on such activities by the drug industry, government regulators and the medical profession, together with the devastating consequences for patients, which are largely foreseeable if you have access to all the data, several of the following chapters focus on specific drugs or classes of drugs. Here we are given an in depth examination of 'popular' drugs that have very little or no effect but very real dangers (i.e. potential harms outweigh potential benefits) or have been marketed mainly for off label uses (which is both illegal and unscientific as there is no evidence of efficacy) or that should be used in a very restricted way but are targeted for widespread use. Topics covered include 'slimming pills', Neurotonin, NSAIDs (specifically the COX-2 inhibitors), anti-diabetic drugs, the SSRI 'antidepressants', and antipsychotics.

A book of this nature would not be complete without a critique of modern psychiatry, tellingly described as 'the drug industry's paradise'. Nowhere are the excesses of 'disaster capitalism'[2–3] more in evidence than within this specialty. This chapter is priceless – distressingly priceless. In addition to graphically illustrating the book's main thesis with accounts of hidden suicides in normal people taking SSRIs (e.g. in a drug company sponsored trial; this is after being screened for both depression and suicidal ideation before being enrolled in the trial), it also makes a significant contribution to the ongoing debate regarding the validity of psychiatric diagnoses and efficacy of psychiatric interventions. The accounts of suicides in children, together with other harms caused by the application of increasingly elastic psychiatric diagnoses and the concomitant use of dangerous psychotropic drugs (the real dangers of which are hidden by drug companies), is both chilling and deeply saddening.

The unnecessary loss of human lives and the debilitating effects on patients are sorely lamentable. However, this is compounded by the fact that doctors are deprived of the information they need in order to assess risks and benefits for the drugs they prescribe, and therefore must unwittingly contribute to the ongoing harms caused by drugs. Because of the suppression of crucial information by drug companies (willingly supported in most cases by the regulating agencies), no one outside of these companies knows the true efficacy and potential harms associated with the use of their drugs. This issue was also raised by Dr David Healy in his book describing the murky story of the SSRIs and the associated shenanigans of the companies that brought them to market.[4] He notes that it is obvious that these drugs may work quite effectively in one group of patients and that they may be extremely deleterious in another (leading in some instances to self-harm and homicidal behavior), while being largely ineffective in another. Unfortunately, due to the current state of things we will never know the defining characteristics of these three groups. Dr Gøtzsche takes these observations a few steps further, showing that this is the case for most of the drugs in current use, particularly the biggest selling ones. In effect, we are seeing the undermining of Western biomedicine by those who supply its major therapeutic modality.

The evidence presented in this book is very convincing, and we may well

wonder how the drug industry giants have gotten away with all of this for so long. Shouldn't the perpetrators of such crimes be brought to justice? Unfortunately we have only seen the dispensing of partial justice, with the imposition of relatively small fines in only a few cases, or out of court settlements with minimal publicity. Such a dire situation demands redress at all levels. But that is unlikely to happen any time soon – the system is too entrenched for that. In order to understand how we have got to this point and to grasp the extent and scope of this crisis, I will leave it to Dr Gøtzsche to elucidate the issues and point the way towards a satisfactory resolution.

This book should be mandatory reading for both students and practitioners of Western medicine. Moreover, it will provide much needed clarity to practitioners of complementary healthcare who are working in a Western clinical setting, and dealing on a daily basis with patients who are prescribed drugs that may be ineffective and potentially dangerous, under the mantle of 'modern evidence-based medicine'.

Reviewed by Tony Reid

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Shen's Textbook on the Management of Auto-immune Diseases with Chinese Medicine

By Shen Pi'an, translated by Mao Sguzhang
Donica Publishing, 2012
ISBN 9781901149008

This book contains 22 chapters and 750 pages. The author, a Professor of Chinese medicine for more than 30 years, is a prominent clinician in rheumatology and immunology in China. In this book, he explains how to manage the autoimmune diseases with Chinese medicine. Firstly, this book systemically introduces the concept, development, diagnostics and therapeutics of autoimmune diseases from the perspective of traditional Chinese medicine (TCM). The author provides an in-depth explanation about aetiology, pathology, pattern identification and treatment of autoimmune diseases with Chinese medicine based on his many years of clinical experience. Secondly, this book has chapters of commonly seen autoimmunity diseases, such as rheumatoid arthritis (RA) and systemic lupus erythematosus, with information on the clinical manifestations and diagnosis in Western medicine as well as Chinese medicine. All of these are very useful to Chinese and Western medicine practitioners who are interested in autoimmune diseases. Finally, this book provides lots of advice for patients with autoimmune diseases about how to relieve symptoms and control the progression of the disease. The advice should be very beneficial to the patients to guide them to live with a healthy life method for their diseases.

Throughout the book, the author tries to establish a 'bridge' between Western medicine and TCM. The book aims to not only help Chinese medicine practitioners understand the diagnosis and treatment of autoimmune diseases in current Western medicine, but also help relevant practitioners of Western medicine to understand the management of autoimmune diseases with TCM. This 'bridge' is achieved through establishing the conceptual link between Western medicine and TCM. For example, immune function is a concept of Western medicine; the authors proposed that 'immune function' is closely related with some concepts/theory of TCM, such as 'Vital Qi', 'Spleen and Stomach theory', 'fever due to internal damage', 'Kidney-gate of vitality theory' and 'Bi syndrome theory'. It means that all of these factors of TCM can lead to the disorder of human immune function. Such 'conceptual links' are presented throughout the chapters about various diseases.

The book's content was originally from the clinical experience of the author, therefore it is very useful for practitioners to guide their clinical practice and provide advice to their patients. In the chapter on aetiology and pathology, the author explains the aetiology of autoimmune diseases in Chinese medicine due to constitutional insufficiency with depletion of kidney and disharmony of the Ying and Wei, and their subsequent pathological products, such as phlegm-damp, and blood stasis. The resultant internal damage of the Zang-Fu is considered

as the final stage of pathology. In order to be understandable to other relevant practitioners with a Western medicine background, authors also use some clinical features of modern autoimmune diseases to compose the aetiology and pathology of autoimmune diseases in TCM, including how symptoms are similar to fluin the early stage of diseases and the internal damage of organs as the final evolution of the diseases. Thus, this book is easier for both Chinese and Western medicine practitioners to access than other books on the topic.

In the chapter on treatment, the author proposes combining internal and external treatment, including herbal medicine, acupuncture and moxibustion, to improve the effect. The author also proposes diet therapy. The author considers the management of diet helping patients with autoimmune diseases to control the progression of diseases and relieve the symptoms. This theory is consistent with the view of modern medicine. Many specialists believe that diet therapy is beneficial to the control of autoimmune diseases. For example, studies have shown that diet therapy can alleviate disease activity and symptoms in patients with RA.[1] Being able to use diet to control the progression of their diseases also empowers patients to help themselves.

What I find most interesting is the whole story around a core concept of TCM, Qi. The author shows that constitutional insufficiency with depletion of Zheng Qi plays the key role in the dysfunction of the immune system. As the root cause of autoimmune diseases, insufficiency of Zheng Qi can directly or indirectly lead to the formation of various pathological factors, such as the insufficiency of Kidney Yin, the disharmony of Ying and Wei, the formation of phlegm-dampness, and stasis of blood and phlegm. Thus, in the treatment part of this book, the author also focuses on the treatment on Zheng Qi, such as enriching Zheng Qi and enriching Kidney Yin and Yang. Supporting Zheng Qi to alleviate pathological factors is the core treatment aim in this book. Traditionally, some Chinese medicine practitioners believe that the system of Wi, Qi, Ying and Xue is the main site of TCM pathology of autoimmune diseases, but the author proposes that 'Triple Burner' is the main site of pathology. 'Triple Burner' is the passageway for the circulation of Zheng Qi, so this is consistent with author's view on Zheng Qi being the key role of autoimmune diseases.

This book will be appealing to Chinese medicine practitioners, rheumatologists, and other practitioners who are interested in autoimmune diseases. I highly recommend this book to Chinese medicine practitioners who are involved in or interested in the treatment of patients with autoimmunity diseases.

Reviewed by Yanli Zhou

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Current Research Report

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EXAMINATION OF SURFACE CONDITIONS AND OTHER PHYSICAL PROPERTIES OF COMMONLY USED STAINLESS STEEL ACUPUNCTURE NEEDLES

Once upon a time when acupuncture needles were not sterilised single-use needles, they were autoclaved by practitioners for re-use. The question of how sharp, strong, flexible, and indeed how long they would remain relatively sharp, was often discussed. In fact some acupuncturists devised ways of keeping their needles sharp. From memory, single-use sterile needles were introduced into Australia during the early to mid 1980s emanating from Japan, Korea and Europe. From experience practitioners seemed to agree on which were the better needles at the time.

Thirty years later, we are now in receipt of an Australian study exploring the same issue: this time by applying technologically sophisticated instrumentation. According to the authors, their study is one of four offerings giving attention to the acupuncturists' principal tool of use.

The study aims to examine the surface conditions of needles manufactured by two of the leading suppliers to Australia. Both are manufactured overseas: one from China and the other from Japan. No prizes for guessing the needle manufacturers, particularly when the authors designated the needles as 'H' and 'S'. Microscopy pictures of the shafts and tips of ten needles of the same gauge and length from each of the manufacturers are supplied. At a magnification index of 5000x, the images provided clear indication of needle tip sharpness, lumps and alien matter on the needles. No doubt practitioners have seen images of this kind supplied by manufacturers as part of advertising materials. However, magnification levels have usually been around 100x to 400x.

The needles were inserted into gel type material meant to be a surrogate human tissue. After insertion the needles were manipulated by an experienced practitioner in two ways: lifting and thrusting, and rotation. Needle manipulation was also measured using a needle sensor instrument which attempted to calibrate both the movement and force applied to needle and the extent to which foreign materials were left in situ or indeed whether bits of gel material were found on the shaft or tip.

In addition to providing pre- and post-needling images of each of the needles the authors also attempted to identify the alloy composition, providing a detailed description of needle constituents.

What did they discover and say?
The most telling aspect of this paper are the images of the needle tips. We see them before and after being used. Needle tip images pre and post use are especially revealing, indeed disturbing to view especially for one group of needles known as 'H' in the study.

The second group of needles, the 'S' group fared better. However, we also need note that at a magnification level of 5000x one will without doubt discover all manner of debris and deformities whether inspected pre or post use.

If there is such a difference in needle quality between two of the worlds leading acupuncture needle manufacturers one wonders what the condition of other commercially available needles are like. Given that both groups of needles have been in use for around thirty years, one would think that the tally of adverse reactions such as haematomas and bruising would be especially high. Perhaps what does matter is how practitioners have managed to work with remarkably deformed needles. Nevertheless, one simple question arises. How would one determine a minimum standard for needle production, sharpness, deformities and composition? Whether this is achieved through self regulation among manufacturers, legislation or by other means is an open question.

Acknowledging that the researchers clearly specified their intention to examine surface characteristics of acupuncture needles, they also form part of a larger category of sharps implements used in a medical context. What would be useful know is how acupuncture needles compare with, for instance, needles used for injections in other medical or dental settings. A base comparison would be useful.

The issue of adverse effects from acupuncture is also raised by the authors which takes the discussion into new territory. The main adverse effects appear to be haematoma/bruising, pain experienced on needling or skin reactions usually due to alloy composition of the needles.

To venture into territory suggesting that bruising and/or needle pain is essentially

caused by using poorly manufactured needles is somewhat gratuitous. One can also cause bruising or pain by using better quality needles. What we don't know is the extent to which poorly manufactured needles in and of themselves will more likely cause bruising or pain.

The authors also raise the idea of fear of pain related to the needling experience. A notion such as this forms part of a much larger and complex issue and goes beyond the scope the paper. Yet the authors suggest that if needles were made sharper, improving the needle tip quality, needle shy patients would somehow be more inclined to present for acupuncture.

If as is being suggested there is substantial variance in needle quality, composition and by implication quality control during manufacture between two of the largest suppliers, the challenge to the profession is not only medical but also social and political. According to this paper the profession may need to demand that suitably produced needles become the norm.

Peter Ferrigno

Xie, YM, Xu, S, Zhang, CS and Xue, CC. Examination of surface conditions and other physical properties of commonly used stainless steel acupuncture needles. Acupunct Med 2014;0:1–9

Research Snapshots

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EFFICACY AND TOLERABILITY OF RISPERIDONE, YOKUKANSAN, AND FLUVOXAMINE FOR THE TREATMENT OF BEHAVIORAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA: A BLINDED, RANDOMIZED TRIAL

BACKGROUND: Behavioural and Psychological Symptoms of Dementia (BPSD) refer to a range of non-cognitive symptoms seen in dementia patients, including psychosis, agitation, aggression, anxiety, depression and sleep disturbance. Current treatment options for BPSD in elderly patients are limited and can involve the use of antipsychotics, which can produce severe adverse effects.

OBJECTIVES: To compare the efficacy and tolerability of three pharmacological interventions for the treatment of BPSD, using a randomised, head-to-head, rater-blinded trial design. The interventions were the atypical antipsychotic risperidone, the selective serotonin reuptake inhibitor (SSRI) fluvoxamine and the Japanese Kampo formula Yokukansan which is also known as Yi Gan San.

The aim was to help establish a reliable BPSD treatment strategy.

METHODS: All participants were inpatients at a psychiatric hospital in Japan. All had been admitted to the hospital due to the severity of BPSD. Informed written consent regarding the trial was gained from each participant where possible, and a legal representative of each participant was also consulted, in accordance with the relevant ethics committees and the Declaration of Helsinki.

Initially all participants underwent a washout period of at least one week, during which all psychotropic medications were discontinued. The trial consisted of an eight-week treatment period where 82 participants were randomly assigned to receive oral risperidone (0.5–2.0 mg/d), Yokukansan (2.5 – 7.5 g/d) or fluvoxamine (25 – 200 mg/d). The dosages were flexible and were adjusted throughout the trial at the discretion of the trial investigator, who also administered the drugs. The dosages were within the normal ranges for elderly patients with psychotic disorders.

Yokukansan formula is typically prepared as extract granules and contains Atractylodes Lancea Rhizome (Baizhu), Poria Sclerotium (Fulling), Cnidium Rhizome (Chuanxiong), Uncaria Hook (Gouteng), Japanese Angelica Root (Danggui), Bupleurum Root (Chai Hu) and Glycyrrhiza (Gancao), as registered in the Japanese Pharmacopoeia.

There were 27 participants in the risperidone group (mean age 80.72 years), 27 participants in the Yokukansan group (mean age 83.50 years) and 28 participants in the fluvoxamine group (mean age 83.20 years).

A blinded rater assessed the participants at weeks 0, 2, 4, 6 and 8 (end point), primarily using the Neuropsychiatric Inventory-Nursing Home version (NPI-NH) outcome measure to assess efficacy in terms of psychopathology. Secondary outcome measures were the Mini-Mental State Exam (MMSE) to assess cognitive function, Functional Independence Measure (FIM) to assess daily life function, and the Drug Induced Extra-Pyramidal Symptoms Scale (DIEPSS) to assess severity of uncontrolled movement caused by taking antipsychotic drugs.

RESULTS: Seventy-six (76) out of 82 patients completed the trial. The study team found that overall the three interventions had equal efficacy in reducing BPSD in elderly patients, but risperidone was less well tolerated. The total NPI-NH scores were significantly reduced from 26.20 (SD 15.77) to 17.72 (SD 11.49). Severe, moderate and mild adverse effects occurred more frequently in the risperidone group. Cognitive function and daily life function did not change significantly over the eight weeks in any group.

CONCLUSION: It was concluded that the three interventions had equal efficacy in the treatment of BPSD in elderly patients, but Yokukansan and fluvoxamine were better tolerated and therefore should be recommended over risperidone.

COMMENTS: Designing a clinical trial for elderly patients with cognitive

impairment and neuropsychiatric symptoms require careful consideration regarding ethics. Involving a placebo group may not be appropriate. As the authors mentioned, the lack of a control group was a limitation of the study as environmental or other influences may have played a role in the improvements of the participants' symptoms.

Although the MMSE and FIM scores did not change significantly in any group, it might have been useful to know the rate at which they had previously been declining, in case the interventions had affected the rate of decline. Similarly, a follow up study showing any changes in outcome measure scores after the treatments had been discontinued might have provided useful information.

Teranishi, M, Kurita, M, Nishino, S, Takeyoshi, K, Numata, Y, Sato, T, et al. Efficacy and Tolerability of Risperidone, Yokukansan, and Fluvoxamine for the Treatment of Behavioral and Psychological Symptoms of Dementia: A Blinded, Randomized Trial. J Clin Psychopharmacol. 2013:33(5);600–7. doi: 10.1097/JCP.0b013e31829798d5

Anna Hyde

A LONGITUDINAL STUDY OF THE RELIABILITY OF ACUPUNCTURE DEQI SENSATIONS IN KNEE OSTEOARTHRITIS

OBJECTIVE: This study investigated the reliability of measuring deqi sensations and its relationship with clinical outcomes in a population of knee osteoarthritis (OA) patients.

METHODS: Thirty knee OA patients were randomly divided into three groups: the high-dose acupuncture group, the low-dose acupuncture group and the sham acupuncture group. Verum acupuncture was administered to six acupoints in the high-dose acupuncture group and to two acupoints in the low-dose group. The sham acupuncture consisted of the Streitberger placebo needles at six non-acupoints. The deqi sensations were measured using the Massachusetts General Hospital Acupuncture Sensation Scale (MASS). Each participants were asked to rate the sensations twice during each treatment on a scale of 0 to 10, where 0 is no sensation and 10 the most unbearable. The clinical outcomes were measured before the first acupuncture session and at the last acupuncture session using the Knee injury and Osteoarthritis Outcome Score (KOOS). The participants had six sessions of acupuncture over a period of four weeks.

RESULTS: Thirty participants completed the study. It was found that the feeling of soreness and aching were significantly stronger in the real acupuncture group when compared with the sham acupuncture group. Heaviness was the most reliably rated sensation, whereas coldness was the least reliably rated. When compared to sham acupuncture, real acupuncture significantly improved the KOOS subscales scores for pain ($p = 0.025$), function in sport ($p = 0.049$) and quality of life ($p = 0.039$).

CONCLUSION: It was concluded that real acupuncture produced stronger deqi sensation and better clinical outcomes. Deqi can be reliably measured using the MASS in knee OA patients.

COMMENTS: This study suggests that the strength of deqi sensations affect the therapeutic effects of acupuncture and that deqi can be reliably measured. As deqi sensation is subjective, the study could have also looked at its relationship with psychological factors. Quantifying deqi sensations may enable researches to investigate the strength of deqi sensations and the type of sensation that will produce optimal therapeutic effects in different conditions. Further, previous studies have found that stimulating the muscles, nerves and blood vessels can evoke sensations such as soreness, aching, numbness, heaviness and distension. These sensations are also associated with deqi sensations. Therefore, research on deqi sensations may give a better understanding of acupuncture mechanisms.

Spaeth, R.B., et al., A longitudinal study of the reliability of acupuncture deqi sensations in knee osteoarthritis. Evid Based Complement Alternat Med. 2013;2013:204259.

Dawn Wong Lit Wan

AUSTRALIAN FEASIBILITY STUDY FOR ACUPUNCTURE AND STANDARD EMERGENCY DEPARTMENT CARE FOR PAIN AND/OR NAUSEA AND ITS IMPACT ON EMERGENCY CARE DELIVERY

OBJECTIVE: To evaluate the feasibility of delivering acupuncture in an emergency department (ED) to patients presenting with pain and/or nausea.

METHODS: This study took place at the Northern Hospital ED in Melbourne, Australia, between January and August 2010. Two hundred people presenting to triage with pain measured on the VAS scale of 1–10 and/or nausea measured on the Morrow Index of 1–6 gave consent to participate as the acupuncture group. The people were screened chronologically from earliest to most recent triage and then again by their physician in charge to assess their suitability for acupuncture. The control was a usual care group of two hundred people whose retrospective data from ED electronic health records closely matched those in the acupuncture group. After patient consent was received, acupuncture treatment prescriptions were developed for each patient individually. Manual acupuncture was performed at the bedside in the ED cubicle or treatment room using Chinese manufactured 0.25mm gauge, 30mm or 40mm needles

and deqi was obtained. Acupuncture was delivered by emergency medical physicians with medical acupuncture qualifications, acupuncturists registered with the Chinese medicine registration board of Victoria or final year RMIT university acupuncture students under supervision of registered acupuncturists. The ED doctor was free to assess and consult the patients at any stage and pharmacotherapy was permitted as necessary. Needle retention time was 20 minutes. Immediately after needle removal the acupuncturist recorded patient-reported pain and/or nausea scores, adverse events, and participant's acceptability of a) the ED visit, b) the acupuncture treatment and c) their willingness to repeat acupuncture in the future for a similar condition. Demographic data, adverse events and time management were also recorded.

RESULTS: 89% of patients were interested in acupuncture before or after their medical consultation, with 69% consenting to and completing treatment. 98.5% of patients in the acupuncture group reported a satisfaction score between 5 and 10, with more than half willing to repeat acupuncture, and 57% reporting a satisfaction score of 10. Musculoskeletal pain, pain in the abdomen or flank region, headache or vertigo were among the most common presenting symptoms considered to be suitable for acupuncture treatment by the physicians. There were statistically significant differences in pain scores before (mean = 7.01, SD = 2.02) and after acupuncture (mean = 4.72, SD = 2.62) ($t(193) = 14.81$, $p < 0.001$) and nausea scores before (mean = 2.6, SD = 2.19) and after acupuncture (mean = 1.42, SD = 1.86, $p < 0.001$) in the acupuncture group. There was no significant difference between waiting times for both groups; however those who received acupuncture before consultation with a medical doctor ($n = 55$) had a significantly shorter waiting time (66 ± 10 min, SE) than those who received acupuncture after their medical consultation ($n = 145$, 134 ± 4.95 min, SE, $p < 0.0001$). There was also a considerable difference ($p < 0.0001$) between the time staff took to manage patients who received acupuncture before (mean = 182, SD = 99 min) and after (mean = 273, SD = 152 min) medical consultation. There were four patients in the acupuncture group who reported adverse events, two with slight bleeding and two with mild pain at needling site, but no major adverse events were reported.

CONCLUSION: The study suggests acupuncture to be a safe and acceptable treatment for ED patients. In combination with usual medical care, acupuncture may reduce pain and nausea symptoms among ED patients. Careful planning is required for future studies to achieve recruitment targets within the complex ED environment. Future research should develop high quality, large scale RCTs with specific inclusion/exclusion criteria and evaluation of cost-effectiveness. Patients with musculoskeletal conditions were most commonly suitable for acupuncture, suggesting it would be a practical area for future ED acupuncture research. Acupuncture did not delay conventional care. Continuing ED staff education is recommended on basic acupuncture theory and knowledge of future study protocols.

COMMENTS: Until now the possible advantages of acupuncture in hospital EDs have been relatively unknown and untested in Australia. This feasibility study was appropriately designed for an ED where the range of conditions of patients presenting with pain or nausea is vast. The quality of this study was high with aims, ethics approval, patient consent, selection criteria and adverse events stated. The study stayed true to traditional acupuncture protocol via allowing the acupuncturist to evaluate patients and devise practical acupuncture treatment prescriptions for each individual. Also, the analysis of acupuncture's impact on ED staff and time management was a thoughtful inclusion and results in these areas were significant. This pilot has attracted media and public attention and brought about community awareness. The study was funded by the Department of Health Victoria and provides another positive step towards acupuncture's integration into the mainstream healthcare system, a united effort to maximise outcomes for patients.

Zhang AL, Parker SJ, Smit DV, et al. Acupuncture and standard emergency department care for pain and/or nausea and its impact on emergency care delivery: a feasibility study. Acupunct Med. 2014, Feb;(0):1–7.

Nancy Lee

Conference Reports

WFAS Sydney 2013 8th World Conference on Acupuncture

Sydney, Australia
2–4 November 2013

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Arriving at my first World Federation of Acupuncture-Moxibustion Societies (WFAS) conference, the environmental Qi was palpable. It was a positive gathering of more than 850 acupuncture and Chinese medicine practitioners from all over the world, each present to learn, share discoveries, catch up with colleagues and advance our profession with a united hope for human health, under the conference theme 'From the Classical to the Modern'.

The following are some of the sessions that I found interesting. Unfortunately, there was so much to choose from that expanding on them is not possible for this article.

Day One Highlights

The opening ceremony featured a corroboree from the native owners of the land, which lit up the faces of our international crowd. Dignitaries sat upon the stage and took their turns to speak. Professor Liu Baoyan, the president of WFAS, gave an opening speech about the use and barriers to use of acupuncture internationally, which was very important and informative. It was great to see people step up and help out, as AACMA CEO Judy James was suddenly unwell; Paddy McBride from New Zealand took over the chairperson's role with ease.

Maria Rosa Speronello (Italy) shared pearls of wisdom from her ten years of private clinical practice on children, followed by Dr Luz Maria Ros Torres (Mexico), who talked about her acupuncture research on ADHD in children as an allergy disorder. Interestingly, Dr Torres traced one case of a child with ADHD back to his allergy to his schoolteacher's perfume!

Debra Betts (New Zealand) shared her findings from her randomised trial on the role of acupuncture for threatened miscarriage. Debra also shared feedback from the trial, which gave us insight into the positive value of active listening.

From Australia, David Hartmann gave a historical perspective on TCM that was both interesting and poetic. Stephen Janz, representing the new Chinese Medicine Board of Australia (CMBA), patiently clarified the amendments to the CMBA policy on infection prevention control for acupuncture practice. Dr Rey Tiquia, after his many years of studying and converting chrono-acupuncture from the northern hemisphere to the southern, flipped the audience's minds upside-down as he led us to realise we really are 'down-under'.

Day Two Highlights

Professor Sun Jieguang from Hong Kong presented his clinical application of tongue acupuncture at his workshop. He shared results on patients affected by diseases of the brain, such as Autism Spectrum Disorders and Parkinson's Disease, and demonstrated his technique.

Clare Pyers (Australia) presented her method of interpreting blood tests according to Chinese medicine. She was original and concise with her interpretations. We hope Clare writes a book on this.

During the lunch poster session, Phillip Strong from Australia spoke about the MoxAfrica project. This is a charitable organisation set up to research the use of moxatherapy for tuberculosis treatment in resource-poor environments. The impact of this project is definitely worth a look [www.moxafrica.org].

Another charitable organisation, run by Dr Bisong Guo from the United Kingdom, presented information on their project 'Immunity by acupoint' [www.shenfoundation.net]. Her discussion on the bigger picture of global health and patient education was interesting. It was a pleasure to meet and be in the presence of such a wise and elegant woman.

Following afternoon tea, Asako Murata from Japan discussed the tools of Japanese acupuncture-moxibustion and their influence on our tools used today in Australia. I found this to be very interesting.

Day Three Highlights

John McDonald (Australia) shared the results of his randomised, double-

blinded sham-controlled clinical trial of acupuncture's effects on mucosal immunity in perennial allergic rhinitis. It was interesting to see how the results looked, as I had been a control subject in the study.

Dr Carla J Wilson from the United States told us about the use of a Chinese medicine herbal cream as part of a mixed-methods treatment for HPV-related anal cancer. Dr Wilson emphasised the healing effects of patient education. Dr Denis Colin (France) followed this with his theories on the pathways of metastasis of different cancers using five-element theory as a base. He also discussed the importance of recognising and treating the spiritual aspects of the corresponding affected organs. Professor Chen Hao (China) then reported on a trial on relieving pancreatic cancer pain with electro-acupuncture to the Huato Jiaji points.

After lunch, Daniel Deng's (Australia) 'Body of evidence' workshop was very interesting. It involved noting the smallest of details on the skin and relating them to the yin/yang diagnostic method from the Su Wen. Daniel's energy and powers of observation are superb.

Dr Zhen Zheng (Australia) explained various acupuncture analgesia concepts and how they can vary between individuals, as well as how to apply these concepts to clinical practice. Dr Zheng was very informative, articulate and inspiring as a leading researcher into pain management.

This was where my WFAS experience came to an end. There were sessions well on into the afternoon as well as a closing ceremony, but my flight home to the Gold Coast did not allow for these.

My overall impression of the conference was that it was well organised. The quality and quantity of food at the breaks and lunch was more than adequate. The translations of Chinese presenters were impressive, with translators clearly fluent in both languages and the concepts of TCM, and the headset equipment easy to use. There was a large selection of trade stalls exhibiting needles, moxa, beauty products, electro machines, herbal dispensing units, books, universities, infrared lamps etc.; in the three days of WFAS I didn't see it all.

Entertainment on the Saturday evening included Peter Firebrace from the UK launching his second CD 'Chinese Medicine Blues', using the traditional passing down of knowledge via song to rave reviews. He was clever, deeply rooted in the classics as well as funny and musically talented. The Sunday evening Gala Dinner was wonderful, with delegates greeted on arrival with champagne and gathered outside the ballroom, which overlooked Darling Harbour. Everyone was dressed up and in the mood to celebrate. Dinner was delicious and the band was great to dance to.

Upon reflection of WFAS, the many varied interpretations and refinements of Chinese medicine was recognised. The modern has come from the classical, and loyalty to these roots was present in the sessions, which created a depth of understanding for me as a student. Attending WFAS showed me the many facets of our diverse profession. The presentations allowed me to recognise the passion and dedication inside the speakers, and it was exciting to ask questions and receive instant feedback as well as spark discussions with other professionals during the breaks.

To my fellow students: I recommend you use your student discounts while you have them, and attend the conferences no matter what stage you're at. I'm saving up my pennies for the next stop: AACMAC Melbourne 2014.

UPCOMING INTERNATIONAL CONFERENCES

2014

2–4 May	Melbourne, Australia Australasian Acupuncture and Chinese Medicine Annual Conference (AACMAC) Visit www.acupuncture.org.au
13–16 May	Miami, USA IRCIMH (International Research Congress on Integrative Medicine and Health) Visit www.ircimh.org/2014
16–19 May	San Francisco, USA 16th World Conference on Qigong & TCM – West Visit www.eastwestqi.com
27 May–1 June	Rothenburg, Germany 45th TCM Kongress Rothenburg 2014 Visit www.tcm-kongress.de/en
30 May–1 June	Beijing, China Society for Acupuncture Research Conference 2014 Visit www.acupunctureresearch.org
25–26 August	Beijing, China 2nd International Conference and Exhibition on Traditional & Alternative Medicine Visit www.omicsgroup.com/traditional-alternative-medicine-conference-2014/
3–5 September	Costa Navarino, Greece 1st International Mediterranean Congress Auricular Acupuncture Visit www.auricular-acupuncture.com
3–7 September	Slettestrand, Denmark 4th Scandinavian TCM Congress Visit www.tcm-kongres.dk
31 October– 2 November	Houston, USA WFAS Houston 2014 Acupuncure & Integrative Medicine Conference Visit www.wfas2014.acaom.edu

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AJACM acknowledges the diversity of Chinese medicine theories and practice, and encourages the integration of research, practice and education. It promotes the use of rigorous and appropriate research methodologies in the field of Chinese medicine. AJACM publishes original research articles, general papers, reviews, case reports and case series that will contribute to current practice knowledge and encourage future research directions. The Editorial Board also welcomes the submission of letters, opinions and commentaries.

Authors of randomised, controlled trials (RCTs) are encouraged to consult the CONSORT standards available from www.consort-statement.org/consort-statement/. Authors of systematic reviews are encouraged to consult the QUORUM statement: Moher D et al. Improving the quality of reports of meta-analysis of randomised controlled trials: the QUORUM statement. Lancet 1999;354:1896-1900 (Available from www.thelancet.com).

Case reports and case series are to follow the guidelines in Writing Chinese Medicine Case Reports: Guidelines for the Australian Journal of Acupuncture and Chinese Medicine by P Ferrigno, JD Ryan and JC Deare, available from www.ajacm.com.au.

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TEXT

Manuscripts of original research or review articles should have Introduction, Methods, Results, Discussion, Acknowledgments and References. Authors of other articles should use appropriate headings. All manuscripts should have a Clinical Commentary section, written in plain language for practitioners, describing the clinical relevance of the article.

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- specify academic and/or technical contributions;
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1. WHO Standard acupuncture point locations in the Western Pacific region. Manila: WHO Regional Office for the Western Pacific; 2008.
2. Cahn A, Carayon P, Hill C, Flamant R. Acupuncture in gastroscopy. Lancet 1978;28(1):182–3.

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