

## There is more to acupuncture than the weekend course.

Richard James

Overheard at a meeting of acupuncturists: “Do you know what those doctors are doing? They are claiming to teach acupuncture in just two weekends! Theory, point-finding, needle technique, electroacupuncture, auricular, the lot!!” The speaker is a non-medical professional acupuncturist (PA) registered with the British Acupuncture Council (BACc). After three years of basic training she has been in practice for several years and continues postgraduate training and supervision; as well as running a busy private practice she is employed by the local GPs. She was genuinely shocked and horrified at the idea that anyone thought they could learn the art in four days. She did not know that I am currently involved in the design and delivery of the very courses she was criticising. What justification could I offer, for this apparent travesty of education?

I feel it is important to make a response because of the rift that still exists between the medical establishment and the PAs. This is potentially harmful. It means that members of the two groups are less likely to communicate, patients who might benefit are less likely to be referred for acupuncture and those who self-refer may suffer because the GP and acupuncturist do not exchange information. The rift is grounded in ignorance and prejudice. As I straddle the fence, I hear the prejudices aired on each side (see Table 1).

**Table 1**

In medical circles:	In PA circles:
<ul style="list-style-type: none"><li>• traditional acupuncturists' ideas are dogmatic medieval mumbo-jumbo and not grounded in reality</li></ul>	<ul style="list-style-type: none"><li>• doctors are unholistic, all they see is a disease, not a person</li></ul>
<ul style="list-style-type: none"><li>• any association with the “quacks” will undermine one's status within the medical establishment.</li></ul>	<ul style="list-style-type: none"><li>• they don't care about people, only about fulfilling their quotas (of vaccines etc), then getting them out of the surgery</li></ul>
<ul style="list-style-type: none"><li>• they are dangerous because they don't know about anatomy, nor hygiene, nor how to make a diagnosis so should not be allowed to practise (at least, not without supervision)</li></ul>	<ul style="list-style-type: none"><li>• they are dangerous because they don't understand acupuncture; they use oversimplified techniques to “suppress the symptoms”</li></ul>
<ul style="list-style-type: none"><li>• if they (PAs) achieve “protection of title” we (doctors) won't be allowed to practise acupuncture</li></ul>	<ul style="list-style-type: none"><li>• they want to ban lay acupuncturists because they feel threatened, knowing their own training to be inadequate</li></ul>
<ul style="list-style-type: none"><li>• they have a vested interest in keeping patients coming back for many treatments</li></ul>	<ul style="list-style-type: none"><li>• they are lackeys of the drug companies and have a vested interest in suppressing natural treatments</li></ul>
<ul style="list-style-type: none"><li>• they (being private practitioners) are only in it for the money</li></ul>	<ul style="list-style-type: none"><li>• they only want to do acupuncture so they can get into private practice</li></ul>

Put like this, these may seem ridiculous, yet they are still commonplace. As prejudice and ignorance are mutually reinforcing, information and dialogue should provide a remedy. So, what are the facts?

Well ... the British Medical Acupuncture Society (BMAS) does offer courses of two weekends, but it makes no claim that they are comprehensive and lead to full qualification. It is emphasised that they are Basic courses. On completion of such a course, plus the successful completion of a safety assessment and submission of 30 case studies, a doctor may be awarded a Certificate of Basic Competence (COBC). This is recognition of just that - basic competence.

Being doctors, the trainees have already undergone extensive education and professionalisation so there is no need to spend time on anatomy, physiology, hygiene, first aid, pathology, diagnosis, practice management, information handling, health psychology and sociology, etc because they already have working knowledge of these. (I did have doctor/patient relationship on the list but some might comment that doctors come second to PAs in this area, in spite of their training.) Secondly, they are courses in Medical Acupuncture. The focus is on aspects of acupuncture which may be usefully integrated into medical practice and/or which are amenable to physiological explanation and scientific evaluation. These are taught unencumbered by the unfamiliar complexities of the traditional oriental approach. The syllabus includes a small repertoire (33) of the most useful traditional acupuncture points and an introduction to trigger points and myofascial disorders. The scientific evidence for acupuncture's efficacy is reviewed and neuroendocrine explanations explored. The rationale for point selection is physiological and empirical. Safety aspects are emphasised. There is a significant proportion of supervised hands-on work. Very brief overviews of auricular-, electro- and traditional acupuncture are given, to provide a context. Thus the course equips general practitioners (GPs) and medical specialists to take a new approach to a range of common painful and functional conditions. Many patients can be helped and other, potentially expensive or dangerous, interventions may be avoided. Also, acupuncture is introduced to doctors who might otherwise ignore it. Surely this is a good thing?

“Well”, (she might respond), “yes and no”. Medical acupuncture, as described above, may be valid, effective and easily taught but it is also an extreme oversimplification – there is much more to acupuncture than a weekend course.

There is, of course, a wealth of detail, which these short courses omit. Traditional courses offer more than 10 times as many points with their energetic actions, needle techniques, etc as well as the location and safety aspects; the meridian pathways are studied in detail with their various interconnections; different styles of needling are taught, together with other interventions such as moxibustion, and practised exhaustively under supervision; an elaborate set of concepts is presented to guide observation and link it to action (see Table 2).

This describes the recommended core curriculum. In fact traditional acupuncture is even more diverse; practice in the West is woven from a variety of threads arising from various parts of the Far East and interwoven with influences from other Western healthcare disciplines such as naturopathy, osteopathy, bodywork therapies and humanistic psychology. This pluralism is well illustrated in Hugh MacPherson and Ted Kaptchuk's “Acupuncture in Practice: case history insights from the West”, Churchill Livingstone, 1997.

**Table 2**

from **British Acupuncture Accreditation Board Accreditation Handbook, 2<sup>nd</sup> edition May 1995, Appendix A**

**5.2 Acupuncture Core Syllabus**

*5.2.1 Brief History of Acupuncture*

- in China, from its origins to the present day and its development in other countries and cultures
- in the U.K.

*5.2.2 Basic Theory*

By the end of the course the student should be conversant with the following basic theoretical concepts and use them appropriately to their diagnosis and treatment, to be tested by written examination:

A. Health and Harmony according to Chinese Medicine:

- Concept of Dao/Unity
- Concept of Yin/Yang - qualities and inter-relationships
- Concept of 5 Elements/Phases/Wu-Xing - qualities, correspondence and inter-relationships
- Concept of cyclical rhythms in Chinese Medicine (e.g. Stems and Branches, Seasonal and Diurnal changes, Chinese Clock)
- Concepts of Qi, Blood (Xue), Body Fluids Jin-ye) qualities, types, production, functions, circulation and inter-relationships
- Concept of different levels of Qi - The 3 Treasures (Jing/Qi/Shen), The 3 Powers (Heaven/Earth/Humanity)
- Characteristics and functions of the 12 Organs/Officials/Zang Fu and extraordinary Fu
- Characteristics and functions of the Meridians/Channels/Jingluo: 12 Main and Secondary and the 8 Extraordinary Meridians.

B. Causes of Disharmony:

- Internal (emotional)
- External (climatic)
- Miscellaneous (Constitution, Diet, Exercise, Work, Sex, Poisons, Trauma, Parasites, Epidemics).

C. Patterns of Disharmony according to Chinese Medicine, as understood through the concepts of:

- 5 Elements/Phases/Wu Xing, including concept of Causative Factor
- 8 Principles (Ba Gang)
- Qi/Blood (Xue)/Body Fluids (Jin Ye)
- Organs/Officials/Zang Fu
- Channels/Meridians/Jingluo
- 6 Jing/4 Stages/3 Jiaos

*5.2.3 Knowledge of Acupuncture Points*

- Location of all points on all 14 meridians by anatomical description and of major points by practical demonstration
- Names, classifications, actions and indications of commonly used points.

*5.2.4 Methods of Diagnosis*

- The Four Methods (Si Jian) – Looking, Listening (and Smelling), Asking, Palpating, with particular emphasis on pulse, tongue and body diagnosis and taking the case.

*5.2.5 Treatment*

A. Principles of Treatment:

- Practical application of theory and diagnosis to treatment in each individual case
- Appropriateness of acupuncture treatments/when to refer
- Assessment of appropriate treatment of Root and/or Branch (Ben and/or Biao) underlying disharmony and/or presenting condition)
- Treatment planning according to prognosis, including treatment of acute and chronic conditions and emergency situations
- Appropriate selection of points.

B. Principal Treatment Techniques:

- Needling - selection of types and gauges of needles insertion, depth, duration, manipulation and withdrawal safe needling and contra-indications
- Moxibustion - direct and indirect methods appropriate use and contra-indications.

C. Additional Treatment Techniques:

- Bleeding - appropriate use and contra-indications
- Cupping - appropriate use and contra-indications
- Ear acupuncture - appropriate use
- Electro-acupuncture - appropriate use
- Massage - appropriate use
- Plum blossom needling - appropriate use and contra-indications

D. How to deal with emergencies/adverse reactions arising during treatment.

E. Differentiation and Treatment of common physical/mental/emotional/spiritual disorders according to Patterns of Disharmony, as outlined in section 5.2.2.C.

- Including the appropriateness of acupuncture treatment for: emergencies, infectious diseases, life-threatening disorders, infants and children, pregnancy and childbirth.

All of this detail requires much study and places great demands on students at the traditional colleges. However, some doctors would argue that this is all a waste of time; claiming that there is no such thing as an acupuncture point or a meridian and that the theory of *Zang/Fu*, *Chi* and *body fluids* is simply nonsensical. They choose to distance themselves from acupuncture's philosophical origins and concentrate on a reductionist/mechanistic approach to research and development. To these doctors acupuncture is merely another medical technique. Indeed several other terms are now in use (dry needling, intramuscular stimulation (IMS), sensory stimulation) which reflect this perspective and get away from the fringy connotations of the word acupuncture. Adopting this perspective, medical acupuncturists commonly emphasise "we're doctors first, acupuncturists second" and insist on the primacy of a diagnosis. That is one based in orthodox biomedicine, of course. Such doctors do not recognise the validity of viewing the patient in any other way.

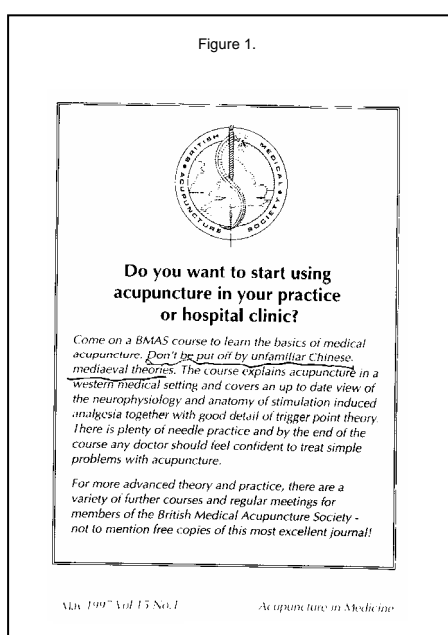
Yet the pathological diagnosis may be quite irrelevant to the planning of an acupuncture treatment. It may be more important to know "the nature of the patient who has the disease, than the name of the disease the patient has". This notion is illustrated with reference to the diagnosis of peptic ulcer by Ted Kaptchuk (*The Web that has no Weaver*, Congdon & Weed, NY, 1983, p.208-9). While medical/surgical treatments are aimed at the disease, with only passing regard for the patient, traditional acupuncture is tailored to the individual patient, to help them to normalise. Worse, the adoption of a simple and obvious medical diagnosis may block the development of a fuller understanding of the problem. How often do we see the patient with tennis elbow treated with simple medical acupuncture, only to return some time later with the other elbow affected, or with a shoulder problem? With a blinkered view of the immediate problem, the practitioner may remain blissfully unaware of the co-existing constipation, history of bereavement and inability to "let go" which all point to the underlying dysharmony of the Large intestine meridian and the Metal "Element". I commonly see such patients, who are very appreciative of a fuller meeting on a more intimate level.

Acupuncture is much more than a technique to traditional acupuncturists. To perform acupuncture is to engage in relationship with a client, to form an impression of who and how they are at that point in time, to intervene using various styles of needling and a range of other techniques and, most importantly, to do all of this in the context of a particular world view. The client is viewed not as a biomechanical assemblage of material components but as a unique energetic being, vibrant and whole, adaptive, self-regulating, self-healing and developing. While he/she is made up of parts (chemicals, cells, systems, etc) it is crucial to recognise that the whole transcends the sum of the parts. What is more, this includes the therapeutic interaction, which is a dynamic interplay between two vital beings. The state of the practitioner is an important variable; state of health, state of mind, state of vital balance, state of consciousness. The importance of this has been expressed in the saying that healing depends on "not what you do, but what you are".

This understanding is expressed in terms of *Chi* (*Ch'i*, *Qi*, *Ki*) commonly translated as "energy" or "vital force". *Chi* may not be explained in anatomical terms, any more than you could explain love of music by dissecting the bones of the ear, yet it can be a very real personal experience to those who are open to it. The direct experience of *de-chi* (needle sensation), followed by inner change, may be very meaningful and validating to an ill person. It is correspondingly alienating to have this dismissed as imaginary nonsense. It

is this perspective which makes traditional acupuncture radically and essentially different from biomedicine.

There is concern that the short weekend courses might contribute to the rift between the professions. Doctors, steeped in reductionism from schooldays on, are presented with an oversimplified and mechanistic version of acupuncture. They are likely to pick up derogatory comments about the traditional viewpoint as a result of historical prejudices and have little incentive to explore it. If they do explore it, their limited understanding may lead to disappointing results and this lack of efficacy may be generalised (unscientifically) to traditional acupuncture as a whole. As these trainees go on they become researchers and teachers of the same limited approach and so it goes on. Thus the prejudices and rift are perpetuated. I find it reassuring that the BMAS is now taking active steps to weed out such prejudicial comments from its course literature (and its advertising! see advert in *Acupuncture in Medicine* 1997;15(1):9 (see fig. 1) and subsequent letter from David Paine, *Traditional acupuncture training*, *Ac in Med* 1997;15(2):116) and is drawing positive attention to the wider aspects of acupuncture.



Indeed the BMAS is supporting the development of a programme of workshops to make the traditional approach more accessible to doctors – accessible both in terms of time and resources and in terms of philosophical palatability. [Unfortunately support for this project was soon dropped – ed.] These workshops will form part of the BMAS’s ongoing modular programme of Intermediate level training which is currently being developed. This leads to the award of Diploma in Medical Acupuncture, which is the entry-level qualification for the Certificate of Accreditation. Only those doctors who are thus accredited will be endorsed by BMAS for independent specialist status and reaccreditation is required every 5 years. So we see that BMAS is not complacently accepting the status quo but is actively working towards setting a high standard for the practice of acupuncture by its members.

Meanwhile the traditional colleges are rising to the challenge set by the British Acupuncture Accreditation Board (BAAB). In the past they have been criticised (variously) for failing to include essential anatomy and pathology, for including cranky and unvalidated concepts and styles, for ignorance of research methodology and for lamentably didactic teaching styles. All of these are being addressed. The profession has matured greatly over the past three decades; establishing a democratic process and setting up a supervisory educational body under an independent chair. The work continues.

Turning to research, I see the “weekend course” mentality leading to a limited approach, just as it does in education. The reductionistic, mechanistic perspective is implicit in the “gold standard” of the Randomised Controlled Trial and therefore in the current vogue for meta-analysis. The reductionists are applying their methods to teasing out the neuroendocrine underpinnings and have learned a great deal about pain control. This has lent credibility to the use of acupuncture in pain clinics but perpetuates the problems of oversimplification. The relevance of a holistic or vitalistic perspective is rarely considered. Where is the dynamic healing relationship between two human beings, in a meta-analysis?

Acupuncture generalists help clients with a wide range of conditions, often not involving pain. Current neuroendocrinology does not enable us to explain these phenomena and is not helpful in predicting areas for research. Take the example of PC.6 (Neiguan); the use of this point for nausea and vomiting, famously researched by the late Prof. Dundee et al, was not predicted by “science” but by the classical teachings. By identifying a finite phenomenon, of current interest, and applying a rigorous approach to study, Dundee was able to validate a useful technique. Our challenge now is to extend that approach. Having shown PC.6 to be effective, can we identify other anti-emetic points with greater effect, or which potentiate its effect? Bob Flaws discusses a broader perspective on nausea (in pregnancy) in Ch.9 of “Acupuncture in Practice” (MacPherson & Kaptchuk, op cit).

Perhaps there are other simple phenomena that could be studied similarly, eg. bronchodilatation, gastric acid secretion, gut motility. This would be very useful work but the greater challenge is to go beyond that, to apply the same rigour in a creative exploration of the more complex phenomena of acupuncture. Rather than putting effort into identifying “the best bronchodilator point” we could apply our efforts to assess the relative validity of traditional-style concepts. For example, we could assess the merits of Maciocia’s analysis of the role of the Liver meridian in asthma (“A new theory of asthma” p111-128 in Maciocia G, *The Practice of Chinese Medicine*, Churchill Livingstone, 1994) in relation to the more established concepts of Wind-Cold, Phlegm-Heat, Lung *xu* and Kidney *xu* (*Essentials of Chinese Acupuncture*, Foreign Languages Press, Beijing, 1980).

Another research challenge is the interactive and individual nature of the treatments. This is an area where we can legitimately borrow Heisenberg’s Uncertainty Principle – the observer (indeed the fact that observation is occurring) becomes a significant variable and changes the phenomena under observation. To paraphrase Lao Tzu: “the acupuncture which can be studied (in a reductionist way) is not the real acupuncture”. So often we see trials comparing the use of correct acupuncture with placebo acupuncture. While there has been much debate about what might be an acceptable placebo procedure there is often the glib assertion that a fixed set of points, used repeatedly, is “correct” for all of the recruited patients, throughout their course of treatment. This is not how acupuncture is used in traditional practice. To transcend these obstacles, the researchers will need a good working understanding of the traditional acupuncture concepts. They will not get this understanding from a couple of weekend courses but will need to immerse themselves thoroughly in the ideas. Conversely, it is difficult for traditionally trained practitioners to appreciate the subtleties of modern research method and the rigour and attention to detail that is required. Happily good progress is being made in bringing together the two disciplines by organisations such as the Research Council for Complementary Medicine and the Acupuncture Research Resources Centre.

Turning finally to politics, we see another effect of the weekend course mentality. There are still some doctors, even among those who claim an interest in complementary therapies, who call for PAs to be banned or brought under the supervision of doctors. While demanding that the acupuncture profession should base its work on controlled trials, they continue to assert, in the face of evidence to the contrary, that PAs are more likely than doctors to damage their patients. The people who make these assertions are usually, in my experience, those with weekend-type trainings and a reductionist attitude. They have little acquaintance with or understanding of traditional acupuncture and PAs. I have no doubt that acupuncture and its potential beneficiaries will suffer greatly if such doctors became the supervisors and controllers of the profession. If we are to develop truly

Integrated Health Care, we need leaders with a broad and deep perspective. It seems likely that the successful candidates will have done more than weekend courses.

Fortunately a wide range of more-than-weekend trainings is now available in this country. Doctors with a very basic training can go on to the intermediate programme offered by the BMAS; PAs will undergo a rigorous training over several years, at one of the several colleges supervised by the BAAB. Either group can progress to degrees at Bachelors or Masters level such as those offered at the University of Westminster. You might say we have been through a *Yang* phase of proliferation, expansion and separation within the acupuncture fraternity in this country. What we are now seeing, as *Yin* naturally follows *Yang*, is the coming together of traditional and medical acupuncture and consolidation of a new perspective. Out of this dialectical union of the two approaches, who knows what vigorous hybrid will be born? The delivery may be prolonged but, hey!, isn't acupuncture good for labour pains?

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After training at the College of Acupuncture and at University College Hospital Medical School, I joined the British Acupuncture Association and Register in 1976. I served the College of Acupuncture for some years as a lecturer, clinic supervisor and governor and remain registered with the BAAC. I joined the BMAS in 1991 and have contributed to teaching on the basic and intermediate level courses and at scientific meetings. I joined the education sub-committee in 1996, taking on responsibility for developing the traditional aspects of the programme, and subsequently served as its chairman. I maintain a practice of holistic acupuncture in Gloucestershire and am a Principal Lecturer in the School of Integrated Health at the University of Westminster, where I lecture in Complementary Therapy Studies and lead the MSc Advanced professional Practice. In writing this I am expressing my own views, rather than those of any organisation.