Australian Journal of Acupuncture and Chinese Medicine

CONTENTS

01 Editorial

02 Guest Editorial - C Patterson

04 Understanding the Practice of Acupuncture with Women with Fertility Problems: A Qualitative Approach - S Cochrane, C Smith and A Possamai-Inesedy

14 A Consumer's Reflections on Traditional Chinese Medicine and Traditional Western Medicine - H D'Cruz

21 Contextualising the Use of Qualitative and Quantitative Research Methodologies in Chinese Medicine: Epistomological and Ethical Issues - A Moore and P Komesaroff

27 Narrative and the Evolution of Qi - P Ferrigno

34 Interview with Professor Jianping Liu, on Evidence-Based Medicine and its Relevance to Chinese Medicine

38 AACMAC Brisbane 2012: Selected Conference Abstracts

43 Book Reviews

48 Current Research and Clinical Applications

50 Research Snapshots

52 Conference Reports

54 Upcoming International Conferences

Special Issue:
QUALITATIVE RESEARCH

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Editorial

This is the first issue since national registration of Chinese medicine commenced in Australia in July 2012. We believe that registration symbolises the start of a bright future for this profession down under. The growth of a profession is not unlike that of a child or a plant, requiring love, care and provision of appropriate nutrients and guidance. As practitioners who all love and care about this profession, we need to know what then are the appropriate nutrients and guidance and where do we obtain them from?

For a thriving plant, the nutrients come from the soil and the environment. To ensure a plant is growing well, you have to examine the soil, understand its chemical composition, make good use of it and adjust it when necessary. The 'soil' for Chinese medicine is the health system of Australia. With 'research' and 'evidence' forming large components of the soil that need nurturing. Our choices are: making good use of these parts and adding other nutrients over time to suit the plants; ignoring the soil or even treating it as toxic; or re-potting the soil all together. Any smart gardener would know the first choice is the most realistic and sustainable way.

The problem is that some 'nutrients', i.e. some specific types of research and evidence, have been prepared for biomedicine and may not be appropriate for Chinese medicine. An interview of 42 Chinese medicine practitioners in Australia showed that all of the interviewees relied heavily on textbook information, expert advice and personal experience to make clinical decisions; and none referred to published clinical trials.[1] The results reflect two possible aspects: (1) our practitioners may not appreciate such research and have little understanding of the significance; and (2) existing clinical trials focus too much on proving Chinese medicine being better than the placebo control (efficacy) and little on how to improve clinical practice.

So how do we improve the 'soil' over time? How do we develop research methods that suit the needs of Chinese medicine? Many researchers around the world have been trying to answer this question. 'Qualitative research' can be one solution.

To help our readers understand the use of this research method in Chinese medicine, AJACM devotes the current issue to 'qualitative research'. We are fortunate to have Dr Charlotte Paterson, a world-renowned qualitative researcher in health, to write the Guest Editorial. She contrasts qualitative research with quantitative research, and illustrates how this method has been used in Chinese medicine to help us make sense of the humanistic aspect and arts in our medicine. She then analyses each of the four papers in this issue, two written by doctoral candidates, one by a Chinese medicine scholar and practitioner and the fourth by a social science scholar and practitioner.

We believe this special issue provides you, our reader, with a fresh view about other ways to study our profession. Through the eyes of patients and practitioners, the key subjects of the four papers, you will discover and re-discover aspects of Chinese medicine you may not know or might have forgotten.

As usual, we continue to bring the world to you by providing research snapshots, book reviews and conference reports.

In this issue, we sadly say goodbye to A/Prof. Caroline Smith, who has decided to focus on her research and leave the Editorial Board. Caroline was a founding Editorial Board member and has been instrumental in the development of this journal. We wish her well in her future endeavours.

We also warmly welcome two new Editorial Board members: Adj. A/Prof. Hong Xu from the Victoria University and Suzanne Cochrane from the University of Western Sydney. Hong has a research and practice focus on Chinese herbal medicine; and Suzanne, who recently completed her doctoral research, has expertise in qualitative research. Both will certainly broaden the scope and bring fresh ideas to our journal.

We hope you enjoy reading this special issue. We certainly enjoyed making it.

Zhen Zheng
Editor-in-Chief

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Guest Editorial

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What we can learn from Qualitative Research

This special issue is focused on qualitative research methods – methods that bring everyday practice to life by providing new insights and explanations. Qualitative research collects and analyses data in the form of words (from interviews, focus groups, observation, or written data) instead of numbers.[1] It is based on the theories and perspective of the social sciences — sociology, anthropology and education — and it answers questions about the 'how' and 'why' of human behaviour, human interaction and the meanings that people make of their experiences. Qualitative research methods may be used to investigate the perspectives of patients and practitioners and the characteristics of the interaction and communication between them. In addition, qualitative research may be used alongside, or 'nested in', quantitative studies and trials. In this issue, you will find interesting examples of four of these areas.

Suzanne Cochrane illustrates how interview studies and focus groups are used alongside clinical trials (RCTs) to produce a multi-faceted understanding of the research subject. She describes how in-depth interviews with practitioners led to the design of focus groups, which in turn informed the design of a trial of acupuncture for women with fertility problems. In addition to highlighting the complexity and individuality of such treatment, the paper describes the effect of treatment on practitioners themselves. Qualitative research can augment RCTs in a variety of ways: to develop a complex intervention so that it is acceptable to all stakeholders; to improve the design and implementation of the trial itself, in a pilot stage or as the main trial unfolds (addressing recruitment, randomisation or outcome measures);[2] or to monitor the process and implementation of the trial and intervention in order to interpret quantitative results.[3–4]

Heather D'Cruz uses an autobiographical narrative method to critically reflect on her experience as a 'consumer' of Chinese medicine and Western medicine consultations. By embedding her analysis in the wider frameworks of consumer involvement in research and in narrative methods, and by drawing on 10 years of extensive personal experience, she illustrates how useful such analysis is in making recommendations to improve professional practice. Patient/consumer perspectives are more commonly investigated using interviews and focus groups, thereby drawing on a wider range of experiences.[5–6] However, such studies rarely have the advantage of following experiences over long time-spans and only rarely involve consumers directly in the analysis.

The third paper, by Amber Moore and Paul Komesaroff, explores the use of mixed methods — qualitative and quantitative methods employed together in one study — expanding upon the earlier themes of Cochrane. They discuss the key theoretical, methodological and practical features of both methodological perspectives and consider some of the central ideas of medical ethics. They illustrate theory by reference to the placebo effect and a research 'case study' from within the Chinese medicine community.

The final paper, by Peter Ferrigno, analyses an aspect of the practitioner perspective. He uses a novel case study and narrative approach to understand the everyday life experiences of patients in terms of studies of qi. Ferrigno analyses the story depicted in a famous painting as well as a more familiar single patient case study and grounds his analysis in the classical theories of Chinese medicine and philosophy. The use of critical reflection and combining theory and practice leads to practical conclusions about the importance of exploring the patient's narrative within the consultation. As before, it is more common to access practitioner perspectives using individual or group interviews – such as the fascinating insights into acupuncture practitioner's experiences of treating people with rheumatoid arthritis.[7]

I am delighted to see this issue of the journal focus on qualitative research and I hope these papers will inspire more qualitative research into Chinese medicine.

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Understanding the Practice of Acupuncture with Women with Fertility Problems: A Qualitative Approach

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ABSTRACT

As part of the development of an acupuncture protocol for a randomised controlled trial (RCT) to enhance female fertility, experienced practitioners were interviewed to explore what factors they considered to be important components to their acupuncture practice with women with fertility problems. The interviews were wide-ranging and an analysis of the discussion generated a series of questions that were then put to a broader focus group of experts in the field. The extracts of the interviews presented here also raise other issues about how acupuncture is practised and the implications of this for acupuncturists – such as the complexity of the acupuncture therapeutic engagement, the specialist knowledge necessary for work in fertility, and the self-nurturing required by the acupuncturist to sustain practice. More exploration into the nature of acupuncture practice requires increased use of qualitative research methods.

KEYWORDS acupuncture practice, qualitative research methods, grounded theory, *yi*, female fertility.

Introduction

Most research in acupuncture and Chinese medicine treats the 'intervention' as relatively straightforward — these sets of points, or this herbal formula, or this qigong exercise or diet, plus (in more individualised studies) modifications according to defined presenting problems — delivered as one would a retail item in a shop. Clinical reality is less straightforward. There are multiple factors that influence what treatment (or intervention) is given at that particular time with this patient by this practitioner. For acupuncture in particular, the historical record refers to the importance of the acupuncturist — their ethical stance, their ability to be fully present when inserting a needle, their hand skills — as well as, of course, their knowledge of disease progression and assessment of the patient in front of them. It is this aspect of practice in which qualitative research methods are useful to aid our understanding.

As part of a larger study of the contribution of acupuncture to assist female fertility, a smaller qualitative study was undertaken of the approaches to practice of several acupuncturists. The following is a report of that study. This examination of

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acupuncture practice will contribute to the discussion of the value of qualitative methods in Chinese medicine research in the discussion section of this paper.

The purpose

This study of acupuncture practice in relation to female fertility arose from a plan to do a pilot clinical trial using an acupuncture intervention for women with fertility problems. There was no previous model on which to base the research. Although there was a range of recent studies, none (outside IVF studies) specifically used an acupuncture protocol to enhance female fertility. Engaging acupuncture practitioners specialising in fertility in an exploration of their practice was the starting point to refine and develop a treatment protocol to use in the subsequent clinical trial.

This study aimed to address the following research questions:

> *What are the parameters of an acupuncture intervention to enhance female fertility? What guidance does existing clinical practice offer in the development of a trial protocol?*

The following review of the literature provides a background to contemporary research in Chinese medical gynaecology and provides a context to assist understanding of the evidence base within which practice occurs.

The literature

An overview of systematic reviews (SR) of acupuncture in obstetrics and gynaecology[1] concluded that the data available in SRs was contradictory and inconclusive. A SR which undertook an overview of studies of acupuncture treatments for reproductive and gynaecological disorders found that menopause and dysmenorrhoea were the most frequently studied, and had shown positive indicators of effectiveness. 'Acupuncture to treat PMS [Premenstrual Syndrome], PCOS [Polycystic Ovary Syndrome] and other menstrual related symptoms is under-studied, and the evidence for acupuncture to treat these conditions is frequently based on single studies'.[2] The research evidence for using acupuncture for fertility is limited.

Accumulated clinical experience indicates acupuncture regulates the menstrual cycle. TCM gynaecological textbooks all provide treatment approaches to a range of menstrual irregularities – the cycle is too short or too long or variable, the bleeding is too scant or too heavy, menses are accompanied by a range of other symptoms such as abdominal pain, headache, acne or mood changes.[3–6] In a series of articles published in Nanjing in 1998–99 Professor Xia Gui-cheng[7] identified the importance of menstrual regulation to the resolution of both menstrual disorders and the promotion of fertility. His approach was subsequently adopted by Jane Lyttleton[8] and broadcast through her teaching and publications throughout the English-speaking TCM community. There are no published clinical trials that test the premise of regulating the menstrual cycle in order to promote fertility. There is a tradition within Western herbalism called multiphasic prescribing for menstruating women that mirrors this approach.[9] There are studies, however, which do examine the influence of acupuncture on different aspects of the menstrual experience. Chinese medicine theory would posit that an improvement in a single component of menstruation will positively influence other components (and the whole). Promoting the full discharge of blood, for example, during the menses will positively feed back into egg formation and ovulation. Evidence to support this assertion is not available at this time.

Stener-Victorin and Wu[10] in an overview of contemporary literature, further supported by Smith and Carmady[2], found that the use of acupuncture to treat reproductive dysfunction has not been well investigated. They state 'only a few clinical studies have been reported, most of which are flawed by poor design and a lack of valid outcome measures and diagnostic criteria, making the results difficult to interpret'.[10] The incidence of 'poor quality' clinical studies perhaps speaks to the difficulty of achieving high quality clinical research that is acceptable both to acupuncturists and research scientists.

There is little published research that supports the role of acupuncture in promoting fertility, outside the context of IVF clinics. Findings on the physiological mechanisms of acupuncture offer some guidance to understanding the possible contribution that acupuncture makes to female fertility.[10–13] Other research reports of Chinese medicine's supportive contribution to fertility are largely case reports.

Clinical case reports support the value of acupuncture in the lead up to conception although no clinical trial has been reported to date either supporting or contradicting this case-based evidence.[8,14–16] Acupuncture has a long history in the treatment of fertility problems, and there is apparently much consistency in the actual points chosen.[17] Chinese medicine texts and case history books, for example, frequently cite the use of acupuncture to induce ovulation. A study by Chen Qiong using acupuncture in women with endometriosis-induced infertility, reported in a recent publication on infertility[18], indicated significant effectiveness. In the same publication there is a report of a study undertaken by Ding Hui-jun[19] into tubal infertility effectively treated by acupuncture.

The literature does not give clear guidance on an optimal acupuncture intervention for use in a clinical study to enhance women's fertility. Another approach was required.

Methods

The process began with interviews of practitioners experienced in fertility acupuncture to develop an understanding of the issues, approaches and techniques that they used. The themes that emerged from these discussions were then used as the substance for an expert focus group convened to provide guidelines for a fertility acupuncture protocol. Ethics approval was granted by the University of Western Sydney Human Research Ethics Committee in 2009 and the study was undertaken at the University's Centre for Complementary Medicine Research between March and September 2009. Participants completed informed consent forms.

METHODS FOR COLLECTING DATA

The semi-structured interviews were undertaken to provide the initial input into the focus group. The semi-structured interview guide (see Appendix) was based on two main themes. The fertility acupuncturists were asked about their practice and what factors they considered important when working with women with fertility problems. The interviews followed a similar script and all central themes were covered in each. The interviews were conducted by the author (SC – who has a background with similar training and clinical experience), two in person and one by audio-visual conferencing. Interviews were digitally recorded and professionally transcribed. Each interview lasted approximately one hour.

PARTICIPANTS

The three interviews were conducted with Australian-based practitioners to explore how they worked with women with fertility problems. All three practitioners had more than 20 years experience as acupuncturists, much of that time working predominantly with women with gynaecological problems. The three interviewees were selected because of their experience, their history of thoughtful reflection on their own work (apparent via publications, teaching and past discussions with the author) and their accessibility to the interviewer as colleagues. Personal familiarity with the participants allowed greater depth of discussion because the interviews built on themes known to be of common interest. This potentially limited the study to a particular type of practice; however, there was diversity amongst the three – one was 5 Element trained and the remaining two TCM trained and also used Chinese herbal medicine. Achieving diversity in practice style was not a high priority compared to specialty and years of experience. Within the context of a small practitioner group specialising in this way in Australia, being known to each other was inevitable. Even internationally, mutual knowledge or common links would have been unavoidable. This familiarity could be considered a controversial issue by those attached to the idea of objectivity in research interviews. Ezzy explores this at some length and concludes:

> *Emotional distancing makes it harder to hear the voices and experiences of research subjects. It turns research participants into passive objects and knowledge into conquest. Knowledge experienced as communion requires mutual recognition, which acknowledges the interdependence of the researcher and the researched.*[20]

In the broader study, of which these interviews were a part I tried to weave a path between the 'objective scientist' and the 'engaged person-in-dialogue' in the hope that I could speak to readers of all persuasions by reporting the range of data that emerged from the research.

Analysis

A thematic analysis of each interview provided the basis for questions posed to the focus group (recruited fertility acupuncture specialists). At the conclusion of the third interview it became clear that there was sufficient material to guide the larger forum discussion. Grounded theory[21–25] was used as a guiding approach to generate data and to codify and theorise from the data from participants in the field. The transcripts of the interviews were read by two researchers (SC and CS) and agreement was reached on key themes.

SOME THEMES THAT EMERGED

COMPLEXITY

The three acupuncturists' responses provided insight into the complexity represented within the therapeutic exchange of acupuncture when applied to women with fertility problems.

One respondent reported:

> *It's a different journey when you are working with someone who is trying to fall pregnant… you know, it's a very different emotional journey.*

Another that:

> *They've probably got a little bit more invested in what I can do or not do, than someone who's coming for a different sort of disorder.*

The third stated:

> *It's not just their body, it's their huge trust that they place in you. And especially when you've got that added thing of, you know, you're* [their] *last resort.*

These responses pointed to the importance of relationship, as in any medical encounter.

WHAT DOES ACUPUNCTURE DO?

The most apparently challenging question was: *What do you do when you do acupuncture?* This question speaks directly to the issue of standardisation in acupuncture research. All three participants hesitated; one answered:

> *What do you mean, what do I do?... Sometimes I'm really clear about what I'm doing. Sometimes I'm not. So do you mean, am I tuning into how that person feels or am I gathering myself?... The thing that I think of most of all, and that bothers me as well, is I just feel very responsible. I feel that this person trusts me.*

Another responded:

> *Do you want to come back to that one? That's a really big one and, yeah, I don't think there's an easy answer to that.*

The third saw herself as facilitating another's access to *energetic balance and harmony.*

FERTILITY AS A SPECIALIST ARENA

Participants identified the particular situation of women engaged on a fertility journey:

> ***SC: For you facilitation of their healing journey needs to be an empowering one?***
>
> *Yep, absolutely… I think that's important particularly with assisted fertility, where so much control is taken away from them. And they get so immersed – for many women they lose control over their bodies, but also their life gets very narrowly focused, without seeing the bigger picture of where they're going.*

The interviewees also raised the importance of being a knowledge expert and sharing this information was also raised:

> *You know, there's a more mundane view of it too. You know, my relationship with them is about making sure they're thoroughly informed, know all their options, know what I can and can't do, know what other doctors can and can't do, and I see myself as a primary care person in that sense... So I guess if I'm holding anything, I'm holding their big picture, in terms of what they can expect, what they can't expect, what's possible, what's not possible, maybe a time frame, although I'm not always honest about that one. Rather than me… and in some sense I'm there to hold them energetically and emotionally too but if that's a big need, I refer them somewhere else as well, because that's not my expertise.*

RESPONSIVE TO PRESENTING PATTERN

The most consistent response to requests for details of treatment approaches from the initial three interviewees was '*It depends…*':

> *It depends on them and how they are as well. You know, they're not all like this but that heightened sensitivity. It depends where they're up to in the whole fertility thing, depends whether they've been trying for a long time, whether they've been to a whole lot of other people, whether they're doing IVF. I'm really careful… I'm really aware of the language I use before I even stick pins in them. And then it depends on how fragile they are, just like everybody. But I think maybe it is heightened with some particular women.*

This participant emphasises, as did her colleagues, the importance of individualisation over standardisation. Although these acupuncturists report varying their whole approach as well as treatment — depending on how the woman is on the day, on what other support she has, on how informed she is about her own body and fertility and so on — general guidelines did emerge. These practitioners considered both Chinese medicine pattern differentiation and a biomedical understanding of factors such as hormonal climate to be essential frameworks for successful work with 'Western' women.

> ***SC: So a TCM diagnosis is central to your practice?***
>
> *Yes… it's central, it's central but I also always want to know if the tubes are patent... I also always want to know if the sperm are functional. And so, and I have to tick those boxes before I even start treatment because if either of those come up as being a problem, then maybe there's a whole different route and it might not be with TCM… I always go through all those boxes first and then we do the Chinese medicine analysis… And then my treatment's based on Chinese medicine analysis but my view of the possibility of an outcome might be coloured by the biomedical diagnosis, and whether we do TCM or not.*

EMOTIONAL VULNERABILITY OF THE PATIENT

Sensitivity to the perceived or expressed needs of the woman patient was a theme in each interview. The particular vulnerability of women dealing with the prospect of infertility dominated the interviews. This further reinforces the respondents' emphasis on individualised responses to patients.

> *It probably depends on what their expectations are in seeking my support as a practitioner. I guess a foundation of my therapeutic approach would be to try and maximise their reproductive potential. But – also very mindful of their emotional journey. And for me, I would give probably equal emphasis to both... it would be very rare for someone not to present during a consultation the kind of emotional distress that they've been through.*

The idea that the process of delayed fertility damages a woman's self-concept requiring a response from the acupuncturist was raised by one respondent:

The women who become so distraught and so despairing over their own bodies and their alleged failure and their self hatred... a lot of the time is spent actually talking with them about that belief and how they feel about themselves. So I think it's a big thing.

This led to a discussion of the language used in consultations and how much Chinese medicine concepts of, for example, yin yang, qi and blood are shared with patients and how these can be helpful for those with 'unexplained infertility'.

PRACTITIONER AS VULNERABLE AND ENGAGED

There was a sub-theme that suggested that practitioners had some difficulty balancing their own needs with the needs of their clientele. Each reported different methods to negotiate this conflict. As this issue was more related to personal practice it was not included as a theme in the subsequent focus group forum. It would, however, be another fertile area for further investigation with an emphasis on what acupuncturists believe is exchanged within their therapeutic encounter and how they manage this.

SC: Do you think anything's exchanged at all?

Yes I do. I do. Again, sometimes I will feel as though it's predominantly coming from me and that person is kind of sucking it in. There will also be those who are really sucking at trying to suck it out of you. Then there are a lot of people, a lot of people who are, how do I put it? There is sometimes this wave of gratitude, almost sort of tearful, 'like God, you're helping me with stuff' – which bothers me because you've got a long way to fall then and I do worry about that. But I do think that there's a very clear exchange and I think that, the space between that person and myself and what goes on verbally and emotionally and actually physically is the point. I think that that's the whole point, certainly for me, of the practice.

SC: So, do you get something out of it?

Yeah a lot of the time.

SC: Can you say more about it?

What do I get? The shits sometimes (laughs). I really think that when someone is absolutely with me, with what I'm saying, with what I am trying to do – it really is a collaboration.

THE TREATMENT SPACE

The three participants also emphasised attention to the treatment environment and its role in imparting a sense of safety to patients being primary.

I think creating a nurturing environment is important. I'm not sure that is specific to reproductive work. It's about creating that environment irrespective of what – I'm not sure I would do anything different in a physical context. I mean my room space is important to me as a nurturing environment. But because I'm working with fertility or pregnancy, obviously what I've done is probably a reflection of that energetic... [Elements of environment?] *It's about intimacy, a small space to create intimacy. It's about having – yeah it is about colour. Colour's really important. For me it's about having warm colours. I like art, so quite often I have some art which is reflective imagery. Or I might have… those inspirational messages. I've got a couple of those that I have around, which is about empowering messages.*

Another reflected:

No, that doesn't change. I don't get out incense. Maybe it would be helpful if I did but no, [the environment for fertility compared to other patients] *doesn't change at all. I rely on myself rather than anything specific in the room.*

ADJUSTING TREATMENT TIMING

Issues of timing, both timing of treatment in relation to the menstrual cycle and how the acupuncturist sets up the initial contract, were discussed.

The full life span of trying to nourish an egg within a follicle, you know, starting off from the very primordial follicle up until one that's ready to be ovulated, it's actually more like a nine month span. Now, so I have that concept in my head but I don't ever say that to patients. A patient who is trying to fall pregnant can just about cope with three months and nothing more. So even though in my head I'm thinking six to nine months, I don't say that at the first consultation.

Three months is as much as I get anyone to agree to.

SC: Right, and do they hold you to that? Do they say, your three months is up, now I'm off to a naturopath, or something?

Depends if we've seen improvements or not.

But, you know, the reality of clinic is that it's very seldom like this. Women go off and do a lot of different things without telling you anyway. They're not going to just do what you say, especially women trying to fall pregnant, they do everything all at once.

FOCUS GROUP AGENDA

The extracted results of key factors that emerged from these interviews, that were subsequently taken forward into the larger focus group of more diverse acupuncturists, were:

- **The definition of acupuncture**
  What constitutes 'acupuncture'? What do you do when you do acupuncture?

- **Acupuncture treatment and menstrual cycle**
  What do you each think is essential in an acupuncture treatment of a woman designed to promote conception?

  Is the stage of her menstrual cycle the key indicator of which treatment principle, point selection and needling technique you use?

  How precise is it necessary to be? For example, is a Day 8 treatment very different from a Day 10 treatment?

- **TCM/OM diagnosis**
  How important is the differential diagnosis to acupuncture point choice?

- **Timing of acupuncture**
  Does timing matter in relation to the menstrual cycle? Season? Time of day? What timing is important if women are intending to undertake Assisted Reproductive Technology (ART)? Or acupuncture between ART cycles?

- **Number of acupuncture treatments**
  How many treatments are necessary to be adequate (for maximising fertility)? Would you expect to give acupuncture weekly? More than weekly? Monthly?

- **Needling technique**
  In reporting on acupuncture research it is important to specify details such as needling depth, needle direction, insertion mode, retention time, manipulation, order of insertion, unilateral or bilateral. Are there particular techniques which you would deem essential in acupuncture for fertility management?

- **Relationship with patient**
  How important is the therapeutic relationship in fertility acupuncture? Is this more important than when treating other disorders?

- **Lifestyle components**
  How important is lifestyle change? Do you give specific diet and exercise recommendations to fertility patients? Does this advice vary with differential diagnosis or is it standard? What is it?

- **Collaboration with other therapies**
  Do you work collaboratively with other modalities? E.g. herbalism, homeopathy, counselling, nutrition. Does this non-acupuncture health care make a major contribution to the treatment package?

- **Importance of biomedicine**
  How important is a biomedical diagnosis to your choice of acupuncture treatment? Do you require a full biomedical work-up (blood tests, ultrasounds, laparoscopy) prior to treatment?

- **Referral**
  At what point do you advise a patient to stop treatment? Refer on to ART or adoption services? What are the indicators that you use to seek other treatment options?

- **Treatment environment**
  Have you created a special environment in which to treat women with fertility problems? What are the components of that place?

- **Personal agency**
  How important is your personal style or how you are on the day/at the point of treatment?

- **Specific acupuncture points**
  Are there particular acupuncture points that are essential to fertility treatment?

The outcome of the focus group process is reported elsewhere.[26] Two of the participants interviewed here were also members of the focus group.

Discussion

To summarise, participants' commentaries on their practices with women with fertility problems were relatively consistent. It emerged that acupuncture practice is complex and that working with women on reproductive issues required an extra level of expertise.

None of the participants viewed their work as practitioners as a casual task or technical fix. There was certainly a component of, in some way, walking a fine line between acupuncture as an esoteric practice and as a very practical way of working with people. Questions from the researcher that asked about either the concrete practice or esoteric aspect, that is to say firmly on either side of this line, generally elicited responses that refused to be located on just that side. Although this conceptual tension within acupuncture practice was not taken directly into the focus group it emerged there as well.

The evident discomfort displayed by all three when asked what they do when they do acupuncture speaks to this divide between 'objective' and 'subjective' knowledge and practice. The *practice* of acupuncture presents no difficulties because one simply 'does' it without struggling to find words to describe what is being done – acupuncture is enacted and firmly embodied. As a Western practitioner at least (this may also be the case in

modern Asia) to begin to discuss with an 'objective' questioner what is happening, what you are doing, immediately produces a discomfort — how do we conceptualise that mix of being present, engaging energetically, holding a sum of details about pulse, tongue, menstrual patterns, visual cues, etc — allowing oneself to be available to another and inserting needles in them. How do you describe the moment which is the 'onset of the current of intentionality, *yi*' — when the hand is free to enact the purpose/intention that has emerged from that mess of detail and, dare it be said, intuited or sensed direction. Jullien describes *yi* as something that can be 'blocked' or 'cleared' — it is 'the authenticity of the inner artless movement that comes to light' – it is emergent.[27]

Not every acupuncture encounter is engaged in this way; however, the impression emerged from the interaction with the three experienced fertility acupuncturists interviewed that they worked to achieve such an engagement and this could be at a cost to themselves. One described leaving clinical work because she found it personally unsustainable, another that she needed an extended daily meditation practice to remain at work, and the third used laughter in clinic and exercise out of clinic to be able to engage in this way. *Yi* does not come without a cost and it requires discipline.

The in-depth interviews with the three experienced practitioners provided important insights into the practice of Chinese medicine in the contemporary West and was designed to specifically explore the current practices of a selected few fertility acupuncturists to identify their approaches to treating women as a preparation for conception. Issues that arose included the importance of the therapeutic relationship formed with a client, the position of Chinese medicine in relation to the mainstream health care system, the challenge of working with women in anguish about their poor or slow fertility, and the difficulties of self-care when working closely with clients. The literature refers to significant evidence that, in any health encounter, the therapeutic relationship is a major influence on health outcomes[28–9] although there are few references to the experiences of practitioners of acupuncture in building and sustaining such a relationship. There is some indications that TCM practitioners may form a more productive therapeutic alliance than psychologists.[30] The literature also refers to the quality of a 'listening physician' fostering more accurate diagnosis, having a healing and therapeutic effect and strengthening the ongoing therapeutic relationship.[31] The particular 'listening stance' of the acupuncturist is not explored anywhere outside Chinese medicine literature. One study assessing acupuncture patients' experience of acupuncture concluded that 'patients' perception of practitioner empathy was associated with patient enablement at initial consultation and predicted changes in health outcome at 8 weeks'.[32] The interviews with the three practitioners in this study also underlined the importance of these factors while offering more specific acupuncture-related perspectives. One example is the location of Chinese medicine at the margins of fertility health care provision and rarely the first and primary provider which often means Chinese medicine becomes the 'last resort' when other modalities have failed. Another perspective of the practitioners interviewed is the centrality of Chinese medical theory and diagnostic frameworks as a guide to effective treatment. Despite being marginalised as a result of their theoretical frameworks, and however compelling the biomedical data, these practitioners were advocates for the value of Chinese medicine in this field. In fact, it became apparent that biomedical data and perspectives were folded into the Chinese medicine process – informing but not guiding.

The strength of Chinese medicine, and acupuncture in particular, as a transformative medicine requiring a direct and present engagement of practitioner and patient was evident in the interviews. The absence of set, clearly defined protocols to guide practice is frustrating for beginners or researchers but it reflects the fluidity and interactivity of 'good' practice where a 'conversation between the body and the practitioner through the needle'[33] is both immediate and changing. Acupuncture researchers[34-6] have attempted to identify what are specific effects of acupuncture and distinguish these from the non-specific effects such as the therapeutic relationship. The degree to which these effects — specific and non-specific — are measurable by standard quantitative research methods alone is questionable. Without interviews such as those conducted in this exercise, aspects of the practice itself that are meaningful to practitioners risk going unnoticed. Also unnoticed would be the areas of disagreement and failed consensus which could form the basis of fruitful investigation.

It is worth examining, then, what sort of acupuncture-related knowledge can be usefully researched. Both quantitative and qualitative research methods can identify who is using acupuncture; that is, prevalence, patterns and cost, as well as issues of clinical effectiveness. Quantitative methods as currently constructed can unravel physiological responses to acupuncture and examine issues of clinical efficacy. It is qualitative research alone that can explore issues of perception and meaning and the psychosocial determinants of health and illness and responses to acupuncture therapy. As Bishop and Lewith[37] explain, the broader reach of qualitative research is based in its ability to 'explore phenomena using a bottom-up approach, grounding emergent themes and theories in participants' everyday experiences'. Such an understanding of qualitative research can be a powerhouse generating questions, aspects of which can subsequently be put through the mill of quantitative inquiry. Qualitative methodologies, including observational studies, offer greater external, or ecological, reliability: that is, patient and practitioner beliefs are more similar to those encountered

in everyday practice; therapeutic relationship factors are more similar to those encountered in everyday practice; patients receive a whole treatment intervention (for example, not just attending and being treated for one condition).[37]

Conclusion

We acupuncturists may assume that our practice is somehow transparent and self-explanatory. Daily in clinic we have our own ways of relaying to our patients what it is we do and why. Using qualitative research methods could help us to understand and explain its nuance and richness more fully and to appreciate the differences between practitioners, and between acupuncture and other medical interventions.

Clinical Commentary

This paper encourages acupuncturists to reflect on their practice. It focuses on the experiences of several practitioners who specialise in working with women with fertility problems. It explores the challenges of working in the fertility field and the particular opportunities acupuncture offers in a clinical encounter. There are questions that we all may need to think about in relation to our work in TCM.

APPENDIX

Notional script for interviews of acupuncturists who specialise in fertility:

- What do you do when you do acupuncture?
- When you're working with women on fertility issues do you conceive of your task differently?
- Do you use a particular approach with sub-fertile or infertile women?
- Do you set up a particular environment in which to treat these people?
- So what are the elements of that? What is a nurturing environment? Is it about colour?
- And is there a particular style of acupuncture that you use more for fertility than you would for other things?
- How you talk to that person, is that just as important as the actual points you use?
- Do you work just with women or do you do couples?
  Do you work with them together?
- Do you give a lot of information and advice?
- What about the biomedical knowledge, is it really important for your practice?
- Do you usually get women to do their Basal Body Temperatures (BBT)?
- What's sort of weighting do you give to acupuncture and herbs and lifestyle?
- Are there particular acupuncture protocols that you use?
- Are there particular acupuncture points that are critical to fertility?
- Is there any lifestyle advice you give for a woman with fertility problems?
- Are there particular food proscriptions or prescriptions that you use?
- What do you think is exchanged during an acupuncture treatment?
- Do you get something out of it?
- How much is the relationship with you central to the success of treatment?
- On a particular day do you think that the outcomes of any treatment depend on how you are?
- Are there things that you do to prepare yourself for a treatment?
- What practices, skills, stratagems, methods of operation do you employ?
- Do you choose your treatment according to the menstrual cycle and all those sorts of things?
- What else is minimum adequate treatment?
- Is there anything else that you think I should include as a basic, or a minimum, or an adequate protocol for fertility?
- What do you think would be the key elements of such a protocol?
- Do you have an idea of what is an adequate length of time to treat, in terms of the individual treatment and then in terms of a course of treatment?

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A Consumer's Reflections on Traditional Chinese Medicine and Traditional Western Medicine

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ABSTRACT

This article presents a consumer's reflections on traditional Chinese medicine and traditional Western medicine, with a particular focus on the processes in the relationship between the practitioner and the consumer. It does not engage with the broader debates about efficacy and 'scientific validity'. The article aims to show why it is important to listen to patients-as-consumers about their experiences of health services. It is informed by contemporary scholarship that sees consumer participation as an ethical practice, and as essential to compliance with treatment and service effectiveness. The article uses an auto/biographical methodology that is consistent with encouraging consumers' participation in health and welfare services, and in evaluating interventions beyond narrowly-defined outcomes, experimental designs, and randomised controlled trials. This personal narrative is a reflection on experiences over at least 10 years of receiving health services from practitioners of traditional Chinese medicine (TCM) and traditional Western medicine (TWM) in a large regional town in eastern Australia. Differing models of health, intervention, and the relationship between practitioners and consumers, influence individual practitioners' approaches to consumers. Recommendations are offered on how listening to a consumer's experiences may improve professional practice in health services.

KEYWORDS consumer participation, traditional Chinese medicine, traditional Western medicine, professional practice, auto/biography, narratives.

Introduction

This article presents a consumer's reflections on traditional Chinese medicine (TCM) and traditional Western medicine (TWM), with a particular focus on the processes in the relationship between the practitioner and the consumer. It aims to show why it is important to listen to patients-as-consumers about their experiences of health services that may offer insights to health professionals in regard to the processes, if not the outcomes, of health care. This personal narrative is a reflection on experiences over at least 10 years of receiving health services from practitioners of TCM and TWM in a large regional town in eastern Australia. The article does not engage with the broader debates about efficacy and 'scientific validity'.[1–3]

There is substantial literature from a range of disciplines and professions on the importance of consumer participation in health and welfare services.[4–12]

Consumer participation may be condensed into two main aims: (1) As an end in itself: Professional ethics may espouse consumer participation, promoting values such as 'greater inclusion' and

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empowerment';[13] aiming to equalise power and minimise hierarchy between service users and professionals, and to increase professionals' empathy for service users' experiences.[14] Ethical practice aims to be collaborative, to show respect for consumers' knowledge, values, beliefs, and strengths;[15–17] and perhaps more controversially, 'to explore (and critique) implicit assumptions that may be inherent within traditional professional value bases'.[18]

(2) As a means to an end: Consumer participation is promoted to foster patients' independence and self-management;[19] and where professionals through 'interactive knowledge',[20] gain a better understanding of the patients' experiences allowing specific goals to be set, appropriate therapeutic interventions, and in some professions, like physiotherapy or occupational therapy, to be able to measure outcomes.[21–2] The ultimate aim is to maximise compliance with the interventions.

Consumerism as an approach to participation may be critiqued as 'merely concerned with rights', appearing to give equal or greater weight to patients-as-consumers than to professionals and their expertise.[23] There is also a tendency to perceive professional services as a commodity similar to material goods with related attitudes to quality and satisfaction. There are also legal liabilities for duty of care confronting professionals associated with their perceived greater expertise that may temper how consumers may participate in various health services.[24–5] So, while this article aims to show why it is important to listen to consumers of health services, it is also mindful of the complexities associated with differences in expertise derived through formal education and personal experience. The article examines personal experiences of the practitioner-patient relationship (process), and suggests ways to improve professional practice in health services that would not disrespect professional expertise.

Methodology

Auto/biographical approaches such as narratives or story-telling are useful to find out people's perspectives in a range of areas, for example, their experiences of problems,[26] participation in health interventions as processes, and evaluating outcomes.[27] Stanley[28] has argued that writing about the self cannot be separated easily from writing about other's lives, for which the personal story has resonance. Sometimes narrative approaches involve a researcher re-telling the stories of participants, for example, 'delinquent girls' life stories' connecting 'their public actions ... and their private lives, [including] sexual abuse by family members',[29] or 'life story work' with ex-prisoners with an intellectual disability.[30] However, a narrator can also tell stories about her own experiences, for example, as a practitioner reflecting on her practice, implementing disability policies.[31]

Narrative approaches do not mean that an individual's story is an exact fit to others' stories. However, there is potential in generating more stories told from a range of perspectives, that may both resonate and differ so that wider human experience can be understood. Whether the story being told is about the self or about others, a single case-study allows for in-depth examination of individual cases; generalisation is inferential and impressionistic,[32] with the findings relatable to broader social patterns.[33–4]

The criteria of trustworthiness applied to scientific studies are not applicable to narrative approaches.[35] Instead, credibility is demonstrated by showing that 'reality' is represented in a meaningful way in re-presenting lived experiences. Transferability of knowledge is achieved through asking what can be learnt from the everyday experiences recounted. While the replicability of an individual story is not possible, nor is it the aim, it is possible to generate more stories on the same topic to expand knowledge beyond the single story. Objectivity is not possible, due to the positioning of the research participants within their own stories, and in this case, of the narrator telling her own story. Nor is objectivity desirable, if the aim is to generate knowledge from human experiences to improve professional practice, while recognising that there may be multiple perspectives of the same 'facts' influenced by different personal histories, biographies, and institutional location, such as being a 'health practitioner' or a 'patient'.

This article does not identify where the experiences being narrated have occurred and therefore protects the identities of third-parties. The experiences of users of health services will be recounted using topic headings that are relevant for professional practice. The author's awareness of the differences between TCM and TWM has emerged over the years, as help has been sought for chronic health problems. It has not been a planned, systematic comparison between the two models of health care. Instead, as a patient of health care provided by TWM and TCM practitioners, awareness of the differences has generated a personal interest and reflection on the experiences, including how the experiences have differed and why they have been experienced as different.

The author's perspectives are significantly influenced by her professional affiliations and experience over more than 30 years: as a professionally-qualified social worker with experience in direct service provision to children and families; in policy and programme development and research; and as an academic and qualitative researcher at several Australian universities where she has taught in social work programmes.

'Helping people': relationships between practitioners and patients

Professional 'helping' generally involves stages that are common to most professions, although they may be named differently. The stages include: (1) finding out what the problem is (why has the patient come to see you?); (2) naming the problem (or, making a diagnosis); (3) offering help in various forms (material, technical, therapeutic, pharmacological, 'talk'), depending on the profession; and (4) some method of ascertaining effectiveness, that may include telling the patient to return if the problem is not resolved and conducting various diagnostic tests. Within this framework, this article reflects on the key differences between TCM and TWM by focusing on: (1) finding out what the problem is; (2) categorising the patient as 'sick' or 'unwell'; and (3) perceptions of effectiveness.

(1) FINDING OUT WHAT THE PROBLEM IS

The amount of time allocated to patients differs significantly between TCM and TWM. TCM practitioners typically spend up to an hour on a first consultation that may include treatment, with subsequent consultations for about 40 minutes, again including some treatment. However, treatment is only provided after a detailed consultation about the patient's description of the problem. The TCM practitioner asks a lot of questions to clarify the qualitative aspects to explore whether the patient has symptoms that he or she has failed to mention, and to ascertain life circumstances that may influence the problems being experienced. This in-depth questioning occurs even after the initial consultation as, it appears to me, there is an expectation that the problem may have changed since the previous visit. The patient's circumstances may also have changed. It is also a way of checking on the effectiveness of the previous intervention.

This experience with TCM differs considerably from consultations for TWM. In TWM, the GP tends to work to a tight schedule, with expectations that each patient will be finished within 15 minutes. This approach tends to hurry the patient along, with little time for the practitioner to ask in-depth questions. The time allowed for each patient with a large number of patients still waiting to be seen can communicate an impatience and a subtle 'hurry up'. I have had the experience of telling a GP about one set of symptoms which we discussed, after which she stood up, ready to show me out of her office. I was embarrassed to tell her that I still had more to discuss, and then felt like I was taking up her time or even wasting her time with 'trivial' ailments. There are also legal requirements on GPs that may disrupt their tight schedules, as on one occasion, when the news went round a waiting room that a patient had presented with yellow fever that necessitated a substantial amount of work and that was the cause of lengthy delays for other patients. This is clearly not the GP's fault and the scheduling that expects a 'standard' consultation can be completely disrupted by one non-standard consultation.

I have been told by GPs that my symptoms do not make sense – because the recounting of various aches and pains and other signs of being unwell do not readily coalesce into a pattern that can be diagnosed. It may well be that I have omitted to tell about something that I believe is unimportant, or that I have told my symptoms using descriptions that are unfamiliar to the GP. Also, multiple problems may co-exist and may contribute to apparently-odd symptomatic patterns. However, expert questioning to further explore the problem does not occur. The reliance on technologies to aid diagnosis in TWM and the use of 'normal' and 'abnormal' scores in test results can also work against the patient's actual experience of ill health or feeling unwell. This was my experience for many years as I had just about every test available to find out why I felt so unwell all the time. All tests came back 'normal' and so there was no possible action to be taken.

As it turned out, my increasing debilitation was due to three seriously-blocked arteries that was not diagnosable using cholesterol tests and blood pressure checks and I did not meet any of the other indicators of risk of heart disease, such as being overweight, being a smoker, and so on. Because all these indicators were 'normal' there was nothing to diagnose – until I had a heart attack and a subsequent angiogram identified the seriousness of the problem (attributed to 'family history'). After which, the surgical and medical care I received were excellent.

It was also reassuring and instructive to listen to the stories of about a dozen people who were present at the cardiac rehabilitation sessions I attended, particularly about their experiences of misdiagnoses by their GPs. Rather than this being an indictment of medical expertise, it emphasised the difficulties of making clear diagnoses until the event had occurred, after which treatment is easily decided.

(2) CATEGORISING THE PATIENT AS 'SICK' OR 'UNWELL'

In TCM, the model is of prevention and intervention. Cause and effect are conceptualised differently because there is recognition that a person may be or feel unwell without having a serious illness that is diagnosable by medical technologies. This view is encapsulated in a response from a TCM practitioner to my lamentation of the continuing lack of diagnosis using various tests under TWM. She said, 'It is good that the tests are normal. They show that you are not sick, but you are also not well'. There appears to be a continuum rather than a dichotomy between 'sick' and 'well'. Hence, treatment

of energy imbalances is offered and the patient's experience of feeling unwell is accepted as valid and 'normal'. There is also a clear recognition of the limits of TCM and patients are advised to see their GP for particular problems, such as chest pains and shortness of breath.

On the other hand, my experience of TWM is that the diagnosis tends to pathologise the patient, even when no diagnosis is made, as outlined above. The patient is reduced to a set of symptoms as a diagnostic category, even when there do not seem to be clear grounds for this. This approach does not seek explanations in the patient's circumstances as causes of the problem (as prevention), but solely as an opportunity for treatment. Furthermore, when patients' diagnostic tests return consistently with 'normal' results, the hope that 'something' may be found to validate the experience of feeling unwell is continually dashed. This reliance on medical technologies to generate 'answers' and their continual failure to do so, also tends to invalidate lived experiences of debilitation, fatigue, or whatever else. This has a tendency to implicitly generate other categories of pathology, such as 'malingerer' or 'hypochondriac'.

The need for a diagnosis has been so strong that frustrated GPs have offered me SSRIs (Selective Serotonin Reuptake Inhibitors – anti-depressants) for depression and anxiety, after I said that the failure to find a medical diagnosis was causing me depression and anxiety. I meant this as a way of explaining the consequences of having a lived experience continually invalidated, and at the same time, being expected to function in a stressful work environment while feeling so unwell. So it turned out that depression and anxiety became seen as the cause, not the consequence, of my experiences of ill health.

While there was some recognition of the extreme stress of work (workload and toxic workplace dynamics), there was no possibility of being given respite through sick leave unless a medically-diagnosed condition was possible. Instead, I was advised to get another job or to refuse extra work, as if this was an actual option available to me in the workplace. All this approach did was to blame me as the patient rather than appreciating the consequences of workplace demands on health. One GP told me that my health problems were work related, but she was not going to give me a medical certificate as I would use it for a Work Cover claim. Failing a physiological explanation, a diagnosis of a mental or emotional illness apparently was possible — hence, the possibilities offered by depression and anxiety — but even these diagnoses involved receiving medication and nothing else.

(3) PERCEPTIONS OF EFFECTIVENESS

I have received herbal remedies and acupuncture from TCM practitioners. The herbal remedies were prescribed for otherwise-undiagnosable stomach problems for which I was using over-the-counter medication as advised by my GP. The herbal treatments took a few days to work, but they did resolve the problem.

Whenever I have received acupuncture interventions from a TCM practitioner I have 'felt better'. Usually this occurs while I am in the clinic receiving acupuncture, as I can feel the changing quality and intensity of pain, for example, of sinus headaches or painful shoulders. There is a sensation of the pain 'draining away' from the insertion site of the needle. Quite often, while the needles are being inserted or manipulated, I have experienced sensations in other parts of my body, sometimes quite distant from the site of the inserted needle. I have tentatively mentioned these experiences to the TCM practitioner who affirms that is the meridian path. However they never tell me in advance what is to be experienced and have even expressed surprise when I have described the experiences as they occur.

When I have asked TCM practitioners why they are surprised at my experiences, they have told me that it is unusual for patients to show such sensitivity to the acupuncture treatment. I enjoy continuing this treatment away from the clinic with auricular acupuncture, which I find soothing. All I can say is that the acupuncture treatments for various experiences of pain for different reasons seem to work. This does not mean that I am symptom-free forever, any more than I expect to be after receiving TWM treatments.

With TWM, clearly there is relief to be experienced from antibiotics that work directly on infections that can be diagnosed in a GP's surgery. There are also over-the-counter and prescribed medications which are effective for treating other acute and chronic problems like allergies, sinusitis, and heart conditions.

As a patient, I always want to know 'Why?' so that I can prevent the problems. Instead, this seems to be a futile question when treatment in TWM is to alleviate symptoms, and quite often why the symptoms are occurring is unknown or too complicated or expensive to investigate. While TWM can claim that there is 'evidence' in terms of 'cause and effect' related to pharmacological interventions, and more drastically, surgery, as discussed above, treatment cannot be offered when there is no clear diagnosis of 'ill health' or 'sickness'. There is also considerable scepticism towards complementary medicine such as TCM, and perhaps my description of 'outcomes' and 'effectiveness' of acupuncture may be dismissed as a placebo or imaginary.

Insights for professional practice?

The reflections above that compare and contrast two aspects of health care received from TWM and TCM practitioners are not intended to negatively portray TWM practitioners. I may have been very fortunate in the TCM practitioners I have consulted and I have received excellent care from practitioners of TWM. The reflections and related insights for professional practice recognise the different demands on time amongst GPs and the expectations of an 'ideal medical consultation in non-urgent circumstances',[36] including lengthy and wide-ranging discussions between practitioner and patient, may be unrealistic and unrealisable. It is also implied in my descriptions of the processes of health care that TWM and TCM have treated different conditions, with clear boundaries between the two approaches, although at the time of receiving services, I did not know what the symptoms meant, and I was seeking relief wherever I could find it.

However, it is important that there is recognition of the potential insights for professional practice, while bearing in mind the different models of health and sickness informing practitioners of TWM and TCM. The following suggestions are made for practitioners – many of which are applicable to both TCM and TWM, and some which are specific to TWM. First, it is suggested that the limitations of medical technology and testing are understood in TWM, and that a patient with a 'normal' test result within a statistical distribution may still be unwell. Secondly, all health practitioners, whether of TWM and TCM, should realise that patients may not tell all their symptoms to allow for a pattern to be identified. Therefore, expert questioning may elicit additional information that aids in diagnosis. Thirdly, all health practitioners, whether of TWM and TCM, should realise that a patient may have multiple problems and that expert questioning may elicit patterns that allow for multiple diagnoses. Fourthly, all health practitioners, whether of TWM and TCM, should appreciate the vulnerabilities of patients and the emotional and practical consequences for them, of not being able to receive a diagnosis of troublesome symptoms. Fifthly, TWM practitioners should realise the consequences of pathologising patients including using mental health diagnoses as explanatory theories for experiences of ill health, rather than as consequences of chronic, yet undiagnosed problems. Finally, the differing systemic boundaries on practitioners of TWM and TCM should be appreciated, including time constraints on consultations and legal imperatives associated with public health that apply to TWM practitioners.

Conclusions

This article has discussed one consumer's experiences of health services, received from TWM and TCM practitioners over at least 10 years for chronic health problems. It shows why it is important to listen to consumers' experiences as part of evaluations of health services. It questions the value of normal distributions and statistical probabilities when applied to individual experiences. It also shows why it is important to listen to consumers who present to health practitioners and whose accounts of problems with their health are stories that express how the person understands his or her experience. Consumer participation therefore does not mean dismissal of professionals' expert knowledge. It does mean that expert knowledge can inform in-depth engagement with consumers about their personal experiences, seeking to locate the individual's experience within broader, general expert knowledge of health, sickness, and 'being unwell'. In-depth, expert questioning to aid diagnosis could take the form of inductive, hypothesis-testing, seeking to identify how the pattern of presented symptoms may represent a range of diagnoses, that can be refined through pertinent questions.

Finally, patients' claims for effectiveness of complementary therapies including TCM are often dismissed as 'anecdotal' and placebo effects. However, in discussing complementary therapies in treating alcohol and other addictions, Miller[37] says that, 'In this context, complementary therapies — where the service user is able to get one-on-one attention and have something that feels therapeutic done to them — leaves them feeling happier than when they walked through the door.' Therefore, while debates may rage with regard to claims of 'scientific evidence', efficacy, and effectiveness in different models of health and sickness, it is also important to consider that improved processes of consumer participation and awareness of patients as individuals may improve outcomes.

Clinical Commentary

This article has discussed one consumer's experiences of health services, received from TWM and TCM practitioners over at least 10 years for chronic health problems. It shows why it is important for health practitioners to listen to consumers' experiences when evaluating health services, and because consumers' accounts of health are stories that express how the person understands his or her experience. The article offers insights for professional practice that include ways of using professional knowledge to improve communication of symptoms and understanding of effectiveness as both processes of care and outcomes related to clinical interventions.

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Contextualising the Use of Qualitative and Quantitative Research Methodologies in Chinese Medicine: Epistemological & Ethical Issues

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ABSTRACT

Research into the effects of medical interventions is one of the oldest traditions of any medicine, as is the study of its ethical dimension. In this paper, we briefly describe and recount the history of both quantitative and qualitative methods in clinical research. We discuss key theoretical, methodological and practical features of both methodological perspectives and consider some of the central ideas of medical ethics. We sketch a theory of the relationship between the quantitative and qualitative as essentially complementary and interdependent. The theory is illustrated by reference to the placebo effect and a research 'case study' from within the Chinese medicine community. We conclude that despite the challenges, combined research methodologies in Chinese medicine offer both scientific and ethical benefits.

KEYWORDS qualitative research, quantitative research, ethics, Chinese medicine research, philosophy of medicine, philosophy of science.

Evidence in medicine: background

Concepts of knowledge and evidence evolve over time and sometimes generate vigorous controversy. Quantitative research encompasses a wide range of methods and techniques. In the Western medicine and Chinese medicine (CM) setting, key features include: the quantification of phenomena arising in experimental settings, in which several variables are measured while specified conditions are controlled; and the use of often complex statistical methods in order to derive meaning from the measured results.[1] The use of such an approach to assess the efficacy and effectiveness of particular techniques and treatments is now referred to as 'evidence based medicine' (EBM). The linking of clinical decision making with systematically compiled data is a rapidly evolving component of medicine that is widely regarded as central to the current practice of Western medicine. Its rise to recent importance is due to developments in the field of epidemiology since the 1950s and the formation of the EBM working group in 1992, which argued that the information of most value for clinical medicine is that derived from large scale, appropriately controlled population studies.[2]

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Along with the success of EBM, awareness developed of the importance of the patient experience in both clinical practice and research and this led to an increasing utilisation of qualitative research methods. The latter had first been developed alongside quantitative population studies in the middle of last century, as researchers began attempting to investigate, and philosophers grappled to understand, the phenomenology of illness and caring. Philosophical insights into the nature of perception and judgment were applied in the development of both quantitative and qualitative approaches, especially those elements of the philosophy of Immanuel Kant that dealt with the nature of knowledge and our ways of thinking about things, not just our observation or experience, and how they contributed to the generation of understanding of the world.[3] The recognition of interpretation as inherent in the concepts of knowledge and evidence is consistent with classical epistemologies and emphasises the unexceptional nature of qualitative knowledge within the Western framework of reason.

Qualitative research, which seeks to fill the epistemological gaps within quantitative research, encompasses a wide range of philosophical perspectives, methodologies and techniques. Despite this heterogeneity, there are several common key features that may help elucidate the nature of the field. These include: an emphasis on a continuity between theoretical frameworks and research methods; recognition of the importance of participants' frames of reference and of close contact between participants and researchers in the data collection phase, with the ability to explore emerging questions and issues that arise; and rich and copious data that are analysed using techniques that facilitate the description of emerging concepts and patterns.

A number of theoretical standpoints, with their own methodologies, can be employed under the rubric of qualitative research, including, among others, ethnography, phenomenology, grounded theory, narrative study, feminism, and postmodernism.[4] These different approaches may be distinguished by their use and interpretation of one or more of the following data collection techniques: observation, one to one interviews, group discussions, and examination of written, visual, audio, historical and documentary data. A unifying feature is that all qualitative research provides 'an in-depth and interpreted understanding of the social world of research participants by learning about their social and material circumstances, their experiences, perspectives and histories'.[5]

Challenges in the use of pure methodologies

The relationship between the quantitative and qualitative research domains is complex. On the one hand, the quantitative is embedded within some qualitative research methods, such as the identification of themes in thematic analysis, while conversely, the qualitative is observable in the quantitative, such as in the development of descriptive statistics.[5] The two approaches stand in an interdependent, overlapping and dialectical relationship, with the quantitative giving rise to hypotheses which are in turn extended and made meaningful by the qualitative interpretations generated from the results. Similarly, in the deployment of statistical methodologies the significance obtained from numbers, initially a quantitative result, gives rise to a qualitative process of interpretation, and consideration of relevant social implications. This qualitative methodology may then generate further quantitative hypotheses to be tested, and so on. This process of making sense between the quantitative and qualitative domains, and vice versa, is itself subject to a variety of interpretations and provides a rich field of exploration.

An appreciation of the depth and complexity of experience is one of the most important features of qualitative research. The idea that individuals come from environments that both form and are formed by them[6] has been largely absent from the ideology of quantitative research in medicine since its identification with science[7] and the promotion of the medical gaze in the last century.[8] The objectivist perspective favoured by medicine places emphasis on the role of a particular kind of observer who is separate from the conceptual conditions of knowledge. The challenge with this approach, however, is that there is still a subject and object, which thereby occupy an uncertain status in the prevailing paradigm. The denial of the role and influence of the researcher, the research environment, financial and competing interests, and the role of practitioners in fixing both the questions raised within the clinical encounter and answers that are considered to be valid, have led to researcher effects and bias that continue to play significant roles in the outcomes of research, let alone in the formation of the research questions themselves. Some of these controversies are exemplified in contemporary discussions about the nature and role of the so-called 'placebo effect'. It may be said that the attempt to extract not only the practitioners, but also the patients themselves, from the practice of medicine, is the source of the opacity of the nature of the placebo from the viewpoint of the quantitative field.

This question of the placebo effect — what it is, how we account for it — is at present the subject of vigorous investigation[9–11], although no authoritative consensus on its underlying mechanisms is yet available.[12–13] The ethical appropriateness of including a group that is administered a placebo in clinical research has long been questioned and remains a topic of intense debate.[14–15] What can be said, however, is that the 'effect' refers to a range of behaviours, attitudes and physiological and psychological responses that cannot be described in mechanistic terms but can nonetheless be broadly encompassed as a general

numerical effect on measurable variables. The placebo effect does not exist in the qualitative realm of enquiry but is ever-present in quantitative research as an inextinguishable trace of the qualitative world.

Recognition of the problems raised by the exclusion of individual patients from active roles in medical research has given rise to a number of compensatory innovative responses, such as the use of increasingly complex trial designs, increased attention to exclusion characteristics, adjustments to outcome measures, ever-increasing conditions required by ethics committee, and the elaboration of refined methodologies such as comparative effectiveness research. In acupuncture research, the use of protocols such as CONSORT and STRICTA, are being encouraged.[16] Pragmatic trial design is an example of another response to the challenge of accounting for individual patient and practitioner effects.[17] That the importance of the placebo has been built into the conventions of quantitative medical research suggests an increasing anxiety associated with the exclusion of qualitative knowledge. This anxiety, qualitative in very nature, is generated by, and at the limits of, the quantitative paradigm.

In clinical medicine itself, approaches are emerging that also renew the emphasis on the human experience of illness and caring. These include personalised medicine, individualised care, integrative medicine, and patient centred care, all of which have encouraged the conduct of qualitative studies examining the patient viewpoint and understanding.[18–20] Qualitative studies have also investigated practitioner and student attitudes,[21–3] including awareness of and attitudes towards ethical issues.

Ethics in medical research

Ethical issues are at the centre of both clinical and research practice. Both fields of activity require complex negotiations involving values, preferences, opinions and beliefs, in different and sometimes changing social and cultural environments. Supposed 'principles' of medical ethics — such as the right to autonomy or self-rule and the duty to act in the best interests of patients or research participants — may have different weights and significance depending on the context. For example, a patient's 'right to choose' may be overridden in a variety of circumstances, such as those involving decisions about access to, and the judicious distribution of, resources, or they may be compromised or attenuated by lack of time, competing interests or other influences. Voluntary and mandatory codes of practice can enhance awareness of the importance of ethical considerations and guide the behaviour of both clinicians and researchers. In the field of research the Australian National Statement on Ethical Conduct in Human Research[24] provides a broad framework for ethical discourse which places emphasis on the values of research merit and integrity, justice, beneficence, and respect. For example, the statement specifies that for research to be ethically acceptable the potential benefits should outweigh the likely harmful outcomes and that, except in clearly defined circumstances, the consent of the participants must be freely obtained. Adherence to such ethical values and principles is not a secondary or supplementary aspect of medical research but is now recognised to stand at its very core.

The two clusters of methodologies share common ethical issues, such as respect for participants and recognition of the importance of consent and privacy. However, they also raise their own distinctive questions. In the quantitative realm, for example, ethical questions generally refer to specific instrumental or operational aspects of a study, especially questions about techniques and protocols. In the qualitative field, ethical issues arise from the deconstructed, self-reflexive nature of the researcher and the endeavour to engage in evolving, meaning-generative relationships with participants and their field of experience as, for example, in participatory research in communities. In quantitative research the fundamental ethical requirement is to demonstrate that the dignity and rights of the individuals involved are being upheld. Where the approach taken is a qualitative one, the key issue is to recognise and respect the experiences of the participants and to acknowledge the meaning generating capacity of the relationships between them and researchers.

The methodological diversity underlying qualitative research represents a response to the complexity of the processes just referred to of meaning generation in relation to personal experience. Quantitative research is inherently objectivist, in the sense of presupposing a radical independence between the subject and object of knowledge. By contrast, qualitative methodologies draw attention to the dependence of knowledge and truth on the process of observation itself and the cultural and theoretical context within it occurs. Some qualitative frameworks, such as those of feminism and postmodernism, explicitly include the observer as a key variable. However, these are the exception, and many other qualitative approaches retain a commitment to the separation of the research process from that of action and change, thereby preserving fundamental features of the dominant epistemological paradigm of medical research.

The ethical discourses about quantitative research have developed out of this tension between the objectivism of science and dialogue between researchers and research participants: that is, they are a response to the inherently non-reflexive nature of quantitative thinking. In the latter, the removal of the agency of the research participant at the level of knowledge acquisition requires its re-insertion in the form of

supplementary 'principles' of ethics, such as the principles of respect, beneficence and justice. As a result of its evolution as an extension of the quantitative paradigm which nonetheless preserves the basic structure of objectivistic knowledge, qualitative research seeks to follow the same ethical principles, even if the ways in which they are realised sometimes differs: for example, in the more active, participatory versions of qualitative methodologies the distinction between 'researcher' and 'research participant' becomes somewhat blurred, thereby changing the nature of conversations about consent, risk etc.

The ideas and concepts that are subject to the processes of measurement, including the hypotheses that are tested, clearly precede quantitative assessments of them; qualitative thinking is in this respect more fundamental than quantitative thinking. Furthermore, because not all aspects of experience can be expressed quantitatively there are irreducible residues of qualitative experience that perdure within the quantitative domain.

Case study

The above points can be illustrated by a study currently being undertaken by the authors which utilises quantitative and qualitative methodologies to characterise the attitudes, beliefs and behaviours of CM practitioners in Australia. The overall aim of the study intends to provide a comprehensive description of CM practice which conveys both the large scale cultural structures and local values and attitudes of individual practitioners. Quantitative data obtained from a nationwide survey are being analysed using descriptive statistics in the form of frequencies and percentages, to provide an overall quantitative description of eight domains within CM practice in Australia: demographics; clinical practice; evidence; registration; education; professional development; professional associations; and the future of CM in Australia. In addition to this, qualitative, semi-structured interviews are being conducted to provide a deeper characterisation of CM practitioner and key stakeholder attitudes and values. Data from the interviews and qualitative survey responses are being analysed using established qualitative techniques, including thematic analysis. In the research design the qualitative and quantitative data complement each other: the qualitative data are analysed for recurring topics and themes, which are used to generate quantitative hypotheses, while conversely, the quantitative information obtained from a national survey is tested and interpreted in the medium of qualitative dialogues. The results and discussions based on the findings will be published in upcoming journal articles. It is hoped that knowledge of the clinical and cultural dynamics of CM will contribute to the development of both clinical practice and policy recommendations.

Each methodology clearly provides its own insights and evokes its own theoretical interpretations. The combination of methodologies, however, also raises some contentious issues. These include that of population sampling, which is understood differently by the two perspectives. The quantitative paradigm demands that sufficiently large numbers be included to constitute a 'representative' sample, while the qualitative one focuses not on statistical arguments but on the inclusion of all relevant substantive demographic factors. The contrasting approaches go to the heart of the differences between the two methodological perspectives: quantitative research is concerned with abstract representations of phenomena across whole populations while qualitative approaches seek to provide inventories of the full range of concrete variables that manifest themselves in the complex and differentiated array of social life worlds. As a descriptive study, our project seeks to pierce the qualitative unknown by investigating a population that has not hitherto been investigated in this manner, in spite of previous limited workforce studies.[25–6] It is our hope that the use of both quantitative and qualitative methodologies will allow the complex array of ethical, social and cultural factors to be identified so that effective policies and educational strategies can be developed.

What does this mean for CM?

Like other social practices, CM embraces a complex array of discourses, techniques and ethical standpoints. It has its own body of knowledge and standards of truth and validity, its own professional networks, and its own approaches to clinical praxis and education. The current research project has posed the question of the specific nature of the practitioner-patient relationship in CM. The encounter between practitioner and patient is the central dynamic force underlying all clinical practice, including that of Western medicine, and the characterisation of a particular practice must seek to identify any features that are unique to or distinctive of it. Our research suggests that CM can be distinguished precisely in these terms, by the quest of the practitioner and patient collectively and jointly to re-discover wellness, that is, through the distinctive ethical project underlying CM.

It may be argued that one of the defining principles of both scientific research and clinical medicine is the proliferation of viewpoints, of the fostering of competing and evolving theories of phenomena and experience which can be tested in varying degrees by experiment. The fecundity of ideas and concepts in fact emphasises most trenchantly the crucial role of qualitative ways of thought, which resist limiting the plenum of creative possibilities to a single standard of judgement. The qualitative domain allows us to consider and engage actively with participants' views and experiences about their sickness and

healing, which are infinitely variable. The conversations that may thereby be generated cannot be reduced to mere reporting, but invariably evoke ethical engagements, as participants and researchers together seek to deepen their understanding of the research question, the research activity, and their experience of the research topic. Ideally, participants may feel empowered to engage with the research process as active subjects. They may feel more included in the research experience, in the investigation of their experience, and in the reporting of the findings and subsequent decisions.

CM practitioners may understand that these are some of the reasons their patients may choose to participate and prosper within the CM framework. Research in CM involves a level of complexity inherent in an internally reflexive system. We suggest that research in CM is not only well suited to qualitative methodologies, but that the inclusion of such methodologies in studies investigating the use and effectiveness of CM is essential not only to enhance understanding of CM but also to ensure its ethical conduct.

Clinical Commentary

The relationship between research and clinical practice is increasingly emphasised within the Chinese medicine (CM) field. This paper attempts to outline the two broad methods of research, quantitative and qualitative, and to examine their ethical dimensions and comparative features, as highlighted in the placebo effect. The benefits and challenges of combining both methodologies are exemplified by reference to a current study into the nature of CM practice in Australia. We conclude that the use of combined methods in CM research offers both scientific and ethical benefits.

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Narrative and the Evolution of Qi

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ABSTRACT

This offering forms part of a larger group of contributions on qualitative or naturalistic inquiry into Chinese medicine ideas and practice. In Chinese medicine, the clinical encounter may be understood as an occasion when matters of the mind and body are articulated and understood as patterns of qi. What is remarkable is how an encounter may be read as an engagement with universal myths, metaphors and symbols situated within a body of medical knowledge called Chinese medicine. Amplifying the patient's narrative, it is argued, enriches our understanding how qi manifests in the body, offering an insight into states of being. In this paper the idea of the case study, typically used as a way of exploring Chinese medicine ideas, is broadened in scope suggesting that practitioners go beyond the usual inclusion of signs and symptoms and incorporate the narration of everyday life experience as a way of enriching our understanding of Chinese medicine ideas.

KEYWORDS Chinese medicine, narrative, qi, case study, lived experience.

Introduction

This paper is situated in the context of accessing and apprehending Chinese medicine ideas in a contemporary Western context with special attention given to ways in which we understand what is generally referred to as the clinical encounter. As this paper will argue, by amplifying the narration of self, the clinical encounter, re-construed as the narration of self might also be viewed as a contemporary re-enactment and reproduction of Chinese medicine ideas.[1–2] A perspective of this kind furnishes practitioners with an additional route to apprehending Chinese medicine ideas, enriching our understanding of the phenomena[3] of lived experience. The fundamental premise may be stated: that the Chinese medicine encounter encourages narration of self and at the same time is able to include and make sense of lived experience.

A foundational setting

Suggesting a view of this kind necessarily returns attention to some of the theoretical and philosophical foundations of Chinese medicine. Considered as a medical and human endeavour, Chinese medical ideas are supported by creation myths[4–6] such as the immanent and transcendent Dao, the creation of yin yang and the presence of a universal force said to animate all life and the many ways in which this force is spoken about. Replete with symbol and metaphor the language of Chinese medicine not only offers an account of how things came into being but how ideas, human relationships and institutions remain and change in human life. When we construe any medicine as a human endeavour we cannot avoid the process of attaching meaning to states of health. Not to use metaphor and symbol as a way of understanding medical concerns and, indeed, the human condition is a linguistic impossibility.[7–9]

The symbolic expression of such creations myths has pervaded throughout many aspects of Chinese life: in science,[10] historical analysis,[11] art,[12] literature[13] and politics.[14] In relation to medicine,

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all living things, a consequence of the union of yin yang reflected the universe and nature's patterns within. Knowing about nature's cycles meant that one could apprehend how heaven and earth are said to be present in the human body. By comprehending the unceasing flow of qi, whatever the context, an individual was especially placed to begin to understand the human body and as importantly, our being[15] in the world. An important received message from such a paradigm view suggests that if we are subject to the forces of creation, sickness and disease may be taken as humanity's interference with or lack of understanding of the constantly shifting harmony of forces of nature. The 'enemy' to be feared is not nature but our insensitivity to nature at work within us.

Chinese medicine and its supporting ideology propose an explanation of continuity, transformation and change in the world while simultaneously containing elements of mystery. Deeply embedded within nature's cycles, humanity reflected the process of transformation and change. Recognising transformation and change as the unceasing movement of qi offers human beings the opportunity to know about self, mind, body[17] and the human condition. In a strong sense, Chinese medicine offers an eloquent response to fundamental human questions such as why am I here, how do I live my life, what am I meant to do? Indeed, a medicine of this kind alludes to the idea that medicine is more than repairing the body. Arguably, more importantly, it speaks about restoring the person, re-familiarising them with natural forces at work. Chinese medicine proposes a theory of knowing the world and at the same time also provides a set of ideas on how to be in the world.[18–21]

Engaging with and understanding qi need not be taken only as occurring in the clinical encounter. Practitioners have recourse to a text that represents a personal conversation between two mythical characters. Known as the *Nei Jing*, this text is considered a practitioner's 'first text' and belongs to one particular tradition which gives emphasis to experiencing qi through practice and through a literary approach to medicine.[22] Unlike contemporary medical texts, the *Nei Jing* reads like a story where two people engage in conversation about medicine and life. The two mythical characters are the emperor Huang Di and his master physician Qi Bo. Revered as a canonical text, their conversation may be read as being set in 'a time before time'. In reading sources of this kind, the student practitioner is afforded a different means of absorbing Chinese medicine ideas. Said to contain a revealed wisdom, Huang Di and Qi Bo's conversation offers the would-be physician a path to understanding and accommodating the relationship between medical knowledge and practice. Invited to immerse oneself in and behind the words, the willing reader would be transformed by the experience offering them a deeper understanding on how being in the world and medicine are related.

Such philosophical ideas provide a basis for developing a clinical gaze[23] that unreservedly acknowledges the life world of a client, allowing the practitioner to make sense of lived experience. In doing so, Chinese medicine articulates a praxis that embraces the mind and body whilst also having profound implications on the sphere of transaction between 'self' and 'other'.

Accepting that human beings are little universes imbued with qi, we rely on language[24] to explain and describe our world of experience. Whether the language invoked is 'scientific' or 'ordinary' the bridge with which people share and transmit ideas and experience is language: by giving voice to the voiceless, you have got to find a language.[25] Language makes possible the notion and experience of self-awareness. The language of Chinese medicine in particular is 'ordinary' and 'scientific'. Ideas such as qi, yin yang or *wu xing* theory are simultaneously simple and scientific. What is being suggested is that Chinese medicine supplies a language and ideas that are simple; speak clearly and at the same time point to deeper significance and meaning on states of being.

Not unlike our presence in the world: qi comes and goes, in different times and places, is held to be a constant, and always changing regardless of the context in which it is explored. Our being in the world: ideas, thoughts, expression, feelings, values and behaviours can be similarly construed.

Narrative

The section that follows gives attention to and explores the significance of story-telling or narrative in the clinical encounter.[26] The narrative underscores the importance of attaching meaning to expressing ideas as a way of conveying practitioners into the client's world of experience. Why give attention to story? Not unlike the *Nei Jing* conversation, people have a predilection to telling stories. Chevalier puts it as, '… I think that we're wired, our DNA tells us to tell stories. We tell stories all the time about everything and I think we do it because the world is a kind of a crazy chaotic place. Sometimes stories, we're trying to make sense of the world a little bit, trying to bring some order to it'.[27]

Engaging in story helps us to '… remember the past, turn life into language and disclose ourselves and others the truth of our experiences'.[28] In the clinical encounter, the body ceases to be an object in need of repair and perceived as an embodied self in a unique life-world. The expressive body, taken as qi with form, is construed as retaining all the necessary resources to create change. By placing emphasis on the client's lived story, the client is afforded a centrality not usually experienced in a bio-medical setting. Change is identified as symptom relief but also as a way of recognising that people are able to re-create new and different narratives of self. This does not suggest that we consider

Chinese medicine principally as a 'talking cure'. Rather, that the symbolic reality expressed in story-telling informs practitioners of the coming and going of qi and, in turn, supplies practitioners with knowledge of how to engage qi, stimulate bodily repair and restore their being. The notion of narrative is perceived as an evolving reflection of self and that Chinese medicine ideas provide a route to understanding states of being.

What is being suggested is that for Westerners, knowing qi can be witnessed and experienced through story-telling and talk. Chinese medicine knowledge, expressed through the power of symbols and imagery permits practitioner and client to understand the body and mind as qi in motion. Understanding qi as *shen* for instance, is an exceptionally important route to apprehending states of being.[29]

Exploring narrative from differing historical, social and linguistic cultural contexts provides an important path in the acquisition of Chinese medicine knowledge. Two quite different stories are offered, one not immediately recognisable as medical in orientation and nor are they both representative of a traditional Chinese medicine case study.[30–2] The purpose in selecting the following examples is to demonstrate a number of important recurring ideas linked to the transmission of Chinese medicine knowledge in a contemporary Western context:

- Firstly, apprehending and experiencing qi provides an ontological and epistemological approach to understanding the human condition.
- The interpretation of Chinese medicine ideas from a contemporary Western perspective.
- That Chinese medicine ideas may be accessed and apprehended not only anywhere and at anytime but with anyone.
- That ideas from different places and time can have relevance and meaning in other social contexts.
- That qi is an especially useful code and method with which practitioners apprehend the illness experience or states of being.
- Finally, descriptions of self and being in the world, confers access to understanding the natural movements of qi.

Rembrandt: The return of the prodigal son

The following story is not from a Chinese medicine encounter. There is no practitioner and there is no patient. However, we are listening to an individual recounting how one's decisions and reflections on a life lived affects one's sense of being in the world and how one relates to others. Significantly, some of the themes within the story may be understood from a Chinese medicine perspective. The narrative develops the idea of the search for meaning and spiritual transcendence as the narrator moves between and through symbol. The narrative is presented both as and through a work of art, not unlike the creation of Chinese characters. The narrative serves to illustrate the presence of Chinese medicine ideas and symbols contained in the experiences of everyday life, albeit about fundamental human concerns.

The story recounts what may be understood as an authentic, indeed spiritual experience, stimulated by the symbolic meanings associated with three main figures represented in a painting. The content of the painting is Western in origin, depicting a biblical scene. The purpose for including a 'case study' of this kind is to suggest that although the medical ideas are far removed from the cultural origins of the depiction they may still be applicable in different cultural settings. The painting is Rembrandt's *The Return of The Prodigal Son* (Figure 1). Nouwen[33] is the storyteller who locates himself in the meaning of returning home as the prodigal son. Indeed, Nouwen likens himself not only to the two sons and the father, but also to aspects of Rembrandt's life. He notes that at the time of painting, Rembrandt was close to death, suggestive of Rembrandt's final approach home and to his 'father', and as Nouwen suggested, back to his origins. Nouwen happened to be on his personal journey back 'home'. Nouwen's transformative experience is located and moves between the meaning of the narrative in the painting and the painter.

Nouwen wrote:

> *Moving my eyes from the repentant son to the compassionate father, I see that the glittering light reflecting from golden chains, helmets, candles, and hidden lamps has died out and been replaced by the inner light of old age. It is the movement from the glory that seduces one into an ever greater search for wealth and popularity to the glory that is hidden in the human soul and surpasses death.*[34]

Eventually, Nouwen states:

> *...Both sons in me can gradually be transformed into the compassionate father. This transformation leads me to the fulfillment of the deepest desire of my restless heart. Because what greater joy can there be for me than to stretch out my tired arms and let my hands rest in a blessing on the shoulders of my home-coming children.*[35]

Nouwen's story and Rembrandt's work is symbolic of birth, death and rebirth: a healing that goes to the core of being human, expressed as one returning home after having experienced the world away from home. Like the mythological basis of New Year celebrations or the symbolic meaning of the Crucifixion, both of which mark a new beginning, the search is a yearning for renewal in returning. Reconciliation with one's origins and past is a central theme. For Nouwen his sense of homecoming and renewal is to become and understand what it means to be a compassionate father, a way of saying he is returning home, to his origins.

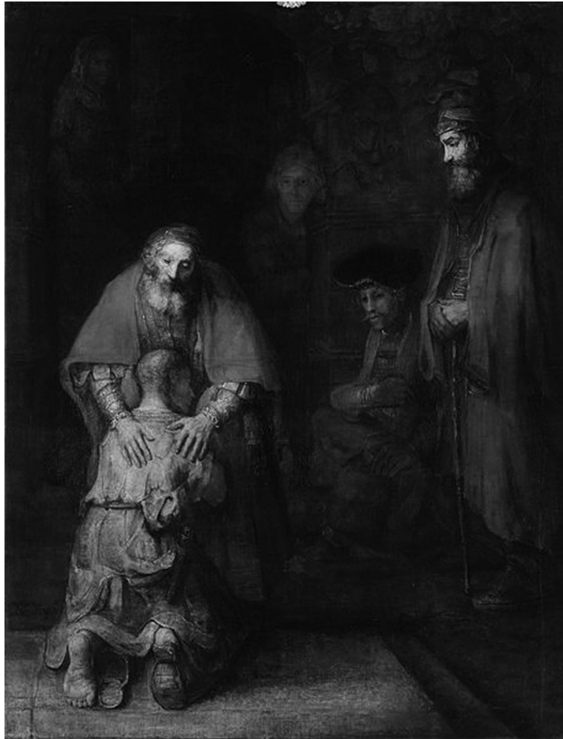

FIGURE 1 Rembrandt van Rijn, *The Return of the Prodigal Son*, c. 1661–1669.[40]

Important questions arise in terms of how and in what ways can Chinese medicine ideas such as *wu xing* be applied to understand human issues such as wisdom, return to one's origins, acceptance, reconciliation with others and self, finding peace and being at home. Indeed, one challenge would be to work through this depiction by invoking a *wu xing* analysis.

In Chinese medicine terms, Connelly[36] addresses similar issues when she writes on 'homing': the sense of returning home, of being at home in oneself, being reconciled with others, understanding ones origins, caring for others or indeed how one wishes to be cared for by others. As Connelly suggests, and perhaps not unlike Li Dong Yuan's thesis, our illness as lived experience occurs on earth. Treatment, for instance, is designed to touch the 'Earth' within a person. Much of our illnesses have to do with how we live on earth and how we treat our earth. Connelly explores and elaborates on the various meanings of home and earth. Earth is said to be the place on which one's life is enacted. One's personal sense of health and the potential of what one may become are to pass through time and re-connect with nature's forces allowing for previously unknown but knowable possibilities. Like the symbols of Heaven, *tian* 天, and Earth, *tu* 土, representing the totality of the cosmos, the experience of suffering associated with being on Earth is placed in a relationship with things away from earth, alluding to the idea of the mysteries of Heaven. Healing, reconciliation, attainment of knowledge and experiencing the way of Heaven is seen as representing the prodigal son's departure and return home to his origins.[37] It is a story of leaving and returning and discovering the 'source' or as Eliade suggests, to a place where the purpose, '...is not to conserve the memory ... but to transport the patient to where that event is in process of accomplishment – namely, to the dawn of Time...'.[38]

However, true to the nature of story, telling the way is not a singular path, rather it is pointed to through the discourse. Chinese medicine like poetry or art remakes reality, offering a way to re-create language and meaning. Chinese medicine can make the strange familiar. At the same time, Chinese medicine can also make the familiar strange. The realm of metaphor links the client's narrative and bodily felt experiences adds to the significance and meaning of Chinese medicine ideas. For the practitioner, the story raises the question of how and what way could acupuncture support and enrich a prodigal son's return home? Meaning is revealed, understood and communicated between client and practitioner or between storyteller and willing listener.

Ambrosia

In the following case study, there is a practitioner and a client and the symptom pattern now looks more like a contemporary Chinese medicine description. Ambrosia is a plump, round faced forty-three year old woman who moved into the area some three years ago. She arrived on time after leaving work, wearing light brown slacks, low heeled leather shoes and orange-brown top. She had thin straight hair, no make-up and silver-looking earrings. Having asked why she was presenting for acupuncture Ambrosia paused a while, went into thought and then offered three reasons in order of importance: 'being possessed by consuming lethargy, always feeling the cold, and having too much weight'. As she spoke of her symptoms there seemed to be a strong plaintive cry in her voice, particularly when she referred to her unbroken tiredness.

What impressed the practitioner from the first meeting was the manner in which she identified and spoke of the issues which concerned her, clearly indicating how deeply connected they were to her sense of well being. Though the pattern diagnosis was that of a kidney-spleen *yang xu*, emphasis will be given to Ambrosia's story and revelations about the self during the course of her acupuncture treatments. In other words, the focus will be how Ambrosia spoke of her state of being which is taken, at the same time, as part of the pattern kidney-spleen *yang xu*.

For Ambrosia, there was a deep feeling of desperation about being constantly tired. At times, she was so tired that on returning from work she felt like going straight to bed. She did

this from time to time. Large chunks of her weekends were spent sleeping. Yet somehow, Ambrosia managed to present another face to the world at large. From her perspective, the way she presented herself at work gave little or no indication that she was exhausted, really wanted to go home or stop what she was doing. At home, the situation was much the same. She did her best not to appear exhausted and at the same time was ready to give a helping hand at home. This was also a way of trying to convince herself that she was not tired and worn out.

Ambrosia managed to go on, in her work and at home. Outwardly, she gave signs of managing her life with sufficient energy and confidence. Inwardly, Ambrosia was utterly exhausted and desperately wanted to know why all this was happening to her. In her mind, she was doing all the right things: was living a not particularly stressful lifestyle, ate the right foods, enjoyed her time at work and at home and had a loving family.

Inwardly, she stated that her exhaustion seemed to 'consume the very core of being Ambrosia'. Two important issues emerged for Ambrosia. Firstly, that she was losing confidence in herself and at the same time becoming quite fearful. What made it worse was that she could not name her fears. Rather, her fear was deep seated. When she experienced intense bouts of fear her body trembled from the inside, she went cold, felt tired, sleepy and eventually urinated a lot. She also wanted to avoid social contact. So intense was her fear, Ambrosia described it as 'the dark night of my heart and soul'.

Ambrosia's fear of 'losing it', as she put it, brought her to the point of losing faith, not faith as in religious belief but losing faith in the experience of confidence. Ambrosia's sense of purpose and drive that gave substance to her life seemed to be vanishing right through her. She did contemplate suicide but decided against it because the courage to be outweighed the desire to yield to her despair.

In many ways, her illness happened to be a watershed. Reflecting on her condition Ambrosia now views the fear and suffering connected with her lethargy as the first step to affirming herself in spite of the fear of not being at peace. Connected with this realisation went the sense that 'others have also gone through a similar crisis and I can proceed even if it is very dark and full of fear'. For Ambrosia, her illness also gave new meaning to trusting and having a sincerity that gives substance to being a solitary individual. As her symptoms improved, she made the comment that she was better able 'to bear things from below'. Indeed, her definition of suffering was 'to bear things from below', suggestive of the idea that she felt more supported and grounded.

Connected to 'bearing things from below' Ambrosia recounted that she was able to resolve a long standing hurt. Some three years ago, she had a falling out with a close friend. They had not spoken since that time and as far as Ambrosia was concerned, the situation was irresolvable. About a day after the fifth treatment, Ambrosia rang her estranged friend and within a 40 minute phone call, what she saw as an impossible situation was now resolved. That her sense of alienation was beginning to change while her other symptoms were improving was a stunning revelation for Ambrosia. Even though she was scared about making the call Ambrosia felt confident. It was a strange feeling for her.

And what about her severe exhaustion? She is still tired and did reduce her weight. However, and as importantly, Ambrosia is able to do the sort of things she was previously not doing: go on outings on the weekend, stay up with her children and partner and have people over for dinner. For Ambrosia life seemed to have purpose and motives became clearer as if fuelled by a 'refining fire'. One of her parting comments was, 'It's OK to be fearful as long as your faith stays a nose length in front.'

Conclusion

In this paper, the evolution of qi was presented as 'case studies'. However, the notion of the case study was enlarged to mean not only the usual qi patterns described in contemporary Chinese medicine texts but also to understand everyday life experiences as studies of qi. Listening to a person narrate the self confers passage to qi and indeed can occur anywhere and anytime because qi 'speaks for itself'. In a strong sense, reading a book, a poem, gazing at works of art, making peace with another, coming to terms with being an individual can transform one's sense of being and one ceases to feel mediocre, accidental or mortal.[39] What is being alluded to is that any person prepared to work with qi will experience qi and that stories provide a special route to understanding Chinese medicine ideas.

Understanding the cosmos and one's connection with external forces allows people to become embedded into universal themes. Access to Chinese medicine ideas through the therapeutic encounter convey practitioners into ways of exploring fundamental human concerns, recognised as an intimate and fluctuating relationship between mind and body. Apprehending the fluctuations of qi for instance are passages to understanding an inner world of amplifying the domain of the spirit. Chinese medicine may be construed first as a way of repairing the body but also as a way of affirming life, often alluding to other dimensions of awareness and thought and the potential to understand humanity's place in the universe.

For practitioners, to apprehend Chinese medicine knowledge requires one to absorb and experience qi, which is central to everyday life. Giving attention to another's story during the therapeutic encounter may be considered as a passage to understanding everyday life because qi is at the centre of things.

In this way, the experience returns the person to an inward vision, achieving a deeper sense of reality. A fundamental tenet of Chinese medicine thinking is if people focus their attention on the cosmos 'living' within the body and keep the mind 'tuned' one discovers another natural home. This natural home offers people a way of realising a universal cosmological principal, which practitioners recognise as qi. The proposition is that Chinese medicine is fundamentally the study of the evolution of qi and that how we structure a life lived may be read as qi. Thus gazing at works of art, reading a book, how we spend our time alone and in relationship or in the clinical setting all offer a route to apprehending Chinese medicine ideas. And, in particular the Chinese medicine setting offers a way of including and understanding lived experience.

Clinical Commentary

This paper offers a different and additional view to understanding Chinese medicine ideas and their application. It proposes that in addition to the more usual inclusion of signs and symptoms practitioners give attention and listen to aspects of a client's everyday life as a way of understanding patterns of qi. This offering also suggests that Chinese medicine ideas supply the necessary structures to achieve this end. Insofar as research endeavours that aim to explore the efficacy of acupuncture for instance the paper strongly alludes to the idea that large aspects of the lived experience of clients need to be included in Chinese medicine research endeavours.

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Interview with Professor Jianping Liu, on Evidence-Based Medicine and its Relevance to Chinese Medicine

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Introduction

Prof. Jianping Liu is the Director of Centre for Evidence-Based Chinese Medicine, Beijing University of Chinese Medicine. He was awarded in 2006 as 'Chang Jiang Scholar' Professorship under the Ministry of Education in China. He has been working on the clinical effectiveness evaluation of traditional Chinese medicine (TCM) since 1997. He currently leads more than 10 national level projects and has international academic cooperation with researchers and institutes from Australia, the United States, Denmark, the United Kingdom, and Norway. Prof. Liu has more than 370 publications in peer review journals including 69 SCI journal papers. He also has 18 systematic reviews in the Cochrane Database of Systematic Review related to Chinese medicine for various conditions.

Prof. Liu is a member of the Advisory Board of the Cochrane Complementary Medicine Field and editor of the Cochrane Hepato-Biliary Group. He is also on the Editorial Board of another 11 Journals.

Prof. Liu has a broad and in-depth understanding of evidence-based medicine (EBM) and evidence-based practice (EBP).

EBM is not warmly welcomed by many practitioners because most practitioners do not understand what EBM is about and what systematic reviews and clinical trial are for. We invited Prof. Liu to share his views on the current situation, challenges and outlook of EBM in the field of TCM.

The Questions

Li: Hello Prof. Liu. To start our interview, could you please describe your work in China?

Liu: I established the Centre for Evidence-Based Chinese Medicine in Beijing University of Chinese Medicine in 2005. We have six full time staff, six PhD and six master's students. The Centre provides courses in the areas of clinical epidemiology, EBM, health economics, medical literature reading, and medical statistics for undergraduate and postgraduate students at the university. We have more than 30 international and domestic research projects about TCM clinical evaluation. The Centre has become a pioneer in EBM for TCM in China.

Li: Thank you very much! There is a question asked by many practitioners: How should we understand the difference between systematic reviews (SRs) and large trials?

Liu: SRs and well designed multi-centre randomised controlled trials (RCTs) are both regarded as the gold standard of clinical evidence. However trials are the first-level evidence, which collect data directly from patients, whereas SRs are the second-level evidence based on literature. To be more exact, SRs are nowadays mostly based on published clinical trials. Clinical trials give direct data about one intervention while SRs synthesise the data from multiple clinical trials with similar interventions and patient population.

Li: So SRs are based on clinical trials. Then why is it important to conduct SRs of Chinese medicine?

Liu: In spite of the long history of application, there is lack of reliable clinical evidence for the consumers to determine the

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usage of Chinese medicine, which undermines its acceptance. In the past, TCM practitioners have kept their understanding of TCM and experiences in practice mostly in case reports and records of observation. Nowadays, there are more and more clinical studies in TCM area, such as clinical trials, observational studies, and case series. However, it is very difficult and time consuming for the practitioners and patients to read all of them and make judgment.

SR is a very important approach to get a complete view of existing high-level evidence of clinical studies based on literature review and it is used for the development of best practice. Firstly, SRs generate clinical recommendations by presenting a full picture of current clinical evidences, which helps guide the clinical practice and helps health authorities to develop regulations and guidelines. For example, the logo of the Cochrane Collaboration is actually a representation of the results of a SR of RCTs where corticosteroids were given to women at risk of giving birth too early. The first included RCT was reported in 1972, indicating that the treatment was effective in reducing the infant death from complications and immaturity by 30 to 50 per cent. Twenty years later, seven more trials had been reported. However, because no systematic review of these trials had been published until 1989, most obstetricians had not realised that the treatment was so effective. Instead, they applied more expensive and less effective treatments and tens of thousands of premature babies have probably suffered and died unnecessarily. This is just one of many examples of the human costs resulting from failure to perform systematic, up-to-date reviews of RCTs of health care.

Secondly, SRs can help researchers identify knowledge gaps. Based on the comprehensive search and analysis of high level clinical studies, SRs identify adequate clinical evidence for recommendations and also the research gap where reliable evidence is absent.

Thirdly it supports new drug development because once the kind of evidence needed is identified, it becomes easier to proceed with the new drug development. What's more, SRs summarise all existing high-level clinical evidences both qualitatively and quantitatively, which is very helpful for the consumers to get comprehensive, objective and profound knowledge in a short time. Last but not the least, SRs could improve the quality of clinical study design by evaluating the methodological quality of existing studies, so that the researchers can learn from the 'lessons' from the finished studies and improve in the future.

Nowadays, Lancet, one of the world's best known, oldest and most respected general medical journals, requires authors to submit a clinical trial together with a SR, because it is essential for the researcher to get a full picture of the current clinical evidence within the area before initiating and conducting a clinical trial.

Li: It seems that SRs are indeed very important and meaningful nowadays. Actually many practitioners and researchers are interested in conducting a SR, but don't know where to start. What are the priorities in SRs of TCM?

Before determining the topic for a SR, you might consider the following two questions:

First, how many trials have been published in this area? It would be more meaningful to focus on the area with sufficient existing trials because a SR functions as a comprehensive summary, and there is usually more urgent need in the area with greater research interest. For example, it would be better to do a SR of *taiji* for migraine rather than *taiji* for cold. Although it could be also meaningful to explore the effectiveness of *taiji* for cold, it might be difficult to carry out a SR review as there may be limited clinical studies available.

Second, what about the popularity of this TCM therapy by consumers? The ultimate goal of EBM practice is patient-centered care. The interest of the patients, practitioners and policy makers to some degree guides the interest of the researchers. SRs should focus on the TCM widely used by the consumers first, thus being able to bring about reliable recommendations for clinical decision. For example, we should pay more attention to the outcomes which patients care more, such as survival time and quality of life, instead of too many biomarkers and laboratory indices.

Li: Thank you, I think it would be very helpful for those who are thinking about carrying out a SR. Also I remember you mentioned that 50% of the existing SRs concluded that there was still insufficient evidence about acupuncture and Chinese herbal medicine. How should we interpret the findings? How does it compare with other interventions?

Liu: Among the 145 Cochrane reviews in complementary and alternative medicine (CAM) field, there are 82 reviews, 56.6% of the total, that find insufficient evidence for conclusive recommendations.[1] This means that there is still a big research gap in acupuncture and Chinese herbal medicine, and we cannot bring about conclusive recommendations for clinical decisions based on the current findings from the limited number and low quality of clinical trials. There should be more clinical studies with rigorous design and adequate implementation in the future. However, this is not a problem in TCM only, rather it's universal. A review based on the newly published and updated Cochrane review found that only 14% of the 155 papers concluded with adequate evidence.[2] We cannot recommend any treatment method with confidence if

there is insufficient reliable evidence. Instead, we see the gap and need for future research.

Li: There seems to be both difficulties and outlooks in SRs! What are the problems and challenges of current SRs in TCM? Are there other ways if SR does not fit TCM best?

Liu: Currently, SRs usually include only RCTs, thus missing information from other types of studies, for example, non-randomised controlled studies, observational studies and non-controlled studies. On the other hand, SR and RCT were introduced into TCM field in the 1980s. These new concepts have been taken up by Western medicine for a much longer time and are gradually being taken up by TCM.

Although RCTs are believed to be the gold standard of interventional studies, in some areas, they are not the most appropriate type of study design due to ethical issues and size of sample, etc. For example, if patients wish to receive a herbal decoction instead of Western medicine, it would be difficult to randomise the patients into TCM group and Western medicine group. And, actually, most types of clinical information of TCM are within the categories of clinical studies mentioned above.

Secondly, SRs concentrate on the evaluation of internal validity, which undermines the strength of external validity, thus bringing the problem in generalising the study results in a larger population. What's more, due to the general poor study quality of existing TCM studies, there is still insufficient information and inconclusive results for clinical decision.

There are many challenges in conducting SR in TCM area but also solutions.

Firstly, the topic of TCM SR is narrowed down because many of the TCM interventions lack definition and clear classification. When we conduct clinical trials, it's important to identify the intervention in the design stage.

Secondly, there is lack of diversity and capacity of the review team. It is very important for a research team to have expertise in all the relevant areas. I think when doing a SR, the team should consist of researchers with professional skills in clinical, methodological, statistical areas and also language.

Also one of the challenges of SR in TCM lies in the heterogeneity of TCM interventions. There are usually a lot interventions and outcome measurements involved in the clinical literature which is difficult to synthesise. For example, if one trial is about herbal decoction, which is the most traditional format, such as *Xiao Chai Hu Tang*, and another trial is about herbal proprietary medicine such as *Xiao Yao Pill*, even if the control groups receive the same Western medicine and the two trials report the same outcomes, we cannot combine them in one meta-analysis, because different forms of herbal medicine are regarded as different interventions. Even herbal decoctions with different formulae are heterogeneous thus should not be synthesised. In a word, we could not mix apples with oranges when we regard them as different fruits. However, we can still provide qualitative data and analysis in the SR. In the future, the standardisation of interventions, controls and outcome measurements is very important in clinical trial reporting.

Many of the clinical studies of TCM are published in Chinese, which makes it difficult for the English speakers to obtain from outside China. I suggest international cooperation especially at the literature searching stage.

Lastly, the quality of clinical studies is still generally poor. The SRs based on these trials with low methodological quality and reporting are by some people thought as 'garbage in, garbage out', and this is also the main reason for why we always fail to publish SRs of TCM in the top journals. For clinical trials and SRs, we should always conduct research according to relevant international guidelines, produce the protocol before the study, and stick to it along with the whole study process.

When we get away from the challenges and shortcomings, we should also consider the question that, is there any other way for TCM apart from SR? The clinical practice of TCM is individualised and dynamic, and sometimes it's difficult and inappropriate to conduct blinding and randomisation. On one hand, we should work out high quality study designs and figure out the methodology which is more suitable to TCM. On the other hand, apart from SRs, we should also pay attention to the information more relevant to the clinicians, including observational studies, case series and case reports.

Li: That's inspiring. However, many TCM practitioners have the question that would EBM become cookbook therapy and reduce Chinese medicine, for instance acupuncture, a complex intervention, to standard therapy. Some people have the fear that future acupuncture practice will become not real TCM acupuncture; for example, if acupuncture is not better than sham, then acupuncture will not be funded.

Liu: First of all, I don't think there should be any fear or concern that EBM would reduce the use of real TCM. EBM is a method, or idea of presenting the best evidence. It is based on the actual practice, and finally aimed at providing recommendation for the practice. By conducting research and collecting evidence, EBM only reduces the use of practice without actual effectiveness by providing recommendation of 'not doing'. We need to explore better approaches to study TCM as a system of complex intervention.

The clinical research of TCM including acupuncture emerged since the 1980s, which is not long ago. There are still many issues to be discussed and improved in clinical research. There has been a lot of exploration in the types of sham to apply in the acupuncture trials, and we have to say that the answer has not completely been addressed yet. Clinical study develops together with medical practice; and I believe that if something really works and we can use the appropriate study to present it, it can not weaken the popularity, rather, exactly the reverse.

Li: That's very encouraging. But if acupuncture points are used in a few trials, then only these points are to be used in future practice. Do you think this will happen?

Liu: No, I don't think so. We are conducting trials of acupuncture because this whole treatment theory and system needs evidence to be accepted by professionals. In order to meet the design of clinical trials, we have to select some certain points for acupuncture. However, once this individualised system is accepted based on reliable evidence, and if the acupoints do work, they will be applied clinically.

Li: How is EBM developed in China? How will it impact on Chinese medicine practice?

Liu: The medical care in China will be evidence-based in the future, and China's policy makers are promoting the establishment of clinical guidelines and standard pathways in the health system including TCM. Thus I think in the future, EBM practice is more and more important, and could be essential for clinical decision making.

Li: Where will Chinese medicine be in 10 years? EBM only?

Liu: *(Laugh)* Well, I am not sure whether EBM will be the only way. But definitely, it will be prevalent in the next 10 years, and even 100 years. EBM is one way to develop best clinical practice based on not only unbiased evidence, but also respect of the patients' preference and the expertise of the practitioners. So when we hold the data from the evidence-based studies, let's say, SRs in our hands, we still have to listen to patients' attitudes and expectations, also make judgments and decisions together with our experiences. For example, there has been evidence saying that acupuncture is effective for migraine, but your patient really doesn't feel like receiving acupuncture, you have to communicate properly with him/her, or consider other treatment methods such as pain killer, herbal medicine or massage. We should pay attention to the evidence of the effectiveness of Chinese medicine and simultaneously explore the ways to assess the capacity of Chinese practitioners.

Li: That's wonderful. Thank you very much Prof. Liu!

Note: To further understand the definition of various terms mentioned in this interview, please visit http://www.cochrane.org/glossary/5.

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AACMAC Brisbane 2012: Selected Conference Abstracts

EDITOR'S NOTE: The 2012 Australasian Acupuncture and Chinese Medicine Association Annual Conference (AACMAC) was held in Brisbane on 25–27 May 2012. Seventy-seven abstracts were submitted, and 44 were for peer-review. An assessment panel, consisting of three Editorial Board members and one International Advisory Committee member, was established to assess the quality of each abstract, and select those meeting the AJACM standards for publication in this journal. To be selected, the abstract must present original data and/or thoughts; and must be structured with some form of aim, method, results and conclusion. Fourteen were finally included.

Current practice amongst acupuncturists treating threatened miscarriage in Australia and New Zealand
By Debra Betts

Background: Threatened miscarriage is a common complication of early pregnancy that may result in miscarriage and premature labour. Although only a 'wait and see approach' is advised medically, treatment recommendations exist within acupuncture texts. However these are conflicting, potentially creating treatment uncertainty and limiting clinical practice. As women increasingly seek acupuncture for their fertility, opportunities exist to offer interested women treatment. To explore this potential, acupuncturists' views were sought to add to the limited information currently available. Methods: A mixed methods study involving a self completed questionnaire and semi structured interviews; an online survey link was sent through Australia and New Zealand acupuncture associations requesting practitioner's views. Descriptive statistics were used to analyse data. Thirteen participants were purposefully selected for interviews to further explore perceptions of clinical practice. Interviews were conducted and recorded via Skype, transcribed verbatim and analysed through thematic analysis. Results: Of the 370 respondents, 214 (58%) had treated women for threatened miscarriage within the previous year. Detailed responses about current practice were obtained from 164 practitioners. Safety concerns focused on inexperienced practitioners causing miscarriage. While the majority avoided points traditionally used to induce labour, 13% would use LI4, 22% SP6 and 38% BL31. Clinical practice reflected diverse treatment strategies within acupuncture texts. Interviews illustrated how practitioners integrated this diversity. Conclusion: Practitioners demonstrated an interest in treating threatened miscarriage and responded positively to clinical practice questions. Feedback gathered contributes to inform clinical practice for this common complication of pregnancy.

The Journal and AACMA: the past, present and future of the Australian Journal of Acupuncture and Chinese Medicine
By Zhen Zheng

Background: The Australian Journal of Acupuncture and Chinese Medicine is the official academic journal of the Australian Association of Acupuncture and Chinese Medicine. It was first published in 2006 aiming to acknowledge diversity of Chinese medicine and promote rigour in research of this profession. Aim: This presentation reviews the six-year publication of the journal and discusses its future direction. Present: From the inception of the journal, the Editorial Board has followed international standards for manuscripts submitted to medical journals to ensure the scientific rigour of papers published. As our requirements become better known to authors, the acceptance rate has increased to more than 50%. To encourage diversity, we have published clinical trials and systematic reviews, as well as case reports and commentaries discussing essential concepts of Chinese medicine, such as *shen*. Among accepted peer-reviewed manuscripts, 60% were original research. About 20% of authors who submitted manuscripts were located overseas, including Asia, Europe, Northern America and Pacific regions. The content of the publication has evolved over the years. In response to the feedback from readers, we have included interviews and research snapshots. Future: Due to consistency in publishing high quality papers, the journal is now included in Scopus, 'the world's largest abstract and citation database of peer-reviewed literature and quality web sources'. Future development strategies are to continue current diversity in the types of publications, to expand to online publication, and to improve impact in the field of Chinese medicine.

Patients and acupuncturists view of acupuncture: implications for designs of clinical trials
By Zhen Zheng

Background: Randomised controlled trials (RCTs) are the gold standard for efficacy studies of any intervention, including acupuncture. How RCTs are designed is largely influenced by the active components of a therapy. For instance, a drug trial can only be conducted after the active compound is identified and tested. Similarly the design of acupuncture RCTs should be based on the active component of a therapy. So far the understanding of such elements is based on belief rather than evidence. There is no study specifically examining these aspects of an acupuncture treatment. Aim: This paper aims to examine the elements of acupuncture from patients' and acupuncturists' perspectives. Methods: Data from qualitative studies were used to examine the experience and perceived effects of acupuncture by patients who had received Western acupuncture compared with those reported by patients receiving traditional acupuncture, or those taking part in sham-acupuncture RCTs. Views of clinical trial acupuncturists were also extracted. Results: Patients who had traditional acupuncture had perceived far richer effects than those receiving Western acupuncture or taking part in sham-acupuncture controlled trials. The experience of trial acupuncturists who took part in sham-acupuncture RCTs differed greatly from that experienced by the acupuncturists in pragmatic trials. Conclusion: The differences highlight the complexity of traditional acupuncture in practice and the simplicity of acupuncture in clinical trials. Advanced trial designs are needed to properly test the effects of and interactions among various components of an acupuncture treatment.

An evidence-based Tai Chi and Qigong program for diabetes and obesity control
By Xin Liu; Wendy Brown; Yvette Miller; Nicola Burton

Objective: The objective of this study was to evaluate the effects of an innovative Tai Chi and Qigong based program on indicators of diabetes and obesity control. Method: A randomised controlled trial involving participants with pre-diabetes or diabetes recruited from the local community. Forty-one participants were randomly allocated to an intervention (n = 20) or usual care control group (n = 21). Intervention group participants attended a 12-week Tai Chi and Qigong training program. Indicators of diabetes and obesity control were assessed immediately prior to and after the intervention. Results: Linear regression analyses showed there were significant improvements in BMI, waist circumference and HbA1c in the intervention group, compared to the control group (BMI: between-group mean difference = -1.17, 95% CI = -1.66; -0.67, $p < 0.001$; waist circumference: between-group mean difference = -4.78 cm, 95% CI = -6.36; -3.20, $p < 0.001$; HbA1c: between-group mean difference = -0.23%, 95% CI = -0.45; -0.01, $p < 0.05$). There were also significant improvement in fasting blood glucose (mean difference = -0.47 mmol/L, 95% CI = -0.79; -0.14, $p < 0.01$) and trend towards significant improvement in triglycerides (mean difference = -0.25 mmol/L, 95% CI = -0.55; 0.04, $p = 0.09$) in the intervention group, but not seen in the control group. Conclusion: The findings provide clinical and scientific evidence for the effects of an innovative Tai Chi and Qigong based program on diabetes and obesity control. The innovative evidence-based Tai Chi and Qigong intervention program will be introduced and demonstrated during the presentation.

Future directions for acupuncture research
By John McDonald

Acupuncture research is at a crossroads. After initially attempting to use the double-blinded placebo controlled model for acupuncture research, eventually the single-blinded placebo controlled model has been widely adopted. However since currently used forms of placebo controls for acupuncture have been problematic, it is possible that a truly inert form of placebo acupuncture may not exist. When placebo protocols are not inert, this introduces negative bias into studies, defeating the original goal of reducing bias. This dilemma is shared by other therapies which involve complex interventions (like psychotherapy), and where skill levels of the practitioner strongly influence clinical outcomes (like surgery). This raises questions about the appropriateness of the current model of Evidence-Based Medicine levels of evidence to assess clinical efficacy for all interventions. Historically the most successful use of the double-blinded placebo controlled trial appears to have been in pharmaceutical trials which have not used complex interventions and in which the skill of the dispenser has not been a significant factor. The Society for Acupuncture Research has proposed a combination of open pragmatic trials along with mechanism studies which they call a 'top-down' and 'bottom-up' approach. In addition, open pragmatic studies which compare acupuncture with other therapies could provide useful evidence. Improvements to the systematic review process are proposed, including filters to exclude studies from systematic reviews if the acupuncture treatment or the skill levels of the practitioners who delivered it are deemed to be inadequate. This would require the establishment of standards to assess the quality of acupuncture treatment and practitioner background.

Electroacupuncture vs sham electroacupuncture vs standard care for acute and delayed Chemotherapy Induced Nausea and Vomiting: a pilot study
By Chris McKeon; Janet Hardy; Caroline Smith; Ester Chang

Introduction: Chemotherapy Induced Nausea and Vomiting (CINV) is better controlled than in the past, though even with

the latest antiemetics 30% of patients still experience CINV which impacts greatly on their quality of life. A Cochrane Systematic Review in 2006 identified the need for further study with acupuncture for CINV particularly Electroacupuncture. Methods: Patients attending the Mater Adults Day Oncology Unit, Brisbane for first cycle of chemotherapy were randomised to one of three arms; Electroacupuncture, sham Electroacupuncture or standard care. Treatment arms received acupuncture on the first day of chemotherapy, 10 mins prior and for total 30 minutes, returning in 2 days for another treatment. Acupuncture points used were ST36, PC6, LR3 and LI4 bilaterally. Patients completed a daily diary rating nausea and vomiting for 7 days and complete the Functional Living Index Emesis (FLIE) on Day 1, 4 and 7, which is a validated nausea- and vomiting-specific patient-reported outcome instrument that rates nausea and number of vomits and the impact of CINV on QOL. All patients receive standard antiemetics. Results: 60 patients were recruited from April 2009 to May 2011. Initial analysis show that the actual incidence of CINV is low in first cycle chemotherapy and the number recruited was not large enough to show significant benefit. FLIE change Day 1 and 7 (Median + (interquartile range)), standard care -1.02 (19.4), sham acupuncture -1.05 (21.6) and true acupuncture -3.36 (20.8). Nausea score day 1 and 4 standard care 0.00 (19.0), sham acupuncture 0.50 (9.0) and true acupuncture 0.00 (3.75); Day 1 and 2 standard care 0.00 (24.0), sham acupuncture 0.00 (23.0) and true acupuncture 0.00 (2.0). Changes in the FLIE and nausea score was not statistically significant. Discussion: This pilot study has shown the trial is possible to conduct and will identify the sample size needed to conduct a fully powered trial to examine if Electroacupuncture has a greater benefit than standard treatment. The authors are presently applying to NHMRC for the full trial.

Treating female infertility with Chinese herbal medicine: a systematic review
By Karin Ried

Objectives: To assess the effect of traditional Chinese herbal medicine (CHM) in the treatment of female infertility. Methods: We undertook a systematic review of treatment principles and herbal formulas used in randomised controlled trials and cohort studies investigating the effect of CHM on infertility. We included studies identified in previous meta-analyses on the effect of CHM versus Western medicine (WM) on pregnancy rates by our team (Ried & Stuart 2011) and others (See et al 2011). Results: 22 RCTs and six cohort studies involving more than 2000 women with infertility were included in the systematic review. Meta-analyses suggested CHM to be more effective in the treatment of female infertility achieving on average a 50-60% pregnancy rate over four months compared with 30% using standard WM drug treatment. Treatment principles of herbal formulas are based on underlying TCM pattern diagnosis. Individual herbs within a formula are chosen by their therapeutic actions. While herbal combinations may differ between formulas, therapeutic actions of the formulas for a specific TCM pattern are comparable. Commentary: Our meta-analyses suggest CHM to be more effective in the treatment of female infertility than Western Medicine. Our review provides a summary of effective treatment strategies for infertility with Chinese herbal formulas.

Functional Brain Imaging of acupuncture: an update
By Mark Strudwick

There remains a high degree of scepticism about acupuncture since its theoretical basis has no clear reference in Western medical and scientific terms, making any associations between neurophysiology and specific acupuncture concepts difficult to determine. Using neuroimaging and engineering approaches to understand its physiological basis may engender greater acceptance of and improvement in the clinical application of acupuncture. The aim of this paper is to present an overview of the published results which offer a new opportunity to test an ancient paradigm and introduce a provocative new paradigm for Western medicine. Using search terms humans, clinical trial, meta-analysis, randomised controlled trial, and review in the PubMed database returns 72 studies since the first report of CNS response to acupuncture was demonstrated with fMRI in 1998. Of these, 43 are in English. The results of these studies can be divided into three groups: (1) Those demonstrating a correlation between acupoint stimulation and cortical response; (2) Those demonstrating a different response elicited from different points; and (3) Analgesic responses implying activation of the pain network. The results of the studies published in English, when summarised, clearly demonstrate vague and sometimes contradictory outcomes. These discrepancies in findings may likely be the result of: (1) Significant differences in paradigms used; (2) Significant differences in thresholds used for data analysis; or (3) Failure to account for carryover response from initial needle insertion.

Chinese medicine evidence based diagnosis and treatment on peri-menopausal syndromes
By Hong Xu

Hormonal fluctuations are known to affect the quality of a female's life at different stages during their lifespan. In middle-aged women, hormonal fluctuations are especially known to impact on their mental and physical health. In 36 peri-menopausal participants, the Chinese medicine assessment, urinary 2-hydroxyestrone (2-OHE) and 16alpha-hydroxyestrone (16alpha-OHE) tests, the pulsed electromagnetic field (PEMF) and thermography tests were conducted, which indicated that Chinese medicine patterns of disharmony, the hormonal changes, thermography changes

and the magnetic field changes are related. The acupuncture meridian stagnation tested by the PEMF test shows 25.96% in Liver, 19.82% in Kidney, 32.10% in Spleen, 4.46% in Stomach, 7.18% in Gall Bladder and 10.49% in Bladder meridian. Liver Qi stagnation and Liver Kidney Yin deficiency patterns are predominantly presented in this trial. Chinese food therapy and herbs could provide effective treatment on regulating reproductive hormones, e.g. Chinese wolfberry, mulberry, Chinese kiwi fruit, walnut, chestnut, lotus seed, black sesame seeds; *Tian Wang Bu Xin Dan*, *Zhi Bai Di Huang Wan*, *Qi Ju Di Huang Wan*. Regulating Liver Qi, nourishing Liver and Kidney Yin may be considered as the treatment principle in peri-menopausal syndromes, harmonising Spleen could be used as the first treatment step. Some food and herbs may aggravate menopausal symptoms which should be avoided.

Acupuncture service in a hospital: a year on
By Chris McKeon

This presentation is a continuation of what was presented at the previous AACMAC about the acupuncture service in the Mater Adults Hospital Brisbane. The service would have been operating for 18 months at the time of this presentation. Data collected for the last six months has included changes to the survey tool identified after the first six month review. This will include uptake and usage of the service and the data obtained from research of the evaluation of the service. The evaluation of the service consists of a survey completed by the patients after one month of treatment, covering symptom/s treated, benefits, adverse events, should the service continue, use of other complementary medicine and qualitative data. The changes were to data collected on adverse events, medications and treatments used for the symptoms and changes in usage after acupuncture and the inclusion of MYCaW (Measure Your Concerns and Wellbeing) a tool designed for evaluating complementary therapies in cancer support care. Results: 64 patients (569 treatments) recruited, of which 46 completed all parts of the evaluation, 13% male, 67% female. Age 18–40 = 11%, 41–50 = 24%, 51–60 = 20%, 61–70 = 28%, >70 = 17%. Over 93% patients thought the service was a worthwhile addition and would like it to continue. 70% got some or slight improvement of their symptoms. Symptoms treated include pain, fatigue, nausea, peripheral neuropathy, anxiety, stress, mood problems, insomnia, hot flushes and anorexia.

Investigating the reliability of Contemporary Chinese Pulse Diagnosis™ (CCPD)
By Karen Bilton; Narelle Smith; Chris Zaslawski; Leon Hammer

Few studies have evaluated the clinical reliability of pulse diagnosis despite its significance to Chinese medicine diagnostics. This study's objective was to determine intra-rater and inter-rater reliability of practitioners using an operationally defined method, CCPD, to evaluate the radial pulse of subjects. Fifteen volunteer subjects and six testers skilled in CCPD were recruited. The design utilised a real-life practical test–retest with data collected 28 days apart according to CCPD procedures. For each subject test and retest, the same four testers evaluated 34 pulse categories defined by the CCPD system. Intra-rater reliability was measured by comparing individual tester results on day one with day two; inter-rater reliability was determined by comparing all testers across both days. Pulse rates were analysed using ANOVA; all other data employed Cohen's kappa coefficient. Pulse quality reliability cross-referenced percentage agreement with the apposite kappa results. Rate variables showed no significant difference between testers. Excellent to good agreement ($K \geq 0.60$) of 67% intra-rater and 44.1% inter-rater calculations confirmed previous findings that operationally defined pulse systems can generate acceptable reliability. Poor agreement ($K \leq 0.40$) of 14.3% intra-rater and 30.5% inter-rater calculations correlated to three pulse positions and subjects. The lower comparable reliability of five qualities were directly related to location, volume and sensation complexity. Across all data, bilateral palpation methods proved more reliable than single finger techniques. Variance of reliability for subjects corresponded to anomalous vasculature while variance according to positions and qualities suggested the CCPD terminology, descriptions or definitions for accessing these need modification. If following review variance continues, then their clinical usefulness needs to be re-evaluated entirely.

To investigate the effect of (i) needling specificity, (ii) needle manipulation, and (iii) needle retention time on deqi
By Bertrand Loyeung; Deirdre Cobbin; Chris Zaslawski

Introduction: Needle sensation or *de qi* is thought to be essential for a beneficial treatment outcome, particularly when treating pain. While many authors have attempted to qualitatively define *de qi*, no one has investigated the effect of the above needling parameters on its strength. Methods: In this double-blind (assessor and subjects) study, we recorded the needling sensations each subject experienced on a 100 mm long VAS at three minute intervals during each 21 minute needle insertion intervention. Twenty four subjects completed the study and each subject completed eight intervention sessions with at least one week wash out period between each. The eight interventions involved manual acupuncture to either LI4 or a designated non-acupoint (NAP) on the back of the hand and the eight conditions were: LI4m+21, LI4m+1, LI4m-21, LI4m-1, NAPm+21, NAPm+1, NAPm-21, NAPm-1, where m+ = manual manipulation of the needle every 3 minutes, m- = no manipulation, 1 = 1 minute needle retention time and 21 = 21 minutes needle retention time. Results: At $t = 1$, there was no statistical significance difference in the

mean needle sensation scores between the eight interventions ($p > 0.05$, ANOVA). At $t = 4$, $t = 7$, $t = 10$, $t = 13$, $t = 16$, $t = 19$ and $t = 22$, the mean sensation scores for both LI4m+21 and NAPm+21 interventions were statistically significantly higher compare to the other interventions ($p < 0.05$, ANOVA). However, the mean needle sensation scores between LI4m+21 and NAPm+21 interventions was not statistically significantly different ($p > 0.05$, ANOVA). Discussion: Irrespective of whether LI 4 or NAP was needled, needle manipulation every three minutes with a retention time of 21 minutes will give significantly higher needle sensation scores.

The effective initial stress screening and monitoring of successful acupuncture intervention using the new European Cardio Stress Imaging Technology

By Jerzy Dyczynski

The study takes a new holistic approach to initial stress screening and evaluation of its reduction after acupuncture intervention. The complexity of the biochemical, biophysical, neurological and electromagnetic communication in stress can be reliable measured using the Heart Rate Variability (HRV), reflecting the function of the Intelligent Heart. The HRV is an ECG evidence-based tool to assess heart's autonomic modulation, breathing and hormone activities. It is available as a portable device Vicardio with clinical software solution. Vicardio creates a dynamic window into stress and posttranslational stress scenario. Acupuncture is empirically effective in stress improving the heart/brain synchronisation, stressed cell's signalling, breathing/oxygenation, hormone and autonomic nervous balance. Materials/methods: The study included consecutive 201 patients, 78 males and 123 females from 13 to 93 years; average age 52. Excluded were patients with heart rhythm disturbances such as: a trial fibrillation, premature ventricular beats and the patients being on the B-Blocker medication. Vicardio displays the unique combination of the specific multi-channel ECG and HRV analysis delivering a colour coded mapping cardio portrait in two minutes. Two records were performed by all patients in sitting position with natural breathing activity as a baseline and in about 50 minutes later after acupuncture intervention. The Cardio Stress Index (CSI) ranging from 0 to 100% was calculated as a computerised algorithm including: analysis of ECG-Intervals, Pulse Rate, Fourié Transformation, heart's cohesion and HRV as a baseline and after acupuncture. The standardised big acupuncture prescription has been used by all patients and has addressed the following four levels: Intelligent Heart – HT 7 *Shenmen*, LU 7 *Lieque*; Heart/Brain Interactions – Ex-HN5 *Taiyang*, Ex-HN1 *Si Shen Cong*, GV 26 *Shuigou*; Molecular Biology – GV 20 *Baihui*, ST 36 *Zusanli*, LI 4 *Hegu*, LI 20 *Yingxiang*, SP 6 *Sanyinjiao*, BL 2 *Cuanzhu*; Genetics – LI 11 *Quchi*, KI 3 *Taixi*, GB 34 *Yuanglinquan*. No side or adverse effects of acupuncture intervention have been observed by the examined group of patients. Clinical outcomes: The majority of the examined patients showed during the initial baseline record an increased CSI, 43.5% in average, which was significantly reduced to 21.6% in average after intervention. In certain patients the acupuncture intervention may change activity of the COMT gene (Catechol-O-Methyl Transferase), a gene for stress cascade regulation. Conclusions: The study brings new evidence that stress levels can be reliable measured initially and monitored after acupuncture intervention using the new Cardio Stress Imaging Technology. Acupuncture is an effective procedure to reduce stress levels.

Prior to Conception: the role of an acupuncture protocol to enhance women's reproductive functioning

By Suzanne Cochrane; Caroline Smith; Alphia Possamai-Inesedy; Alan Bensoussan

Background: Fertility has become a major presenting condition in TCM clinics. This study sought to explore the potential contribution of an acupuncture protocol in enhancing female fertility. This paper presents the results of a clinical trial to explore the use of acupuncture in the lead up to conception and the outcomes of interviews with the women who received the acupuncture intervention. Methods: The acupuncture protocol used was developed by consensus. The clinical trial was a pragmatic design: 56 women were randomised to two groups one receiving a lifestyle-only intervention and the other acupuncture-plus-lifestyle with the manualised acupuncture intervention responsive to participants' presentation at the time of treatment. Half of the acupuncture recipients were interviewed in depth after the intervention. A mixed methods research methodology offered a richer data set with which to examine the outcomes for the trial population and the individual experiences of an acupuncture intervention. Results: The results for the acupuncture recipients include significant changes in fertility awareness, quality of life scores and time to conception measures. There were also positive menstrual changes indicated. Participant reports reinforced the importance of wellbeing for women with fertility problems and the contribution acupuncture treatments make to a sense of personal transformation. Conclusions: This study points to acupuncture as a safe and beneficial preparation for conception. It also provides additional guidance to practice in that it tested a particular acupuncture protocol that treated according to the menstrual cycle, TCM and biomedical diagnosis, and presenting symptoms. The study results also confirm the importance of understanding acupuncture as an intervention that assists women to transform themselves.

Book Reviews

Traditional, Complementary and Integrative Medicine – an International Reader

Edited by Jon Adams, Gavin J Andrews, Joanne Barnes, Alex Broom and Parker Magin
Palgrave Macmillan, 2012
ISBN 9780230232655

Traditional, complementary and integrative medicine (TCIM) is a concept with various definitions under different circumstances. Although the editors of this book discussed such concepts in the introduction, the desire to define the concept is not the aim and focus of this book. Traditional medicine, complementary medicine and alternative medicine are often considered to have the same meaning and are used interchangeably. It is based on the theories, beliefs and experience indigenous to different cultures. It includes acupuncture, aromatherapy, chiropractic, reflexology, osteopathy, herbalism, homeopathy, naturopathy, massage therapy etc. Integrative medicine indicates the integration of complementary medicine within mainstream conventional medicine.

This book publishes 31 research and review papers written by a group of academics and experts in this field from several countries around the world. The papers have been structured around three overarching parts, each consisting of three interrelated but distinct sections. Part A focuses on TCIM use and consumers; Part B redirects attention to issues of practice, provision and the professional interface and Part C deals with issues around knowledge production, research design and disciplinary perspectives/contexts.

Diversity is one of the features of this book as an international reader. TCIM includes a wide range of practices, products, and technology in different regions around the world, many practising with a long history. This book collates research papers studying TCIM use in Australia, India, the United States, New Zealand, Vietnam, and so forth. The contributors (or authors) of the papers include many academics and experts from universities and research institutions in Australia, the United States, and Canada in various fields ranging from public health science, health geography, herbal medicine, sociology, health policy research, mental health, primary health care research, naturopathy and law.

Many chapters in this book study TCIM from the view of public health, science and sociology. For instance, Section 1 in Part A focuses on prevalence of use, the profile of users and the drivers/motivations for TCIM use. Another chapter provides the study on the mixed therapy regimens in an Australia suburb obtained from ethnographic examination. In Section 2, the chapter covers studying the use of TCIM through the life cycle: during pregnancy, among paediatric populations, and in later life. In Section 3, papers cover the use of TCIM in certain type of diseases including skin disease (acne), cancer care, mental health and care for people with HIV. The focus is on the impact and influence, opportunities and challenges regarding TCIM from the view of public health research.

TCIM has been utilised in various modalities in different areas around the world. In Part B, studies evaluating the biopolitics and promotion of traditional herbal medicine in Vietnam; discussing Ayurvedic medicine utilisation in India; and patient health-seeking and practitioner behaviours are included. However, there is very little information about acupuncture and traditional Chinese medicine, despite it being one of most commonly-used TCIM in the world.

Regarding integrative medicine, this book presents chapters focusing on the integrative practices by adopting TCIM therapies, techniques or products and conventional mainstream medicine. For example, one topic explores the dynamics driving and inhibiting communication between primary healthcare clinicians and their patients regarding TCIM. Two additional chapters evaluate the interface role of pharmacists for patients with regard to the use of and information about dietary supplements and natural health products. From my view, these chapters do not fall within the scope of integrative medicine.

One interesting chapter evaluates the variations in provider conceptions of integrative medicine (Chapter 18). The study chose acupuncturists, physicians, chiropractors and physician acupuncturists and conducted in-depth interviews with these practitioners. By analysing the practitioner attitude toward integrative medicine, referral to other practitioners, knowledge of integrative medicine and the practice of integrative medicine, the study shows how a

clinician's orientation toward integrative medicine may be an important factor to measure crucial aspects of integrative medical care. Another interesting chapter (Chapter 19) studies the relationship of TCIM and modern scientific medicine in an integrative medical system. It explores which medicine should be emphasised and which medical standard should be adopted from modern Chinese history. It also indicates that the proper integrative system is dual-standard in which both TCIM and modern scientific medicines are free to operate according to their own medical standards.

Research methodology and design for the TCIM research is another important topic in this book (Part C). Three fascinating chapters (Chapters 21–23) from experts in this field present their opinions about the roles, relevance and relationship between evidence-based medicine and TCIM. In addition to biomedical research approaches, anthropological perspective has been suggested for TCIM research. The strengths and weaknesses of conventional biomedical research strategies and methods applied to TCIM have been explored and a new research framework for assessing these treatment modalities is suggested.

Other interesting chapters are safety and potential risk around TCIM practice and the liberalisation of the regulatory structure of TCIM in Australia comparing with that in the United States, Canada and British Columbia. Finally, chapters on the perspectives of TCIM in global health and health economics are presented. The future of integrative medicine and the challenges of TCIM research are discussed and several options put forward.

It is worth noting that this book collates previously published research studies or review papers, and most of them are an abridged version of previously published manuscripts.Detailed references are listed following each chapter and presents further information sources for readers and researchers for further exploration on the relevant topic.

Reviewed by Yun-Fei Lu

The Five Levels of Taijiquan

By Grandmaster Chen Xiaowang, Commentary by Master Jan Silberstorff
Singing Dragon, 2012
ISBN 978-1848190931

Millions of people around the world practise the classical internal martial art *Taijiquan*, embodied by myriad styles. No matter what 'dialect' of *Taijiquan* you may practice, gaining a practical understanding of your ability in *Taiji* will always be problematic unless you have the guidance of an expert teacher who has a profound understanding of the art. In writing this text Grandmaster Chen Xiaowang endeavours to explain systematically the complete development of the art of *Taijiquan* in the hope of allowing *Taiji* enthusiasts worldwide to realistically assess their current skill and to provide an insight on how to properly progress. This is a text designed to complement the study of *Taijiquan* with its balance of principles, purposes and difficulties to be encountered in the process of *Taiji* student development. This book contains Chen's Chinese original text with English translation followed by commentary by Master Jan Silberstorff, a high ranking student and family disciple.

In Chen's text, the path of *Taijiquan* development is described by levels or stages of martial skills (*gongfu*) that progressively support each other, with level one being beginner, through to level five, which is the highest skill level. While fundamentally being a martial art, the training is still applicable for those not interested in the martial arts, as most of the training occurs within the self. Every level of *Taiji* is described by the specific principles that need to be mastered, as well as noting the expected difficulties. The description of these levels serves two purposes: firstly, they help measure the student's current ability, and secondly, assist realisation of what should be learnt next, otherwise advancement at higher stages is not possible. To quote Chen, 'Learning Tajiquan means to educate oneself. It is like slowly advancing from primary school to university. As time passes, more and more knowledge is gained. Without the foundations of primary school and secondary school, one will not be able to follow the seminars at university'.

The book comprises an introduction followed by five chapters, with each chapter devoted to each of the levels of *Taijiquan*. The introduction contains much useful commentary clarifying the following chapters. The first chapter, hence level one of *Taiji-gongfu,* is focused on learning and mastering the outer physical movements of the form. This chapter explains proper *Taiji* foundation principles of body alignment, correct angles, and arm and leg co-ordination. The idea of sensitivity of internal energy is also introduced in this section. Common deficiencies described include incorrect stances with inadequate or erratic transference of

force through the body and either weak or too tense forms. He also points out that at this stage the student is unable to perform applications with simplicity and ease. Martial skill in this section, is limited and cannot be used effectively for self-defence except by deception.

Level two is focused on revealing blockages and resolving imperfections, such as excessive or insufficient exertion of force and uncoordinated movements. The integration of individual bodily areas and ideas of coordination between the internal, external, opening and closing movements are explored to improve body unity. Chen also introduces the principles of the unique Reeling Silk exercise (*can si gong*) at level two. While there is some discussion of limited martial skill in this section a student at this level is described as 'a new and undisciplined hand'.

At level three, Chen explains that the student will develop better coordination between internal and external movement, with breathing feeling natural. In this stage he notes that movements should appear gentle, but with increasing internal strength. Indeed, the ability to self-correct is possible at this stage. He goes on to note that control of internal qi allows the formation of condensed medium circuits of energy but it is still weak at this stage. *Yi* (awareness) and qi are believed to be more important than movement. The capacity to project one's energy and dissolve opponents' energy develops. It is in this chapter that a deeper understanding of the martial application of the form becomes a focus.

In the fourth chapter, Chen explores level four, *gongfu*. This is a very high level with an understanding of all the applications and martial concepts concealed within the forms movements. At this stage energy circulation is refined to small spiral movements, and the flow of qi inside the body should be smooth, with every move harmonised with breathing. Chen suggests that there should be a continuous flow of energy between the upper and lower body and that this should form an integrated system. At this level, not only is the practitioner able to read an opponent's intention, but now has the ability to hit the opponent precisely with 'true' force. Chen suggests that 'a person with these capabilities is described as 40 per cent Yin and 60 per cent Yang'.

In level five, every movement is consistent with the principles of *Taijiquan*. Chen draws on the *Taiji* classics to explain: 'With the gentle flow of energy, with the cosmic energy, one's own internal qi moves in a natural way. Moved by a solid form all the way through to the invisible. So no one realizes how marvellous the natural is'. In terms of martial art skills, Chen explains that 'every part of the body should be very sensitive and able to attack like a fist whenever in contact with the opponent'. Furthermore, this level is described as being: 'The only person capable of playing with Yin and Yang without being biased by either of the two'. Even though the student has obtained this level, Chen believes it remains necessary to continue training. In his commentary, Silberstorff notes that Chen is fond of signing books with the phrase, 'Learning is like swimming against the current. If you stop, you move backwards'.

Chen has great knowledge of the art and the poetic *Taijiquan* classics, but chooses to explain the concepts in as practical terms as possible. The text is quite short, containing only what is considered essential to impart to the student. No line is superfluous and it is Silberstorff's commentary that helps expound the depth behind some of the principles. While many *Taiji* practitioners can relate with the descriptions encountered in the first two chapters, subsequent levels are unfamiliar territory to most. These later chapters will no doubt provide interesting insights into higher level practice and possibly challenge many assumptions. The book mentions specific skills and practices such as '*can si gong*' and qi circulation that are integral to *Taijiquan*; but this is not the purpose of this text. Also practices such as these would require a book of their own to explain.

The Five Levels of Taijiquan is specific to student progression in *Taijiquan* and is essentially a guide but it does assume that one is learning or has learnt from a competent teacher. Considering Silberstorff's suggestion that the majority of the millions of *Taiji* practitioners (students as well as teachers) worldwide are only at level one to the beginning of level two, there is much need for such a book as this. Chen, direct descendant in the nineteenth generation of the *Taijiquan* founder family of Chen, is among the few who are recognised as being qualified to write such a book. The workings of internal systems have always been mysterious and closely guarded, and to have such an accomplished practitioner share his understanding of progression through the levels of *Taijiquan* demonstrates much generosity.

By providing such insights Chen and Silberstorff have provided a gift for the many *Taijiquan* students slowly realising the richness of their art.

Reviewed by Paul Burns

The Acupuncture Handbook of Sports Injuries and Pain

By Whitfield Reaves with Chad Bong
Hidden Needle Press, 2009
ISBN: 9780615274409

While not exactly a new text, being published in 2009, this book deserves a second look! One of the bread and butter areas for acupuncture is musculoskeletal conditions and injuries and this book by two American authors focuses extensively on this area. The information relayed in the book is based on the premise of four steps, or approaches, and the book is categorised into these areas. The first step involves the initial treatment of an acute condition or injury. Readers are given the choice of four approaches: (1) tendino-muscular channel; (2) contralateral; (3) upper or lower extremities; or (4) empirical acupuncture strategies. These approaches are considered simple and straightforward and do not need a precise diagnosis of the injury. The second method involves the use of the channel or microsystems using shu-stream acupoints, traditional acupoint categories, the extraordinary channels and microsystems such as wrist–ankle microsystem. The third approach concerns the role that internal organs (*zangfu*) may play in perpetuating pain and its role in a more holistic approach to treatment. The final technique suggested treatment at the site of the injury or condition based on the six pathogens (wind, damp etc) or the tissue affected. Each of these approaches is featured in a separate chapter and includes in-depth information relating to needling techniques, selection of acupoints and other clinical comments.

With these strategies explained, the next section of the book looks at individual musculoskeletal conditions; for example Achilles tendinosis, hip pain, elbow pain, and many more. This section makes up the bulk of the text contributing to 25 chapter areas. The final section of the book involves the appendices which include discussions on orthopaedic tests, grading systems for sprains and strains, topical applications, myofascial triggers, and more. Also included in the appendices is a reference list of texts that were used in assembling the information and, on occasions, comments on how useful these texts can be for the practitioner to follow up on.

Two-colour line drawings are used where appropriate to assist the reader in understanding the direction or site of needling especially in relation to the underlying muscles. The spiral binding also allows the book to be laid flat on a table and facilitates ease of use. In summary it is a comprehensive text that has much to offer the experienced practitioner who wants to diversify and add to their repertoire of approaches towards this common area of treatment. What it is not is a text geared for an undergraduate student. The authors assume the reader knows the location of acupoints and has an understanding of channel and *zangfu* theory. It certainly does not reiterate material that can be found in many acupuncture teaching texts. This book is well worth a second look and I found reading it gave me a deeper and more principled way of looking and treating musculoskeletal injuries.

Reviewed by Chris Zaslawski

Tai Chi Imagery Workbook: Spirit, Intent, and Motion

By Martin Mellish
Singing Dragon, 2011
ISBN: 9781848190290

Tai Chi Imagery Workbook: Spirit, Intent, and Motion is not another sequentially pictured instruction manual on Tai Chi forms. In fact, the book does not assume that the reader knows, or is interested in learning, any Tai Chi form. The author, Martin Mellish, aims to communicate the practical wisdom underlying Tai Chi to increase awareness of the mind-body relationship and reduce unneeded tension. It attempts this by using creative imagined scenarios coupled with pictures and diagrams. Scenarios with imagery such as moving animals, solid mountains, spinal columns as strings of pearls and bowls of fruit in the pelvis are used to engage the reader's many senses to produce meaningful physical awareness. This book would be useful not only to the student of Tai Chi, but also of any healing modality, dance, sport, meditation or conscious physical art.

The book is divided into three parts: Structure, Spirit, and Application with many sub-headings in each part. Contained in Part One is an abundance

of playful mental imagery analogies of the body with supporting pictures. These have a direct relation to fundamental movement concepts under headings such as 'Stepping and Standing', 'The Centre', 'Spinal Alignment', 'Movement of Shoulders, and Arms and Hands'. Familiar imagery examples often used in Tai Chi such as 'a golden cord attached to the crown of your head' and spinal column like a 'string of pearls' through to contemporary imagery such as, 'playing the accordion', are provided with many others to prompt the reader's imagination and resonate a personal physical understanding.

Part Two is focused on the releasing of physical and mental tensions that limit one's potential. Exercises in this section recognise the need to develop awareness of voluntary tensions and thus Mellish suggests it must be a conscious choice to change or let go. The idea of the *Dao De Jing* state of *wu bu wei* (something like 'beyond both effort and non-effort') is the quality these images aim to develop.

Part Three attempts to integrate the ideas developed in parts one and two. Mellish describes, with modern interpretations, how to connect to and develop physical power as described in the Tai Chi classics. With a background in science and mathematics, Mellish uses familiar scenarios and physics to get this across. The biggest chapter here is on 'Push Hands' (*Tui Shou*). Mellish considers Push Hands to offer some of the deepest insights of the Tai Chi tradition, and suggests that without it, 'you have no objective test for whether your movement is correct or not'. A fascinating insight into hard-earned Push Hand principles is revealed, with some memorable Push Hand encounters. Weapons are also discussed in Part Three.

Also included are mathematical notes, scientific research on Tai Chi and the bibliography of books that have influenced many of the ideas in *Tai Chi Imagery Workbook: Spirit, Intent, and Motion*. The mathematical notes explain the physics rendered throughout the book, whereas the scientific research exhibits some of the emerging benefits of Tai Chi and some of the factors that distort the results of such research.

Mellish writes in an easy to follow manner, using a format that alternates between imagined scenarios, illustrations, pictures and underlying explanations in the form of anatomical, scientific, psychological, and personal anecdotes. On integrating imagery and engaging in the scenarios I was able to feel many of the exercises' principles such as improved balance, strength, and relaxation. Mellish's ability to communicate such physical ideas in a book form is admirable but I do feel the sheer amount of exercises and visual ideas contained here would also transfer suitably into an audio visual format, as I found myself constantly flipping through the pages to recall imagery cues. Overall it is a cleverly written book that achieves its aim of instigating an aware physical experience. It would be a great resource to students or teachers of any coordinated body movement.

Reviewed by Paul Burns

Note: *Taiji* has been referred to as tai chi in this review for consistency with the book's title.

Current Research and Clinical Applications

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ACUPUNCTURE IS EFFECTIVE FOR THE TREATMENT OF CHRONIC PAIN AND IS THEREFORE A REASONABLE REFERRAL OPTION

This is a summary of a recently published meta-analysis paper.[1] It is referred to as the Vickers' review in this article. The publication is the work of a number of leading academics from the northern hemisphere referred to as the 'The Acupuncture Trialists' Collaboration. This group was established in 2007 with the objective to synthesise data from high quality randomised trials (RCTs) on chronic pain using acupuncture; providing evidence with better quality for clinicians, physicians and patients which would improve referrals to acupuncturists. Their meta-analysis differs from all other published systematic reviews of acupuncture by utilising individual patient data rather than summary data in published papers. Such an approach enhances data quality, enables different forms of outcomes to be combined and allows for increased precision of statistical sensitivity.

Vickers' commented on the controversial nature of acupuncture therapy due to an apparent lack of differences between real and sham acupuncture. Consequently some researchers consider acupuncture a potent placebo as there is no accepted physiological mechanism of analgesia. Others argue that sham (placebo) acupuncture is not inert. Puncturing the skin anywhere or even touching the skin such as placebo acupuncture needles could alleviate pain, therefore affecting the difference between two groups (effect size). Furthermore, studies with small sample size such as less than 100 participants, are often not powerful enough to detect a small difference between real and sham acupuncture. Results from such studies are often misinterpreted as there is no difference between the groups. That is why Cochrane reviews often conclude that larger studies are warranted.

In addition, different styles of acupuncture are practised in the clinic, with most published studies using formula acupuncture without traditional methods. This does not help identify the importance of differential diagnosis, acupoint location and stimulation practised in the clinic. Another critical factor is difficulty in blinding the therapist, which is the case in almost all non-drug interventions. This issue of un-blinding in studies raises the possibility of both performance and response bias. With this background the authors of the paper undertook the meta-analyses to determine the effect size of acupuncture for four chronic pain conditions of back and neck, osteoarthritis, chronic headache and shoulder.

When studies are combined in a meta-analysis, the results of the poor quality ones downgrade the value of the better ones resulting in questionable interpretability. To overcome this, only high quality RCTs with proper randomisation and allocation concealment were included in Vickers' review. To be eligible, RCTs had to have at least one group receiving needling acupuncture and one group receiving either sham or no-acupuncture with pain duration of four weeks in the musculoskeletal disorders. Endpoint must be measured more than four weeks after initial acupuncture treatment.

Twenty nine of the 31 eligible studies with 17 922 participants were included. Data were from the United States of America, the United Kingdom, Germany, Spain and Sweden. Primary analysis showed acupuncture being superior to sham and no-acupuncture for all four pain conditions ($p < 0.001$). The effect size was larger for acupuncture versus no-acupuncture when compared with acupuncture versus sham interventions. The effect size comparing acupuncture with no-acupuncture for back and neck were 0.55 (95%CI, 0.51–0.58), osteoarthritis 0.57 (95%CI, 0.50–0.64), and chronic headache 0.42 (95%CI, 0.37–0.46) of a standard deviation (SD). While effect size of acupuncture compared with sham interventions for back and neck were 0.37 (95%CI, 0.27–0.48), osteoarthritis 0.26 (95%CI, 0.17–0.34), and chronic headache 0.15 (95%CI, 0.07–0.24), and shoulder pain 0.62 (95%CI, 0.46–0.77) SDs. Sensitivity analyses were undertaken that excluded a set of RCTs that strongly favoured acupuncture and showed effect size reduced for acupuncture having less pain versus sham controls with scores for back and neck 0.23 (95%CI, 0.13–0.33), osteoarthritis 0.16 (95%CI, 0.07–0.25), and chronic headache 0.15

(95% CI, 0.07–0.24) SDs (shoulder was excluded in this grouping).

What these effect sizes mean in real terms is best described on a baseline pain scale of 0 to 100 with pain relief of 50% or more. An often used standard of effectiveness in pain relief is a reduction from say 60 to 30. Using this measure, the rate of effectiveness for real acupuncture, sham acupuncture and no treatment would be 50%, 43% and 30% respectively.

To test for publication bias, data from small and large studies were entered. Small studies had a larger effect for the sham comparison ($p = 0.02$), but not the no-acupuncture ($p = 0.72$). Other sensitivity analyses undertaken to ensure quality of evidence showed overall effect of $p < 0.001$ for separate pain types, inclusion of trials for which raw data was not obtained, only trials with low likelihood of bias for blinding and multiple imputation for missing data.

The final interpretations of this paper are important. Vicker and co-authors suggest that the total effects of acupuncture as experienced by the participants are clinically relevant. However, one part critical to a traditionalist acupuncturist treatment in clinical practice, correct location of acu-point and depth of needling, has not been assessed at this stage. We understand further work is being undertaken by the authors. Until such time as this has been analysed, systemic reviews of acupuncture treatments should be clearly noted as to what style is being used.

In conclusion, Vickers' study indicates that acupuncture is superior to sham and no acupuncture for treatment of chronic pain. As well, their study provides the most robust evidence to date that acupuncture's effects are 'over and above' those of placebo acupuncture even if it is relatively modest and therefore is suitable for referral by physicians. This is the study that acupuncturists are have been waiting for. I highly recommended that every practitioner reads and comprehends the paper; and use it when being questioned about the effects of acupuncture.

Reference

1. Vickers AJ, Cronin AM, Maschino AC, Lewith G, MacPherson, Foster NE, et al. Acupuncture for Chronic Pain, Individual Patient Data Mata-analysis. Arch Intern Med. 2012;172(19):1-10. [cited September 2012] Available from: <http://archinte.jamanetwork.com/article.aspx?articleid=1357513>.

Research Snapshots

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A RANDOMIZED CONTROLLED SINGLE-BLIND CLINICAL TRIAL ON 84 OUTPATIENTS WITH PSORIASIS VULGARIS BY AURICULAR THERAPY COMBINED WITH OPTIMIZED YINXIELING FORMULA (银屑灵优化方)

OBJECTIVE: To evaluate the effect of auricular therapy combined with optimised *Yinxieling* Formula（银屑灵优化方）on psoriasis vulgaris.

METHOD: This was a randomised, controlled, single-blind clinical trial conducted in Guangzhou, China. Eighty-four outpatients with psoriasis vulgaris were randomised to a treatment group (43 cases treated by auricular therapy combined with optimised *Yinxieling* formula) and a control group (41 cases treated by optimised *Yinxieling* formula alone). The treatment duration for both groups was eight weeks. Auricular therapy comprised of blood-letting puncture of the auricular points on the back of ear and vaccaria seeds pressure on Lung (CO 14), Liver (CO 12), *Shenmen* (TF 4), endocrine (CO 18), and *Pizhixia* (AT 4). Each ear was treated every other week for eight weeks in total. Both groups were treated with optimised *Yinxieling* formula decoction, which was a hospital preparation. The formula consisted of *Radix Paeoniae Rubra* (*Chi Shao*), *Rhizoma Curcumae* (*E Zhu*), Sarcandra (*Zhong Jie Feng*), *Radix glycytthizae* (*Gan Cao*), *Fructus Mume* (*Wu Mei*), *Radix Arnebiae* (*Zi Cao*), and *Rhizoma Smilacis Glabrae* (*Tu Fu Ling*). The outcome measure was Psoriasis Area and Severity Index (PASI) reduction rate, PASI score, Visual Analogue Scale (VAS) to evaluate itch severity, Dermatology Life Quality Index (DLQI), Self-rating Depression Scale (SDS), and Self-rating Anxiety Scale (SAS).

RESULTS: The PASI reduction rate in the treatment group was superior to the control group (74.4% vs 36.6%; $p < 0.01$). The PASI score was lower in the treatment group compared with the control group ($p < 0.01$).There were no significant differences between the two groups in DLQI, SDS, SAS and VAS ($p > 0.05$). No obvious adverse advents were found in either group.

CONCLUSION: Auricular therapy combined with optimised *Yinxieling* formula had a superior effect compared with optimised *Yinxieling* formula alone, with no serious adverse effects.

COMMENTS: The study introduced an adjunct, non-pharmacological therapy for psoriasis vulgaris patients. Additional auricular therapy appears to provide significant advantage to herbal medicine treatment alone. The study design was reasonable. Though blinding of participants and practitioners was impossible, blinding of outcome assessors was ensured. However, the study could not confirm whether the therapy has definite therapeutic effects or just a placebo effect. Further studies comparing auricular therapy and placebo should be conducted.

Lu CJ, Xiang Y, Xie XL, Xuan ML, He ZH. A randomized controlled single-blind clinical trial on 84 outpatients with psoriasis vulgaris by auricular therapy combined with optimized Yinxieling Formula. Chin J Integr Med. 2012 Mar;18(3):186–91.

Jingjie (Jason) Yu

BU-FEI YI-SHEN GRANULE COMBINED WITH ACUPOINT STICKING THERAPY IN PATIENTS WITH STABLE CHRONIC OBSTRUCTIVE PULMONARY DISEASE: A RANDOMIZED, DOUBLE-BLIND, DOUBLE-DUMMY, ACTIVE-CONTROLLED, 4-CENTER STUDY

OBJECTIVE: This study aimed to access the efficacy and safety of the *Bu-Fei Yi-Shen* granule combined with *Shu-fei Tie* acupoint sticking therapy, a treatment externally applying herbal paste to acupoints, in patients with stable Chronic Obstructive Pulmonary Disease (COPD).

METHOD: This study was designed as a multi-centre, randomised, double-blind, double-dummy, active-controlled trial in stable COPD patients. Two hundred and forty-four patients were randomly allocated to two groups. The trial group were given *Bu-Fei Yi-Qi* granule combined with *Shu-Fei*

Tie acupoint sticking therapy and oral placebo sustained-release theophylline. The control group were treated with oral sustained-release theophylline, which is standard, effective and well-tolerated in the long term treatment of stable COPD, and placebo *Bu-Fei Yi-Shen* granule combined with placebo *Shu-Fei Tie* acupoint sticking therapy. In both groups, *Bu-Fei Yi-Shen* granule and theophylline (or their placebos) were given twice daily for four months; the acupoint sticking therapy (or its placebo) was applied with 6–12 hour each patching time weekly for two months. Patients were followed up at six months after the end of the treatment. *Bu-Fei Yi-Shen* granule consisted of *renshen* (*Radix Ginseng*), 9 g; *huangqi* (*Radix Astragali Membranaceus*), 15 g; *gouqizi* (*Fructus Lycii*), 12 g; *diyu* (*Radix Sanguisorbae Officinalis*), 12 g; *wuweizi* (*Fructus Schisandrae Chinensis*), 9 g; *yinyanghuo* (*Herba Epimedii*), 9 g; *zisuzi* (*Fructus Perialle Frutescentis*), 9 g.

Shu-fei Tie plaster consisted of *baijiezi* (*Semen Sinapsis Albae*), 10 g; *yanhusuo* (*Rhizoma Corydalis Yanhusuo*), 5 g; *ganjiang* (*Rhizoma Zingiberis Officinalis*), 5 g; *xixin* (*Herba Cum Radice Asari*), 5 g; *yuanhua* (*Flos Daphnes Genkwa*), 10 g.

OUTCOME: The primary outcome measures were frequency and duration of acute exacerbation during the 10-month study. The secondary outcome measures included lung function, clinical symptoms, dyspnea grade, quality of life, six-minute walking distance (6MWD), and the adverse events (AE).

RESULTS: 221 patients completed the study (trial: n = 112; control: n = 109). No significant differences were observed between these two groups at baseline. The study showed that in the trial group the frequency and duration of acute exacerbation were significantly shortened ($p < 0.05$). All other outcome measures also significantly improved when compared with those in the control group. There was no statistical difference between two groups in the lung function. Ten adverse events were recorded in the trial group, three of which led to the patient's withdrawal. There were eight cases with adverse events in the control group.

CONCLUSION: Patients with stable COPD benefited more from the therapy of *Bu-Fei Yi-Shen* granule combined with acupoint sticking. Further studies are required to determine the responsive patient population as well as dosing regimen and therapy duration for this approach.

COMMENT: The authors acknowledged the limitation in the design, including neither single *Bu-Fei Yi-Shen* granule group nor single acupoint sticking group was assessed. Consequently, it is impossible to determine the contribution of *Bu-Fei Yi-Shen* granule and acupoint sticking therapy, respectively. In addition, the duration of the whole study might not have been long enough to reflect the change in lung function. Furthermore, the SD and 95% CI were only presented in graphs; therefore, the absolute figures can only be estimated based on the graphs.

Li JS, Li SY, Yu XQ, Xie Y, Wang MH, Li ZG, et al. Bu-Fei Yi-Shen granule combined with acupoint sticking therapy in patients with stable chronic obstructive pulmonary disease: a randomized, double-blind, double-dummy, active-controlled, 4-center study. J Ethnopharmacol 2012;141(2): 584–91.

Xiankun (Sharon) Chen

Conference Reports

iSAMS – International Scientific Acupuncture and Meridian Symposium

Sydney, Australia
5–7 October 2012

Zhen Zheng

The fourth International Scientific Acupuncture and Meridian Symposium (iSAMS) was held on 5–7 October 2012 at the University of Technology, Sydney with a theme of 'Moving Acupuncture Research Forward – Issues and Solutions'.

As its title suggests, the symposium focused on research. Forty nine keynote and invited speakers came from 11 countries and districts. All speakers are active researchers themselves with diverse backgrounds, including Chinese medicine, Western medicine, public health and social science.

Yet the conference was not just for researchers. Most speakers gave excellent presentations making their complicated research easily understood by non-researchers, so the significance of the research results could be fully appreciated. More than half of the conference attendees were practitioners and who enjoyed the mental stimulation and shared the moments of excitement.

Who would not be excited by the potential role of acupuncture in normalising blood pressure for patients with high or low blood pressure? We were told the effects were specific to PC6 and ST36, but not for GB39. Who would not be excited when Prof. John Longhurst, a cardiologist and physiologist from the United States of America (USA), said that he challenged anyone to come up with some Western medication that could perform the similar bi-directional function as acupuncture does?!

Dr Hugh MacPherson from the United Kingdom, one of the co-authors of a recent much-discussed paper analysing data of more than 18000 patients, confidently told us that the study showed that real acupuncture is better than sham acupuncture in relieving chronic pain. He also elegantly demonstrated how research could influence health policy making. Then Dr Richard Harris from USA demonstrated how brain image research found that real and sham acupuncture had distinct effects on human brain. He concluded that acupuncture is not sham.

Prof. Charlie Xue from RMIT University encouraged us to consider translational research and to implement evidence into practice. He also shared his eight-year experience of introducing acupuncture into emergency departments in Victorian hospitals.

In addition to clinical and laboratory evidence of, if and how, acupuncture works, a number of presentations discussed how best to study concepts and techniques utilised in Chinese medicine. Dr Karen Bilton from Sydney taught us it was possible to teach pulse diagnosis accurately and reliably. Prof. Sheng-Xing Ma from the USA studied gene expression and its application in studying meridian pathways.

Social science and public health researchers at the conference demonstrated how qualitative and public health research methods could be incorporated into Chinese medicine and to enrich the understanding of this ancient yet modern medicine. Dr Elizabeth Sommers from the USA showed us how a community Chinese medicine clinic not only provided services to people in needs, but also built a platform for training and primary care research.

In my opinion, this three-day conference fulfilled its purpose. Many solutions for moving forward were tested, discussed and proposed. I came home feeling full of ideas and hope. Over the past 10 years, I have been to many conferences about Chinese medicine and acupuncture. I will rank this year's ISAMS among the top five. Congratulations to UTS for an excellent job!

AIMA 18th International Integrative Medicine Conference 'Bridging the Gap'

Melbourne, Australia
31 August – 2 September 2012

Richard Li

In August this year, the 18th International Integrative Medicine Conference was held in Melbourne, hosted by the Australasian Integrative Medicine Association (AIMA) with the conference theme of 'Bridging the Gap'.

As agreed in an AIMA Networking proposal 2012, AIMA and the Australian Acupuncture and Chinese Medicine Association Ltd (AACMA) agreed to exchange support and attend each other's conferences. Two AACMA Board members attended, AACMA Secretary Adj. A/Prof. Hong Xu, and myself, as AACMA President. AACMA Board member and AJACM Editor-in-Chief, Dr Zhen Zheng, was an invited speaker.

As the first AIMA conference that AACMA representatives attended, it was a good opportunity for us to show the new face of the Chinese medicine profession as a registered health profession. We were also able to put forward our views to other mainstream health practitioners about Chinese medicine practice in this country, as well as hearing the views of, and learning from, other health professions.

While topics and speakers for the conference of program covered a wide range of approaches to the fundamental practice of integrative medicine, the considerable growth of evidence in complementary and alternative medicine was recognised. The conference addressed an important issue: the need to bridge the gap between the various disciplines to deliver a better health service to our patients.

This conference theme 'Bridging the Gap' was the topic of the keynote panel at the conference, which provided a chance for real dialogue between Western medicine and other health professions. The panel consisted of Prof. Kerryn Phelps AM, President of Australasian Integrative Medicine Association (AIMA); Ms Eta Brand, President of Australian Naturopathic Practitioners Association (ANPA); Dr Stuart Glastonbury, Board Member of National Herbalists Association of Australia (NHAA); and myself as the representative of AACMA.

A range of views and opinions were expressed relating to using common language, barriers and cost of integration and the future of integrative medicine. From AACMA's point of view, while supporting integrative approaches to health care, it should be stressed that we need to be mindful that 'Bridging the Gap' will most importantly result in benefits for patients.

From my perspective, TCM Integration means recognising and bringing Chinese medicine services (provided by qualified registered Chinese medicine practitioners) into mainstream health programs and services. I also raised the issue that Medicare should cover acupuncture services provided by registered acupuncturists, as is the case with medical doctors.

UPCOMING INTERNATIONAL CONFERENCES

2012

10–11 November	Kuching, Sarawak, Malaysia WFCMS 9th World Congress of Chinese Medicine Visit www.2012wccm.com
10–12 November	Beijing, China 3rd International Symposium of Techniques of Acupuncture-Moxibustion and Tuina Contact email: acumoxa@bucm.edu.cn
16–18 November	Bandung, Indonesia WFAS International Congress and Workshop on Acupuncture 2012 Visit www.wfas2012-indonesia.com
7–9 December	New Delhi, India 15th World Conference of Acupuncture Association of India Contact email: kapuracu@airtelmail.in

2013

7–12 May	Rothenburg, Germany 44th TCM Kongress Rothenburg 2013 Visit www.tcm-kongress.de
17–19 May	San Francisco, United States 15th World Conference on Qigong & TCM – West Visit www.eastwestqi.com
21–25 June	Chengdu, China 15th World Conference on Qigong & TCM – East Visit www.eastwestqi.com
2–4 November	Sydney, Australia WFAS 8th World Conference on Acupuncture (World Federation of Acupuncture-Moxibustion Societies) Visit www.wfas2013sydney.com