Australian Journal of Acupuncture and Chinese Medicine

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Special Issue:

WFAS SYDNEY 2013

2013 VOLUME 8 ISSUE 2

Editorial

This is a special issue for the World Federation of Acupuncture-Moxibustion Societies (WFAS) 8th World Conference on Acupuncture, Sydney 2013. The first time WFAS held its conference in Australia was in Gold Coast 2004. Nine years on, Chinese medicine in Australia has moved forward and upward rapidly with national registration coming into place in 2012.

We celebrate this special event by releasing this issue at the conference, publishing a selection of high quality conference abstracts, and interviewing two conference keynote speakers, Professors Alan Bensoussan and Charlie Xue, two most prominent Chinese medicine educators and academics in Australia. Professor Xue, the Chair of the Chinese Medicine Board of Australia, recalls his work in many areas of Chinese medicine in Australia over the last 16 years and his vision of Chinese medicine in this country. Professor Bensoussan, Director of National Institute of Complementary Medicine, shares his experience of being a new practitioner, his achievements in the last 15 years and his path to where he is today. We hope their stories will put 'fire in the belly' to our readers. We intended to interview a keynote speaker from China, Prof Baoyan Liu, President of the China Association for Acupuncture and Moxibustion and Executive Vice-President of the China Academy of Chinese Medical Sciences, China. Unfortunately, due to his busy schedule, we will interview him at the conference instead and the interview will be published in the first issue of 2014.

Early this year, I visited northern Europe and had the opportunity to communicate with Chinese medicine associations abroad. In contrast to Australia, Chinese medicine is not a registered profession in any European country, and does not have an established university program in many European countries. United Kingdom, Norway and now Germany (as of September 2013) are exceptions. Our peers overseas look to Australia for examples and are fighting hard for their statutory status. In this issue, we publish two foreign correspondences on Chinese medicine in Belgium and in Norway.

As usual, we publish peer-reviewed articles. One of them discusses the cognitive–behavioural effects associated with Chinese medicine consultation. Traditional consultation is considered essential as it helps differential diagnosis. The authors suggest that the process itself perhaps has therapeutic effects due to the holistic framework and underlying philosophy. We hope this fresh look at consultation encourages our readers to be aware of cognitive–behavioural therapy-like effects of Chinese medicine. The other two peer-reviewed articles are lead-authored by two current post-graduate students. In one paper, the author analyses a failed case and reflects on why acupuncture treatment was not successful in relieving pregnancy-related nausea and vomiting. Sometimes, even with correct diagnosis and treatment, the patient might not get better. This case highlights the importance of patient–practitioner collaboration and managing expectations. It is not common for practitioners to discuss failed cases, yet we perhaps learn more from such cases than successful ones. The third paper reports a case in which a skin rash in a pregnant woman was successfully treated. The case was considered difficult to treat by a general practitioner, yet a practitioner without years of dermatology training treated the case successfully simply by following Chinese medicine principles.

All three papers highlight, from different angles, the essence of our medicine: to see and treat people holistically. How often we forget the fundamentals during busy clinical practice. Once I heard an experienced practitioner saying: 'It is easy to use acupuncture to treat pain, just needling *Ashi* points'. The above-mentioned case report could be due to new practitioner's luck, but it could also be that our students can teach experienced practitioners a thing or two about not forgetting the basics.

In current research reports, we introduce to you a recent Cochrane systematic review on Acupuncture for Fibromyalgia. The lead author John Deare also reflects on the arduous process of writing this review, and provides advice for those who want to write such a review. In this issue, there are also book reviews and conference reports as usual.

Please remember this is our members' journal, and academics are not the only people who can write papers. As you can see in this issue, two papers are from post-graduate students. We encourage educators, students and practitioners to share their clinical cases, their thoughts and experience. If you want to share clinical experiences, please write them as case reports, which we consider the best way to illustrate clinical thoughts.

We hope you enjoy reading this issue, and enjoy the WFAS conference.

Zhen Zheng
Editor-in-Chief

Interview with Professor Alan Bensoussan, WFAS Sydney 2013 Keynote Speaker

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Introduction

Professor Alan Bensoussan is a Professor of Chinese Medicine, and Director of Australia's National Institute of Complementary Medicine. He is one of Australia's prominent researchers in complementary medicine and was instrumental in establishing both the Centre for Complementary Medicine Research (CompleMED) – of which he is the Director – and the National Institute of Complementary Medicine (NICM), where he is the Executive Director. Under Alan's leadership, CompleMED has forged a broad network of links with other national and international organisations within government and industry, and is currently involved in collaborative projects with institutions in China, Hong Kong, United States and the United Kingdom.

Professor Bensoussan has been in clinical practice for 25 years and is an active researcher, attracting funds from the US National Institutes of Health, the Australian National Health & Medical Research Council, AusIndustry, Department of Education, Employment and Workplace Relations (DEST), State governments and industry. He sits on a number of government committees both nationally and internationally, and has frequently served as consultant to the World Health Organisation. He is Chair of the Australian Therapeutic Goods Administration's Advisory Committee on Complementary Medicines, and served for the inaugural term of Australia's National Medicines Policy Committee. He has published two books, including a review of acupuncture research and a substantial government report on the practice of traditional Chinese medicine in Australia, which contributed to the national registration of Chinese medicine practitioners throughout Australia in 2012. Professor Bensoussan's research contributions, particularly his clinical trials and public health research in Chinese medicine, have been widely reported and recognised.

The Questions

SC: What do you see as the key tasks for new practitioners of Chinese medicine? What matters most in a TCM practice?

AB: Based on my own experience as a practitioner there are three major components of becoming a successful TCM practitioner:

1. The first and most important is compassion – being open and present enough to listen to the patient and understand what they are saying and their experience is so important. The other aspect of this is to be able to change and adjust your response to the patient as they change.

When I first graduated from Acupuncture Colleges Australia my first practice was in 1983 in York in the UK for 18 months. I started work and within a short time I realised that my training had not equipped me enough. I needed to really start by listening to my patients. The advantage for me in being in York was that I knew no-one and there was nobody who expected me to be anyone other than a TCM practitioner. This really assisted me to change my own perception of myself and grow in my self-perception as a practitioner. From York I went to China for six months and then returned to set up my North Sydney practice. These early years of practice and study reinforced that being with the patient was central to TCM – not some idea of the patient or a TCM theory – the actual living patient has primacy.

2. Taking the time to study and learn from your cases. TCM opens up a different perspective of (and for) the patient and their illness. They mostly come to TCM clinics already defined by biomedicine in a particular way. The TCM perspective – and it may emerge from a chance connection between a symptom and timing or season or a colour or taste – offers a way of refiguring the process of illness and therefore opens new possibilities for treatment.

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Aust J Acupunct Chin Med 2013;8(2):2–3.

When one graduates presume you know nothing. During the early years of practice take the time to study each case exhaustively. It is only through this path that I began to get any skill or confidence in diagnosing and then prescribing acupuncture or herbs for my patients. I spent hours each day reviewing and studying each case. Continue to read and understand and allow yourself time to concentrate on this task.

3. The other important issue is this one of generalising versus specialising. I remained a generalist, although developing some strengths in gastrointestinal tracts (GIT), and I now see this as perhaps a mistake. I think now that after around 10 years of generalist practice it is the appropriate time to choose a specialty – gynaecology, skin disease, paediatrics, GIT, musculoskeletal disorders for example – these are all valuable areas of TCM in which we have a lot to offer. To successfully practise as a specialist in these fields requires a great depth of knowledge of the complexity of diagnostic and treatment methods. It is hard to sustain such knowledge as a generalist. We perhaps fear the consequences of restricting our practices to a specialty but as practitioners and to progress TCM as a profession we need to specialise.

When I am asked to make a referral I don't know who the TCM specialists are, and with practitioner regulation in place I think this opens the possibility for more specialisation in TCM.

SC: Do you miss practice?

AB: Yes I do miss practice. I moved out of my practice five years ago because of the burden of work here at the University, but I loved it and I miss that focus and being present and, for a while, sheltered from the administrative demands of my position. I was working in clinic eight hours per week but could not sustain this. Perhaps when I resign from my university post I will return to practice.

SC: What do you consider the major achievements of your work?

AB: I gain most pleasure from making new paths and working with other 'bush bashers' – people who can also see another way to go and are prepared to put the time and energy into carving new paths.

At an international level the TCM achievements that I have been part of are:

1. Practitioner recognition by government has been a major step forward and a dramatic policy change that has been led by Australia. From this we can build issues such as professional competence.

2. The TCM research agenda has also been advanced in Australia. NICM/CompleMED represents the largest concentration of TCM research in Australia which has been ranked by the Commonwealth Government Excellence in Research for Australia scheme as performing 'well above world standard', the top rank of 5. The clinical trials we have undertaken are often the first of their kind and our preclinical studies are also pioneering.

3. The policy area of product regulation has taken a lot of my time (15 years) at the Therapeutic Goods Authority. Now all TCM products in Australia must be Good Manufacturing Practice (GMP) and now traditional claims are recognised.

SC: What do see as the challenges facing TCM?

AB: The major political challenge is that complementary medicine (CM) is still the poor relation despite the high level of public use of CM modalities, and it still draws the scorn of some scientists.

The scientific challenge is if we continue to talk about TCM's central tenets then we will need to defend these with evidence or we will continue to be vulnerable to scientific criticism. My research priorities (and if I had the resources I would devote the rest of my career to these) are:

- To develop practical approaches to evaluating the synergistic nature of multiple component Chinese herbal medicines

- To better demonstrate the electro-physiological nature of acupuncture points, and

- To better understand the physiological mechanisms behind the long term cumulative effect of acupuncture.

The science in these areas is not yet compelling and these are important parts of the scientific plausibility of TCM. The other development that would change TCM's future internationally would be the production of a few vanguard products that have high level product-specific evidence to back them.

SC: You have been a vital player in the development of TCM. Do you see succession on your retirement as a problem?

AB: As a 'baby boomer' I recognise that most of our generation leave minor vacuums in various fields – simply a case of changing demographics. I do, however, have great confidence in TCM. New TCMers have access to a richer set of resources than we had in our training and they have the strength of greater awareness of evidence-based practice issues. My one question is do they have the 'fire in the belly' or the enthusiasm to make the sacrifices required? They are amply qualified but are they 'hungry' enough?

Interview with Professor Charlie Xue, WFAS Sydney 2013 Keynote Speaker

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Introduction

Professor Charlie Xue is the Head of School of Health Sciences, RMIT University, Director of the Traditional & Complementary Medicine Program, RMIT Health Innovations Research Institute and Inaugural Chair, Chinese Medicine Board of Australia. Prof Xue's main interest is in clinical research to evaluate the efficacy and safety of herbal medicine and acupuncture for respiratory diseases and pain management. His research has been supported by many research grants from the National Health and Medical Research Council (NHMRC), Australian Research Council (ARC), State and Federal Governments, as well as international research grants. Prof Xue also advises partners in industry, the profession and organisations such as the World Health Organisation (WHO). In addition, Prof Xue is a Grant Review Panel Member for the NHMRC. Prof Xue has more than 140 publications in peer reviewed journals and significantly contributes to evidence-based medicine and practice. Prof Xue is a keynote speaker at the WFAS 2013 8th World Conference on Acupuncture. We invited him to share his experience and knowledge of Chinese medicine for AJACM readers.

The Questions

JS: What are your special interests in Chinese medicine research and education?

CX: My overall interest in Chinese medicine research and education is to develop evidence-based Chinese medicine practice and research.

JS: What do you see is your current role in the field of Chinese medicine in Australia and internationally?

CX: Over the years I have contributed to Chinese medicine education and research and clinical practice standards in Australia and internationally through a range of activities. Firstly, I was the head of Chinese medicine at RMIT University for 16 years where I led the development of four degree programs, plus an international program in Hong Kong. The programs have contributed to producing quality practitioners for the Chinese medicine profession. My role in research, particularly in clinical studies, has focused on chronic disease and the ageing population and has contributed to evidence generation, evidence synthesis and evidence translation for determining the potential role of Chinese medicine for common chronic conditions. I was a board member for the Chinese Medicine Registration Board of Victoria for 12 years, including three years as the Deputy President of the Board. From 2011, I was appointed the Inaugural Chair of the Chinese Medicine Registration Board of Australia by the Australian Health Workforce Ministerial Council of the Australian Government. I think this all comes together to have a common theme to promote a standard setting, quality practice and evidence-based practice and research.

JS: In your opinion, what are the major achievements in Chinese medicine in the last ten years?

CX: The major achievements in Australia have been developing quality higher education programs, statutory regulation

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Aust J Acupunct Chin Med 2013;8(2):4–5.

framework for professional registration, initially in Victoria and then nationally, increasing the number of research projects, particularly in clinical research, as well as establishing a stronger platform for communication between Chinese medicine and other health care professions.

JS: In your opinion, what are some matters requiring attention in the current Chinese medicine/acupuncture profession?

CX: I think there are four areas that require the profession to give priority. Firstly, continuing professional education. This is a challenge because of diverse practitioner educational backgrounds with some needing more education and training in biomedical science, infection control, ethics, and understanding contemporary health practice issues including drug-herb interactions, as well as being effective communicators with other health care professions – in the Australian healthcare system, Chinese medicine is not standalone. The second area will be postgraduate studies and to be involved in research. It is not for everybody to be a PhD scholar, however what is really important is to promote evidence-based research and practice. All practitioners need to have a good understanding about scientific methodology and become effective consumers of research literature. The third thing is to develop research strengths that can answer critical clinical questions, for example benefit versus risk and value for money of Chinese medicine interventions for specific health conditions; and finally, I think international collaboration to maximise benefit of limited resources will be a critical area.

JS: What are the most urgent questions we need to address in Chinese medicine, in terms of research and education?

CX: We need to establish an evidence base that supports the use of Chinese medicine and if that is demonstrated, then determine value for money of these interventions and conditions.

JS: How do you think the status of Chinese medicine will change in the next 20 years?

CX: I think Chinese medicine should become a component of integrative care in a contemporary health care system in Australia and internationally. Certainly reviewing the systems in place in China and South Korea, but we should go one step further and ensure that the integration is well supported by quality evidence.

JS: What advice do you have for current students and new graduates on how to survive the first few years of practice?

CX: Be realistic on the time required for building up the clientele, continue to study, improve your clinical skills and experience, find a clinical mentor and engage in group discussion on specific cases.

JS: What advice do you have for practitioners on how to respond to negative comments about TCM in the media?

CX: There is a need to have a clear policy statement from the profession that the Chinese medicine profession supports and promotes evidence-based practice development, and will work towards this direction. We are not there yet, and it requires close partnership in research and practice with other health care professions.

Thank you very much for your time and answers!

For more information about Prof Xue, please visit www.rmit.edu.au/staff/charlie-xue

Does Chinese Medicine Consultation Share Features and Effects of Cognitive–Behavioural Therapy? Using Traditional Acupuncture as an Example

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ABSTRACT

Background: Acupuncture, as part of Chinese medicine (CM), is based on a holistic therapeutic theory. Individualised differential diagnosis is the essence and an integral part of its practice. It leads to an individualised treatment plan. Little research on the nature and effects of the CM consultation has been conducted. Previous studies showed behavioural and cognitive changes after traditional acupuncture treatment. In this article, through a hypothetical case, we illustrated a CM consultation process, examined the changes produced and compared the features between CM consultation and cognitive–behavioural therapy (CBT). Main text: The two therapies share nine out of eleven features, including five specific factors that took different forms in CM and CBT and four non-specific factors known to partially mediate the relationship between psychological therapies and positive therapeutic outcomes. Although Chinese medicine treatments induce changes in behaviours as well as cognition, CM consultation does not share two essential features of CBT, namely a framework of the interaction between behaviour and cognition and teaching patients how to identify and dispute dysfunctional thoughts. Discussion: CM consultation has CBT-like features and effects. Existing qualitative studies suggest that changes in behaviours and cognition after traditional acupuncture treatment are probably due to the CM consultation process or its combined effect with needling, rather than acupuncture needling alone. This hypothesis provides a new perspective on the contributing factors to acupuncture effect. CBT-like features and effects of traditional acupuncture is underestimated by practitioners and researchers, and need to be taken into consideration in acupuncture trial design and clinical practice.

KEYWORDS Chinese medicine consultation, cognitive–behavioural therapy, acupuncture, patient perceived changes, individualised diagnosis and treatment

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Aust J Acupunct Chin Med 2013;8(2):6–15.

Background

Individualised differential diagnosis is considered the essence of Chinese medicine (CM).[1] Acupuncture researchers and practitioners have argued that treatment stemming from such a diagnosis is an integral part of the practice of this holistic medicine.[2–4] To date, there have been a number of studies examining the effects of individualised acupuncture treatment,[5,6] and found such a treatment was marginally better than standard treatment[6] or sham acupuncture.[5] There are, however, very few studies assessing the therapeutic effects of the process of CM consultation. During any health-related consultation, it is inevitable that the practitioners and patients interact. The attention, empathy, bedside manner, and compassion from the practitioners have non-specific therapeutic effects on the patients.[7,8] However it is possible that beyond those non-specific effects, specific effects could result from CM consultation.

Findings of some qualitative studies, reviewed in more detail later in the paper, suggest that CM consultation process may be associated with the types of outcomes that would be expected from cognitive–behavioural therapy (CBT).[9–15] For example, patients report that they have changed their view about their body after a course of acupuncture treatment. They 'listen to their body', 'learn to live with' their body, and often modify their lifestyles and diets. A recent study also reports that after eight sessions of acupuncture treatment, patients with chronic pain demonstrated significantly improved personal control and coping strategies.[16] That is to say that traditional acupuncture may bring about both thinking and behavioural changes, the two essential objectives of CBT. These findings, and our own clinical experience, have led us to investigate the similarities and differences between the features and effects of CM and CBT.

CBT is based on the theory that how people feel and what they do is largely dependent on what they think and believe. The objective of the therapy is to enable a client to modify underlying maladaptive ways of thinking, thereby changing how they respond to their problems and their environment.[17] Therapists use a wide variety of strategies to facilitate changes in patients' thinking and belief systems, thereby changing emotional and behavioural aspects of the health problem.[18] CBT was originally used to treat psychological conditions, such as depression and anxiety. In the last two decades, the use of this therapy has been extended to help patients overcome and cope with physical illnesses and psychosomatic conditions. Numerous studies have found that CBT is an effective adjunct to conventional medical treatments for obesity,[19] chronic pain,[20] chronic fatigue syndrome[21] and asthma.[22]

In this article, we aimed to examine whether the CM consultation shared features and effects of CBT. We compared textbook information about the features of CBT and standard CM consultation. We used a hypothetical case study to illustrate the consultation process. Finally, we summarised and discussed evidence regarding the types of therapeutic effects elicited by CBT and CM.

An example of Chinese medicine consultation

John is a 65-year-old retiree. He has had low back pain for many years, and the pain comes and goes. In the last two months, John noticed that the pain had become more intense and persistent. Lumbar x-rays showed that he had degenerative changes in the lumbar vertebrae 3, 4 and 5 (L3–L5), with some narrowing of the joint space at L4/L5. He was told that his pain was due to degeneration in the spine associated with aging. He is on anti-inflammatory medications, which produce some temporary pain relief.

He has been worried by this persistent pain, and a friend recommended that he see an acupuncturist. Acupuncture is a therapy he has heard of and seen on television, but he does not know much about it. John is open-minded and happy to try anything as long as it may produce long-term relief.

John's first appointment lasted for one hour, and the Chinese medicine practitioner (let us call him Peter) spent half an hour asking questions about his condition, and spent the other half-hour treating him with acupuncture. Prior to leaving the clinic, Peter prescribed a patent Chinese herbal medicine, and gave John a list of things he needed to do at home, including changes to his dietary habits, lifestyle and exercise. His subsequent consultation was 40 minutes. Each time Peter spoke to him for about 10 minutes asking how he felt and whether he had done the homework; Peter then treated John for 30 minutes.

John has observed the following during the consultations.

1. Peter asked many questions about the pain, such as the location, distribution, quality, severity, what made it worse, what relieved it, and at what time of the day the pain got worse.

2. Peter also asked him some questions that he had never been asked when he saw a medical doctor. For instance, he was asked whether he felt cold or hot in general, whether he sweated easily or not, what his energy level was like, whether he had other pains in the body, how his sleep was, his appetite, his bowel motion, his urination, how often he got up at night to urinate, what worried him, how many siblings he had, etc. He was also asked to show his tongue, and the pulses of both his hands were felt for a couple of minutes.

3. Peter spent time explaining to him that he had Kidney Qi deficiency with an invasion of cold and dampness. He was told that Kidney Qi was very important in Chinese medicine and that it peaked at 30 years of age and then declined. Kidney supports the low back and when it is weak one may feel pain. John's work as a builder required him to work in an open environment, which allowed the wind and cold to affect his body.

4. Peter said that acupuncture and herbal medicine would enhance Kidney Qi and reduce pain.

5. Peter also asked him to do some gentle exercises, to keep himself, in particularly his low back, very warm when working in the garden, and to avoid uncooked food and cold drinks.

6. John noticed that his treatments were not always the same. Peter always treated any new problems as well as the low back pain. For instance, once he hurt his knee, and Peter said he had to treat the knee together with the low back pain. Peter explained that there were Qi channels traveling along the back, going down to the back of knees, and then to the feet. If the injured knee was not treated, the low back pain would get worse and John may start to experience foot or heel pain.

After the first session, John was impressed that the acupuncture was not painful and did give him some pain relief for a couple of days, and the herbal medicine had improved his stigma. After a few sessions, John found himself more energetic and experiencing less pain. More interestingly, he found that he was observing his energy level, the weather and his diet and linking them with his pain. He also observed his night urination and used it as an indicator for his Kidney energy.

John's experience is common among patients seeing a traditionally trained acupuncturist in Australia and other Western countries, although there is considerable variation in each individual practitioner's consultation style. In a CM consultation, apart from asking questions associated with the main complaint, an acupuncturist or CM practitioner asks ten standard questions (Table 1) to help reach a differential diagnosis.[23,24] Like John, most patients do not initially see the relevance of these questions to their health, but they soon recognise some links and use them as indicators for their level of health.

The features of CM consultation include a structured dialogue and consultation, an assessment of the overall health of a patient, an understanding of the deficiency (weakness) and strength of one's level of Qi, Yin, Yang and *Shen*, an assessment of aetiology of the problem, an individualised diagnosis and treatment plan. Explaining the diagnosis to the patient is also an important feature, although it might not be practised by every Chinese medicine practitioner. The ultimate goal of the treatment is to balance the Yin and Yang, strengthen any deficiency, reduce the excess, eliminate the problem and prevent further relapses.

TABLE 1 Ten questions that must be asked during a Chinese medicine consultation[23]

1. Do you feel cold or hot easily?
2. Do you sweat easily? Do you sweat at night?
3. Do you have any discomfort in your body?
4. How are your bowel motions and urination?
5. How are your appetite, diet and taste?
6. Do you feel any discomfort in your chest or abdomen? Do you cough, have palpitations, or have indigestion?
7. How are your hearing and vision?
8. Do you feel thirst and how often do you drink?
9. How is your sleep?
10. How are your menstruation and vaginal discharge (women only)?

Major features of cognitive–behavioural therapy

CBT has a set of protocols and procedures to follow. Therapists help patients to identify and evaluate automatic thoughts and core beliefs, and teach patients the techniques to recognise and challenge them. A course of treatment is usually ten to 12 sessions of 30 to 60 minutes duration. Patients are given homework to monitor and evaluate their thoughts and behaviours.

Table 2 lists the 11 common features and principles of CBT recommended by authoritative textbooks.[17,18,25] Some are about the structure of the consultations and others are about the content and the purposes. Some are specific to CBT, and others are non-specific and appear in most therapies.

A main feature of CBT is to change one's dysfunctional thoughts and maladaptive core beliefs. CBT therapists teach patients how to identify, assess and respond to their dysfunctional thoughts and beliefs, and help patients learn the techniques required to change them. During the consultation, therapists use a number of techniques (e.g. Socratic questioning) to explore how patients feel about an event and to increase their awareness of their thoughts and interpretations of the event. Through careful examination of the evidence and usefulness of maladaptive ways of thinking, therapists help patients generate alternative interpretations and identify the consequences of these new interpretations of their emotions, behaviours, and their situation. The understanding of the problems and use of these techniques are reinforced by using homework and a diary record. Therapy is structured and time-limited. In order to prevent relapse, patients are encouraged to use these techniques after termination of the treatment and be their own therapist.

Another major feature of CBT is that the formulation of the therapy evolves as more information is gathered from the individual and conceptualised in cognitive and behavioural terms. In general, the formulation is developed on the basis of the information collected during the first consultation. It assists the therapist's understanding of the layers of the problems and informs the treatment plan. As therapy progresses, new data are incorporated in the case conceptualisation and the formulation is refined. New problems could arise and the order of the problems to be solved could also be changed.

Furthermore, CBT is goal-directed and requires the therapist and patient to work collaboratively towards effective problem solving. Therapists help patients to identify goals of the therapy in behavioural terms and evaluate the thoughts that might hinder achievement of the goal. Patients are required to be active participants in this process and to test the effectiveness of current strategies, beliefs and assumptions so as to ultimately acquire more adaptive coping skills.

The rationale of using CBT in pain management has been well described by Turk.[26] Patients' belief of the causes of pain, attitude to the impacts of pain and expectations of others and themselves all contribute to the severity of pain and their ability to cope with the pain. Behavioural therapies aim at 'increasing the sense of personal competence' whereas cognitive techniques aim to enhance 'self monitoring to identify relationship among thoughts, mood, and behavior, detraction using imagery, problem solving'. The final goal is to enhance self-efficacy by teaching patients the techniques to cope with their pain and its impact. CBT is not necessarily specific to each different type of pain and is often delivered to a group of patients who have pains of various origins.

A comparison of Chinese medicine consultation and cognitive–behavioural therapy

Table 2 illustrates the similarities and differences between CM consultation and CBT. Examples given about CM were based on standard CM consultation and diagnostic process. Among 11 CBT features, two are specific to CBT[18,27] and do not present in CM; five are specific to both therapies, but in different forms and with a different focus; and the remaining four are non-specific to either therapy.[27,28]

Two essential features of CBT highlight the core principle of CBT – that how one thinks and behaves impacts on their presenting problems; consequently, the therapy is designed to teach patients how to identify and change their unhelpful thoughts. Although CM recognises the interactions between one's emotional and physiological changes, it does not specifically challenge cognitions as that practised in CBT. CM, however, does try to change one's thoughts about their illness by providing a framework in which the connection between emotion and body is explained. As indicated in the hypothetical back pain case, the practitioner believes that as the Kidney Qi gets stronger, the patient will experience less fear. The CM framework, while clearly not cognitive–behavioural, nonetheless offers an alternative way of interpreting the pain and relevant events.

Five features specific to both therapies share similarities, but also have differences. For instance, both therapies are individualised and may change in details during the course of the therapy depending on how patients respond to the therapy and how the practitioners treat new data. However, in CBT therapists search for changes or new data in cognitive terms. In the low back pain case, John's fear of aging might be the initially identified problem. In latter sessions, John might report that his late father's last years of life involved tremendous suffering, and this further reinforced John's fear of aging. A CBT

therapist may then explore the relationship between John and his father in greater depth and develop an understanding of its impact on John's cognitions and behaviours, which in turn has implications on his low back pain. By contrast, in CM, the therapist would focus on whether the restoration of Kidney Qi was taking place. John's new story would be interpreted as a fear that further drains the Kidney Qi. The therapist would reinforce the idea that Kidney Qi could be improved with CM treatment, and would modify the treatment accordingly, such as introducing herbal treatments.

Four features that are non-specific to either therapy are about the structure of the consultation and patient–therapist interaction. They exist in most therapies.

TABLE 2 A comparison of Chinese medicine consultation and cognitive–behavioural therapy

Major features of cognitive–behavioural therapy[17,18]	Analysis	Explanation
Specific to CBT		
Assumes that thought and behaviour are affected by how one thinks	Specific to CBT, but not present in CM This is the core principle of CBT, and does not present in CM	CM does not specifically explore patients' thoughts and understanding of their health and well-being. It does, however, regard emotion as a cause of health conditions. For instance, if one gets angry easily, it can cause headache, premenstrual tension or low back pain due to upsurge of Liver Qi. Therefore CM somatises emotional or psychological problems.
Teaches patients to identify, evaluate, and respond to their dysfunctional thoughts and beliefs	Specific to CBT, not present in CM	CM teaches patients how to monitor their level of Qi, Yi and Yang, but does not specifically teach patients to evaluate or respond to their thoughts and mood. CM places great importance on *Shen*, a level of consciousness. It is understood that calmed *Shen* often results from balanced Yin and Yang.
Specific to both CBT and CM		
Based on an ever-evolving formulation of the patient and the problem in cognitive terms (Beck 1995)[18]	Specific to CBT and CM, but in different forms	CM practitioners treat the new problems as well as the main problem if they think the two are related. CM considers each patient has his or her unique pattern of syndrome presentation, and the pattern could change due to what happens recently. Consequently, the treatment is individualised and modified during each session if necessary. In CM, the ever-evolving formulation focuses on physiological and emotional discomfort, and the theories of CM or meridians are used to explain the interaction of the two. In CBT the focus is on cognitions, behaviours and their impacts on the presenting problems.
Goal directed, problem solving collaboration	Specific to CBT and CM, but with different focuses	In CM, patients are often given an explanation about why one might be ill, and where the treatment will lead to. CM's goals are to elicit **behavioural and physical changes**; and the problem solving aims to address obstacles to changes in behaviours, such as lifestyle, diet, and identifying and controlling of emotion. CBT goals are to elicit behavioural and cognition changes, and the problem solving aims to address obstacles to changes in behaviours and cognitions.
Use of homework assignment	Specific to CBT and CM but with different focuses	In CBT, homework is given with written record so that the patients can monitor their unhelpful thoughts and behaviours. In CM, patients are often given tasks, such as changing diet, doing exercise, or observing certain symptoms, to do at home. Some practitioners also give patients diaries to record their progress, but often homework is given without accompanying written record. The assignment is not about reflection, but about completing tasks.

TABLE 2 A comparison of Chinese medicine consultation and cognitive–behavioural therapy cont.

Major features of cognitive–behavioural therapy[17,18]	Analysis	Explanation
Specific to both CBT and CM cont.		
Educative, aims to teach the patient to be his or her own therapist, and emphasises relapse prevention	Specific to CBT and CM	'Treat before diseases occur' (*Zhi Wei Bin*) has always been considered the highest goal of CM. In one of the classic literatures, it is said that 'the best practitioners treat before diseases happen; the average treat when one is already having the disease'. Prevention is the core of CM. Patients are often taught how to regulate and preserve their Qi by various techniques, such as diet, exercise and meditation.
Use a variety of techniques to change thinking, mood and behaviour	Specific to CBT and CM, but with different techniques and different purposes	Herbs, acupuncture, Qigong, diet advice and meditation are used to change moods, physical discomforts and behaviours. Those techniques are not specifically designed to change one's cognition.
Not specific to either CBT or CM		
An active, structured dialogue	Not specific to either therapy	CM practitioners focus on the main complaint, then ask ten common questions. The consultation is structured.
Focus on the here-and-now	Not specific to either therapy	The consultation mainly focuses on recent events. In order to find the causes of the problem, sometimes information such as the health status of the patients when they were young is required.
Requires a sound therapeutic alliance (Beck 1995)[18]	Not specific to either therapy	Practitioner–patient relationship is important in any type of therapy. However, the alliance is explained differently in CBT and CM. Good bed-side manner and empathy have always been an essential part of CM. Furthermore, in CM practice, it is understood that the level of Qi of the practitioners and the patients are inter-related. In CM, there are social and physical connections between the practitioners and the patients.
Often time limited	Not specific to either therapy	A CM consultation varies from 30–60 minutes, and patients see the practitioners once or twice a week for three to four weeks. The frequency and length of treatments vary depending on the problem.

A comparison of the beneficial outcomes of traditional acupuncture treatment and CBT

A comparison of changes after CM consultation and CBT would be ideal. However, we were unable to identify studies specifically examining the effects of consultation alone without CM treatment. We compared patient-perceived benefits after traditional CM or traditional acupuncture as reported in qualitative studies with therapeutic outcomes induced by CBT. The CBT-like effects of CM were listed according to the categories of therapeutic outcomes provided by authors of published qualitative studies or judged by the authors of this paper.

A systematic review found that CBT reduced pain behaviour, altered pain experiences and enhanced positive coping for chronic pain patients.[29] Other studies also confirmed this conclusion and showed that CBT improved patients' sense of self-control over their pain (self-efficacy), reduced their reliance on the health care system and medications and improved their quality of life.[30,31]

Many CBT-like effects have also been found after CM treatment. Two interview studies, one retrospective[32] and one prospective,[9] indicate that at the end of a course of traditional

acupuncture treatment the majority of patients not only reported reduced physical symptoms, but also improved physical and psychological coping and experienced whole-person effects. The latter included an improved sense of wellbeing and self-awareness; the development of a holistic view about the health; a feeling of being able to take control of one's life; experiencing increased relaxation, energy and resiliency, and enhanced ability to function in relationships and at work; and taking responsibility for their health and lifestyle. Such improvements lead to enhanced confidence and reduced reliance on medications and doctors' visits. Physical, emotional and social changes are considered by patients and the researchers to be inter-dependent and indivisible, which further reinforce self-reliance.

Those therapeutic results are also supported by data from structured and semi-structured questionnaires.[12,14,15] Over 80% of patients reported improved emotional wellbeing.[14] 54% had changed the way they viewed their health, and over 40% reported changes in life and lifestyle, or behaviours, including diet, exercises and relationships.[14,15]

Table 3 summarises seven domains of the therapeutic outcomes of CBT. It is clear that all types of benefits were also reported by patients who underwent traditional CM treatment or traditional acupuncture. The most common outcomes are improvements in physical and emotional symptoms, enhanced physical and emotional coping and self-efficacy, and reduced reliance on other therapies. About one quarter of the patients also had changes in cognition[14] and increased ability to better function at work and in relationships.[13]

Discussion

On the surface, CBT and CM seem to be unlike each other, with CBT identifying and solving obstacles to cognition whereas CM aims to balance Yin and Yang, which often results in improvement in physical and emotional complaints. It is, however, reasonable to hypothesise that CM, being holistic, could induce systematic effects, including those on cognition and behaviours. Through examining and comparing the similarities and differences in the major features and effects of CM consultation and CBT, we find that CM shares nine out of 11 main features with CBT.

TABLE 3 A comparison of the types of therapeutic outcomes after traditional acupuncture treatment or CBT

	CBT[29]	Traditional acupuncture	Examples of therapeutic outcomes reported by patients who had Chinese medicine or traditional acupuncture
Physical changes	Yes	Yes	Symptom relief[9] and reduced intensity and duration of chronic complaints;[13] Reported by 75% of patients[14]
Emotional changes	Yes	Yes	Felt happy, calm and / or relaxed;[13] Reported by 83% of patients regardless of the types of their initial complaints[14]
Physical coping	Yes	Yes	Increased energy, changes in diet and lifestyle, and regular exercise;[13] Reported by 40% of patients[14]
Emotional coping	Yes	Yes	Reduced stress, having a sense of wholeness, balance, centeredness, and wellbeing[13]
Reduced reliance on medications or health care system	Yes	Yes	Reduced use of prescription medications, and reduced doctor visits[9,13]
Enhanced hope and confidence (Self-efficacy)	Yes	Yes	Experiencing increased sense of wellbeing, resilience, being more in tune with the body; feeling the treatment helping them relate to themselves and others much better, judging themselves differently, and experiencing improved spiritual awareness[9,13] 54% reported inner life changes and 27% reported major life changes, such as job or relationship[14]
Enhanced the capacity to identify and positively cope with unhelpful thoughts	Yes	Yes, but yet to be studied specifically	27% reported greater ability to take responsibility for health, decision making skills and recognition of a more holistic outlook,[14] increased ability to function in relationship and in work[13]

Furthermore, both may change patients' behaviours and cognition associated with their health. Both may change patients' views about their health problem and enhance their self-control, and improve physical and emotional wellbeing and teach patients new skills to cope with their pain. However, it is not clear if people who had CM treatment could cope positively with unhelpful thoughts, a key outcome of CBT. The two therapies differ in two major features that are specific to CBT; therefore CM has CBT-like effects, but is not a form of CBT. Nevertheless, this paper provides a new perspective on the effects and purpose of CM consultation. The consultation itself could be a critical component of the treatment, beyond its original function for gathering information to reach a differential diagnosis.

WHAT MEDIATES THE CBT-LIKE EFFECTS OF CM CONSULTATION?

It is necessary to identify what contributes to the specific cognitive and behavioural changes in patients after CM treatments. Are the changes mediated through CM's philosophical understanding of the body as a whole and treating physical and emotional aspects of one's body, the needling effects, or the combination of both?

In a study by Walker and colleagues,[32] patients reported that learning self-help strategies taught by acupuncturists, understanding the philosophy underlying acupuncture, needling or the patient–practitioner relationship (either as the main factor or a combination of a few or all) contributed to the results of the treatment. Gould and colleagues[14] found that patients who had more than 21 sessions of acupuncture were more likely to make lifestyle changes than those who had fewer sessions. In addition, only 18% of patients who did not experience benefits from acupuncture made lifestyle changes in comparison to 52% of patients who had gained benefits.

Furthermore, MacPherson and colleagues[10] found a high correlation between empathy from the acupuncturists and patients' enablement, and the latter was strongly related with improved well-being. Other studies indicated that the holistic view expressed by patients, including recognition of the interactions between the physical body and emotion and between health and lifestyle, was related to an enhanced self-awareness of both physical and mental wellbeing.[12,14]

How much of the physical and psychological changes are due to the style of CM consultation that encompasses an explanation of CM philosophy and how much is due to the physical stimulation of needling is unknown and has not been specifically examined. There is now growing evidence for the independent effects of medical consultations in Western medicine on health and wellbeing.[33,34] Therefore, one needs to seriously consider the possibility that the CM consultation is a critical component of the treatment.

The role of the CM consultation is perhaps better explained by a comparison between acupuncture practised by traditionally trained practitioners (traditional acupuncture) and that by physiotherapists or medical doctors (Western acupuncture). The former takes up the Chinese medicine theory of meridians and Yin and Yang, and treats a patient as a whole; whereas the latter emphasises the needling action, utilises the theory of neurophysiology and focuses on relieving the symptoms. Paterson interviewed patients treated by traditional acupuncturists and those treated by Western acupuncturists.[9,35] Patients treated by medical doctors and physiotherapists did not feel that they had been treated as a whole person in spite of improved physical symptoms. Comparing the two studies, patients who had Western acupuncture appeared less likely to change their view of health, experience an enhanced sense of wellbeing, or feel more in control of the life, when compared with patients who were treated with traditional acupuncture. It appears that how the illness was explained and how the patients were treated with acupuncture played an important part in these changes.

Hughes[36] directly compared the experiences of patients who were treated by traditional acupuncturists or Western acupuncturists or both at different times. Regardless of the therapeutic paradigms, the patients reported reduced pain, improved motilities, and felt more relaxed. However, a broader range of changes, such as an enhanced sense of wellbeing and energy, were only reported by patients who had treatments with traditional acupuncturists. Patients who had traditional acupuncture also viewed lifestyle changes and their therapeutic relationship with the acupuncturist as being part of the treatment, whereas those who had Western acupuncture only focused on the needling process.

It is interesting to note the similar experience reported by patients in a sham-acupuncture controlled trial and patients being treated by Western acupuncturists. In a migraine trial,[37] the participants felt that they were 'playing their part' as the subjects but not as the patients because they found the trial focused on needling and migraine, but neither on them as a whole person nor on other health symptoms that might be related to their migraine. The results imply that acupuncture treatment in a sham-acupuncture randomised controlled trial (RCT) is a procedure that is close to the Western style of acupuncture, which emphasises needling and the diseases; but not the traditional style that emphasises the person who has the disease.

Those preliminary results indicate that patients' perception of traditional acupuncture, whether in clinical practice or in clinical trials, is more than just needling, and encompasses many components. Patients who had traditional acupuncture are more likely to report behavioural and cognitive changes

when compared with those who have Western acupuncture. The different outcomes between the two are likely mediated through the consultation process and the acupuncturists' holistic view of health and illnesses.

Implications

The CBT-like effects might partially explain the holistic nature of CM. Such effects might have been under-estimated by practitioners. The individualised differential diagnosis is essential to CM treatments, but the process leading up to the diagnosis might bring about cognitive and behavioural changes. How to maximise such effects in clinical practice requires further research.

The CBT-like effects of CM is also under-estimated by researchers. Sham-acupuncture controlled trials assess the true effects of needling, but not those of acupuncture, as a therapy. We recommend randomised pragmatic trials that include a proper CM consultation and careful measurement of changes in cognition and behaviours. These trials would aim to evaluate the whole treatment effect, rather than attempting to isolate the needling component from the rest of therapy.

Conclusion

In this paper we draw data from textbook information and quantitative and qualitative research to discuss the CBT-like features and effects of CM consultations. It is not an experimental investigation, therefore we cannot be certain that the CBT-like effects are mediated via CM consultations, rather than the needling, or a combination of both. Nevertheless, we hope this paper provides a fresh look at the individualised differential diagnosis, and promotes consideration of CBT-like effects of CM consultation in research and practice.

List of abbreviations used

CBT: cognitive–behavioural therapy

CM: Chinese medicine

Competing interests

The author(s) declare that they have no competing interests.

Acknowledgements and Funding

No funding was available for this research.

Clinical Commentary

Chinese medicine (CM) consultation shares nine out of eleven features with cognitive–behavioural therapy (CBT). Traditional acupuncture induces cognitive and behavioural changes, which are perhaps due to a combined effect of needling and CM consultation. Clinicians are encouraged to consider the CBT-like effects of CM in their practice, and be aware of the therapeutic effects of the consultation itself.

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WFAS Sydney 2013: Selected Conference Abstracts

EDITOR'S NOTE: We are pleased to publish high quality abstracts from WFAS Sydney 2013 8th World Conference on Acupuncture. The conference attracted more than 250 abstract submissions. After a strict peer-reviewed process, the Editorial Board of AJACM selected 22 for publication. Each abstract was reviewed by two Editorial Board members. These abstracts were selected because of their high scientific quality and original data. We hope you enjoy reading them.

Chinese medicine in Australia: the nature of practice and perspectives of practioners and key stakeholders

By Amber Moore (Monash University); Paul Komesaroff; Kylie O'Brien; Alan Bensoussan; Hong Xu

In 2012 the largest survey of primary Chinese medicine (CM) practitioners in Australia since 1996 was undertaken, to investigate the clinical practice features and professional structures of CM in Australia. This is particularly significant given the recent transition to a national regulatory framework for CM. Results (n = 655, response rate 42%) demonstrate that the current practice of CM in Australia is made up of a diverse range of practitioners, practice styles and values. Findings reveal that primary CM practitioners work in a number of settings using a variety of CM modalities, with nearly two-thirds practising within sole practices (60%), 42 per cent practising predominantly acupuncture, and 58 per cent a combination of acupuncture and Chinese herbal medicine. Participants reported 'frequently' or 'almost always' engaging in behaviours characteristic of a health professional, including: patient receipting practices, providing detailed prescriptions, engaging in ongoing professional development, and reporting adverse events. CM practitioners consider both findings from evidence based medicine research and classical CM theory and practice to be important. Key themes arising from the interviews with practitioners and key stakeholders (n = 30), demonstrate a variety of perspectives on issues including education, clinical practice features, continuing professional development, and the benefits and limitations of national registration. The results indicate the Australian Chinese medical workforce to be engaged within several complex structural forces, including small business constraints, increasing interaction with other health care providers, and regulatory requirements. Despite these influences, CM practitioners report engaging ina high level of professional behaviours, providing further support for the increased integration of CM into the Australian health care system.

The views of patients with anorexia nervosa receiving an acupuncture or acupressure intervention

By Sarah Fogarty (University of Western Sydney); Caroline Smith; Stephen Youyz; Sloane Madden; Geoffrey Buckett; Phillipa Hay

Background: Anorexia nervosa is a serious illness with significant morbidity. The evidence base for existing psychological and pharmacological interventions to manage anorexia nervosa is not strong, and use of new adjunctive therapies that improve the effectiveness of existing treatments and improvemental health outcomes is highly desirable. This study investigates the views of patients with anorexia nervosa receiving an acupuncture or acupressure intervention. Method: A randomised controlled trial was conducted in Sydney, Australia. Twenty-six patients with anorexia nervosa were randomised to a six-week intervention of acupuncture or acupressure with light massage. Treatment was administered twice weekly for three weeks, then weekly for three weeks. A post treatment questionnaire was administered to explore participant views of the study interventions and consultations. Questions examined important aspects of the clinical encounter including the patient's perception of the practitioners' relational empathy (CARE), treatment perceptions and the therapeutic relationship. Results: Participants highly valued the therapeutic encounter and in particular the characteristics of empathy, positive regard and acceptance, non-judgemental responses and trust. Having someone to talk to, feeling less stressed, more relaxed and contact with the study staff were also perceived to be important to the participants. Participants in both groups scored highly on the CARE scale assessing empathy, with similar mean scores obtained for acupuncture (50 SD = 0.00) and acupressure (49.5 SD = 0.885). Conclusion: Study participants perceived the therapeutic relationship and empathy as an important part of the acupuncture or acupressure intervention as an adjunct therapy for the treatment of anorexia nervosa.

The role of acupuncture in the treatment of threatened miscarriage: findings from a randomised trial and semi structured interviews

By Debra Betts (CompleMED, University of Western Sydney); Caroline Smith; Hannah Dahlen

Objectives: Threatened miscarriage is a common complication of pregnancy with risk factors for miscarriage or premature labour. Although only a 'wait and see approach' is advised medically, treatment recommendations exist within acupuncture texts. The objective of this study was to examine the feasibility of offering acupuncture as a therapeutic treatment for women presenting with threatened miscarriage. Methods: A mixed methods study involving a randomised controlled trial and semi structured interviews. A manualised acupuncture protocol with individualised diet and lifestyle advice was compared to an active control group receiving a touch intervention with medical diet and lifestyle advice. Eleven participants were purposively interviewed about their experiences on exiting the trial at 12 gestational weeks. Interviews were recorded, transcribed verbatim and analysed through thematic analysis. Results: Forty women were successfully randomised. For those women receiving acupuncture there was a statistically significant reduction of a symptom self-selected as their primary concern ($p = 0.04$). Thematic analysis revealed that women were dissatisfied with the medical care and advice they received and saw entering the trial as 'finding something you can do'. Women valued the opportunity to 'have someone to talk to' and perceived acupuncture as having benefits for their physical symptoms of bleeding, cramping and back pain. Conclusion: This pilot RCT demonstrated that acupuncture was a safe and feasible intervention and provided additional benefits to touch in reducing a symptom nominated by women as a concern. Further research is justified to further explore acupuncture use in this area of clinical practice.

The efficacy of acupuncture in treatment of functional nausea, bloating and abdominal pain in patients on the characteristics of the electrogastrogram (EGG)

By Lihua Xu

Acupuncture has been used since antiquity for gastrointestinal complaints including nausea and abdominal pain, although its effects on gastric myoelectric activity are unknown. The aim of this study was to examine the effect of acupuncture on symptoms of nausea (N), abdominal pain (AP) and bloating (B) and on the characteristics of the electrogastrogram (EGG). Methods: 22 patients (f = 19, m = 3) aged 17–66 years, 44.14 ± 2.74, who had symptoms refractory to conventional treatment and with normal or abnormal gastric emptying studies were studied. Symptoms of N, AP and B were scored on a visual analogue scale (VAS) with 0 for no symptoms and 100 for severe. All patients completed a VAS for symptoms on entry in the study. Fifteen minutes of baseline EGG were recorded and, at the first study, patients drank water until full. Acupuncture needles were inserted into points P6, SP4 bilaterally and DU20 for 30 minutes. The EGG was recorded for the entire study and the patient completed the VAS for symptoms at the end of the study. Patients returned for one or two additional treatments with at least two weeks interval between treatments. Water load was not performed at the second or third visits. EGG was analysed to record the percent of power represented in the frequency ranges of 1–2.5 cpm, 2.5–3.7 cpm, 3.7–10 cpm and 10–15 cpm at baseline and during acupuncture at each treatment. Data was combined from the three studies ($n = 22$). Scores before and after acupuncture treatment were compared by ANOVA and t-test. Results: Acupuncture significantly decreased the severity of nausea, abdominal pain and bloating, and increased the percent power in the normal 3 cpm range in the recorded EGG. Conclusions: In this study, acupuncture treatment improves symptoms of nausea, abdominal pain and bloating in subjects with these symptoms of unexplained aetiology. In addition, treatment is associated with an increase in power of the EGG at three cycles per minute. Further studies are needed to determine if the change in gastric myoelectric activity can account for the symptomatic improvement. Acupuncture appears promising as a treatment option in patients.

TCM pattern differentiation for hepatitis C virus within a small sample group

By Christine Berle (University of Technology Sydney), Deirdre Cobbin, Narelle Smith, Chris Zaslawski

Background: In 2010 an estimated 224000 people in Australia lived with chronic hepatitis C virus (HCV), with another 9700 anticipated annual infections. Pattern differentiation (PD), an integral aspect of traditional Chinese medicine (TCM) differentiates biomedical diseases into patterns. PD is used to diagnose, direct the treatment principle and determine treatment protocol. The aim of this study was to determine whether acupuncture could improve health outcomes of people with HCV. Methods: Hepatitis TCM patterns and associated symptoms/signs were identified from TCM literature. Sixteen HCV participants were enrolled in a randomised, controlled pilot study and allocated to an acupuncture treatment or sham acupuncture control group. Each participant was assessed against these patterns (symptom/signs) at baseline and on completion (week 12) using an innovative methodology which allowed evaluation. Results: Seventeen patterns were identified with participants expressing both different and multiple patterns. Three major patterns expressed group aggregate mean percentages of; Liver yin vacuity 47.2%, binding depression of Liver qi 46.9% and Liver Kidney yin vacuity 45.1%. Further sub-category sex grouping revealed ranking changes; Liver yin vacuity (male = 43.4%; female = 51.92%), binding depression of Liver qi (male = 51.6%; female = 42.86%) and Liver Kidney yin

vacuity (male = 46.4%; female = 48.96%). There was a significant mean percentage decrease in pattern expression at week 12 compared to baseline for the secondary and tertiary patterns for the acupuncture treatment group (56.3% versus 47.5%; p = 0.045 and 48.1% versus 33.6%; p = 0.037, respectively). No significant change was found for the major patterns of the control group or for the treatment group's primary pattern. Conclusion: The quantification of patterns of a HCV sample group allowed the identification of HCV patterns within this study group and the evaluation of treatment outcomes.

Accidents do happen! A discussion of acupuncture incident and adverse effect reporting in New Zealand
By Kate Roberts (New Zealand School of Acupuncture and TCM)

Aims: This paper aims to raise awareness among practitioners, and other health related professionals, of the incident reporting for acupuncture-related adverse treatment effects. It provides a chance to reflect on potential safety issues within clinical practice and identify chances to improve reporting systems. Methods: A five-year retrospective analysis of incident reporting via the main compensation provider in New Zealand (ACC) was conducted. In addition to this, a report of clinical incidents from the largest education provider of acupuncture in New Zealand was undertaken. Discussion: Between the years of 2006 and 2010 a total of 27 acupuncture-related treatment injuries have been reported to the key insurance body in NZ, ACC. This included three wound infections and a pneumothorax which was also lodged as a complaint to the Health and Disability Commission. In the same time period, at the largest TCM training institution in New Zealand, four clinical incidents resulting in injury have been lodged to administration. These included two burns, one fainting episode and one pneumothorax. In addition to this there were various complaints regarding safe needle disposal. There is currently no official system of data collection within the professional acupuncture bodies in New Zealand but self-reporting is encouraged. Conclusion: While the rate of incident and adverse effects from acupuncture is minimal, there are still preventable injuries occurring in clinical practice. A more consistent and transparent system of reporting could lead to identification of areas for continuing education for practitioners and highlight areas for education providers to focus on.

From the classical to the modern: views on the efficacy and safety of Chinese herbal medicine
By Hong Xu (Victoria University)

Background: The safety and efficacy of Chinese herbal medicine have been lengthily examined, and a system of theory and practice has been established and developed gradually in the past thousands of years through life and clinical practice. The further development in safety and efficacy has never stopped and is progressing rapidly in the modern world, assisted by modern scientific methods. Objectives: The herbal bioactive elements and levels of toxicities are two of the important aspects. Main results: The concentrations of elements determined by Inductively Coupled Plasma Mass Spectrometry (ICP-MS) and Atomic Absorption Spectrometry (AAS) indicated that herbs which were traditionally used for invigorating blood and modernly used for benefiting coronary and vascular disease, e.g. *Tian Ma* (*Rhizoma Gastrodiae Elatae*) and *Shan Zha* (*Fructus Crataegi*) contain a relatively higher dosage of Lanthanum (La); herbs which were traditionally used for detoxifying and modernly used for benefiting immune function, e.g. *Jin Yin Hua* (*Flos Lonicerae Japonicae*) and *Bai Hua She She Cao* (*Herba Hedyotidis Diffusae*), contain a relatively higher dosage of Selenium (Se). Acute liver toxin studies in rats indicated that herbs/foods which were traditionally used for benefiting liver function could be used for reducing liver demage, e.g. *Wu Hua Guo* (*Ficus carica*). However, some herbs which were not listed in the traditional category of toxicity could cause acute liver damage. Conclusion: Modern studies demonstrated the objective evidence of the established therapeutic effects, explored the direction of pharmaceutical development and advanced the views of safety use of herbs. Herbal toxicity and methods of formulation in reducing potential side effects need to be further studied and developed.

No Roots, No Fruits: the importance of the classics in modern times
By Peter Firebrace

Background: As Chinese medicine enters a new phase of international growth and is transplanted into very different soils, the integrity of the plant itself is key to its flourishing. Without roots, there will be no shoots, no flowers and no fruits, reducing Chinese medicine to a parody of itself, decreasing its effectiveness and preparing for its inevitable decline. With strong roots, the plant will take on a new lease of life, of vigorous growth and development, a true embodiment of the long life vision of the ancient practitioners and writers. Objectives: To show how the Chinese philosophical and medical classics, written in another time and another culture, have not only historical relevance for us today, but present and preserve key concepts that are essential to the practice and survival of Chinese medicine in our modern world. Method: Analysis of the essential concepts of Chinese medicine that form the basis of a different perception of health and disease to Western medicine. This perspective is set out in the philosophical classics such as the *Laozi* and *Zhuangzi*, in the medical classics such as the *Neijing* and *Nanjing*, the *Jiayijing* and *Zhenjiu Dacheng*, in the *Yang Sheng* Nourishing Life and *Neidan* Inner Alchemy traditions, and in the contributions from such giants as Hua Tuo, Sun Simiao and Li Shizhen. Results: Chinese medicine stands at a crossroads. Its deep roots in the classics have shaped the Chinese medicine we practise

today, but in the search for acceptance and the pressures to conform to the dominant paradigm of the Western medical model in the modern world, this deep-seated foundation is at risk of neglect and degradation. As practitioners and educators its future lies in our hands. The heritage we received is ours to pass on in turn, adapted to modern times, enhanced, and not degraded. Conclusions: So many bright minds down the centuries have shared their thoughts in texts, commentaries, images, body maps and diagrams, all with one aim in mind – to preserve health and prevent disease. While going forward into new times and new places, Chinese medicine needs to preserve its roots or lose its effectiveness and its unique identity.

'Does it really matter?': students' perception of the *Huang Di Neijing Suwen*
By Kate Roberts (New Zealand School of Acupuncture and TCM)

Purpose: Discussion of the *Neijing Suwen* (Yellow Emperors Classic) has formed part of the NZSATCM BHSci (Acup) fourth year curriculum since its inception in 2008. Discussion tutorials based on selected chapters form the basis of delivery for this subject. This paper aims to investigate students' perception of the relevance of this classic to clinical practice and to gauge their understanding of the concepts included within the text. Methods: Email questionnaires were sent to the 2013 and 2012 cohort of fourth year students to gauge interest in discussing the topic area and to ascertain any initial themes for discussion. Following this a focus group was held and, using a semi structured format, students were asked to discuss highlights in their understanding during their study of the classic. Data was analysed using thematic analysis. Results: Thematic analysis brought out the overarching theme that students used this text to place their learning into a historical perspective. Students stated that the text 'puts theory into perspective' and creates 'a connection to the past'. The focus group further identified specific aspects students valued including 'macrocosmic influences matter' and the purpose of 'seeking ideal practice' illustrating how this classical text influenced clinical practice. Conclusion: The findings from this paper showed how students benefited from the inclusion of the study of the *Neijing* during their fourth year of study. The Classic supported their theoretical understanding of acupuncture and the holistic nature of TCM.

Swimming in the mainstream: the growth of acupuncture and Chinese medicine in New Zealand
By Paddy McBride (New Zealand Register of Acupuncturists)

Since the New Zealand Register of Acupuncturists was founded in 1977, the practice of acupuncture and Chinese medicine has come a very long way. The first meeting was attended by eight practitioners – we now have more than 500 members throughout the country. In 1977 it was not possible to study acupuncture in New Zealand – the first practitioners all had to travel overseas in their quest for knowledge. Acupuncture is now offered as a Bachelor Degree recognised by the New Zealand Qualifications Authority. A study of general practitioners in 2006, published in the *New Zealand Medical Journal*, ascertained that the majority considered acupuncture to be mainstream medicine. We don't believe that we are yet as mainstream as we would like to be but there is no doubt we are making great progress. The general public of New Zealand are beginning to embrace both acupuncture and Chinese herbal medicine. New Zealand's Accident Compensation Commission has accepted members of NZRA as treatment providers since 1990. Every year more people access acupuncture treatment to assist in their recovery from accidental injury. Once they have experienced how effective it can be, they invariably return to the clinics for treatment of other conditions. With the growing ethnic Chinese population, particularly in Auckland and to a lesser extent, Christchurch, New Zealanders are being exposed to more and more of the Chinese culture generally. What was once so very foreign is rapidly becoming mainstream.

The effect of acupuncture treatment compared to sham laser for lateral elbow pain: a randomised controlled pilot study
By Christine Berle (University of Technology Sydney); Chris Zaslawski; Deirdre Cobbin; Peter Meier; Sean Walsh; Seong Leang Cheah

Background: Lateral elbow pain is a common painful musculoskeletal condition affecting approximately 1–3% of the population. Methods: A randomised participant-blinded controlled pilot study was undertaken to determine whether acupuncture could relieve pain and improve function for this condition. Twenty participants were randomly allocated to either a standardised acupuncture protocol (n = 11) or sham laser (n = 9) over ten sessions. Outcome measures were PPT test, McGill/Melzac pain, DASH and VAS pain questionnaires. Participants were evaluated at baseline, on completion of treatment (week five) and one month later. Results: There was no significant difference between the groups at baseline for any outcome parameter. There were no significant changes found at completion or one month follow-up for the PPT and VAS measures. There were significant improvements for the acupuncture group for the McGill questionnaire at week five for the affective (p = 0.01) and miscellaneous (p = 0.02) sections; week nine total score (p < 0.03), affective (p = 0.01) and miscellaneous (p = 0.01) sections; the DASH at week five for work (p = 0.02) and sport (p = 0.01) modules and week nine general (p < 0.04), work (p = 0.01) and sport (p = 0.006) modules. There were no significant changes for any outcome measure for the control group. There was no significant difference found between the two groups for blinding efficacy (expectancy/credibility scale) and experience of *deqi* at baseline or on completion. Conclusion: Results indicate that acupuncture may be helpful in alleviating pain and improving

arm functionality, but small participant numbers preclude any definitive conclusions, a larger sufficiently powered study is required.

The practice of acupuncture and moxibustion to promote cephalic version for women with a breech presentation: implications for clinical practice and research
By Caroline Smith (CompleMED, University of Western Sydney); Debra Betts

Objective: To examine what expert acupuncture practitioners and researchers considered key aspects of treatment to promote cephalic version, and to establish a protocol through consensus to guide an effective and safe treatment protocol for the self-administration of moxa by pregnant women. Method: The Delphi method was used to seek the opinions of key informants. Sixteen English-speaking international, Australian and New Zealand acupuncturists working in the area of pregnancy were invited to participate in the study. Result: Two rounds of the Delphi process were undertaken, 12 participants completed round one, and 10 completed round two. Safety was identified as an important factor in relation to the expectant mother and her baby. Eighty per cent of participants agreed that moxa should commence between 34 and 35 weeks. Ninety per cent agreed to self-administration of moxa by the woman, and use of smokeless and odourless sticks. Seventy per cent agreed moxa should be applied for a minimum of ten days, and should be applied once a day for 30 minutes. Ninety per cent agreed study clinical outcomes should assess side effects including burns, and maternal and foetal outcomes. Conclusion: The findings from our study demonstrate the clinical validity for our future research protocol, and highlight other areas for research to evaluate the role of acupuncture and moxibustion with normalising birth.

From clinical practice to clinical trial: the development of a clinical trial protocol for period pain
By Mike Armour (University of Western Sydney)

Objectives: Many clinical trials of acupuncture do not capture the complexity of how traditional Chinese medicine (TCM) is practised in the community. We aimed to use the knowledge of experienced clinical practitioners to develop a clinical trial protocol for treating period pain that reflects a balance between research and practice. Methods: An online and postal survey of all registered acupuncture practitioners in Australia and New Zealand was undertaken to provide broad information on the scope of clinical practice. European and Chinese trained practitioners from NZ and Australia who either identified as experienced practitioners in the women's health survey, or were identified due to their clinical experience in women's health, were invited to take part in focus groups and interviews. Written data on pattern discrimination and point usage was also collected. Data was analysed using quantitative methods and thematic analysis to provide a rich data set. Results: Nineteen practitioners (11 New Zealand, eight Australian) contributed information on important treatment components (such as lifestyle advice, treatment timing, treatment frequency and needle stimulation), important acupuncture points and key patterns of disharmony for period pain. Conclusions: Community based, clinically experienced practitioners provided a diverse perspective on key aspects of clinical treatment of period pain with acupuncture. This information was used to develop a manualised acupuncture protocol for an upcoming randomised controlled trial on acupuncture for period pain.

Development of a novel questionnaire for the TCM pattern diagnosis of stress
By Shuai Zheng (University of Technology, Sydney); Peter Meier; Chris Zaslawski

Background: The term 'stress' is a common diagnosis used by both patients and practitioners alike to describe a 'condition' generally regarded as subjective in nature. That is, each individual will report varying somatic or cognitive symptoms. Currently there are no definitive diagnoses or signs and symptoms for 'stress' for both biomedicine and traditional Chinese medicine (TCM). Method: Signs and symptoms for General Anxiety Disorder and commonly reported signs and symptoms for stress were cross referenced against modern TCM textbooks to relate each sign and symptom to possible patterns (*zheng*) and then cross referenced again against the signs and symptoms list to form two gender specific questionnaires. Pattern identification measurement is based on percentile rank of signs and symptoms present against possible number of signs and symptom per pattern for each gender. The questionnaires were administered at two separate time intervals on the same day to 20 participants (n = 10 male, n = 10 female) who identified themselves as stressed. Test-retest reliability and the most frequently scored patterns were then calculated. Results: Test-retest analysis found that the Pearson's correlation for females was 0.84 while for males it was 0.85. In addition the most common patterns reported were heart blood deficiency, heart qi deficiency and liver blood deficiency. Conclusion: Findings from this preliminary study show potential for this instrument as a novel diagnostic tool for the identification of the patterns associated with stress.

Evaluation of auricular points treatment for obstructive sleep apnoea
Chao-Nan Yang (Chang Bing Show Chwan An Memorial Hospital); Pei-Shan Hung; Cheng-Yu Wei; Dauw-Song Zhu; Jiawei Zhang

Background: Obstructive sleep apnoea (OSA) is one of the most common and disruptive sleep disorders. OSA has causal relationships with many diseases, such as stroke, hypertension, coronary artery disease and obesity related metabolic diseases. The treatment methods in Western medicine

include conservative treatment, continuous positive airway pressure, oral devices and surgery. In traditional Chinese medicine (TCM), Chinese herbal medicine and acupuncture treatment are the mainstream, but some people are afraid of acupuncture or dislike the bitterness of herbal medicine. Therefore, auricular points treatment might be a third option in TCM. Objective: To study the clinical effect of auricular therapy on OSA, and to find out the constitution of TCM syndrome classification statistics of OSA patients. Methods: The patients were randomly divided into two groups, with 30 cases in the treatment group treated with auricular point sticking and pressing beads and 30 cases in the control group treated with auricular point sticking plaster pressure. The two groups were treated at the same auricular point, once per week. Both groups received one course in total, with two weeks per course. Before treatment two groups filled in sleep questionnaires and TCM constitution assessments; before and after treatment they received monitoring of polysomnography. Results: Comparing the respiratory disturbance index (AHI) before and after treatment, significant differences could be seen in both groups ($P < 0.01$ in treatment group, $P < 0.05$ in control group). Comparing the snore index before and after treatment, significant differences could be seen in both groups ($P < 0.01$). Conclusion: In patients with OSA, constitution types are mainly qi deficiency and phlegm dampness constitution. Auricular therapy can effectively improve AHI and snore index in OSA patients.

Building community trust and protecting public safety: the Australian national registration of Chinese medicine practitioners

By Charlie C Xue (Chinese Medicine Board of Australia)

Background: In 2008 the Council of Australian Governments (COAG) decided to establish a single National Registration and Accreditation Scheme (the National Scheme) for ten health professions. A further four health professions joined the scheme from 1 July 2012, including Chinese medicine. Prior to this, regulation of Chinese medicine practitioners was in place in the state of Victoria only. The National Scheme was established under the *Health Practitioner Regulation National Law Act 2009* (the National Law). There is a National Board for each of the 14 regulated health professions. The Australian Health Practitioner Regulation Agency (AHPRA) is the single agency that supports the National Boards and the National Scheme. Objectives: The role of the Board is to protect the public and set standards and policies that registered Chinese Medicine practitioners must meet. To be registered a practitioner must meet all the Board's registration standards including: criminal history checks; continuing professional development; professional indemnity insurance; recency of practice; English language skills; and grandparenting and general registration eligibility. Other functions of the Board include: handling notifications; assessing overseas trained practitioners who wish to practise in Australia; and approving accreditation standards and accredited courses of study. The presentation will provide a comprehensive update on the regulation of the profession and the progress of the Chinese Medicine Board of Australia. Main results: By June 2013, there were 4070 registered Chinese medicine practitioners in Australia. New South Wales hosts the largest registrant base with 40.52%, followed by Victoria (28.28%) and Queensland (19.29%). Much has been learnt to date. Besides the common challenges, several unique issues such as language, qualification, as well as transitions of legal issues from the former Chinese Medicine Registration Board of Victoria, that the Board has given priority to ensure timely implementation of the practitioner registration process. Conclusion: National registration of the Chinese medicine profession is a landmark development in Australia and the Western developed world.

The effects of acupuncture on mucosal immunity in perennial allergic rhinitis: a randomised, subject-and-assessor-blinded, sham-controlled clinical trial

By John McDonald (Griffith University); Allan Cripps; Peter Smith; Caroline Smith; Charlie Xue; Brenda Golianu

Between 2009 and 2012, 148 adults with perennial allergic rhinitis were recruited and randomised into three groups: real acupuncture, sham acupuncture and no acupuncture. Objectives: The primary objective of the trial was to measure any changes in mucosal immunity after acupuncture, specifically any modulation of pro-inflammatory neuropeptides (SP, VIP & CGRP), any modulation of neurotrophins (NGF & BDNF), and any shift in Th1/Th2 cytokine balance. Secondary outcomes included clinical measures and self-assessment tools such as the Mini rhinoconjunctivitis quality of life questionnaire [MiniRQLQ]. Methods: The real and sham acupuncture groups received acupuncture treatments twice weekly for eight weeks. All groups were assessed by an allergy specialist at baseline and at one and four weeks follow-up. Peripheral venous blood was collected at baseline and four weeks follow-up, and saliva samples were collected at several time-points. Data are presented as mean and standard error of mean. Results: No significant differences were seen in levels of SP, VIP, CGRP, NGF, BDNF or cytokines four weeks after acupuncture treatment. However significant down-regulation in salivary SP was seen 18 to 24 hours after acupuncture (101.09+26.49 pg/ml) compared to pre-treatment (517.95+383.56 pg/ml) ($p = 0.040$). Significant improvements in clinical symptom scores were seen in the real acupuncture group after the first two weeks of acupuncture treatment (Week 1 – 23.27+2.68; Week 3 – 20.33+2.98) ($p = 0.023$) and these improvements persisted

for four weeks after treatment (Week 12 – 17.60+3.37) (p = 0.003). Conclusions: Acupuncture is effective in alleviating symptoms of allergic rhinitis however modulation of neurotrophins, pro-inflammatory neuropeptides and cytokines does not appear to account for this clinical improvement.

The Chinese Medicine Board of Australia's policy on infection prevention and control for acupuncture practice

By Stephen Janz (Chinese Medicine Board of Australia)

Background: The prevention and control of infection is a key professional responsibility of the acupuncture practitioner. In keeping with its primary objective of protecting public health and safety the Chinese Medicine Board of Australia (the Board) has developed Infection prevention and control guidelines for acupuncture practice (the Guidelines). The guidelines are in addition to the NHMRC Australian guidelines for prevention and control of infection in healthcare (the Australian guidelines) which the Board has adopted. The Board's guidelines highlight key features of the Australian guidelines; clarify acupuncture specific areas which are not clearly addressed in the Australian guidelines; and provide emphasis and clarification specific to controlling the risk of infection in acupuncture practice. Aim: The CMBA Guidelines aim to identify specific requirements for the prevention and control of infections in acupuncture practice that are not covered in the Australian Guidelines. The development of the CMBA guidelines take a risk management approach consistent with Australian guidelines and are based upon the best available evidence. Method: The Australian guidelines were examined by the Board to identify areas which required further acupuncture specific guidance. A literature search was then conducted using the State Library of Queensland online search tool and Google using the keywords 'acupuncture' 'infection' 'prevention' 'control'. Limited acupuncture specific infection control literature was identified and one evidence based set of guidelines was found. A further search was conducted for evidence based guidelines for established procedures with a similar procedural risk profile to acupuncture. NHMRC immunisation guidelines and WHO guide to best practice for injections and related procedures were identified. Draft guidelines were developed by the Policies, Standards and Guidelines Advisory Committee (the Policy Committee) based upon the identified evidence based guidelines, revised and approved by the Board for stakeholder consultation. Stakeholder feedback was reviewed prior to finalising the document. Results: Additional guidelines have been developed concerning hand hygiene and the use of alcohol based hand rub; single use of critical items such as acupuncture needles and bamboo cups; appropriate use of gloves; routine skin preparation and post treatment procedures; non-sharp waste disposal; and the prevention and management of sharps injuries. Conclusion: The Guidelines are published on the Chinese Medicine Board of Australia website (www.chinesemedicineboard.com.au) and apply to all Chinese medicine practitioners registered in the division of acupuncture. The Guidelines may be of interest to other health professionals, educators, and regulators concerned with acupuncture practice.

Physiological activities elicited by acupuncture and its sham device in humans and rats

By Kenji Kawakita (Meiji University of Integrative Medicine); Kaoru Okada; Maria Carneiro; Eiji Sumiya; Chie Ogasawara; Yukihito Sugawara; Shigekatsu Aizawa; Syuji Goto

Objective: The purpose of this study was to evaluate the physiological activities of various sham interventions used in recent clinical trials of acupuncture. Such interventions were assumed to be inert. Methods: Neural activities elicited by various acupuncture stimuli, including acupuncture manipulation, press tack needle (PTN), and sham acupuncture stimuli, were recorded electrophysiologically from the afferent fibres in humans and pain-related neurons and/or reward-related nuclei in the rat's central nervous systems. Peripheral nociceptors were classified into C mechano-heat (CMH) units and A mechano-sensitive (AH) units in humans, and central neurons were classified into nociceptive specific (NS) and wide dynamic range (WDR) neurons based on their responsiveness to mechanical and thermal stimuli in rats. The protocols of both experiments were approved by the ethical committee of our university. Results: In humans, all CMH (n = 10) units were activated by real acupuncture, PTN and various sham interventions, but not by sham PTN. In rats, acupuncture manipulation including real PTN activated the NS neurons in the periaqueductal grey matter (PAG, n = 5) and the nucleus accumbens (major nucleus for rewarding system, n = 4). No response was elicited by sham PTN. Conclusion: Various sham interventions used in the published clinical trials could activate the CMH units, presumably C polymodal receptors in human. Only sham PTN could be considered an inert intervention in humans and rats. Real and sham PTN might be useful for future clinical trials of acupuncture.

An innovative approach to individualised acupuncture treatment: preliminary findings of a study on individual variations in endogenous pain controls

By Zhen Zheng (RMIT University); Kelun Wang; Dongyuan Yao; Charlie CL Xue; Genevieve Iversen; Lars Arendt-Nielsen

Introduction: A painful stimulation applied to one site of the body inhibits pain at a distant part. This is called conditioned pain modulation (CPM). The same painful stimulation inhibits pain at or close to the site of stimulation, which is labelled as segmental inhibition (SI). Such controls have been shown to partially explain acupuncture analgesia. Aim: This study aims to

investigate if there were individual variations in potency of CPM and SI; and if such variations were association with individual response to acupuncture. This abstract reports the preliminary findings. Methods: Forty-one healthy humans were recruited to undertake a cold pressor test, which reliably produces CPM and SI. Subjects were asked to put their left hand in icy water (1–4°C) for five minutes. Pressure pain thresholds (PPT) were measured on the bilateral forearms and right leg before, during and 20 minutes after cold pressor. Rating to cold pressor pain was recorded at 2Hz during the five minutes using an electronic Visual Analogue Scale. Thirteen out of forty one subjects then had real or sham acupuncture treatment to left LI 10 and LI 4 for 20 minutes in a random order on different days with one week apart. PPT was measured before, immediately and 30 minutes after acupuncture. Individual variations in CPM and SI were identified. Analysis of variance was then used to analyse the interaction between individual differences in potency of CPM and SI and their response to real and sham acupuncture. Results: During cold pressor, one group of subjects (n = 16) reported increased then decreased pain at two minutes after immersing the hand in icy water (pain adaptive group); whereas the other group (n = 25) reported increased then stabilised pain response (pain non-adaptive group). There was no difference between the two groups in CPM, but pain adaptive group had more potent and long-lasting SI than the pain non-adaptive group ($p < 0.05$). There was no difference between real and sham acupuncture on PPT changes. There was group difference in their response to acupuncture on PPT measured at where acupuncture was (group by type of acupuncture by time interaction $p = 0.009$). That is in pain adaptive group, there was no difference between analgesia induced by real and sham acupuncture. In pain non-adaptive group, real acupuncture increased PPT for a short period, and the effect did not last more than 20 minutes; but sham acupuncture induced better analgesia at 20 minutes after acupuncture. Conclusion: Our preliminary findings indicate that adaptability to pain and potency of SI are perhaps important contributing factors to individual response to real and sham acupuncture. Studies with a larger sample size are required to confirm the finding.

How we treat women's health: The results of the 2012 Australian and New Zealand Women's Health Practitioner Survey

By Mike Armour (University of Western Sydney); Caroline Smith; Debra Betts

Objectives: Surveys from the United Kingdom and Europe report that treating women's health is a popular area of clinical practice. However, there is little data describing the characteristics of acupuncture practice in Australia and New Zealand. The aim of this study was to investigate the practice of acupuncture for women's health. Methods: An online or paper survey was distributed via email or post to all 3 498 active members of major professional acupuncture bodies in Australia and New Zealand. Data was collected on the treatment of each subsection of women's health: menstrual, fertility and pregnancy related conditions. Commonly treated biomedical diagnosis, the interventions used and information on referral networks were collected for each subsection. Demographic data and practice characteristics were also collected. Results: 377 practitioners responded (10.7%) to the survey. Ninety six per cent reported they had treated women's health conditions in the past year. Of those practitioners who treated women's health, 97 per cent had treated menstrual conditions, the most common conditions included pre-menstrual syndrome (90%), menopause (89.5%) and primary dysmenorrhea (89%). Ninety per cent treated fertility including general fertility health (93%), fertility related stress (86%) and as an adjunct to biomedical treatment (85%). Ninety one per cent treated pregnancy with common conditions including nausea (92%), back and hip pain (92%) and birth preparation (89%). Conclusions: Acupuncturists in New Zealand and Australia treat a wide range of women's health conditions using a variety of treatment interventions.

From apprenticeship to the classroom: the teaching of TCM hand skills – an exploratory protocol

By Suzanne Cochrane (University of Western Sydney)

Background: The transformation of Chinese medicine education in the last century has been from a set of knowledge and skills transmitted by senior experienced doctors to a small number of students or apprentices, who observe and participate in their clinical practice, to a classroom based university setting graduating multiple doctors to service a different and demanding health care system. It would be expected that manual or hand skills would suffer most in these changes as the opportunity for observation and daily practice is more limited. There has been little examination of what teaching methods are used in TCM classrooms for transmitting hand skills nor of the impact of classroom based teaching on student skill levels. An exploratory research project that begins this examination has been initiated and will be completed in 2014. Objective: To examine teaching methods for practical hand skills in TCM educational institutes. Method: The first stage focuses on observation of classroom teaching of hand skills in relation to pulse diagnosis and acupuncture needle manipulation in three Chinese TCM universities using videorecordings of a real time class. The resulting videos are to be analysed for teaching methods used and a textual analysis done of the teacher's contribution to the class and the teaching techniques they used. Results and Conclusion: The results will be contrasted with contemporary teaching in Western TCM educational institutions. Future research could include more comparative data on actual skills in the TCM trained Chinese and Western student; the balance of skills-training that happens in clinical settings compared to classrooms (and whether this matters); and perhaps a contrast of the apprenticeship trained practitioners with their classroom trained peers.

International Perspectives on Registration of Acupuncture

Recognition and registration of acupuncture in Belgium: a status quo

Tom Verhaeghe, ECTMA Executive Committee

The Colla Law of 1999 provides for registration of four non-conventional practices (homeopathy, osteopathy, acupuncture and chiropractic), with the aim to ensure patient safety. Each of the four practices has its own Chamber, providing advice to a Joint Commission and to the Minister that ought to be carried out before the beginning of 2014.

Homeopathy was discussed first. The Royal Decree of the Minister on the recognition of homeopathy is finished and can be found at www.homeopathyeurope.org/media/news/newsletter-26-july-2013/copy_of_regularisation-of-homeopathic-medicine-in-belgium.

Osteopathy practitioners have largely finished their meetings and have even had their hearing in the House of Representatives. A full report on this by Nathalie Muylle (Christian Democratic and Flemish) and Maya Detiège (Socialist Party Different) can be found at www.lachambre.be/FLWB/PDF/53/2644/53K2644002.pdf (French/ Dutch). Osteopaths are now waiting to see what the Minister will make of the opinions of the Chamber for Osteopathy and the parliamentary debate.

But what about the regulation of acupuncture?

THE CHAMBER FOR ACUPUNCTURE AND THE JOINT COMMISSION

The Chamber for Acupuncture has formulated six recommendations. An overview can be found at www.health.belgium.be/eportal/Healthcare/healthcareprofessions/NonConventionalPractices/19083706_FR?ie2Term=acupunctuur&ie2section=83&fodnlang=fr#.UfzPaY0tR8F (French).

The first recommendation is about the appropriateness of the registration of non-conventional practices: 'The Chamber for Acupuncture recommends to the Joint Commission the registration of acupuncture as it is relevant.'

The second recommendation sets out the definition of non-conventional therapies: 'Acupuncture is a technique that is complementary to health care, which includes amongst others its historical roots in traditional Chinese medicine, and whose purpose is to achieve a therapeutic effect by stimulation of specific points on the human body using sterile needles.'

The third recommendation concerns the training needed to achieve the required profile in the practiced non-conventional practice and the following was unanimously voted for:

1. Non-physician acupuncturists:
Must have at least a Bachelor's or Master's degree in nursing or physiotherapy (at a future meeting the Chamber for Acupuncture will comment on the training necessary for the holders of a diploma of dentistry or midwifery to apply acupuncture).

Plus another minimum of 1 500 hours spread over at least three years, with:

- at least 40 credit points on theoretical study; the program must, in addition to training in acupuncture, include the following courses: history of medicine, statistics, EBM, epidemiology, anatomy, physiology, scientific pharmacology, pathophysiology, psychology, psychiatry and sterility,
- a minimum 20 credit points on clinical practice, including an internship and a thesis,
- the training is to be concluded with a final exam.

2. MD acupuncturists:
Amazingly, MD acupuncturists proclaimed at this meeting that 192 hours is enough for them to study acupuncture and some other points (see full text). The Belgium Federation of Acupuncturists (EUFOM), Belgian Association of Acupuncturists Graduates China (ABADIC) and Belgian Acupunctors Federation (BAF) have not gone against this. They trust that the patients will be able to decide for themselves which acupuncturists have received robust training.

The fourth recommendation speaks out about continuing education: 'Continuing education must be accredited under the following conditions: adequately maintain medical records of all patients; at least once over a period of five consecutive years reaching a total of 500 patient contacts per year; provide proof of participation to 20 continuing education credits per year, equivalent to 20 hours per year; the continuing education must be accredited by an accreditation committee of peers.' MD acupuncturists were opposed to the 500 patient contacts per year, and voted

against the recommendation. However, it was resolved to be an absolute minimum (total votes: 6 for, 2 against, 1 abstention).

The fifth recommendation lists allowable and non-allowable actions. A lot of discussion went into this but it was eventually voted for unanimously. The following is the list of acts:

- Acupuncturists should not strive to unlawfully practice (as defined in Royal Decree 78 [RD 78]) medicine.
- Acupuncturists are to do an initial screening to determine whether the patient's complaint can be treated with acupuncture alone or if the help of a conventional physician should be invoked. The findings of this must be written down in the medical record 'Primum non nocere'.
- During treatment further examinations are to be carried out to investigate whether the complaint can be treated with acupuncture alone or with the help of a conventional physician. This should also be recorded in the dossier.
- The acupuncturist will not start or continue the treatment if the patient does not agree with the limitations of acupuncture and does not want to consult a conventional doctor.
- For each patient, the acupuncturist must keep a record for every treatment session that sets out the treatment plan based on the school of thought and theoretical framework in which he or she was taught.
- An acupuncture treatment should not be billed as a medical, physiotherapy, nursing, etc. procedure.
- The acupuncturist must deter from making unscientific claims and the patient should be adequately informed of their precise professional qualifications as caregiver.

Finally, the sixth recommendation is about the regulation for announcements: the Chamber for Acupuncture gives as advice to the Joint Commission that, concerning announcements, acupuncturists should respect the medical ethics code that was developed by the National Council of the Order of Physicians, as well as the deontological code already prepared by BAF and EUFOM, supplementary to that.

These are the six recommendations that were all voted for in the Chamber for Acupuncture. The original texts can be found online (see previous link, in French and Dutch). These opinions went to the Joint Commission, which formulated four recommendations to the Minister. The Minister, of course, also reads the recommendations of the Chamber for Acupuncture.

Marc Mollekens, BAF president, provided us with reports from the Joint Commission. Their four recommendations are as follows:

- The practitioners of non-conventional practices should be insured against any possible damage caused to patients.
- There must be a medical committee that monitors the ethics of non-medical practitioners. This committee should include one or more delegates of each registered non-conventional practice. There should also be established a unitary organisation in order to disseminate to practitioners information about the profession, to monitor membership of a professional federation, to promote scientific research, and to monitor continuing education and acupuncture training courses.
- In the Commission's opinion, the registration of homeopathy, acupuncture, chiropractic and osteopathy is necessary, because it acts as a safety guarantee. Criteria are to be established by the various Chambers. The Joint Committee recommends that the RD 78 is extended and that transitional measures are necessary for those already in practice.
- The fourth recommendation is about announcements and publications and refers to the sixth recommendation of the Chamber for Acupuncture.

This concludes the report of the official meetings of the Chamber for Acupuncture and the Joint Commission.

In tandem with the meetings, we lobbied most of the political parties and their representatives responsible for decision-making regarding health care. Since university delegates often have to contend with the scientific claim that acupuncture is an unproven practice (and that all medicine practice should be evidence-based), we wrote a paper called 'Acupuncture: from proto-science to science', which contextualises scientific research into acupuncture, critically weighs how applicable principles of evidence-based medicine (EBM) are to a heterogeneous and pluralistic form of treatment like acupuncture, and finally summarises the scientific studies anno 2013. The paper shows that acupuncture in the context of chronic pain is more effective than placebo, comparatively scores better than some other (reimbursed and so-called evidence based) medical practices, is much safer than some other therapies, and finally is cost-effective in the treatment of chronic pain. The paper also indicates that the evidence base of acupuncture is increasing, and that we can expect to find more evidence in other treatment areas in the future. This paper is being translated into English and rewritten into a European format and will soon be made available to ETCMA (European Traditional Medicine Association) members for lobbying purposes.

We are now waiting for our Senate hearing, where we will present the paper and take an active role in the debate. After that it shouldn't take too long before the Royal Decree is published. Since the Minister followed the recommendations of the Chamber for Homeopathy when regulating homeopathy (as stipulated in the Colla Law of 1999) we trust that she will follow the recommendations of the Chamber for Acupuncture, which were outlined above.

Next time we hope to give you more and hopefully good news on the registration of acupuncture in Belgium.

About the Norwegian Acupuncture Association

Erik Nygaard

The Norwegian Acupuncture Association has, as of 31 December 2012, a total of 720 full members. The Association was founded in 2005 after a merger between the two largest associations in Norway at that time (Norwegian Society for Classic Acupuncture [NFKA] founded in 1978 and Norwegian Main Association of Acupuncturists [NAHO] founded in 1993). The Norwegian Acupuncture Association is the largest organisation for acupuncturists in Norway.

The members elect both the President and the members of the board at the annual General Assembly. In 2013 the board consists of: Cecilie Brewer (President), John Erling Håndstad (Vice-president), Lise Torp Hellum, Arne Kausland, Anne Uleberg and Nina Cathrine Skoglund. Deputy representative: Mai-Liss Molund. The Secretary General, Erik Nygaard, runs the Association's secretariat. In addition, two consultants are employed: Merete Lindén Dahle and Hege Damsgaard Helsing.

POLITICAL AIM

The Norwegian Acupuncture Association´s principal aim is to have statutory regulation (authorisation) within a few years. We sent an application for authorisation to the Health Authorities in 2009 and are still waiting for the application to be answered.

EDUCATION

Basic training required for membership is 240 study points (four years full time study) of which 90 study points is in Western medicine. Students from the University College of Health Sciences Campus Kristiania are considered qualified for membership with the Association. In 2008 the University College of Health Sciences Campus Kristiania fulfilled the criteria for a Bachelor´s degree in acupuncture.

LEGAL ASPECTS

In 2004 Norway got a new legal act related to alternative and complementary medicine. This act is very liberal and with few requirements. Therefore, we can say that Norwegian acupuncturists are mostly self-regulated through membership of the Association. However, when it comes to marketing of alternative medicine, there are many strong restrictions in Norway.

REBATES

Acupuncture treatment is not funded in any way, so patients have to pay for the treatment themselves.

INTERNATIONAL AFFAIRS

The Norwegian Acupuncture Association has been a member of the World Federation of Acupuncture-Moxibustion Societies (WFAS) since 1987 and a member of the European Traditional Chinese Medicine Association (ETCMA) since 2007.

CHINESE HERBAL MEDICINE

There is, at the present, no tuition in Chinese herbal medicine at the University College of Health Sciences Campus Kristiania. This is due to the strict Customs and Excise regulations regarding import of herbs to the country. Nevertheless, the Association has about 20 members with an education in Chinese herbal medicine. with only a handful of these are active practitioners today.

Book Reviews

Jin Gui Yao Lue: Essential Prescriptions of the Golden Cabinet

By Zhang Ji (Zhang Zhong Jing)
with translation and commentary by Nigel Wiseman and Sabine Wilms
Paradigm Publications, 2013
ISBN 9780912111919

A tremendous amount of work, time, and thought goes into a text of this kind and Western readers have been doubly blessed by being presented with two versions of *Jin Gui Yao Lue* in recent years. The first is entitled *Understanding the Jin Gui Yao Lue: A Practical Textbook*, published by PMPH, and authored by Sung Yuk-ming PhD. When I reviewed this for *The Lantern* in 2009 I used a Chinese version for comparison and found it stood up to the test of scholarship very well indeed, and credit goes to the editor, Harry Lardner, for the flow and clarity of the text. Now, hot off the press, another publication has fallen onto my desk seeking a review. This is *Jin Gui Yao Lue: Essential Prescriptions of the Golden Cabinet*, translated and compiled by Nigel Wiseman and Sabine Wilms, and published by Paradigm Publications. I cannot but compare it with the earlier Sung text.

Both texts could be criticised by serious scholars of the classics for not including a fuller commentary: beyond occasionally noting that there have been various interpretations, there is no specific or detailed comparison of the various opinions which inevitably arise. However, in my opinion, for the Western target readership, this can be seen more as a boon than a failure. I say this only because in the West, most graduates have had but a scant introduction to *Jin Gui Yao Lue*, and so the old rule of 'less is more' most definitely applies as the next step in familiarising ourselves with this classic text at a basic level, before we proceed to attempt scholarly mastery.

The subject matter of both texts is the same. In fact, such is the coincidence of the information covered, that they are clearly based on the same original Chinese text and commentary. There are, however, some important differences, and I will comment on the following aspects: the translation, clarity and readability of comments and explanations, the inclusion of additional material or information, structure, and bibliography.

Both texts present accurate translations. Sung's version presents a very true translation in readable English, and Wiseman and Wilms have chosen to adhere more strictly to the original Chinese syntax, providing additional words in brackets to enhance intelligibility. Thankfully, both achieve excellent translations reflecting the true meaning without resorting to waffle or paraphrase.

In reading both texts, the first thing I observed in regard to the comments and explanations was that the newer text by Wiseman and Wilms strays from the rule of good clear expression, sometimes becoming more complex and convoluted than necessary. This can give the impression to some readers that it must, indeed, be a scholarly work – for it takes some effort to understand it. But it is only the wordiness which makes it appear complex; the complexity does not spring from erudition or complexity of ideas, but from complexity of expression. When one reads the same commentary in Sung's version, he and his editor have really hit the mark – everything is so clear, so fluid, and all is expressed in fewer words. The lucidity of the Sung text makes the ideas easy to grasp. Succinctness is sometimes hard to achieve. I fall into the trap myself at times and am therefore loath to point the finger at others. That having been said, however, my honest observation is that this is sadly the downfall of the Wiseman and Wilms version.

When I read the comments and explanations in the Wiseman and Wilms text, although they are not wrong, they do not offer as complete an explanation as provided by Sung. To cite an example, the text notes on *jue yang* (厥阳) or 'reversing yang' in Chapter 1, Line 10, p 19 of the Wiseman and Wilms text reads: 'Reversal yang 厥阳 *jue yang*: "Reversing" here means counterflow rising.' On p 21 of his text, Sung offers more information: 'Reversal yang: In this case "reversal" means counterflow due to a relative exuberance of yang qi, also known as solitary yang flow.' As we know, 'counterflow qi' or 'rebellious qi' can be caused by any of a number of things, so it is a useful clarification. Random opening of the two books has shown me that Chapter 10 Line 1 and Chapter 17 Line 19 are but two more of many instances where the Sung text offers clearer and more complete analysis and comment.

Other examples include the simple fact that *Bai He Bing* is thus called because *Bai He* was used to treat the condition – mentioned by Sung but not in the Wiseman and Wilms text; and in regard to the use of *Shu Qi* (Chapter 16 Line 12), often avoided because of its close association with *Chang Shan*, Sung (p 442) appropriately includes some results of modern research validating its use, and also advocates that *Shu Qi* should be prepared in ginger in order to reduce its emetic properties. This important clinical information is absent in the Wiseman and Wilms text. These are but a few examples and, in addition, the Wiseman and Wilms text unfortunately fails to provide material on clinical applications, case studies and modern research, all of which can be found in the Sung text.

In regard to structure, the Wiseman and Wilms text includes a detailed schematic overview following the introduction of each chapter, outlining the contents as a useful guide and preview. But it does not contain tables or the conclusions found at the end of each chapter in the Sung text, which provide a summary of key points, and which I personally find are wonderful for review and quick reference.

Looking at both texts, of course, is a fillip to linguistic curiosity, particularly as one considers the different explanations given by each text in regard to the word '*ku*' (哭) for instance, most commonly translated as 'cry' when studying modern Chinese. This appears in Chapter 25, Line 18. The text note in the Wiseman and Wilms version says: 'Crying 哭 *ku*' then adds 'Another version of this text has 笑 *xiao* (laughing) instead.' Sung's text note offers the explanation that '*ku*' (哭) may also refer to laughter.

My curiosity thus piqued, I checked a dictionary recording older meanings of Chinese characters and found that '*ku*' (哭), rather than specifically meaning weeping, referred to making a hoarse sound like the baying or barking of a dog, thus explaining the 'dog' component in the character 犬. It further explained that the two 口 or 'mouth' components meant that there was increased volume – i.e. a loud 'crying out' in the general sense of the word 'crying' – but not necessarily in the sense of 'weeping'. I have been unable to find confirmation, and so to what extent this is the correct explanation I am unsure, but it certainly offers an explanation for the interpretation of '*ku*' (哭) as 'laughing'. (I hope I will be forgiven the diversion, but this is just one of the fascinations that classic literature holds for me.)

In conclusion, the Wiseman and Wilms version of *Jin Gui Yao Lue* offers accurate translation and is by no means incorrect; unfortunately, however, many explanations lack the lucidity and more complete information one might hope for. Furthermore, it has not included clinical applications, modern research, and case studies, all of which facilitate modern clinical application of this age-old knowledge; nor does it have a herb index, which is a significant omission. The lack of simplicity in many explanations tends to make the subject matter appear more complex than it is, and the lack of flow does not allow for enjoyable osmotic consumption. It was also disappointing to find no reference list or bibliography. It does, however, have a very thorough general index.

Reviewed by Robin Marchment

The Double Aspect of the Heart

By Elisabeth Rochet de la Vallee, translated by Madelaine Moulder
Monkey Press, 2013
ISBN 9781872468129

There are some books that help one fall in love with Chinese medicine all over again, and Elisabeth Rochat de la Vallee has written one of them. Or perhaps I should say 'another one', as her contribution to bringing the insights of our classical literature to non-Chinese readers has been substantial.

This book has two layers of translation: Elisabeth's translation of the classic literature (which helpfully includes the Chinese characters for key terms or concepts) and Madelaine Moulder's translation of Elisabeth's work from the French to English, which is both accessible and lyrical.

The text aims to explain the 'vital relationship between the Heart and the Heart master' – the double aspect of the Heart. Elisabeth argues against the use of the term 'Pericardium' and throughout uses 'Heart master' *xin zhu*, or, when referring to the meridian, refers to it as *hand jueyin* rather than Pericardium channel. The double aspect of the Heart is represented by these two meridians and the collaborative functions of sovereign fire and minister fire. It counterbalances the double action of the kidneys, yet is unified in one organ. Elisabeth argues that the classic texts confirm there is only one emperor represented as 'fire' – the ultimate yang: 'It is central because it is the ultimate place where everything converges and from whence everything emanates…it is the centre of the person, and of personal life, as the supreme pole, the centre and origin of the universe.' There are two meridians but only one *zang* or organ.

Elisabeth looks outside the usual classic texts, such as the *Neijing* and

Nanjing (while still including them, of course), and offers us quotations from *Huainanzi*, *Liji*, *Zhuangzi* and *Taisu*, which emphasise that the medical literature of the time was not a separate discipline but part of a fertile discussion of the nature of life, and the still-pertinent issue of how one is to lead a good, nourishing and contributing life. The context from which our medicine has emerged is vital to our understanding of how to apply it within our contemporary framework. This book helps us do this.

This text explores the meaning of each function or action attributed to the Heart *zang* and the significance of acupuncture points on the Heart and Heart master channels. The discussion I enjoyed the most was her understanding of the emotions of the Heart. From the original characters, she teases out the difference between elation and joy, and why elation damages the Heart qi and joy represents the Heart sovereign 'harmony with oneself and harmony with the world and the myriad beings that live there'. Analysing the etymology of the characters, she identifies 'elation' as a hand beating a drum and a mouth singing – the excitement of pleasure that can become frenetic and out of control – while 'joy' is also a drum but is more constrained and organised into harmonious music ('music' and 'joy' share the same character) and contains, by definition, serenity and contentment. Joy rises up from the centre of one's heart; elation bursts forth, scattering and endangering the integrity of the heart.

I cannot recommend this book enough. I know we all struggle with the complexity of what we do: working with a medicine that is marginalised within our health care system, struggling to integrate perspectives from so many different sources, wanting to deliver a treatment to our patients that will strengthen them and transform their suffering, keeping out of the way of the 'scientism' assault and at the same time holding our heads high because of the effectiveness of our interventions. Elisabeth's book and Madelaine Moulder's translation will make your heart sing and confirm that you are in the right place; even if only for a short time, you will feel the resonance and beauty of our tradition.

Reviewed by Sue Cochrane

Hunyuan Xinfa: The Lost Heart of Medicine (special edition)

By Yaron Seidman and Teja A Jaensch
Hunyuan Group Inc., 2013
ISBN 9780989167918

This collaborative book, written by both Australian (Teja Jaensch) and American (Yaron Seidman) practitioners, explores the philosophy and medical thought of Liu Yuan, an eminent Chinese thinker. Liu was an educator, religious thinker and medical philosopher who lived and taught in the Sichuan region between 1767 and 1855 and founded a stream of philosophy known as *Huai Xuan*. The book commences with a story, *Shi Yin Fu and the Ledger of Good and Evil,* which relates the tale of Mr Shi Yin Fu and his development of personal virtue and compassion and its effect on those around him. This story sets the standard for the following nine chapters of the book which explore medicine, philosophy, ethics, morality and psychology amongst other things in pursuit of the Chinese heart. The authors weave a philosophical journey exploring Liu Yuan's writings which are supplemented by their own thoughts and interpretations. Interwoven are quotes, proverbs, poems and short stories drawn from both modern and ancient literature which explore various aspects of the human condition and how the concepts of Chinese medicine and the compassionate concern of the physician can affect the human heart. Some sections delve into concepts of emotion and sensory perception while others focus on the *taiji* and the five phases all the while concentrating on the explication of the Chinese notion of the heart. It argues for the primacy of the relationship between the practitioner and the patient and the need for compassion and understanding in the therapeutic encounter based on the cultivation of heart/mind from a Chinese philosophical perspective.

This is an unusual book, in that has no comparisons to other modern Chinese medicine texts and does not offer immediate treatment strategies and lists of herbs and acupoint prescriptions. What it does offer is guiding principles based on Chinese medical philosophy in how to develop and maintain a therapeutic relationship with your patient and fellow humans. The text is supplemented by several appendices which contain the original Chinese language version of many of the key references to Liu Yaun's writings as well as the Shi Yin Fu story. If you are interested in exploring the concept of heart (*xin*) and its relationship to Chinese medicine this is the book for you. Hard cover and 391 pages in length, it is easy to read and will lead the reader on a moral and ethical journey to re-establish the heart of Chinese medicine back to its rightful position. We can all benefit from reading and reflecting on such a book.

Reviewed by Chris Zaslawski

Current Research Report

Dawn Wong Lit Wan
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ACUPUNCTURE FOR TREATING FIBROMYALGIA

Fibromyalgia (FM) is a complex musculoskeletal condition which involves widespread pain, fatigue and other symptoms such as stiffness and sleep disturbance. FM affects two to four percent of the general population.[1] It is mostly treated by pharmacological means such as antidepressants and anticonvulsants.[2] Non-pharmacological treatments such as acupuncture, massage and relaxation therapy are also being used.[3]

OBJECTIVES: This systematic review aims at investigating the benefits and safety of acupuncture for FM.[4]

METHODS: English and Chinese electronic databases were searched from inception to 2012. There was no restriction on the type of language. Randomised and quasi-randomised controlled clinical trials of acupuncture for FM patients of 18 years old or older were included. The patients met the 1990 American College of Rheumatology classification criteria for fibromyalgia. The type of intervention was limited to acupuncture that penetrates the skin. Pain, physical function, global well-being, sleep, fatigue, stiffness and adverse events were the main outcome measures. Studies were selected and examined by two pairs of researchers. The researchers also assessed the risk of bias, quality of acupuncture treatments, adequacy of acupuncture treatment and the confidence in the diagnosis and treatment delivery.

RESULTS: Five hundred and two studies (439 from the English databases and 63 from the Chinese databases) were obtained from the search. Duplicates were removed and irrelevant studies were excluded. The full-texts of 49 studies were examined for inclusion. A total of nine studies were included in the systematic review. Five types of comparisons were carried out: real acupuncture versus non-acupuncture treatment; acupuncture versus sham acupuncture; acupuncture versus medication; acupuncture as an adjunct therapy; and a particular type of acupuncture versus another. Acupuncture was found to be better than non-acupuncture treatment in the reduction of pain and improvement of global well-being, fatigue and stiffness by a mean of 22, 15, 1 and 0.9 respectively on a 100-point scale. No significant differences were found between real and sham acupuncture in pain reduction. Subgroup analyses compared manual acupuncture with electro-acupuncture and found that electro-acupuncture was better than sham acupuncture overall, and suggested that electro-acupuncture was better than manual acupuncture. Compared to sham acupuncture, Electro-acupuncture reduced pain by about 13 points, fatigue by 15.3 points and stiffness by 9 points on a 100-point scale, and improved global well-being and sleep and by 11 and 8 points respectively on a 100-point scale. One study suggested that acupuncture reduced the number of tender points at up to one month after treatment when compared with standard medication (17.30 points on a 100-point scale). One study compared acupuncture plus standard therapy and standard therapy alone. Acupuncture plus standard therapy reduced pain significantly compared to standard therapy alone by 3 points on a 0 to 10 scale. One study suggested that deep needling with stimulation did not differ from deep needling without stimulation in the reduction of pain and fatigue and in the improvement of physical function.

CONCLUSION: This review points out that the supporting evidence for acupuncture analgesia is modest when compared with no treatment or standard therapy, as only one study was available for each of these comparisons. Another highlight of this review is that no significant difference was found between real acupuncture and sham acupuncture. However, subgroup analysis of the comparison of electro-acupuncture with sham acupuncture suggested that electro-acupuncture was more effective than manual and sham acupuncture in reducing pain and improving the global wellbeing. These effects last up to a month. Acupuncture is a safe intervention to treat FM. The authors recommend that twice per week acupuncture treatments over a period of four weeks appear to be adequate for treating FM. However, maintenance acupuncture sessions are also required. Studies with larger populations are needed to further assess the evidence for efficacy of acupuncture for FM.

COMMENTS: This review was well designed. It has helped to shed some light on the actual position of acupuncture in the treatment of FM. The authors also identified the main concerns about the need for FM Chinese medicine diagnosis and an ideal sham intervention for acupuncture studies, which will be further discussed below.

To date, the causes and influencing factors of FM are still not well understood. Furthermore, the diagnosis of FM is controversial. The American college of rheumatology (ACR) recently updated their diagnosis criteria for FM, the 1990 ACR criteria[5] and the 2010 ACR criteria.[6] Some clinicians still advocate the 1990 ACR criteria, which lay emphasis

on the tender points as an objective way to identify FM patients. Others support the 2010 ACR criteria, which use a more subjective approach to assess the patients' symptoms, and include an assessment of sleep disturbance, fatigue, cognitive function and other physical symptoms.

Chinese medicine considers FM as Bi-syndrome, which is a condition that is mainly caused by the stagnation of Qi and may involve pain.[7] Other FM symptoms such as depression and fatigue can also be explained by the Chinese medicine understanding of Qi stagnation or deficiency. As FM is a Western medicine diagnosis, a standard Chinese medicine differential diagnosis is yet to be established. Differential diagnosis is an important factor for the choice of treatment. In the systematic review, the Chinese medicine diagnosis in the selected studies was poorly reported or neglected. Consequently, most of the studies used formula acupuncture that is one type of treatment for all the patients. Ideally, in practice, treatments should be individualised according to diagnosis. This may be one of the factors that have led to the moderate results that support acupuncture for the treatment of FM. Studies developing new strategies to develop differential diagnosis and incorporate individual treatments should be encouraged.

Another factor that may be reflected by the results of this systematic review is the type of sham intervention. There is still no consensus on the ideal type of sham acupuncture. Furthermore, the mechanism of real acupuncture is not fully understood. Traditional Chinese acupuncture style involves deep needling and strong stimulation whereas the Japanese acupuncture style prefers shallow needling and gentle stimulation. However, both methods seem to have beneficial effects as reflected by this review. Some types of sham acupuncture may be considered to be similar to the Japanese acupuncture style. In this review some studies used non-skin penetrating intervention while others used skin breaking methods with the addition of stimulation. The skin-breaking sham interventions may have the same type of mechanism as real acupuncture and thus produce a similar effect.[8] This is another area of research that needs to be explored more. The design of a good control intervention that has no specific physiological effects is needed.

From this systematic review it can be concluded that in order to better understand the efficacy of acupuncture in the treatment of FM, studies with individualised treatments and better designed sham intervention are required. Better understanding of Chinese medicine diagnosis of FM is urgently needed. From a clinical point of view, the moderate results of this systematic review might be due to the complexity of FM itself. FM also involves cognitive symptoms, which may demand the administration of more than one type of intervention. Frequent treatments and long-term treatments might be a good step forward as the practitioner can monitor the change in symptoms and apply particular treatments.

Pain is one of the main burdens of FM. Long-term use of pharmacological means such as analgesics, anti-depressants or anticonvulsants can lead to side effects such as gastrointestinal bleeding, sedation and physical dependence and also psychological dependence.[2,9] Acupuncture is increasingly being used in the treatment of pain and studies have shown that it is a safe intervention. Thus, acupuncture has its place in the treatment of FM. Moreover, Chinese medicine is a holistic intervention. With a proper diagnosis, acupuncture could be one of the non-pharmacological interventions to alleviate pain as well as the other symptom. This again stresses the urgency to develop Chinese medicine diagnosis for FM.

Dawn Wong Lit Wan

Deare JC, Zheng Z, Xue CC, Liu JP, Shang J, Scott SW, et al. Acupuncture for treating fibromyalgia. The Cochrane database of systematic reviews. 2013;5:CD007070.

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Reflections on Undertaking the Cochrane Review: 'Acupuncture for Treating Fibromyalgia'

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A Cochrane review is a systematic review recognised internationally as being of the highest standard in evidence-based health care. Information generated from a Cochrane review is used by clinicians, consumers, policy makers and other stakeholders to make informed decisions on the topic of focus.[1] Cochrane reviews are updated regularly and available free to all Australians. There are three stages to a Cochrane review: title registration, protocol and the systematic review. Each stage has multiple steps and requires Cochrane's approval before the next stage can be commenced.

Significant steps of a Cochrane review

Title registration	• Register the title of the proposed review
Protocol	• Identify research questions • Develop inclusion and exclusion criteria for publications • Propose search strategies, including databases, types of publications • Develop the methods for assessing the quality of included studies • Develop methods of data extraction, data analysis and how to treat missing data • Define comparison groups
Systematic review	• Identify potential papers • Screen and assess papers for selection criteria • Have foreign language papers translated by international experts within the Cochrane Collaboration or by local experts • Extract data from included papers, undertake assessment and risk of bias • Analyse data, generate forest plots, summary of findings table • Write up the review

As part of our assessment process, we used a tool called Standards for Reporting Interventions in Clinical Trials of Acupuncture (STRICTA)[2] to evaluate the quality of our included papers. STRICTA are guidelines for journals and authors to use when publishing their trials on acupuncture so others can reproduce them exactly. We created a grading system to improve the useability of STRICTA and give value to assessments. Unfortunately time was lost contacting authors to gain sufficient details to be able to fully assess the included trials. Further evaluation required us to gauge the Risk of Bias[3] in our included papers. After answering a number of questions, the Cochrane program generated a graph and a table that clearly showed where the risk of bias was in each paper.

We then went on to do the data presentation using 'Gradepo' and 'Summary of findings' tables. This area was new to us and took some time with much assistance from the Cochrane Musculoskeletal Group at Monash University, Victoria. Once complete, we proceeded with the final write-up of results and commentary which were then sent for initial assessment by the local Cochrane editor. However, we had exceeded our time allowed for a review and so under Cochrane instruction had to redo everything and add newly published papers.

Having redone the review our revised paper was peer reviewed by two editorial reviewers from Cochrane, two academics and a consumer advocate. We initially received conflicting comments which required negotiation to conclude the prolonged editorial process. Five years since the protocol development and our Cochrane review was published!

Looking back, when the opportunity arose to be part of a Cochrane review in my area of interest, I was excited about its prospects. Little did I realise what I was undertaking and the workload involved. The review went through many internal and external rounds of evaluation, which resulted in my developing a thicker skin for having my work critiqued. However, there is a certain amount of pleasure in completing something of this academic rigour and I have come away with a knowledge that couldn't be gleaned in any other way. Since being involved in this Cochrane review process, I have been invited to peer review papers for international journals in the area of complementary therapies and fibromyalgia.

Should you be considering a Cochrane Review, first ensure you have support from appropriate experts and co-authors. These people will be invaluable to you in all areas of your journey as they were for me. My advice: write daily, keep your eyes peeled for new papers and don't give up.

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Research Snapshots

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GERMAN RANDOMIZED ACUPUNCTURE TRIAL FOR CHRONIC SHOULDER PAIN (GRASP) – A PRAGMATIC, CONTROLLED, PATIENT-BLINDED, MULTI-CENTRE TRIAL IN AN OUTPATIENT CARE ENVIRONMENT

OBJECTIVES: To evaluate the long-term effectiveness of acupuncture for chronic shoulder pain (CSP) using a randomised patient-blinded, multi-centre controlled trial.

METHODS: The trials comprised of a six-week treatment period and three-month follow-up period. A total of 424 outpatients with CSP over six weeks and an average pain score of over 50 mm on the visual analogue scale (VAS) were randomly assigned to receive Chinese acupuncture (verum) (n = 135), sham acupuncture (sham) (n = 154) or conventional conservative orthopaedic treatment (COT) (n = 135). The acupuncture points selected for the verum group include *Ashi*, LU 1, LU 2, LI 4, LI 11, LI 14, LI 15, SJ 5, SJ 13, SJ 14, SI 3, SI 9, ST 38, GB 34 and BL 58. An average of eight points were used, each inserted to a depth of 1–2 cm and stimulated manually. Sham acupuncture was standardised to eight needles at defined non-acupuncture points, with an insertion depth of less than 5 mm. Both verum and sham treatments lasted for 20 minutes in each session. In the COT group, patients received 50 mg diclofenac daily and 15 treatment sessions (one to three sessions per week throughout the six-week treatment period) selected from physiotherapy, physical exercise, heat or cold therapy, ultra-sonic treatment and TENS. Injections or cortisone applications of any kind were not allowed. The assessments were carried out at post-treatment and at the end of the three months follow-up. The assessments include pain on VAS, range of motion (ROM), shoulder mobility and full elevation of arm. Both intention-to-treat (ITT) analysis and per-protocol (PP) analysis were applied.

RESULTS: The ITT analysis reported that 65% (95% CI 56–74%) of participants in the verum group (n = 100), 24% (95% CI 9–39%) in the sham group (n = 32), and 37% (95% CI 24–50%) in the COT group (n = 50) experienced a relief of at least 50% in pain intensity at the end of the three-month follow-up. At post-treatment, such pain relief was seen in 68% (95% CI 58–77%) of participants in the verum group (n = 92), 40% (95% CI 27–53%) in the sham group (n = 53), and 28% (95% CI 14–42%) in the COT group (n = 38). The ITT results showed verum acupuncture to be significantly more effective than sham and COT ($p < 0.01$) for both the primary and secondary endpoints. The PP analysis of the primary (n = 308) and secondary endpoints (n = 360), showed similar results for verum versus sham and verum versus COT ($p < 0.01$). For shoulder mobility (abduction and arm-above-head test), the verum group also reported better effectiveness compared with the control groups at two endpoints.

CONCLUSION: The trial indicates that Chinese acupuncture is an effective alternative to conventional orthopaedic treatment for CSP. Verum acupuncture was shown to be more effective than sham acupuncture at non-verum points.

COMMENTS: Compared with other RCTs of acupuncture for pain conditions, this trial has a large sample size (424 participants), allowing increased precision in population estimates. This trial used both ITT and PP analysis and compared them, reducing possible bias induced by either analysis and produced more persuasive results.

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Yisu (Andy) Huang

RETROSPECTIVE STUDY ON TRADITIONAL CHINESE MEDICINE TREATMENT FOR DIABETIC NEPHROPATHY

OBJECTIVES: To examine the diagnostic information, pathogenesis and Chinese herbal treatment of patients with diabetic nephropathy (DN) treated by Prof Zhongying Zhou.

METHODS: This study took place in an outpatient clinic in the Nanjing University of Traditional Chinese Medicine, China. Patients with DN seen by Prof Zhou from February 1990 to June 2010 were retrospectively identified. Only records with complete data and the Western medicine diagnosis of DN were included in this study. Data extraction covers demographic data, dates of visit, medical history, signs and symptoms, related physical examinations, diagnosis, pathogenesis, provided treatments and treatment principles. Prior to analysis with SPSS 13.0, data were pre-treated by: a) rectifying incorrent words; b) uniforming terminology for four diagnostic data, syndrome differentiations and herbal prescriptions.

RESULTS: A total of 92 patients with 162 visits were included in this study. The most common tongue and pulse readings were yellow thin greasy tongue coating (53.1%), dark tongue (40.7%) and thready slippery pulse (33.3%). Patients mainly reported numbness in limbs (40.7%), dry mouth (38.3%) and frequent urination (34.6%). In terms of syndrome differentiation, 'deficiency of liver and kidney' (57.4%) was attributed to about half of the DN visits, followed by 'deficiency of both Qi and Yin' (40.7%) and 'chronic disease transforming into collateral stasis' (24.1%). These DN visits were largely related to 'deficiency' (137.7%), 'blood stasis' (80.3%) and 'heat' (78.4%) syndromes. For most visits, DN aetiology was from kidney (73.5%), liver (67.9%) and stomach (16.1%). Herbal prescriptions contained on average 17.98 herbs. Of the 236 herbs used to treat DN, *Shengdihuang* (*Radix Rehmanniae*) (67.9%), *Guijianyu* (*Ramulus Euonymi)* (66.7%) and *Digupi* (*Cortex Lycii Radicis*) (63.6%) were generally prescribed. Correlating these herbs to their syndrome found that *Guijianyu* and *Digupi* were prescribed for 'chronic illness transforming into collateral stasis', whereas *Shengdihuang* was used for 'collateral heat causing blood stasis'.

CONCLUSION: The researcher concluded that DN pathogenesis was related to liver and kidney deficiency, and Qi and Yin deficiency. Blood stasis, heat, dampness, phlegm and dryness were the major pathogenesis factors in DN and may interact with each other, resulting in complex pathogeneses such as blood stasis-heat.

COMMENTS: This study gave an insight on treating DN patients with Chinese herbal medicine and had particularly explained the observed pathogeneses, symptoms and syndromes, and their related prescribed herbs. However, some clarification is needed in the methodology section. Firstly, the author stated that 'effective cases' of DN were examined, but there were no details with regard to the criteria for such cases. Secondly, the forms of herbs prescribed to the patients (whether granule or raw) were not specified. In presenting the correlation of herbs with symptoms and syndromes, the degrees of correlation were not reported. With regard to the reported percentages of syndromes, the authors explained that each patient may have more than one syndrome during each visit, therefore allowing percentages to go over 100%. The example given was that when a patient diagnosed with both 'kidney deficiency and liver excess' and 'Yin deficiency leading to heat-dryness' in one visit, the 'deficiency' syndrome was counted twice. However, when combining the figures under the umbrella of non-specific 'deficiency', it should only be counted once, considering that the patient is deficient, regardless of the number of specific 'deficiency' syndromes involved. Nonetheless, this is a good study showing how records of Chinese medicine patients can be retrospectively studied in order to better understand and learn from the clinical experiences of Chinese medicine practitioners.

Su K, Zhu F, Guo L, Zhu Y, Li W and Xiong X. Retrospective study on Professor Zhongying Zhou's experience in Traditional Chinese Medicine treatment on diabetic nephropathy. J Tradit Chin Med. 2013;33(2)262–7.

Wan Najbah Nik Nabil

Conference Reports

Society for Acupuncture Research Conference 2013

Ann Arbor, USA
18–21 April 2013

Chris Zaslawski

From 18–21 April, 2013, the Society for Acupuncture Research (SAR) held its international research conference at the University of Michigan in Ann Arbor, USA. Researchers were primarily from the USA, but researchers from China, South Korea and several other nations also presented their original research. The conference format included a mixture of activities including plenaries (panel discussions) keynote speeches and workshops. Four workshops were held prior to the commencement of the symposium; I attended one on *taiji* and the design of clinical trials (led by Peter Wayne) and another titled 'Challenges of Acupuncture Clinical Research in China' led by several Chinese presenters. Following the workshops the conference opened with several speeches, including one given by the SAR President, A/Prof Richard Harris. This was followed by the first of the keynote speakers, Dr Helene Langevin, who gave an overview of her research on acupuncture and the connective tissue matrix.

Day two opened with the second keynote titled 'Acupuncture and the Trauma Spectrum Response: Evidence and Issues' delivered by Wayne Jonas, and another later in the day by Volker Scheid titled 'The Elusive Nature of Facts and the Subtle Effects of Power: Why We Need More Than the Natural Sciences for Acupuncture Research'. Sandwiched in between was a plenary that explored the multiple components of acupuncture as they relate to therapeutic outcomes and patient–practitioner interactions in both research and clinical environments. The panelists were Hugh MacPherson, Charlotte Paterson and Ted Kaptchuk, all well-known researchers in these hotly debated areas.

Day three commenced with the last keynote speech, by Vitaly Napadow, on neuroimaging approaches to acupuncture research. This was followed by a panel presentation on 'Lessons Learned from Research on Manual vs. Electrical Stimulation' presented by both Helene Langevin and Rosa Schnyer. Together, they reviewed the research on both forms of acupuncture stimulation and raised more questions than delivered answers. The last keynote speaker was Professor Liu Baoyan from the Chinese Academy of Chinese Medical Sciences in Beijing. He reviewed the current state of acupuncture research in China, including the results from several large RCTs, and the ongoing developments in clinical research that China has been implementing in its programs. This was followed by concurrent 15-minute presentations involving basic science and clinical research by a variety of presenters, including myself – I presented the background to an international multisite acupuncture RCT currently being undertaken by an Australian research team.

On the last morning of the conference participants were given the option of attending two workshops. The first was titled 'Designing Comparative Effectiveness Research in Acupuncture and Whole Systems East Asian Medicine', which was presided over by Claudia Witt and Richard Hammerschlag. The second, which I attended, was 'Assessing Objective Outcomes for Subjective Symptoms in Acupuncture Research' coordinated by Richard Harris and Robert Davis. This session introduced a variety of devices and data collection systems that can be utilised in research. Participants were given the opportunity to use the devices and get some hands-on experience with them.

The 2014 SAR conference is scheduled in Beijing and will be cosponsored by the China Association of Acupuncture and Moxibustion during 30 May – 1 June 2014. This will be a unique opportunity to hear the best of the USA and China research and is definitely on my agenda!

44th TCM Kongress Rothenburg 2013

Rothenburg, Germany
7–12 May 2013

Phil Vanderzeil

A quaint medieval town in the German countryside is the setting for the annual conference held by the AGTCM. The AGTCM (Arbeitsgemeinschaft Für Klassische Akupunktur und Traditionelle Chinesische Medezin e.v.) is one of the major European organisations dedicated to the management, teaching and practice of Chinese Medicine. TCM Kongress 2013 Rothenburg *ob der tauber* is organised and hosted by a group of Chinese medicine practitioners who come together from Germany and various other European nations.

The conference town of Rothenburg *ob der tauber* was built around 1200 A.D. and is cautiously and strategically perched on the top of a mountain. The main conference venue is called Wildbad, a remarkably large property, with a castle that hangs off the edge of an impenetrable rocky hillcrop above the meandering Tauber River. The castle is eight levels high and is the remarkable setting for this TCM Kongress. The ornately built castle had its origins as a hospital, then a pleasure garden and, at some time, a war refuge.

The second site for the conference is in the ancient walled town of Rothenberg itself, a very large hall that doubles as a vast lecture theatre and dance hall with two adjoining lecture venues.

The Kongress had three themes this year, which included psychiatry, psychosomatic medicine, and geriatrics.

The original conference was held 44 years ago with around 60 to 70 attendees. In 2013, 1 200 people attended the six-day conference. The central European location of Rothenberg and the stunning setting provides the Kongress with vast numbers of attendees, a majority of people coming from countries that are no more than one hour away by plane. Among the attendees were well-published academics, TCM researchers, traditional practitioners, philosophers, and practical presenters, from a variety of backgrounds.

The Kongress had over 200 presentations, with a remarkable array of topics both practical and theoretical; lecture presentations varied from the strongest clinical evidence base to the highly philosophical, and presentation times could vary from three whole days to 20 minutes. Translators were highly skilled and spoke German, English and Chinese.

As an Australian practitioner it was interesting to note that a significant proportion of attendees at the Kongress were either part-time practitioners with limited TCM experience or students from non-fulltime courses. It was a different demographic to Australian conferences such as AACMAC, which traditionally have a high proportion of experienced practitioners. One has to remember that acupuncture and Chinese herbal medicine in Europe is still essentially practised by doctors. Limited registration for non-medical traditional Chinese medicine practitioners still only exists in a couple of countries.

The European medical profession has had a guarding influence and has managed the teaching and practice of acupuncture and Chinese herbal medicine for the past 50 years or more. Recently, it appears that the non-medical TCM profession is gaining strength and autonomy. Professionally I think this is great news for the practice of TCM in Europe.

The Australian contingent were very well received and warmly welcomed, particularly because we had recently achieved practitioner registration in Australia; registration for non-medical TCM practitioners in Europe is still a long way away.

I personally enjoyed this conference on many levels. The presentations I attended stood up to my expectations. My standout presenters were: Dr Li Jie (Netherlands) on Chinese medical classics and high incidence cancers treated with herbal medicine; Nils von Below (Netherlands) on TCM in the health care market; Radha Thambirajah (UK) on acupuncture in the treatment of fear, anxiety and phobia; and Hugh MacPherson (UK) on acupuncture, counselling and usual care for depression, results from a three arm trial.

Most of all this conference was great fun and the main social function a fantastic occasion (nobody throws a party like they do in Rothenburg). Acres of lush greenery, ornate architecture, great food, the high calibre of presentations and exceptionally friendly people make this one of the more interesting conferences I've ever been to.

I would suggest that all practitioners put this conference in their '28 things you should do before you die list'. Get there, it is a must.

8th International Congress on Traditional Asian Medicine (ICTAM) 2013

Sancheong, Korea
9–13 September 2013

Richard Li

The International Congress on Traditional Asian Medicine (ICTAM) has been one of the major international events promoting research and studies on traditional Asian medicines since its debut in Canberra, Australia in 1979.

In 2013, the 8th ICTAM (International Congress on Traditional Asian Medicine) hosted by IASTAM (International Association for the Study of Traditional Asian Medicine) was held from 9 to 13 September in Korea. I was invited to attend the World Traditional Medicine Fair & Festival (expo) in Sancheong, Korea, concurrent to the 8th ICTAM, and subsequently I attended the congress and gave a presentation on 'Our vision for the Australian TCM profession'.

The congress showcased a diversity of studies and practice in the local characteristics of the traditional medicine of each Asian nation: Chinese, Korean, Indian, Mongolian, Tibetan, Nepalese etc. It is obvious that Chinese medicine remains the dominant study area of the conference. A large number of academic papers, mainly from Western countries, were dedicated to Chinese medicine study and practice. It was also interesting to see how many Western historians attended the conference. They have closely studied the history of traditional medicine, as well as researching specific periods of history, the development of the system and its significant influence on the development of traditional medicine.

The expo was the first of such kind in the world. It was a showcase of dedication to traditional medicine, co-hosted by the Korean Ministry of Health and Welfare, Gyeongsangnam-do province and Sancheong-gun. It ran for 45 days, from 6 September to 20 October 2013. With the theme of 'Traditional Medicine: Greater Treasure for the Future', it was intended to promote the exchange of information on traditional medicine and products for enhancing human health and wellbeing. The expo hosted a diverse range of activities, including exhibitions, international academic activities, experiences, planning and celebrations, a world food contest etc. It was amazing to see so many local people, as well as foreigners, enjoying traditional therapy and products.

Chinese medicine is the most commonly practised Asian traditional medicine in Australia. However, with Australia being such a multicultural country, it is essential for us to understand that other traditional medicines exist, and to also understand how they will impact on public health services to consumers. Conferences such as ICTAM should be encouraged for cross-professional learning through sharing ideas, innovation and networking.

Heather Bruce

I chose to go to ICTAM to learn more about Korean and Tibetan medicine, and to experience a gathering concentrating on the context, not the content, of Asian medicine. I found an astonishing array of panels, meaning participants could choose to concentrate on Korean medicine, Indian medicine, anthropologists' studies, the *Shan Han Lun* from a historian's viewpoint, or to mix it all up, as I did.

All talks left me thinking; Volker Sheid began with his keynote address on 'Beyond Integration – reflections on Asian Medicine in the C21st', while Vivienne Lo closed the conference with her personal experience on filling in her own gaps (and mine) – wondering, as a student thirty-plus years ago, what preceded the various proscriptions she learnt from Dr van Buren, and decades later uncovering the classical roots to his astrological and alchemical components.

Afterwards, whilst climbing the forest walk to the temple, an anthropologist asked me what a practitioner got from attending such a meeting. I told her that in co-writing an undergraduate course 30 years ago, we (Judy James and I) concentrated on sending out safe and effective practitioners who could solve problems for those who fell through the considerable gaps in biomedical care. We had no time to look at Asian medicine's extensive history or context. Back then, as within this conference, there was no question that Asian medicine just worked, and did so beautifully.

I felt awe at the depth of commitment, and the historical ruminations from experts living and breathing different aspects of Asian medicine about how it has and still affects lives of countless people. I was inspired by the diligence, humility and eagerness the Korean medicine students displayed when assisting us all, even with language barriers.

For me ICTAM was remarkable as all participants formed a part of the puzzle. Amongst gracious hosts, stunning scenery, at times exquisite banquets, thought provoking plenary and panel sessions, plus added trips to the Haein-sa Temple, a visit to the Korean Institute of Oriental Medicine, the World Traditional Medicine expo (plus a free spa session for nine of us, where I also experienced mother roasting) and a continual stream of practical gifts, it was a brief holiday with lasting effect upon my clinical practice.

UPCOMING INTERNATIONAL CONFERENCES

2013

2–4 November	Sydney, Australia WFAS 8th World Conference on Acupuncture (World Federation of Acupuncture-Moxibustion Societies) Visit www.wfas2013sydney.com
29 November– 1 December	Vienna, Austria ICMART Congress 2013 (International Council of Medical Acupuncture and Related Techniques) Visit www.icmart.org

2014

2–4 May	Melbourne, Australia Australasian Acupuncture and Chinese Medicine Annual Conference (AACMAC) Visit www.acupuncture.org.au
13–16 May	Miami, USA IRCIMH (International Research Congress on Integrative Medicine and Health) Visit www.ircimh.org/2014
16–19 May	San Francisco, USA 16th World Conference on Qigong & TCM – West Visit www.eastwestqi.com
27 May–1 June	Rothenburg, Germany 45th TCM Kongress Rothenburg 2014 Visit www.tcm-kongress.de/en
30 May–1 June	Beijing, China Society for Acupuncture Research Conference 2014 Visit www.acupunctureresearch.org
3–7 September	Slettestrand, Denmark 4th Scandinavian TCM Congress Visit www.tcm-kongres.dk