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The Journal of Acupuncture and Oriental Medicine

INSIDE

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Cover: *A branch of wild rose hip in the snow. Photo © romanika*

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MERIDIANS

The Journal of Acupuncture and Oriental Medicine

Letter from Editor in Chief Jennifer A. M. Stone, LAc

Welcome to the winter 2019 issue of *Meridians: The Journal of Acupuncture and Oriental Medicine*.

I am very pleased to announce that more than 25% of ASA state association members now receive the print version of *Meridians: JAOM*! The print issues are easy to read (either at home or between treating patients), they can be kept in clinic waiting rooms for patients to look at, and they serve as a timely resource reference when speaking with allied health professionals and policymakers. Our goal is to provide all ASA state associations with this valuable benefit, although as always, we provide an online version of all current and back issues free to all ASA members at www.meridiansjaom.com.

Every established medical profession publishes a peer-reviewed scientific journal that serves as a strong factor in legitimizing their profession. A peer-reviewed scientific journal is a publication that contains original research articles written by **scientists** and evaluated for both **technical** and **scientific** quality as well as accuracy by experts in the same field. Data from research published in peer-reviewed scientific publications is what puts acupuncture and Chinese medicine in the category of **evidence-based integrative medicine** as opposed to a number of alternative therapies that remain unproven.

Our modern healthcare system relies on evidence resulting from research to inform clinicians about effectiveness of old as well as new treatments and therapies. Additionally, research informs insurance companies and other healthcare payers which treatments are successful and cost effective so that healthcare dollars are not spent on ineffective or harmful treatments and procedures.

We practitioners know our medicine is powerful and valuable. But unfortunately there are still barriers in the U.S. such as cost and misconceptions that prevent many patients from accessing acupuncture and Chinese medicine. Seniors, people on Social Security disability, and our low income populations could greatly benefit from acupuncture, but for them it's not a covered benefit…yet.

Passionate practitioner/activists who serve on the boards of our state associations are currently working with researchers to answer questions that health policymakers have about dose, frequency, duration of effect, and other considerations as they now begin to weave acupuncture services into our socialized medical systems (Medicare, Medicaid, Workers' Compensation, the VA).

In this issue, please see the interview with Robert Davis, who was the principal investigator of a pragmatic study on acupuncture for low back pain in the Vermont Medicaid population. The study was funded by the state through the Department of Vermont Health Access and is a prime example of how public health policymakers use research to inform changes in which therapies are covered.

A systematic review led by the Washington East Asian Acupuncture Association (WEAMA) successfully resulted in policy changes in Washington that allows acupuncture coverage under workers' compensation. MJAOM reported about this in our summer issue. The full report can be found in Vol 5, No 3. *Systematic Review of Acupuncture for Low Back Pain: Efficacy and Clinically-Meaningful Change and Making the Case for Workers' Compensation: Acupuncture for Low Back Pain* pp. 16-30.

This issue also includes a report by Carla Wilson, PhD, DAOM, LAc, "Opinions of Practitioners of Chinese Medicine and Acupuncture on Integrative Medicine: A Mixed Methods Study." In this article, Dr. Wilson

Meridians JAOM welcomes letters to the editor from our readership. Please send them to meridiansjaom@gmail.com and be sure to include your full name and any licenses and/or titles, your phone number, and email address.

examines practitioners' perceptions on the practice of Chinese medicine within an integrative medicine setting. On the one hand, patients may have better access to acupuncture and other forms of traditional Chinese medicine if it is incorporated into integrative medicine. As Wilson reports, "access to CM care is directly related to health policy and the U.S. economy. Integrative medicine is viewed as a necessary component to building a legitimate and sustainable profession that would ultimately benefit the health of the public." On the other hand, many of the practitioners surveyed were concerned about the potential loss of independence if Chinese medicine is co-opted by the western healthcare system. Data from the survey showed as high as 17% of participants reported that they are currently practicing in an integrated setting with western-trained practitioners.

Each issue of *Meridians: JAOM,* dating back to the first issue published in fall 2014, is the result of the combined, ongoing effort of 50-70 acupuncturists (clinicians, faculty, and researchers) in the U.S. and internationally who volunteer their time to write, review, and edit for this national journal. Each issue is sponsored and supported by the vendors and suppliers who provide us with the tools of our trade. It is our hope that you find ongoing value in this resource and will read it and spread the word about its quality, usefulness, and benefit to the profession.

We welcome your questions, feedback, submissions and letters to the editor: meridiansjaom@gmail.com.

Respectfully,
Jennifer A. M. Stone, LAc
Editor in Chief, Meridians: JAOM

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Opinions of Practitioners of Chinese Medicine and Acupuncture on the Emergence of Integrative Medicine: A Mixed Methods Study

By Carla Wilson, PhD, DAOM, LAc

Dr. Carla Wilson's background in health care spans 35 years in the field of acupuncture and Chinese medicine: clinical practice, teaching, research, doctoral program development and administration, in addition to grant writing and fundraising to promote and sustain integrative health and educational programs. Dr. Wilson's professional and educational background includes many years of building bridges between complementary health practices and western health care. Dr. Wilson earned her PhD at the California Institute of Integral Studies (CIIS) in San Francisco, California, and she holds a Doctorate in Acupuncture and Oriental Medicine (DAOM) from the American College of Traditional Chinese Medicine.
Dr. Wilson serves as associate professor, and researcher at the American College of Traditional Chinese Medicine at CIIS, San Francisco, California. Her research reflects her interest in utilizing evidence-proven complementary and integrative methods and the importance of determining clinical effectiveness in real world settings.

Abstract

Background: This mixed methods study examined the opinions of United States based practitioners of Chinese medicine (CM) about integrative medicine (IM). They were also asked to reflect on its role within contemporary health care in the United States, the impact this may have on patient care, and the future of Chinese medicine as part of integrative medicine.

Methods: Survey participants (licensed Chinese medicine practitioners) were recruited to participate in this research through contact with Chinese medicine professional associations. Ninety-six practitioners from 26 states volunteered to participate in the online surveys.

Results: This research study demonstrates that, while CM practitioners support patient access to a wide range of therapies and approaches to medical care within IM settings, concern was raised about maintaining the distinct philosophy and practices that constitute Chinese medicine as a whole system of care. The current hierarchical structure that exists in many IM settings does not embrace the possibility that CM may be able to provide a range of treatment options for patients that conventional medicine cannot. While some CM practitioners in this study voiced optimism and an interest in working in IM settings, some practitioners equated the opportunity for integration with loss of CM traditions, compromises to CM, and professional subordination.

Discussion and Conclusion: The study data indicates that while CM practitioners are fully trained to practice a complete system of medicine, acupuncture alone is most frequently the modality that is utilized IM settings. The contribution that CM practitioners could bring to the developing field of IM holds great potential. The study indicates that many practitioners were of the opinion that skills, training, knowledge, and experience that are included in patient care remain underutilized in IM settings.

Key Words: integrative medicine, Chinese medicine, acupuncture, interdisciplinary education, Chinese herbal medicine, integrative medicine centers

Introduction

Integrative medicine (IM) in the United States arose from the need to re-humanize health care, to go beyond a biomedical approach, and to acknowledge the complexity of the human experience in health and healing.[1] The healthcare field is expanding; changes in medical organizations, medical school curricula, patient-consumer demands and preferences, and the promise of new and alternative paths to healing are only the most recent in a long history of shifts in medical knowledge and when it is applied.

Integrated medicine has evolved as a result of these changes, and Chinese medicine (CM) in the U.S. is now practiced in environments directly impacted by these changes.[2] There is a limited body of literature on IM research that brings forward the attitudes, beliefs, and opinions on integrative medicine of CM practitioners.[3] This study was undertaken to help rectify this absence of voice and provide definition of this medical practice.[4] The study asked practitioners of CM to define the term "integrative medicine" and reflect on the current role and future of CM within contemporary health care as a vital part of IM within the U.S. health care system. [5,6]

This study examined the views and opinions of practitioners of Chinese medicine or traditional Chinese medicine (TCM) regarding the concept and application of IM. The study also asked practitioners of CM to define the term integrative medicine and reflect on the current role and future of CM within contemporary health care as a vital part of IM within the U.S. health care system. "Traditional Chinese medicine" is the name that has been frequently used. Over time, more common usage has been shortened to "Chinese medicine." In this study, both names are used interchangeably.

Methodology

Permission to conduct this research study was granted by the Human Research Review Committee (HRRC) at The California Institute of Integral Studies, San Francisco, California, and has been conducted in accordance with the standards of survey research.

A mixed methods approach to inquiry was applied.[7,8] The research tool used a survey that consisted of a series of 22 Likert scale and semi-structured questions. Both qualitative and quantitative data were gathered and analyzed. Quantitative data were collected from 22 survey items. To capture the qualitative aspect, thoughts and concerns from participants were selected in response to the open-ended items that solicited opinions. A selected number of participant responses to the survey and to the open-ended questions are included in this paper.

The study was designed to collect data from CM practitioners from the U.S. for the purpose of examining their views and opinions regarding integrative medicine. The survey was distributed to practitioners of CM living within the U.S.

The study participants were asked to do the following:

- Define the term "integrative medicine" from their personal perspective
- Reflect on the role of CM within the emergence of IM
- As CM practitioners, comment on the impact the emergence of IM may have on patient care, professional jurisdiction, and the future of CM as a part of IM

Survey participants (CM practitioners) were recruited to participate in this research through contact with CM professional associations. Invitations were sent to leadership in the field of Chinese medicine and reached 160 practitioners through the following organizations: the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM), the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM), and the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM).

Additionally, invitations were emailed to the leadership of 22 professional state organizations asking that the announcement be sent to the organization's membership. The announcement is estimated to have reached approximately 400 practitioners. Some practitioners passed the research opportunity along to nonmembers who then also volunteered to participate. Of the estimated 560 practitioners approached, 96 practitioners from 26 states volunteered to participate in the online surveys.

Only U.S.-based CM practitioners were included in the study. The sampling method used in this study is a non-scientific sample method known as convenience sampling, and the sample bias is unknowable. Because of the sampling method used and because of the small sample sizes, this data should be viewed as directional in that no statistical significance level can be determined.

Survey Results and Findings

Of the initial 116 practitioners who volunteered to take the survey, 81 practitioners from 26 states within the U.S. responded to the Part One Demographic Survey, while a total of 96 practitioners from 26 states responded to the Part Two Survey. Of these, a total of 61 respondents participated in both surveys (overlap). Of the initial 116 volunteers, 20 did not respond to either survey. Of those who did respond, 15 failed to complete the Part One Demographic Survey before moving ahead to complete the Part Two Survey.

The overall results of the Part One Demographic Survey are reported to the base of all respondents who participated in that survey (81), and the overall results to the Part Two Survey are reported to the base of all respondents who participated in that survey (96). Where the Part Two Survey results are cross tabulated by demographics (for example, years in practice), the base size of the total analyzable data set is 61 (the overlap); however, base sizes in the cross tabulations are most often a subset of the overlap group.

Because of the sampling method used and because of the small sample sizes, this data should be viewed as directional in that no statistical significance level can be determined. Caution should be used not to over-interpret the results or findings.

For this type of survey there are two helpful guidelines when viewing the data: (a) any statistic based on fewer than 50 respondents should be viewed as "unstable data," and (b) large differences that are not clustered around the mean (average) may be meaningful even if the base size is very small. A "large difference" is in the magnitude of ten to twenty points.

Part One: Demographic Survey

The demographic survey asked the participants a series of closed-ended questions designed to provide a personal and professional profile of research participants. The demographic survey participants were 66% female and 34% male. Their ages ranged from mid-twenties to 60 (Table 1). The largest group of respondents fell into the 40-59 year-old age range, and their numbers of years of practice ranged from one year to more than forty years.

In terms of training and education in the field, 93% indicated having received their CM training in U.S. colleges and 19% indicated having engaged in some training at international colleges. Certification and levels of training of practitioners included the following:

Certification: Oriental Medical Doctor (OMD), Doctor of Acupuncture and Oriental Medicine (DAOM), Doctor of Acupuncture (DAC), Doctor of Oriental Medicine (DOM), Acupuncture certificates: Masters in Acupuncture or Traditional Chinese Medicine (TCM) and National Commission for the Certification of Acupuncture and Oriental Medicine, (NCCAOM). (See Table 2).

Table 1. **Demographics: Gender, Age, Years in Practice**

Category	Response Percent	Response Count
Gender		
Male	34%	27
Female	66%	53
Number who answered question		80
Number who skipped question		1
Age		
18-20	0%	0
21-29	2%	2
30-39	16%	13
40-49	28%	23
50-59	32%	26
60 or older	21%	17
Other (please specify)	1%	1
Number who answered question		81
Years in acupuncture or CM practice		
1 - 4	8%	6
5-8	19%	15
9-12	24%	19
13-16	11%	9
17-20	14%	11
21-24	9%	7
25-28	9%	7
29-32	6%	5
33-38	3%	2
39-42	0%	0
43-46	0%	0
Now retired	1%	1
Other (please specify)	5%	4
Number who answered question		80
Number who skipped question		1

Location of practice is reflected in Table 3. The practice settings for participants and are reflected in Table 4. Note that practitioners could choose more than one site to reflect multiple practice settings.

Part Two: Survey of CM Practitioners' Experiences and Opinions of Medicine

Part Two includes thoughts and concerns from selected participants to the open-ended items that solicited opinions. Part Two is intended to help illustrate and explain participants' reasoning and to gain a better understanding of the thoughts and opinions of the research participants.

Table 2. **Training and Degrees**

Category	Response Percent	Response Count
Setting of CM training:		
U.S. college(s)	93%	75
International college(s)	19%	15
Other	12%	10
Number who answered question		81
CM certifications and degrees		
Acupuncture certificate	20%	16
OMD	7%	6
Masters in Acupuncture or TCM	72%	58
Certificate in Acupuncture	15%	12
DAOM	24%	19
DAC	0%	0
DOM	5%	4
NCCAOM	53%	43
MA, accredited U.S. college	10%	8
PhD, accredited U.S. college	7%	6
PhD, European college	1%	1
PhD, China	1%	1
Other medical degrees (please specify)*	30%	24
Number who answered question		81

*Other medical degrees that participants listed: RN, Bachelor of Medicine, MT (ASCP) Licensed Clinical Lab Scientist, MD (Ayurveda), DC, MD (U.S.), PharmD, ND, Doctor of Naturopathic Medicine, PT, MD (China)

Table 3. **Current Practice State**

U.S. States or Territories	Response Percent	Response Count
California	34%	33
Arizona	12%	11
New York	12%	11
Florida	9%	9
Texas	7%	7
Hawaii	6%	6
Colorado	3%	3
Illinois	3%	3
New Mexico	3%	3
District of Columbia (DC)	2%	2
Idaho	2%	2
Minnesota	2%	2
New Jersey	2%	2
Virginia	2%	2
Washington	2%	2
Connecticut	1%	1
Indiana	1%	1
Louisiana	1%	1
Maryland	1%	1
Massachusetts	1%	1
Michigan	1%	1
Missouri	1%	1
North Carolina	1%	1
Pennsylvania	1%	1
Utah	1%	1
Wisconsin	1%	1
Not practicing	7%	7
Number who answered question		96

"Those participants who were enthusiastic and positive about the change identified increased access to a broader set of patients and the potential opportunity to work in collaboration with other medical providers. Those participants who expressed concern were worried that CM could come to be seen as a technique rather than as a whole system of medicine and were skeptical of interaction with other healthcare providers who had a limited understanding of the potential of CM."

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Table 4. **Current Practice Situation**

All Practice Situations	Response Percent	Response Count
General practice	52%	50
Solo practice	41%	39
Acupuncture college teaching clinic	28%	27
Pain management practice	25%	24
House calls	22%	21
Urban practice setting	21%	20
Tutorial or mentored setting	18%	17
Suburban setting	17%	16
Integrated or group practice with Western trained providers	17%	16
Addiction/ detoxification	16%	15
Acupuncture college faculty practice	14%	13
Integrated or group practice with other Asian medicine providers	14%	13
Volunteer acupuncture program	13%	12
Small town community practice	12%	11
Research center or university medical setting	12%	11
Group acupuncture clinic	10 %	10
Not currently practicing	9%	9
Psychiatry/mental health	8%	8
OB/GYN practice	8%	8
Community acupuncture setting	8%	8
Hospital in-patient	7%	7
Hospital out-patient	6%	6
Oncology practice	5%	5
Public health clinic setting	4%	4
Palliative/End of life	4%	4
Prison or incarceration setting	3%	3
Veteran health services setting	3%	3
Not-for-profit clinic	3%	3
In-home rural practice	2%	2
City funded health clinic	2%	2
Veteran acupuncture-only clinic	2%	2
Western medical teaching clinic	2%	2
Homeless or shelter setting	2%	2
Hospice care	2%	2
Other (please specify)	18%	17
Number who answered question		96

Question: How important is the inclusion of CM in the development of IM settings?

Table 5 indicates nearly unanimous agreement of the importance of including CM in IM settings, with little variation by years in practice and certifications or degrees earned.

Question: Will the traditions, practice, and quality of CM be changed by the growth and expansion of IM?

Discussion below indicates strong agreement that the growth and expansion of IM will have a serious impact on CM. The comments provided by the survey participants indicated both enthusiasm and concern.

Those participants who were enthusiastic and positive about the change identified increased access to a broader set of patients and the potential opportunity to work in collaboration with other medical providers. Those participants who expressed concern were worried that CM could come to be seen as a technique rather than as a whole system of medicine and were skeptical of interaction with other healthcare providers who had a limited understanding of the potential of CM.

When asked how the practice of CM will change by becoming a part of IM, practitioners expressed both concern and optimism. A common concern is how CM is to be incorporated into IM—whether it will be on equal footing with practitioners able to fully practice or whether CM will be limited to a "prescription" within the western medicine insurance model.

The deepest concerns center on mutual respect and understanding of the scientific and theoretical underpinnings of CM. In the words of a CM practitioner from New York who has been practicing for 9-12 years, "I think the greatest threat to [acupuncture and Oriental medicine] from the IM movement is the underutilization and under-appreciation of the theoretical knowledge and especially the importance of the use of this in diagnosing and treating patients."

Another common concern expressed among CM practitioners was the influence of insurance companies on how CM is practiced and which costs are allowed and disallowed. A CM practitioner from California, practicing for 5-8 years, stated, "Cost effectiveness may become more of a deciding factor as to which CM modalities are used on a particular patient. Insurance companies may have more of a say in how CM is practiced."

"A common concern is how CM is to be incorporated into IM—whether it will be on equal footing with practitioners able to fully practice or whether CM will be limited to a 'prescription' within the western medicine insurance model."

Table 5. **Importance of Inclusion**

Rating scale distribution:	Ratings combined by values[a]			Rating average	Base of % of responses[b]
	5 and 4 (most important)	3 (middle value)	2 and 1 (least important)		
All respondents	89%	9%	2%	4.67	96
Years in practice:					
1-8 years	100%	0%	0%	5.00	17
9-20 years	88%	9%	2%	4.60	43
> 20 years	86%	14%	0%	4.57	14
Certification:					
OMD, DAOM, DAC, DOM	81%	13%	6%	4.3816	
Acupuncture certificates	88%	12%	0%	4.76	17
Masters in Acupuncture or TCM	96%	2%	2%	4.80	46
NCCAOM	94%	6%	0%	4.84	32

Note. Table created by author.

a. Scale of values: extremely important (5), somewhat important (4), moderately important (3), mildly important (2), not at all important (1)

b. Caution: small respondent base sizes except for category of all respondents

Table 6. **CM Will Be Changed by IM**

Rating scale distribution:	Ratings combined by values[a]			Rating average	Base of % of responses[b]
	5 and 4 (strongly agree)	3 (middle value)	2 and 1 (disagree)		
All respondents	89%	19%	6%	3.93	96
Years in practice:					
1-8 years	76%	24%	0%	4.12	17
9-20 years	70%	19%	12%	3.79	43
> 20 years	71%	14%	14%	3.79	14
Certification:					
OMD, DAOM, DAC, DOM	69%	25%	6%	3.81	16
Acupuncture certificates	82%	12%	6%	4.12	17
Masters in Acupuncture or TCM	72%	20%	9%	3.87	46
NCCAOM	72%	22%	6%	3.94	32

Note. Table created by author.

a. Scale of values: Strongly agree (5), Somewhat agree (4), Neither agree or disagree (3), Disagree (2), Strongly disagree (1)

b. Caution: small respondent base sizes except for category of all respondents

Despite these concerns, many CM practitioners express cautious optimism about the potential of IM to their field. Many stated their belief that if CM is integrated as a partner in the practice of wellness and medicine and given full access to patients, both CM and western medicine stand to benefit. One practitioner from Texas practicing 9-12 years put forward an expansive view of how the IM setting could look:

> I think it depends upon the various potential settings in which CM practitioners would be integrated into other modalities. If the scope of practice remains the same for CM practitioners, and the integrated practice is one of dialogue between the various other kinds of practitioners where the best possible outcomes for each patient is the objective, it shouldn't affect the TCM practice.

Another CM practitioner from California practicing 9-12 years responded succinctly, "Ultimately, I think that patient accessibility, which increases through IM environments, is more beneficial than not."

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Question: Do you think that IM centers are developing in ways that appropriately include CM, acupuncture, and a whole systems approach to treatment?

Integrative medicine centers are developing in a variety of different ways in the U.S. Some are located in hospital settings, some in smaller private clinical settings, and some are situated in corporate healthcare settings. There is no specific design or standard way that CM is being included in medical settings. It seems that acupuncture is the aspect of Chinese medicine that is most often included in IM settings.

Payment, salary, and appropriate fee scales for acupuncture are shared concerns in the survey responses. The amount IM centers are able to bill for services influences the rate of payment for practitioners. This factor may also guide the amount of service available to patients in an IM setting.

Acupuncture is slowly being integrated into pain management in many conventional health care settings. However, cost and limited reimbursement for this service remain obstacles, especially in primary care and safety net settings.

In relationship to the concern about payment and how these treatments are presented, a practitioner from Idaho with 29-32 years of practice stated:

> The devil is in the payment details. A team of practitioners can certainly use a patient-centered approach (which may or may not be whole systems in nature); however, if the reimbursement of the care provider is still based upon tallying up amounts of treatment procedures, the result will be not much different in the end. A change toward emphasis on "health" maintenance / disease prevention would produce real gains for patients and ultimately for payment providers.

Chronic pain is a major public health problem that places many burdens on individuals, including impairment of physical and psychological functioning, lost productivity, and problems with side effects from pain medications. Access to care is a key component within IM settings.

A practitioner from Hawaii practicing for 17-20 years answered "No" to the question in Item 5 and offered the following perspective:

> My experience at [a medical center] in Seattle is that acupuncture is relegated to specific out-patient departments that have sympathetic department heads (International Clinic and CFS Clinic) and/or that received funding (Ryan White / HIV out-patient). Over the years, the MDs in these departments have developed a comfort and familiarity with acupuncture and refer appropriately and frequently (last time I was there); but in-patient remains off limits and other out-patient units remain closed as well.

As IM centers incorporate more CM practitioners on their teams, there will need to be team leaders that understand the scope and effectiveness of CM. However, in the absence of clinical team leaders that do not (yet) have any clinical CM training, application of CM in such settings will be accordingly underrepresented and not properly understood. A practitioner from Connecticut with 25-28 years of practice stated the following:

> No, I do not think so. Most IM centers that I have seen in my geographical area include TMC [traditional medicine of China] or acupuncture as a very small component of patient care, mostly I believe because patients want TMC/acupuncture treatment and these centers include it so they can market to a wider number of patients. In these settings, as I have seen, TMC or acupuncture therapies are only allowed in very limited roles as determined primarily by western medical doctors and not by practitioners of TMC or acupuncture.

Question: Are there possible risks, loss, or compromise to the practice or traditions of CM becoming a part of IM?

The majority of CM practitioners agree that there is a risk of compromise to CM practice as a result of becoming part of IM.

Survey respondents addressed boundary and professionalism concerns from a variety of perspectives. A Californian practitioner with 13-16 years of practice stated:

> There is always risk that conventional medicine will try to co-opt or "steal" Chinese medicine. Examples of this include acupuncture training programs (in California) and the efforts of some states to allow RNs to practice acupuncture. The obvious danger to such approaches is that TMC will become "watered down" and the most portable aspects of it cannibalized by superficially trained western medicine practitioners.

Among the consequences of conducting practice in integrative settings are the restrictions that are placed on practice and use of traditional techniques. According to a practitioner from New Mexico with 29-33 years of practice:

> I see this as direct result of our willingness to stand up and tell people who we are and what we can do. If we are clear about the strengths of our medicine there will be no loss. If we allow the MDs to direct the use of acupuncture and Asian medicine then we will be limited to their understanding of what we can provide for patients.

A practitioner from New York with 9-12 years of experience listed several potential losses or compromises to CM:

> . . . the adjustment of the delivery of modalities to expectations in the IM setting. Failure to use moxibustion in hospitals, separation of the use of herbal therapy, liniments, cups, *gua sha*, or other practices from the set of interventions used by the clinician. Either due to arbitrary restrictions in the IM setting, because of engineering issues, or because of the clinicians' inability to support the use of these modalities. Additionally, pressures in the integrative setting may diminish the use of appropriate diagnostic approaches and concepts to the detriment of the patient.

Question: Should CM remain as independent and separate practice?

For many, this question resulted in nuanced responses, and the complexity of the issue was front and center as it was with a Texas practitioner with 33-36 years of practice: "Yes, for purposes of identity and knowledge preservation. No, for purposes of institutional and policy based integration." In other responses, the complexity was expressed by one practitioner from Hawaii with 13-16 years of practice as a desire that more people could benefit through increased access to CM, while a practitioner from Washington, D.C., with 5-8 years of practice stated: "TCM should not be co-opted into a corrupt system that is set up for the gain of Big Pharma, corporate hospital systems, and insurance companies."

Table 7. **Possibility of Risk, Loss, or Compromise to CM Practice as a Result of IM**

Rating scale distribution:	Ratings combined by values[a]			Rating average	Base of % of responses[b]
	5 and 4 (strongly agree)	3 (middle value)	2 and 1 (disagree)		
All respondents	77%	17%	6%	4.08	96
Years in practice:					
1-8 years	88%	12%	0%	4.24	17
9-20 years	74%	21%	5%	4.05	43
> 20 years	71%	21%	7%	3.93	14
Certification:					
OMD, DAOM, DAC, DOM	81%	6%	13%	4.13	16
Acupuncture certificates	76%	12%	12%	3.94	17
Masters in Acupuncture or TCM	74%	22%	4%	4.00	46
NCCAOM	75%	19%	6%	4.00	32

Note. Table created by author.

a. Scale of values: Strongly agree (5), Somewhat agree (4), Neither agree or disagree (3), Disagree (2), Strongly disagree (1)

b. Caution: small respondent base sizes except for category of all respondents

Table 8. **Should CM Remain Independent and Separate from IM?**

Rating scale distribution:	Ratings combined by values[a]			Rating average	Base of % of responses[b]
	5 and 4 (strongly agree)	3 (middle value)	2 and 1 (disagree)		
All respondents	25%	23%	52%	2.59	96
Years in practice:					
1-8 years	29%	18%	53%	2.53	17
9-20 years	23%	30%	47%	2.67	43
> 20 years	7%	50%	43%	2.64	14
Certification:					
OMD, DAOM, DAC, DOM	25%	38%	38%	2.81	16
Acupuncture certificates	29%	35%	35%	3.06	17
Masters in Acupuncture or TCM	28%	22%	50%	2.59	46
NCCAOM	16%	28%	56%	2.44	32

Note. Table created by author.

a. Scale of values: Strongly agree (5), Somewhat agree (4), Neither agree or disagree (3), Disagree (2), Strongly disagree (1)

b. Caution: small respondent base sizes except for category of all respondents

The response from a California practitioner with 5-9 years of practice is representative of the inherent challenge expressed by many in their replies to this question:

> This is a slippery slope. . . How to be a part(ner) of the IM movement and at the same time maintain a firm grasp on methods and traditions that are key to providing quality health care. CM must maintain autonomy and maintain its identity and not be absorbed by western medicine/IM.

Western medicine will have an opportunity to be of more service to patients by knowing how and when to refer to CM providers, especially if CM will be offered as a whole system. If the healing potential of CM continues to expand, the public will have increased access to a broader set of options for a great many health conditions. Because CM can be safely utilized alone or in conjunction with biomedicine, the acceptance of this medicine will be embraced by both the public and a variety of western medical providers.

Question: Will there be increased access to CM due to the growth of integrative medicine?

Concerns were raised about potential turf battles that might result within an IM setting, which could eventually result in limited access for patients. A New Jersey practitioner with 17-35 years of practice says:

> One would hope that as more traditional western trained physicians come on board to engage in the practice of IM, we would see increased patient access to CM. But this may not be the case if IM continues to be offered within the consultative care model. This model requires a western-trained gatekeeper or primary decision maker that then decides what type and how much IM care a patient may receive. There is a need to explore how current IM models increase or decrease access to CM. Rather than see a "turf battle" take hold that can potentially isolate practitioners (i.e., "medical acupuncturists" (MDs) vs. the majority of acupuncturists, who are non-MDs), hopefully we can find a way to work together so that everyone benefits.

There was a shared point of view that insurance companies will continue to resist reimbursement for CM. Acupuncture reimbursement may increase, but it is unknown if reimbursement rates to acupuncturists will increase. A District of Columbia practitioner with 5-8 years of practice states:

> This will depend on how much we stand up to be counted as a profession, so to speak. Insurance companies must be brought to the negotiating table. We can talk to western med establishments until we are blue. The game changer is in directly dealing with the insurance companies. They are eager to save money and are actively promoting wellness of their aging patients to prevent high cost procedure utilization.

It is not unusual for a CM practitioner to work with patients who have limited or no insurance for acupuncture. Problems and inherent weaknesses in the U.S. healthcare system complicate access to health care in general as well as to CM. Although Table 10 shows that the majority of participants disagree that CM should remain independent (52%), there is much less agreement on the issue of integration when the question is framed around maintaining independence. It appears that those who have been in practice longer and those who have master's degrees or National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM) certification may feel more strongly that CM remaining independent would be the wrong direction.[9]

Question: How interested are you in working in an IM setting?

The majority of CM practitioners express a relatively high level of interest in an IM setting. Practitioners with fewer years in practice indicated stronger interest in working in IM settings. This may be due to the development of employment at IM and other collaborative settings or to the possibility that graduates from CM colleges enter the profession with less of an interest in private practice as a sole means of employment.

Data from Table 10 indicate that areas of employment interest and specialty care where CM currently exists could be offered at IM settings.

Question: State your definition of integrative medicine.

A broad range of definitions was offered in response to this request. They were analyzed based on patterns that formed themes. Three themes emerged from the survey data that captured the overarching, recurrent expressions of the survey participants.

The first set of patterns developed a theme focused on medical systems, treatment techniques, research, multidisciplinary teams, modalities, and partnerships. This theme also included the terms mainstream medicine, pluralism, relationships, and science as a means to validate or prove the value of CM.

The second set of patterns formed a theme focused on patient-centered needs, education, patient empowerment, self-determination, and wholeness of body, mind, and spirit. This theme included increased use of terms associated with healing methods, spirit, balance, and methods that might be viewed as foreign to mainstream medicine.

The third theme captured practitioners' concern about the future of integrative medicine associated with defining the term. This group brought additional consideration to the practice of CM and IM. Terms include hostile climate, loss of the medicine, conflict, dilution of the medicine, domination, and loss of autonomy.

Table 9. **Interest in Working in an IM Setting**

Rating scale distribution:	Ratings combined by values[a]			Rating average	Base of % of responses[b]
	5 and 4 (strong interest)	3 (middle value)	2 and 1 (combined low interest)		
All respondents	53%	27%	20%	3.50	96
Years in practice:					
1-8 years	82%	12%	6%	4.12	17
9-20 years	49%	28%	23%	3.35	43
> 20 years	50%	21%	29%	3.36	14
Certification:					
OMD, DAOM, DAC, DOM	38%	31%	31%	3.06	16
Acupuncture certificates	59%	12%	29%	3.59	17
Masters in Acupuncture or TCM	61%	26%	13%	3.67	46
NCCAOM	63%	16%	22%	3.66	32

Note. Table created by author.

a. Scale of values: Strongest interest (5), Strong interest (4), Somewhat interested (3), Less interest (2), Lowest interest (1)

b. Caution: small respondent base sizes except for category of all respondents

Table 10. **IM Settings of Interest for Employment**

Integrative Medicine Settings	Response Percent	Response Count
Interdisciplinary CAM center	46%	40
Pain management clinic	44%	39
Integrative oncology practice	43%	38
In-patient hospital	39%	34
Stroke, brain jury, neurological center	33%	29
Academic research setting	31%	27
CAM research	27%	24
Sports medicine	26%	23
Veteran health care setting	26%	23
Orthopedic clinic	25%	22
Addiction and recovery setting	23%	20
Surgical recovery	21%	18
OB/GYN primary care clinic	21%	18
IVF clinic	16%	14
Pediatrics	15%	13
Geriatric setting	14%	12
Outpatient urgent care	13%	11
Emergency room	11%	10
Outpatient oncology infusion center	10%	9
Hospital-based birthing center	9%	8
Doula midwife practice	8%	7
No interest in working in IM setting	6%	5
Other (please specify)*	21%	18
Number who answered question		88
Number who skipped question		8

*Participants submitted the following responses under "other":

1. Psychiatric, in or out patient
2. Cardiology
3. Hospice
4. MS, PTSD, Parkinson's, cerebral palsy
5. HIV clinic
6. Drug detox setting
7. Neurology
8. Dermatology (if I can use traditional Chinese herbology).
9. Mental health centers
10. Psychiatric in or out patient
11. It needs to be set up as equally respectful of each others education and experience, an open progressive environment with the focus on the patient!
12. I have been working in these settings for many years as part of clinical instruction. At this point in my life, I am ready to minimize my reliance on either private practice or teaching, and would like to be able to settle into a salary with benefits. IM settings are more likely to offer that, at least here on an outer Hawaiian island.
13. I'd like to work in a general practice that is integrative.
14. I do not have a great personal interest in working in an IM setting at this stage of my life. However I have a strong interest in working to help new practitioners do so if they choose to!
15. I would set the rules in my own practice and allow only an MD or DO who doesn't presume to know more about taking care of people's health and well being than I do.
16. I would be interested in almost all of them. I'm just not good in traumatic or bloody situations... (I pass out) Ha Ha, it's true.
17. Community outreach and treatments at same time and mobile IM clinics
18. My own clinic

Theme One

Definitions of integrative medicine that fell into this category were inclusive of multiple approaches to healing and the benefit that this might bring to patients in need of help. This set of practitioners identified patient-centered, team-based, optimal care and partnerships between patient and practitioners.

> [Integrative medicine] is the informed application of disparate systems of medicine toward the common goal of providing optimal care to patients. Informed application suggests a common and highly developed knowledge base acquired by all practitioners to facilitate effective referrals. It implies clear communication of all practitioners involved in a patient's care. (Hawaii practitioner, 17- 20 years of practice)

> Integrative medicine is the collective moving system of multiple systems (conventional, traditional) and modalities which are compatible, interchangeable and effectively working together to accomplish the administration of health care, health promotion, and the prevention of disease and disintegration (aging). (Arizona practitioner, 17-20 years of practice)

Safety and cost effectiveness were included in the first theme. A particularly descriptive definition came from a Washington practitioner with 21-24 years of practice:

> The simplest definition of "integrative medicine" is a medicine that utilizes aspects of both mainstream (allopathic medicine) with aspects of less conventional (and diverse) medicines or healthcare systems (popularly termed "complementary and alternative therapies") that are judged through personal (subjective) experience to be useful or which are tested through appropriately designed (so-called "objective") research to be safe and effective. Integrative medicine focuses on the health and well-being of the individual's body, mind, and spirit, generally utilizes less costly and less invasive procedures than conventional medicine (reducing societal and cultural costs), and focuses on an empowering partnership between the practitioner and patient.

Theme Two

Patterns that emerged in the second theme also included placing the patient at the center and emphasized the physical, emotional, mental, social, spiritual, and environmental health of the patient.

> The term integrative medicine (IM) is multi-faceted. It includes: 1) the integration of the whole person (mind, body, spirit, emotions); 2) integration rather than reductionism such as functional medicine versus specialists medicine; 3) integration as in inclusion of various approaches to health and health care such as allopathic, naturopathic, chiropractic, TCM, Ayurvedic, mind-body, etc.; 4) inclusion of patient-centered care with pro-active self care and education for life-style changes; 5) the partnership of the patient with a healthcare team and the patient's family/friends network; 6) integration of culture and society for fundamental changes to improve health rather than destroy it. (Texas practitioner, 9-12 years of practice)

A California practitioner with 21-24 years of practice stated the following: "IM is a collection of patient-centered practices that strive to include traditional and modern practices that stand the test of evidence-based medicine."

A Florida practitioner with 21-24 years of practice included the importance of patient education:

> Integrative medicine is a multi-disciplinary system operating under a holistic paradigm. The intention is to treat the mind and body of the patient. An important part of that strategy is to educate them into a healthy life style on every level of their being.

A practitioner from Virginia with 9-12 years practice captured the overarching theme with this definition:

> Integrative medicine is the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals and disciplines to achieve optimal health and healing.

Theme Three

The pattern that emerged from this set of survey responses included concern for the future of integrative medicine and how this may impact the practice of CM.

> I think that terms such as integrative medicine and alternative medicine are already beyond repair for the full inclusion of CM, so I think we need to figure out other terms. Unfortunately, as a profession, we have yet to really give a name or definition to what we do. For example, why should our medicine be named by single intervention rather than the whole system (i.e., acupuncture)? Before we can define IM we need to come up with a name and definition of what we do that has general consensus in the field. (New Jersey practitioner, 13-16 years of practice)

A California practitioner with 33-36 years of practice offered the following perspective on IM:

> I do not like the term "integrative medicine." It is a term that comes from western medicine and everything is adjunctive to it. Pieces of CAM [complementary and alternative medicine] practices become incorporated into western practice

> without the underlying philosophy of the CAM practice incorporated. In the best of all worlds, IM would be that there is Chinese medicine standing within its own tradition and interweaving as necessary with western medicine. Personally, the philosophy of Chinese medicine is predominant and I integrate other practices into Chinese medicine.

Patterns in this set of responses spoke to the traditional principles of CM and how this is inherently related to integration of effective health care.

> The essence of integrative medicine is the people. Both the physician and the patient are interested in a healing process that includes the mind, body, and spirit. This point of view has lived at the heart of Chinese medical practice since the earliest known medical cases histories of Sima Qian (ca 86 BCE). There are dimensions of integrative medicine ranging from "the centrality of the individual" to the potential and complexities of common electronic health records. The core of integrative medicine is patient-centered care, continuity of care, chronic disease prevention and management. The discussion is about orienting the health care process to create a seamless engagement by patients and caregivers in the full range of physical psychological and social preventive and therapeutic factors known to be effective and necessary for the achievement of optimal health over the course of one's life. In short, it is about both integrating approaches and integrating systems. As for Chinese medicine and integration—at the risk of a premature conclusion, the process seems to be ongoing. (Texas practitioner, 33-36 years of practice)

Additional concerns that were raised in response to the survey question were associated with acupuncture and CM being relegated to second-class status, unequal and exploited. A New York practitioner, with 21-24 years of practice expressed these concerns:

> IM is a fiction created by the medical community to justify the selective appropriation and exploitation of modalities in a hegemonic and neocolonial fashion. When one speaks of audiology, podiatry, PT, etc. there is no discussion of IM. Let's try: IM is a model for a partnership of equals working to deliver optimal patient outcomes through the application of evidence-based medicine to the approaches of AOM [acupuncture and Oriental medicine] and biomedicine.

Woven through all three themes is the notion that CM will change in order to fit into IM settings. As CM practitioners continue to work to bring CM into existing health care settings, additional options of care would need to be presented to each patient and their community of caregivers.

The following are a summary of the defining patterns that the survey respondents established:

- Formally trained acupuncturists should be employed to provide Chinese medicine at IM centers and healthcare settings as opposed to medical providers with little to no formal training in Chinese medicine.
- Because good medicine is the goal for all patients, integrative medicine should include the full scope of Chinese medicine as opposed to only acupuncture.
- Chinese medicine addresses the whole person, including body, mind, and spirit and should be integral to IM.
- Chinese medicine is safe, noninvasive, and cost-effective, and it should be made widely available to the public.
- Health care should be individualized to best address the person's unique conditions, needs, and life circumstances. Chinese medicine is uniquely prepared to meet these criteria.
- The patient and the practitioner are partners in the healing process.
- IM should use all appropriate healing sciences to facilitate the body's innate healing response.

Discussion

As a descriptive term, integrative medicine is multi-functional and prone to be applied to a wide variety of practices and techniques. The overall definitions of IM were bound by the context of patient care and were inclusive of terms related to technique, patient autonomy, and access to treatment, communication, respect, and patient education.

Research participants offered a broad set of definitions of IM. The narrative data collected from surveys were analyzed to identify patterns of phrases and word use to produce essence-capturing themes.

The most commonly appearing themes were associated with the phrase "patient-centered" or "patient-driven." Participants connected a focus on patient needs to respect, autonomy, optimal care, education, cost-effectiveness, and safety.

The overall collective response to this question suggests that CM practitioners are in agreement with the most commonly used definitions of the term integrative medicine.

Data from the surveys showed as high as 17% of participants reported that they are currently practicing in an integrated setting with western-trained practitioners. Fourteen percent indicated participation in an integrated or group practice with other Asian medicine providers (see Table 4).

Related to the years of practice, practitioners who had been in practice from 9-20 years indicated that integration can occur outside of formal institutions. More experienced practitioners

might naturally become part of an extended community of health care providers that refer and utilize each other's services for the betterment of patients.

An important finding suggests that the relationship between patient and provider is one of partnership; this is suggested by an absence of hierarchy in the language used to define integrative medicine. This absence of hierarchy allows for exchange of information and education opportunities for both patient and provider. This suggests that CM practitioners may identify themselves as educators as well as health care providers.

The demographic survey revealed that as high as 65% of participants engaged in teaching.

Colleges of Chinese medicine train students to educate both the public as well as patients. New practitioners enter the field knowing that this role is expected of them. Acupuncturists naturally gravitate toward health education as a secondary role in patient care. This natural inclination may very well help to develop new skills and responsibilities for acupuncturists working in IM settings. It may be that acupuncturist education could include training in professional health coaching, and thus bring increased value to patient interaction and to patient-centered IM settings.

Views of the Future of the Profession in Relationship to Integrative Medicine

The broad array of opinions expressed in this study indicates that practitioners of Chinese medicine are aware that integrative medicine is having an impact on CM. CM practitioners expressed interest in collaboration, and many are interested in working with other medical providers. Yet data from the surveys indicate concern about the loss of traditional practice methods, such as herbal medicine, as CM is integrated into multidisciplinary health care settings.

As CM is brought into IM centers, there is concern that only acupuncture will be utilized, and thus the application of traditional Chinese medicine may be reduced to only one technique. This reductionist approach will lead to less effective care for patients as Chinese herbal medicine will not be made available in settings that utilize acupuncture as part of pain management programs.

As CM is integrated into mainstream care there were shared concerns that CM, as a complete healing system, will disappear and that the public will access and understand CM as acupuncture. The fear that the underutilization of CM as a healing system could greatly reduce its potential to impact many contemporary illnesses was expressed in response to several questions.

Interest in working in an IM setting was rated near 45%. Settings included pain management centers, interdisciplinary medical settings, and oncology centers.[10] Practitioners with 1-8 years practice experience were the most interested (Table 8). This level of interest may be related to an increase in income but also connected to the hope of reaching more patients and impacting access to care and broadening patient options.

Table 11. **Teaching Experience**

Category	Response Percent	Response Count
Masters programs; acupuncture colleges	65%	53
DAOM programs	25%	20
AOM CEU	28%	23
Biomedicine CME	15%	12
Tutorial	16%	13
Board certifying education course(s)	14%	11
Western medical school(s)	17%	14
Massage school	15%	12
Accredited MA program	6%	5
Accredited PhD program	4%	3
Online CM courses	7%	6
Online education non-CM college	2%	2
Community and patient education	32%	26
Number who answered question		81

The Impact of Integrative Medicine on Chinese Medicine: Access to and Quality of Health Care

Chinese medicine practitioners expressed in favor of their own autonomy of practice. There was agreement that CM is a complete system of health care capable of addressing a wide variety of health care needs, regardless of the popularity and development of integrative medicine. Access to CM care is directly related to health policy and the U.S. economy. IM is viewed as a necessary component to building a legitimate and sustainable profession that would ultimately benefit the health of the public.

Although some CM practitioners expressed concern that IM would negatively impact CM in the U.S., there was overall optimism about the benefits that would be experienced by the public. The overall benefits that can be derived by bringing together traditional medicine and modern technology was a strong and positive theme in spite of concerns about possible loss of autonomy. There was shared agreement that limited access to CM based on financial constraints could be eliminated if CM was fully integrated into public health care settings.

Conclusion

Integrative medicine is a new discipline with its own specialty centers, fellowships, and certification processes. The IM approach augments conventional medicine by integrating western and

non-western therapeutics to achieve optimal patient well-being via the use of a holistic framework.

The goal of IM is to build optimal health and manage disease by maximizing the health of the whole person within the context of family and community. This approach is heavily patient-centered and directed toward attracting patients who need a variety of medical approaches to manage a wide range of health care issues. This model of health care is a response that includes preventative approaches to health and medical conditions that can best be managed by alternative medicine, lifestyle changes, and education.[11]

Integrative medicine has become a model that offers a wider range of modalities to a public interested in more options in health care. Chinese medicine, and more specifically acupuncture, has been identified as a valuable asset to integrative medicine.[12] The CM practitioner, who in most cases is an acupuncturist, can provide care that conventional medicine, for all its strengths, cannot.

Chinese medicine is fully integrated into the Chinese system of health care in China.[13] The legitimacy that CM provides within IM health care settings is reflected in the slow but continued growth of research and inclusion in major cancer centers.

While the overall health care culture is in many ways resistant to change, that resistance can often be particularly strong when it comes to the field of integrative health care. For some, it is still a controversial subject. Consequently, all providers may need to overcome biases. CM practitioners will need to create alliances with other providers in order to contribute to the transformational process needed to advance health care. The building of alliances and professional relationships will help to break down silos that occur when a group's inward focus is on its particular goals and there is an absence of commitment to a truly shared sense of purpose.

The data from this study indicate that practitioners of CM view IM as patient-centered; they view health care as a fundamentally collaborative enterprise fostering cooperation between patients and practitioners, as well as among practitioners themselves. They view CM as an underutilized resource that should be integrated into all existing medical settings.

It may very well be that Chinese medicine can successfully coexist within integrative settings and can help to shape how IM is delivered within multi-disciplinary health care settings. Interprofessional communication is a crucial factor in the forging of professional relationships with other professionals.

Training in this area is needed in CM medicine colleges and in western medical colleges. Effective interdisciplinary training must include the unique experience, expertise, and culture within an IM health care team.[14] This will likely lead to improved patient care and will advance medical knowledge.

As conventional medicine continues to develop and refine advanced technologies associated with diagnostics, new treatments directed toward life-saving interventions, research, and high-tech surgical procedures, it is clear that both interventionist cures and individualized care, available through CM, are necessary to maintain health. Through relationship building, CM practitioners can be full partners in IM healthcare teams that share decision-making and create effective group dynamics that support the expansion of possibilities of an improved practice of medicine that places the patient first.[15]

As science encountered CM, there has been a tendency by western researchers to reduce the techniques of CM to a biomedical western model. IM may just be the formula that can move western medicine toward a new view of human health that encompasses multiple perspectives and the opportunity to advance the understanding and methods of Chinese medicine through research leading to increased efficacy and new views of health and healing.[16]

Perhaps it is the concept of person-centered care that unites all health care providers across all disciplines and health care systems, and the shared desire to provide the most powerful outcome for patients who seek health care approaches that offer them choice, safety, respect, and effectiveness.[17]

Health care in the U.S. is undergoing a transformational process that encompasses both IM and CM, presenting an opportunity for western medicine and CM to learn from each other.[18] The integration of Chinese and western medicine that evidences safe and effective treatment with plausible mechanisms of action will point the way to a more multidisciplinary, comprehensive, and compassionate healthcare delivery model that will benefit many generations to come.

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Most importantly, I offer deep bows of gratitude to the practitioners that contributed to this project by sharing their views and opinions on many matters, addressed concerns of significance, and gave voice to the experiences and perspectives of Chinese medicine practitioners and, thus brought this research to life.

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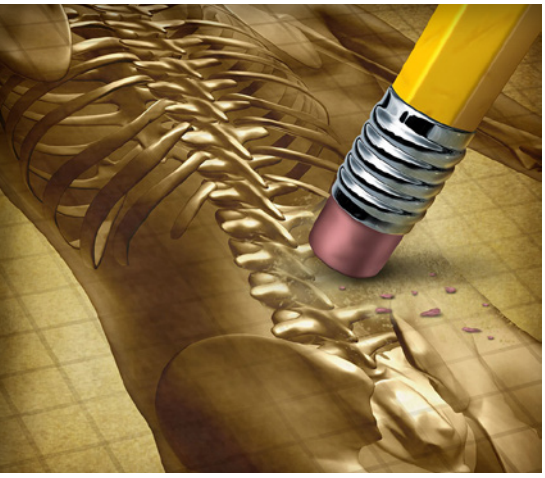


Case Report

Kinetic Acupuncture for Acute Low Back Pain

By Hyungsuk Choi, PhD, OMD, LAc, Adrianus Wong, MD, LAc, and Evan Mahoney, DAOM, LAc

Please see bios at end of the article.

Abstract

Kinetic acupuncture, a new treatment modality, combines acupuncture with movement. The origin of "acupuncture with movement" can be found in *Hui Ci* needling of the classical *Nei-Jing*. This technique has been practiced in various forms ever since in Korea and China. This case report demonstrates kinetic acupuncture treatment for acute low back pain with lumbar disc herniation. A 39-year-old man suffered from severe back pain and could barely walk without support. Two movements inducing traction and oscillation were taught to the patient while the needles were retained. After an hour-long session of acupuncture with movement, the pain level reduced dramatically and the patient could walk by himself. More research using kinetic acupuncture may indicate it to be effective in treating acute low back pain.

Key Words: acupuncture, kinetic acupuncture, low back pain, acupuncture movement therapy, motion style acupuncture, Master Tung's acupuncture, *Dong qi*, acupuncture exercise therapy

Introduction

Background of acupuncture with movement

The technique of acupuncture combined with movement is a unique and less well-known art in the history of acupuncture. In the age of the *Neijing* (The Inner Cannon of Yellow Emperor), *Lingshu* (Spiritual Pivot) introduced *Hui-Ci* (translated as "rehabilitating needling") as one of the twelve needling techniques. *Hui* (恢) means "recovery from ailment" or "rehabilitation from disability." As described by its name, the indication of *Hui-Ci* is mainly for muscle and joint *bi* syndrome. The actual description of *Hui-Ci* in *Lingshu* (Spritual Pivot) itself is very abstract, using only one sentence: *Hui-Ci* is "inserting the needle right beside of tissues and rehabilitating muscle *bi*" (**恢刺者 直刺傍之，举之，前后恢筋急，以治筋痹也, [灵枢·官针])** (Author's translation).

Many ancient acupuncturists in China interpreted this technique in different ways and practiced it in various forms. Cheng Xiaoming described the maneuver of *Hui-Ci* in his book *Acupuncture & Moxibustion* (2006)[1]:

> Slowly needle on the side of the tendon, or the adjacent area, beside the tendon. For example: Knee joint arthritis—don't needle the knee directly, but treat points on the side, like GB-34, SP-9, ST-36, SP-10 in order to let the sensation travel to the joint. This is one kind of long needle insertion technique. During the insertion, you should change direction of the needle, to get the sensation to travel. When the sensation travels to the joint, withdraw the needle, to beneath the skin, and let the patient move the joint, then needle deeply again. This technique usually treats excess symptoms of the joints, muscles, and tendons.

With needles retained in the tissue, the patient moves his/her joint to achieve the recovery of joint function. This procedure can be considered as acupuncture treatment combined with *Tui-na*. Acupuncture exercise therapy has been mainly used for treatment of joint problems in the knees or shoulders. Several studies use this technique for shoulder joint rehabilitation in a post-surgical humerus neck fracture,[2] stroke,[3] knee joint disability after knee replacement surgery,[4] and knee joint arthritis.[5]

Master Tung's *Dong qi* technique (**動氣針法**) is another technique in this tradition that implements acupuncture with movement. The *Dong-qi* technique involves passive or active movement of the affected body part while needles are inserted at distal acupuncture points.[6]

Korean acupuncturists have also been practicing acupuncture with movement. The ancient Korean acupuncturist Heo-Im (**許任**·, c.1570-1647) of the Chosun Dynasty is one of the most famous acupuncturists in Korean history. He introduced the technique of acupuncture with movement in his book, *Chimgu-gyung-hum-bang* (*Book of Acupuncture and Moxibustion Experience*). The book is well-known for its detailed and lively depiction of Heo-Im's treatment procedures:

> In a case of spasmodic and immobile muscles of the hands and feet, he inserted 4-5 round-shaped needles on the muscles, and followed by stretching and flexing of the stiffened joint (**手足筋攣蹇澁以圓利鍼으로 貫刺其筋四五處後에 令人强扶病人하고 病處伸者는 屈之하고 屈者는 伸之하야 以差爲度니 神效니라**).

Heo-Im combined acupuncture and passive movement to treat musculoskeletal problems. Modern acupuncturists in Korea have also combined acupuncture with movement in various ways, such as Motion Style Treatment (MST), which incorporates acupuncture treatment with movement. MST, also known as *Dongjak-chim* (**동작침**), was invented by Korean acupuncturist Joon Shik Shin in Korea, with the first publication in 2004.[6] A clinical study in 2013 using MST for low back pain showed a better result compared to the conventional medication group.[7]

Kinetic acupuncture also incorporates acupuncture treatment with movement. It differs from other techniques as it is based on modern anatomy and kinesiology. Most other forms of acupuncture combined with movement use distal points on related channels according to traditional theory. A 2012 review article reported that only four studies among 17 clinical studies in Korea and only eight studies among 106 clinical studies in China used local points with movement.[6]

In kinetic acupuncture, the needles are retained in local sites such as joint and muscle fibers, combined with the movement of that local muscle or joint. It is a safe, not painful treatment because the needles do not actually move with the joint movement.

These movements are meticulously devised, based on anatomy and kinesiology to prevent tissue injury. First, isometric muscle stretching and contraction are performed with retained needles. Although the needles are deep-inserted and followed by movement, there is no actual change in the muscle length or in the needles' direction. Second, joint cavity needling is combined with joint play, such as oscillation and traction. Because the needles are located in an empty space (the joint cavity), and oscillation or traction have little dynamics on the joint, the movement does not greatly affect the needles.

Case Description

A 39-year-old Caucasian male presented to the clinic with low back pain (LBP). The pain radiated to both of his legs. Two days prior, he started to experience mild LBP and leg pain during the night, several hours after using a vacuum cleaner. Symptoms were exacerbated on the following day and severely affected his mobility.

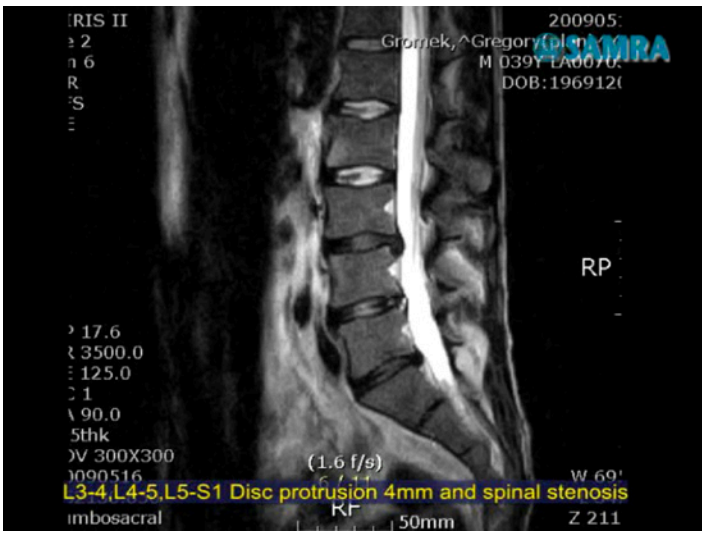
The next morning, he was unable to perform any spinal movement due to a significant level of pain (Verbal Pain Scale = 8-9 out of 10). The pain became worse with involuntary muscle spasm. A moderate level of pain (Verbal Pain Scale = 2-3) remained during rest. Upon his initial visit, he required physical assistance due to his inability to achieve fully erect posture or self-ambulation.

The patient was initially diagnosed with a lumbar disc herniation, which was later confirmed with an MRI. His body temperature was 37.5°C (99.50 F) and his heart rate was 97 beats per minute. He was cleared from common LBP-related red flags, including saddle anesthesia, bladder dysfunction, reduced anal tone, drug abuse, unexplained weight loss, recent infection, a history of cancer, and lower extremity neurological deficit. The other possibilities of systemic or visceral pain were ruled out based on the patient's body temperature, symptoms, and history.

The outcome measures, such as pain intensity, were assessed verbally on a scale from 1 to 10. Ambulatory ability was also

observed before and after treatment. The patient was unable to withstand dynamic physical assessments such as range of motion (ROM) tests and a straight leg raise (SLR) test due to intense pain. An MRI was performed two months after his initial acupuncture visit, confirming L3-4, L4-5, L5-S1 disc protrusion and spinal stenosis (Figure 1).

Figure 1. **Lumbar MRI with L3-4, L4-5, L5-S1 Disc Protrusion and Spinal Stenosis**



Interventions

A written informed consent was obtained from the patient regarding videotaping and publishing. The entire first-day treatment session was approximately an hour long, excluding break time. The patient was instructed to rest as needed. California clean needle technique procedures were followed for the duration of the treatment.

Needling

Distal points

First, to control the severe pain, a distal acupuncture treatment was applied in a sitting posture to prepare the patient for a walking motion. The disposable stainless-steel needles (0.2 mm x 40 mm; Dong-bang Acupuncture, Korea) were used for the distal acupuncture points. The acupuncture needling was performed on the points LI-11 (*Quchi*), LV-3 (*Taichong*), DU-26 (*Renzhong*), DU-16 (*Fengfu*), LI-3 (*Sanjian*), and LI-4 (*He Gu*). The location for needling on LI-3 (*Sanjian*) followed the location of Master Tung's *Da Bai* point, and LI-4 (*He Gu*) followed the location of Master Tung's *Linggu* point.[9] (Table 1 and 2).

Master Tung's acupuncture point *Linggu* is located at the junction of the first and second metacarpal bases. One study showed that this acupuncture point location is mostly effective for headaches among five other different locations of LI-4 (*He-gu*), which is explained in different ancient literatures.[10]

All the needles that were inserted were then manipulated with "rotating" and "lifting and thrusting" technique until the patient achieved *de qi* sensation.

Table 1. Distal Acupuncture Points Used in Procedure

	Distal acupuncture points	Retention time and unilateral / bilateral	Used acupuncture needle
Distal points	LI-3 (*Sanjian*), LI-4 (*He Gu*), LI-11 (*Quchi*), LV-3 (*Taichong*), DU-26 (*Renzhong*), DU-16 (*Fengfu*)	about 40 minutes, through the whole session. Reinserted and depth adjusted as needed. All points were needled bilaterally.	0.2 mm x 40 mm; Dong-bang Acupuncture, Seong-Nam, Korea

Table 2. Distal Acupuncture Points Indication Used in Procedure

Distal acupuncture points	Reason to use the point
LI-3 (*Sanjian*), LI-4 (*He Gu*), LI-11 (*Quchi*), LV-3 (*Taichong*)	To regulate the qi of the whole body and reduce the pain
DU-26 (*Renzhong*)	To reduce acute pain
DU-16 (*Fengfu*) and DU-26 (*Renzhong*)	To regulate the qi in the DU vessel and reduce the pain. DU vessel travels in the whole midline of vertebral spine

Local points; intervertebral space and muscle trigger points

In a sitting posture with the patient bending forward, a disposable stainless-steel acupuncture needle (0.3 mm x 60 mm; Dong-bang Acupuncture, Korea) was inserted pointing upward at DU-3 (*Yaoyangquan*) following the L4 spinous process. By bending forward, the patient created more space in between the vertebrae. The needle was inserted approximately to the depth of 3 cm. When the patient stood and extended his spine, the needle was penetrated in an additional centimeter. Adding this additional 1 cm, the needle was inserted in total to the depth of 4 cm.

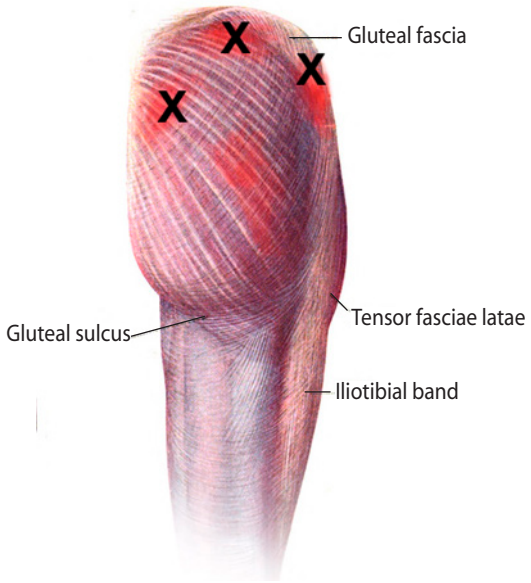
The depth of insertion was determined according to the study done by Brinkley et al., in which the depth of the spinal cord below the skin in the lumbar region was measured from 197 adult myelograms and was found to be a minimum of 4.0 cm and a maximum of 9.1 cm below the skin.[11] Considering that the patient was a 70-kg male of 172 cm, 4 cm was determined as an optimal and safe depth to avoid spinal cord injury. This insertion was retained while walking, swinging pelvis, and oscillation procedures were applied to the patient.

The acupuncture needling was also applied on the local muscle trigger points to release tight muscles and reduce pain from guarded muscles. The local muscle trigger points acupuncture was applied on the gluteus medius/maximus and quadratus lumborum muscle (0.3 mm x 60 mm; Dong-bang Acupuncture, Korea). The trigger point needles were removed immediately after the patient felt *de qi* sensation (Table 3 and Figure 2).

Table 3. Local and Mtrp Acupuncture Points Used in Procedure

	Points	Retention time	Used acupuncture needle
Local points	Intervertebral space L4-5	about 40 minutes, through the whole session	0.3 mm x 60 mm; Dong-bang Acupuncture, Seong-Nam, Korea
Mtrp	Gluteus medius / maximus	no retaining	0.3 mm x 60 mm; Dong-bang Acupuncture, Seong-Nam, Korea
	Psoas / Quadratus lumbarum		

Figure 2. **Muscle Trigger Points (Mtrp)**



Movement

Once the patient's pain level was reduced, two different "treatment with movement" modalities were applied and repeated alternately for forty minutes. The first movement modality was "Walking with needles" and then continued with "Pelvic swing with needles," the second movement modality.

Walking with needles

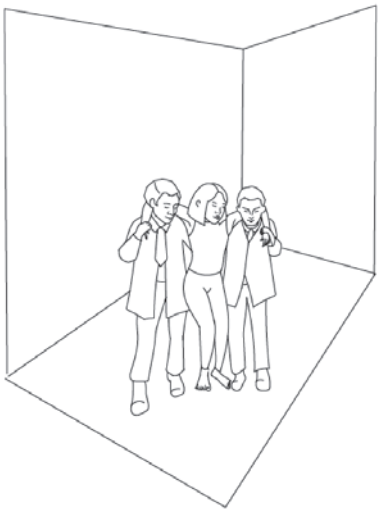


Figure 3. **Walking with Needles**

Two assistants, who were the same height, provided support on each side of the patient's shoulders. The patient, with his shoulders hung, transferred his entire body weight onto the assistants (Figure 3). This hanging position provided a zero-gravity setup to the patient, allowing his entire lower body to relax, which maintained the balance on both sides of the spine and therefore blocked the pain. Both assistants were also able to provide gentle traction and muscle stretching to the patient's lower back and spine.

The patient was instructed to walk straight while maintaining a straight gaze in this zero-gravity hanging position. By doing this, the patient was able to align his spine and release the tightened muscles. The spinal misalignment can adversely affect the patient's gait[12]; therefore, improving the gait can affect the alignment of the patient's spine.

The patient was also directed to walk barefoot in order to feel the texture and surface temperature of the floor. Doing so provided more proprioception and balance. With the exception to DU-3 (*Yaoyangquan*), all of the retained acupuncture needles, (LI-3 (*Sanjian*), LI-4 (*He Gu*), LI-11 (*Quchi*), LV-3 (*Taichong*), were located on the patient's extremities. DU-26 (*Renzhong*) and DU-16 (*Fengfu*) were located on the facial area and back of head, respectively. All of these points except DU-3 (*Yaoyangquan*) were not greatly affected by the movement. Sometimes it was noticed that the acupuncture needles, especially LI-11 (*Quchi*) and LV-3 (*Taichong*), were gradually pulled out. In this case, the practitioner re-adjusted the depth of the needles.

The patient said he occasionally felt a sharp pain whenever he tensed his shoulders or twisted his back. When this occurred, the assistants again told the patient to completely relax and let them support his body weight entirely.

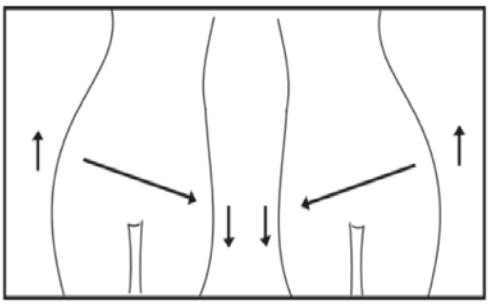
As the patient gradually made progress in walking due to a decrease in pain, the assistants reduced their support and challenged the patient to walk with more gravity-pressure. When the patient felt too much pain, the practitioner re-manipulated the needles, mostly on LI-4 (*He Gu*) and DU-16 (*Fengfu*).

As the pain gradually decreased and patient was able to walk more naturally and comfortably, each assistant, one at a time, stopped supporting him so the patient walked entirely by himself. At this stage, the Verbal Pain Scale was 2-3 out of 10. The patient repeated the sequence of walking for three minutes, with five minutes rest in-between each sequence, and alternated with "pelvic swing with needles" during every 3-4 times of walking.

Pelvic swing with needles

Figure 4(a). **The Patient's Posture During the Pelvic Swing**

4(b). **Demonstration of Pelvic Swing**



The patient was instructed to stand up and lean on the side of the bed, which was the same height as his navel (Figure 4a). It was important for the patient to transfer his entire upper bodyweight while leaning and let his feet barely touch the ground thus reducing the heavy load of his lumbar spine. This position was done to relieve the patient from bearing his full body weight and it allowed a mild decompression in his lumbar spine.

In this position, the patient slowly moved his pelvis laterally. His feet remained on the ground throughout the entire exercise. The amplitude was adjusted based on the patient's pain sensation during movement (Figure 4b). The disposable stainless-steel needles (0.3 mm x 60 mm; Dong-bang Acupuncture, Korea) were briefly inserted, without retention of the needles, on the still-painful trigger points of the gluteus maximus and gluteus medius muscles followed by constant palpation. The patient was instructed to continue with the exercise until the level of the pain decreased. In total, the patient executed three sets of pelvic swings.

The "pelvic swing with needles" modality is especially useful for the patient who cannot extend his/her back due to pain, which can often make the patient assume an extremely flexed forward position of his/her back. By letting the patient bend his/her back in a comfortable way and support bodyweight using his/her own upper body, the pain sensation can be dramatically reduced. This also naturally retracts the patient's spine.

Outcome

Following the initial treatment, the patient was immediately able to walk comfortably and return to normal daily activities. Both the LBP and the radiating pain were reduced to a minimal level. The only discomfort was minor spasm of the muscles, which persistently followed after some random movements; however, this did not significantly affect his daily life.

After the first treatment, the patient returned for ten additional treatments over a period of two months and then twice more during the following year and a half. These treatments followed the same procedure as the initial treatment, while additional dry cupping treatment was also included.

The patient's pain intensity and the ability to walk properly and comfortably were all re-assessed during each follow-up. After the tenth visit, the patient never felt any intense pain and was able to perform his normal daily activities; therefore, the treatment was concluded after the tenth visit. Seven years after his final therapy in the clinic, the patient said, "I have experienced occasional aches and pains and done acupuncture, but nothing like the back pain I had when I met you."

Discussion

This case report on acute low back pain (aLBP) has demonstrated the positive result of kinetic acupuncture. By combining traction and natural gait movement with acupuncture, the patient achieved pain-free walking in one session.

Acupuncture with movement, like kinetic acupuncture, is one of the new modalities of western society, but its roots are derived from the ancient medical arts of China and Korea. Kinetic acupuncture techniques are based on modern anatomy and kinesiology such as isometric contraction, joint oscillation, etc., while other acupuncture and movement treatments are mostly based on traditional theories.

The purpose of local needling is to aid the healing process of the local site by increasing blood circulation and anti-inflammatory effect.[13,14,15] For this case of acute low back pain (aLBP) with disc herniation, the practitioner inserted the needle in the vicinity of endplate and intervertebral disc. Endplate damage can contribute to low back pain,[16] similar to mechanical nerve compression. Increased local blood flow can help the recovery of intervertebral endplates. Intervertebral acupuncture is similar to the analgesic intervertebral injection without analgesic substances. Evidence suggests that acupuncture is as effective as analgesic injection in myofascial pain.[17]

The underlying principle of both movements ("Walking with needles" and "Pelvic swing with needles") is a natural traction of vertebrate using the patient's own weight. By applying traction, the practitioner can reduce the in-between vertebral pressure of the patient. This also gives gentle rhythmic stimulation with movement to the spine. Movement with stimulation is an essential concept of kinetic acupuncture as it relates to the natural adjusting ability of humans. This ability is enforced with proper and safe stimulation. The hypothetical purpose of these movements is to make the patient adjust their own spine and heal the injury of tissue around the spine. Distal acupuncture stimulation is used to reduce the pain of such movements.

Safety

There are concerns regarding safety; however, the movements in kinetic acupuncture are designed to prevent the injuries.

Table 4. **Rules for Safe Combination of Acupuncture and Movement**

- Choose the remote location not related to target movement
- Apply isometric movement with muscle needling
- Insert the needle on the lateral side of muscles or tendons
- Limit the movement to oscillation or traction with joint cavity needling
- Adjust the needle depth to skin deep if the needle movement is not avoidable
- Always be ready to provide support when patient moves in sitting or standing posture.

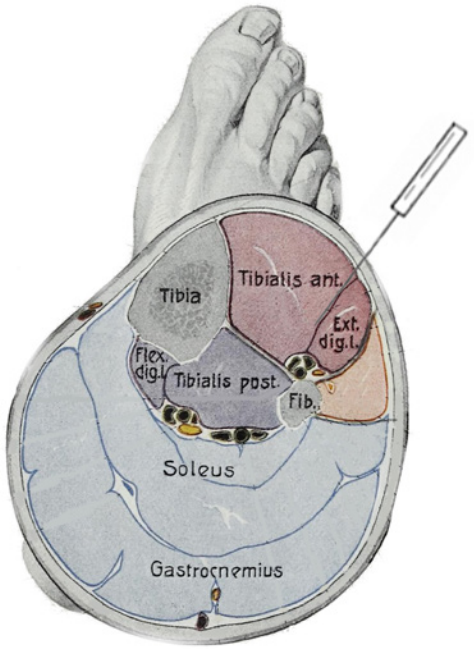
It is possible that the retained needles may bend or break and cause tissue damage if the patient moves. To prevent these possibilities, the practitioner should minimize the movement of the needle while performing the exercise to the patient. There are several rules in kinetic acupuncture related to this (Table 4).

For example, the practitioner may insert the needles on one extremity and let the patient move the other extremity. Or the practitioner may ask the patient to walk around while the needles are retained on the hands, neck, or head. The needles will not move because they are not retained on a moving location of the patient's body. Even with this remote needling, the acupuncture points should be meticulously chosen based on the planned movement to minimize the movement of the needles.

In kinetic acupuncture, the needles are also retained on the muscles and joints that are mainly moving. Muscle and joint needling are considered as major components in kinetic acupuncture. When the needles are on the muscles, the movement is limited only to isometric stretching or strengthening to prevent tissue injury. This technique is used for the treatment of tight muscles, such as in neck or shoulder and/or treatment of weak muscles, such as the anterior tibialis muscle in the foot drop condition.

The practitioner should avoid inserting the needle directly into the muscle belly; instead, it is suggested to insert the needles on the lateral side of that muscle. For example, the acupuncture needling of the ST-36 (*Zusanli*) point is commonly inserted on the anterior tibialis muscle. However, in kinetic acupuncture, the needle is inserted in-between the anterior tibialis and peroneus muscles toward the anterior tibial artery (Figure 5).

Figure 5. **ST36 Location and Insertion in *'Chimgu-gyung-hum-bang"***

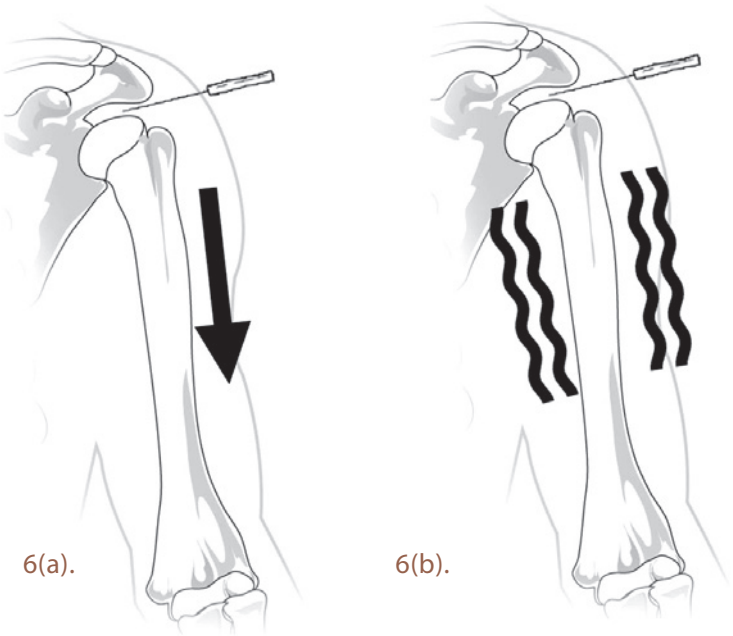


This is Heo-im's location and inserting technique in his book *Chimgu-gyung-hum-bang* (*Book of Acupuncture and Moxibustion Experience* (Figure 5). This location is very similar to Master Tung's "lateral ST-36 (*Zusanli*)" point. This location has stronger sensation and is less affected by the contraction of the anterior tibialis muscle. This ST-36 (*Zusanli*) location can minimize needle movement with ankle dorsal flexion.

In joint cavity needling, the needle is inserted directly into joint space, avoiding insertion at the muscles or at the tendons. The movement for the joint cavity is mostly limited to the traction (Figure 6a) and oscillation (Figure 6b). These two movements are not only effective to use but also have less possibility in creating injury. Flexion and extension of the joint are not recommended. In kinetic acupuncture, the most common selected acupuncture points in joint cavity are the femoro-tibial joint (ST-35 *Dubi*), subacromial space (LI-15 *Jianyu*), intervertebral space (DU points), and wrist joint (LI-5 *Yangxi*, SI-5 *Yanggu*).

In some cases of acupuncture with movement, the needles can still move and cause pain. It is recommended that the practitioner adjust the needles to a hyper-dermal depth similar to the instruction in the *Hui-Ci* technique: "When the sensation travels to the joint, withdraw the needle, to beneath the skin, and let the patient move the joint, then needle deeply again."[1] The practitioner should position him/herself on the side of the patient. To prevent dizziness or falling when the patient sits or stands, the practitioner should be ready to give any support that the patient needs.

Figure 6(a). **Traction with Joint Needling** and 6(b). **Oscillation with Joint Needling**



6(a). 6(b).

Indications and Contraindications

Kinetic acupuncture is absolutely contraindicated for any region that is inflamed. Acute injury, suspected fracture, and soft tissue tears are examples of strong contraindications. Relative contraindications are not well defined and should be considered on a case-by-case basis. In some chronic conditions, if the target joint is completely fused from surgery or disease such as ankylosing spondylolysis, joint kinetic acupuncture with ROM exercises should not be applied. The benefits are too small compared to the high risk of injury.

On the other hand, the best indication of kinetic acupuncture is for the joint with a limited range of motion but without complete fusion. It is a good treatment option for the functional recovery of musculoskeletal problems. By applying stretching movements to the affected muscles, kinetic acupuncture can also be used for conditions such as tight muscles, spasm, and/or cramps as well as using the strengthening method to any kind of motor weakness conditions.

Conclusion

The technique of acupuncture with movement is an ancient and traditional method practiced in Asia but not as well-known in the West. Kinetic acupuncture is a technique of "acupuncture with movement" that utilizes the main principle of modern anatomy and kinesiology, which may be effective in the treatment of acute low back pain (aLBP). A research study using kinetic acupuncture for acute low back pain (aLBP) on a larger scale is recommended. By implementing statistical data, the results of its effectiveness can be further reviewed.

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Catalyzing Emergence: Integral, Evolutionary, and Spiritual Perspectives on Chinese Medicine, Part II

By Lonny S. Jarrett

Lonny S. Jarrett has been practicing Chinese medicine in Stockbridge, Massachusetts, since 1986. He has been teaching and publishing on integral and evolutionary perspectives on medicine for over three decades. Lonny is a founding member of the Acupuncture Society of Massachusetts and a fellow of the National Academy of Acupuncture and Oriental Medicine. Lonny is the author of *Nourishing Destiny: The Inner Tradition of Chinese Medicine* and *The Clinical Practice of Chinese Medicine*. He holds a master's degree in neurobiology and a fourth-degree black belt in Tae Kwon Do. He was recently featured in *The Great Work of Your Life: A Guide for the Journey to Your True Calling* by bestselling author Stephen Cope. Lonny hosts nourishingdestiny.com, an online community for 3,000 practitioners of Chinese medicine worldwide. His teaching schedule is at www.chinesemedicine.courses, and his texts are available from spiritpathpress.com.

Note: This article is abstracted from Jarrett's new book in progress, tentatively titled *Deepening Perspectives on Chinese Medicine*, in which he focuses on integral, evolutionary, and spiritual perspectives on the practice of Chinese medicine. It is the second of three parts that will be published in *Meridians: The Journal of Acupuncture and Oriental Medicine*.

Introduction

In Part I of this series, the basics were set in place for understanding the integral perspective as a foundation for the emergence of an integral medicine, a non-dual medicine that leaves no significant dimension of the self behind. I presented the Four Quadrant model as a basis for Integral Methodological Pluralism and established that methodologies enact perspectives to reveal true, but partial, insight into phenomena. Emphasis was placed on the practitioner's own developing integrity as a foundation of efficacy in the practice of integral medicine.

In Part II of this series, I present the relationship between state and stage development and introduce the dynamics of stage pathology. I will examine repression, shadow, and projection as they manifest in stage-specific allergies and fixations.

States

States are one of the core elements of Integral Theory (along with stages, quadrants, lines, and types) and arise in all four quadrants. We may distinguish states and stages of consciousness as they are experienced in the Upper Left Quadrant (UL), recognizing that states come and go, whereas stages (of ego development, for example) are permanent once they are established.[1]

A "state" refers to a transient experience lasting from a single moment to an indefinitely longer period of time. Waking (gross realm), dreaming (subtle realm), and deep dreamless sleep (causal realm) are three UL states that we all experience regularly. Daydreaming, meditation, contemplation, and peak states are also states of consciousness that we experience in the UL.

Consciously shifting attention to any part of the self—such as the ego, the authentic self, the conscience, or the soul—can yield very different state experiences in an instant. The five-element cycle can be thought of as depicting a succession of states—as thought, feeling, emotion, and sensation cycle, like seasonal change or the weather. Medicines such as acupuncture and practices such as yoga, *qigong*, contemplation, and meditation can induce different types of higher and deeper state experience where the patient or practitioner temporarily loses sense of time and place.

States of consciousness are the domain of the UL. From the perspective of medicine, higher and deeper state experiences are potentially fertile ground for emergence of higher stages of development. An important point to remember is that higher state experiences impart a glimpse of the relatively more enlightened perspective of a future possibility. However, such state experiences often pass relatively quickly, and their meaning tends to be interpreted according to the values of the person having them (UL) and the culture (LL) into which they are being assimilated. As healers, it is our clinical imperative to guide patients toward embodying higher state experience as higher stage development.

Stages

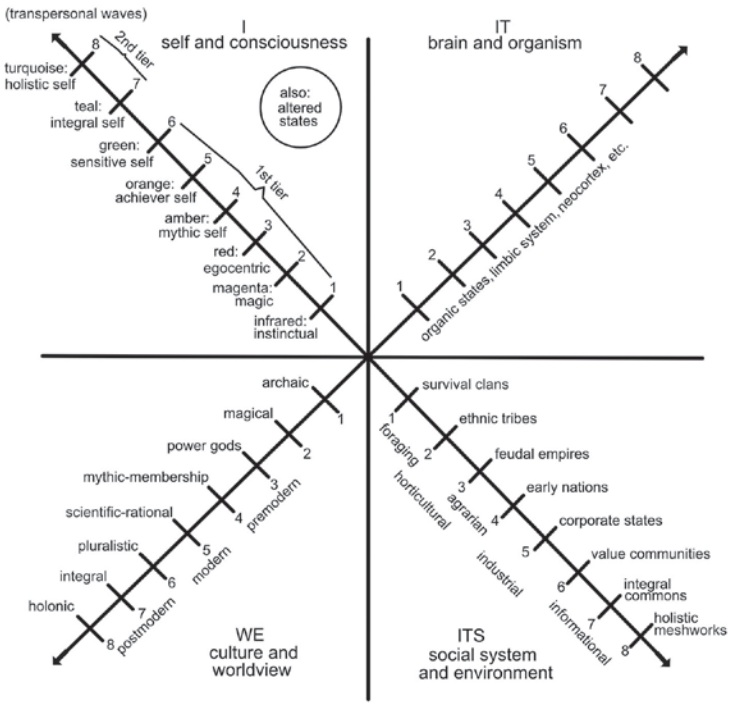
"There is no past that we need long to return to, there is only the eternally new which is formed out of enlarged elements of the past; and our genuine longing must always be productive, for a new and better creation." [2]

–Goethe

Understanding states and stages of development is critical to clinical practice because the efficacious application of all medicine is state and stage appropriate. Figure 1 depicts the correlations between basic stages of individual (UL), cultural (LL), physical (UR), and societal (LR) development. The telos of evolution is toward greater complexity, integration, and wholeness in all four quadrants.

Because stages are permanent and not merely transitory like states, when a new higher and more integrated stage emerges, it transcends the limitations of the previous stage while including its strengths. Hence, there is an archeology of the self-structure in which every previous self has been relegated to the subconscious, hopefully with its limitations overcome and its strengths included. For example, when a 12-year-old child evolves from being able to act on the body and understand relationships between physical objects (Piaget's "Concrete Operational" stage) to being able to think abstractly and act on thought itself (Formal Operational), all the capacities of concrete operations are retained while the limitations of that view are transcended, imparting a greater skill set and expanded world space (sense of reality).

Figure 1: The quadrants define four perspectives that every sentient being looks *through*. Here are depicted stages in the evolution of the self (I), culture (We), the body (It), and society and ecosphere (Its). The trajectory of each line in each quadrant is toward increased complexity and integration.



Adapted from: Wilber K. A Theory of Everything: An Integral Vision for Business, Politics, Science, and Spirituality. Boston: Shambhala; 2000.

Given a nurturing environment, healthy stage development proceeds of its own accord, up to the point of ego emergence. Your volition wasn't involved when it came to differentiating sensory orifices from your ectoderm as an embryo, when you evolved from sensorimotor to pre-operational to concrete operational and on to formal operational cognition, or when your ego began to differentiate out of your unconscious with the advent of language. In most of us, ego solidifies by the age of 21 and, frankly, many people never make it beyond this stage, for it requires the application of will to self-actualize and stabilize ego as the ground for reaching the higher transpersonal stages that wait beyond.

In the demographic of people reading this paper, self-actualization (Maslow's highest stage) is a shared cultural ideal.[3] However, the ego (as a separate self sense) can't go any further than this stage of self-authoring, leaving many feeling isolated and existentially bereft of deeper and higher meaning. Perhaps this is why so many of the world's most educated, nourished, and fortunate people take so many supplements, antianxiety medications and antidepressants, and undergo so much "therapy." For us, the step from the personal into the transpersonal is a momentous leap, calling not just to us as individuals but also to our culture as a whole.[4]

As practitioners, understanding individual and cultural evolution is imperative because it imparts an overarching philosophical context for understanding who the patient with whom we communicate is, what their value system is, and how they interpret their experience. We may assess the aspects of their development that are trailing, that define their center of gravity, and those at the leading edge of their journey. One's developmental "gravitational density" denotes the average state and stage development of the individual. In addition to our average stage of functioning, we also have a lower-stage subpersonality that exists as a background presence, subconsciously influencing our choices. This is the position to which we tend to regress under stress.

Significantly, meeting patients "where they are at" means meeting them at their stage. Stages of cultural worldview are the domain of the LL (Fig. 1). Understanding cultural traditions and values can help us consciously frame therapeutic interactions. It may not be appropriate to talk to a neuroscientist (Fig. 1, scientific-rational, stage 5, LL) about treating them for "possession," just as it may not be useful to discuss neurotransmitter imbalances with a person from a tribe that is isolated from contact with modern culture (Fig. 1, animistic-magical, stage 2, LL).

It bears repeating—medicine is state and stage appropriate. Medicine that might serve one individual can harm another, and medicine appropriate to catalyze emergence at a specific moment in life can cause stagnation or regression at an earlier or later time. For example, meditation is one of the most useful developmental activities that we can engage in for the sake of transcending ego and gaining experience in the transpersonal dimensions of self. Yet if a person with weak ego formation engages in meditation, they can decompensate.

I was once an expert witness in a case where a practitioner had taught Sufi meditation techniques to a patient who had a history of mental illness. This had disastrous consequences. For that patient, building healthy ego structures, not deconstructing them, should have been the medicine of choice. This illustrates the important principle that, while we may have higher state experiences far above the gravitational center of our actual development, to manifest that higher state as a new stage will require traversing all the actual stages of development that exist between us and the promise of that higher experience.

We know that acupuncture can induce the higher state experience of feeling better very quickly, imparting hope of a better future, deeper integration, and a higher stage of development. We also know that things often feel better long before they are better. Hence, it is imperative to exercise caution at this critical juncture in the healing process. *I* discuss this dynamic in *Nourishing Destiny* and *Clinical Practice* in relationship to *Yijing* hexagram 23 and 24, the turning point, and the law of cure.[5]

It is the task of the practitioner of integral medicine to guide patients to use higher state experience as the inspiration to attain higher stages. These are defined in part by the ability to make more wholesome meaning through the embrace of a higher level of complexity.[6] Hence we support patients to reframe previous interpretations of experience in more complex, inclusive, and nuanced terms. We support them as they grapple with the implications of revelations by cultivating a felt sense of obligation through awakening conscience (the voice of the soul informing us of the nature of the gap between the truths revealed in higher states and our actual condition) to make their life a living reflection of their higher insight and experience.[7] This will necessarily entail a conflict between the upright forces engendering the more highly integrated stage and the forces of ego that oppose it, endeavoring to maintain the *status quo* at any cost to self and other.[8]

As we develop to higher stages, we experience increased freedom and objectivity in relationship to states. That doesn't mean that we become free from states; it means we increasingly identify with the position of the witness—that unmoving center of the circle, in the face of cycling experience (Stage 7, Fig. 2).[9] Higher state experience of the "witness" perspective in the causal/spirit realm reveals that thought and feeling have no self-nature. Helping patients experience and stabilize the witness perspective can greatly reduce the charge of their emotions and personal mythologies (constitutionally influenced interpretations of life experience), thus freeing up significant internal resources to promote healthy development that were previously dedicated to repression.

Introduction to Stage Pathology

The capacities of any stage have inherent limitations that are amplified when taken as an absolute perspective. These create problems that can only be addressed by the more highly integrated capacities of the following stage. Healthy integration of a new stage is complete when the previous stage has consolidated, the limitations have been transcended, and the efficient capacities have been included as a basis for new and higher emergence. Development can be negatively impacted by trauma when an individual is stabilized in a specific stage, leaving a stage, in between stages, or just entering a new stage of development.

Diagnosing not just the nature of a trauma, but also its specific impact on stage development is essential if we are to understand the intricacies of its expression throughout the individual. As trauma is released, capacities emergent during the wounded stage will rectify to some degree with positive developmental reflections throughout the hierarchy of the self-structure.

Each stage has its own pathology, and the general rule is that unresolved pathology at any lower stage can undermine the healthy consolidation of later stages, creating distortions and

compromising ongoing development. Pathologies that significantly arrest development at a given stage are most severe. The earlier and more significant the wound, the more far reaching are its consequences in terms of compromising subsequent development.

Another dynamic is that repression arising in later stages can present as shadow in lower stages that is embodied as pathology in associated organs and body regions. For example, repression of tender feelings in the heart (fourth chakra) can restrict the diaphragm, causing stagnation and heat in the liver (third chakra), thus weakening the kidneys (second chakra). In this case the "root" of the pathology lies higher in the heart/mind, and merely addressing the kidneys would be symptomatic.

The two main pathologies of stage development result from incomplete disidentification from a previous stage. This leads to fixations and addictions and incomplete integration of the new stage, which in turn leads to repression, disowning, and "allergies."[10]

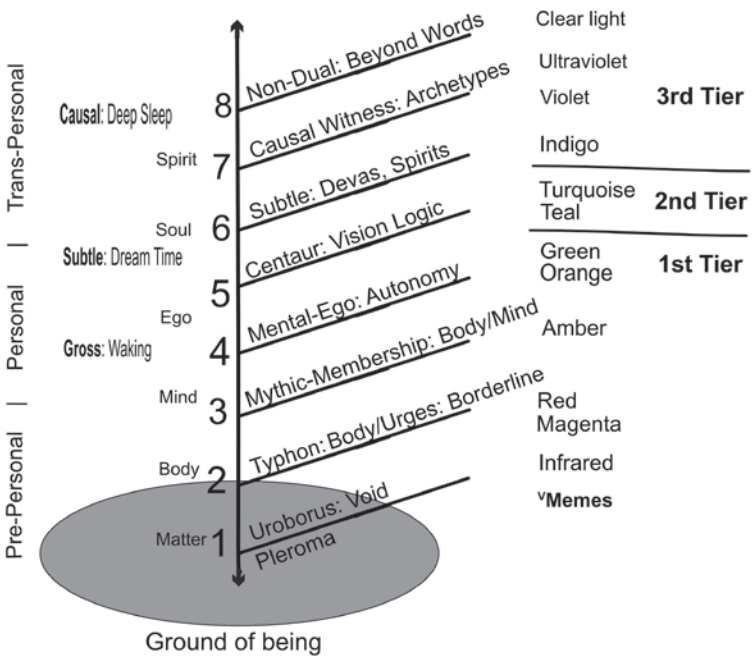
In the case of incomplete disidentification, the individual fails—consciously or unconsciously—to let go of portions of a previously held worldview. For example, trauma sustained in the alimentary oral stages of development can inhibit healthy disidentification with those stages. This can result in eating disorders, oral fixations, and other dysfunctions manifesting through the organs associated with the digestive system (St, Sp, SI, LI). Similarly, an individual may not properly differentiate from their identification with teenage sexuality and thereby fail to find a partner with whom they develop a mature relationship. Each stage of development has its own fixations that manifest across a broad spectrum of body, psyche, soul, and behavior.

Allergies involve stage-specific repression of aspects of the self arising from a previous stage. This repression of the past that we cannot or will not integrate is often projected as denials of future potential on the following stage. For example, a person at the modern scientific-rational stage of development might repress unconscious content in favor of rational cognition. In this case, the baby of intuition may be thrown out with the bathwater of superstition and myth that they associate with the great traditions and magical thinking. Failing to include the strengths of these earlier stages, they develop an "allergy," which manifests as an irrational and repressive hypersensitivity to any expression of soul depth or spirituality.

Hence, those at the earlier magic and mythic stages are deemed "ignorant," while those at the following postmodern stage of development who entertain New Age spirituality are deemed "flakes." Both assessments are a projection stemming from repression of soul, spirit, and the transpersonal realm. In this case, rationality, having overcome the distortions of the magic (superstition) and mythic stages (witch trials, for example), is taken as an absolute principle and dysfunctionally perpetuates its own distortions, such as scientism (the unquestioned fundamentalist belief in rationality and science).

There are two important principles here. The first is that the dimensions of our past that we deny necessarily limit our embrace of future potentials. The second is that the stage emergence of a new capacity, such as rationality that resolves distortions arising in previous stages, will eventually cause its own problems. As the values, perspectives, and capacities of a given stage are dysfunctionally relied on, its worldview fails to account for evolving complexity and will once again have to be transcended.

Figure 2: Here, stages of development are roughly correlated with chakras 1-8. On the left are the state/stages of body, mind, ego, soul, and spirit, the pre-personal, personal, and transpersonal realms, and the gross, subtle, and causal realms. On the right are some of Wilber's color-coded stages. In the Spiral Dynamic model, these are correlated with the evolution of human value spheres divided into two tiers (Wilber has postulated the third tier). The first tier[11] consists of six "subsistence" stages of development that engender cultures at conflict with each other. The second tier consists of holistic and integral stages capable of a top-down conscious embrace of previous stages. The third tier, the transpersonal realm, includes the subtle, causal, and nondual stages.[12]



In Fig. 2, the circle (0, zero) at the bottom designates the undifferentiated, unborn, ground of being—that dimension of self that is ever untainted by life experience and that, in CM, we designate as the primordial source (*yuan*: 元, 原). The arrow arising straight out of the center of the circle denotes the telos of the creative impulse as it arises from emptiness. This straight line is designated as the number 1 (*yi,* 一, "The Creative," the first character in any

Chinese dictionary). In CM this line is congruent with the idea of *zhenqi* (authentic *qi*), *zhengqi* (upright *qi*), and is embodied physiologically in the ideal of the heart/kidney axis.

Here in Fig. 2, I've designated eight stages of development roughly corresponding to the chakras (Wilber divides these for finer resolution to yield 16 stages).[13] On the left I've designated these as pre-personal/personal/trans-personal, gross/subtle/causal, and the continuum of matter/body/mind/ego/soul/spirit. On the right, I give Wilber's designation of the cultural stages of evolution as elaborated in relation to CM in my text, *Clinical Practice*. In Spiral Dynamics, these are correlated with evolving value systems (ᵛmemes); however, Wilber considers them in a broader context.[14]

Values can be ranked in a hierarchy of inclusivity, informing us of the trajectory that the individual is on, signaling their trailing, current, and imminent stage of emergence. We may consider:

Is the patient thoroughly embedded and blind to the assumptions and partiality of culturally given values?

Or, have they just begun to run up against the limitations of their current stage of development, starting to question unexamined assumptions?

Is the individual entering a new stage with one foot in the old and one in the new?

To what degree is this transition causing conflict, as aspects of the last stage are denied and repressed to yield an allergy or not transcended to form the basis of an addiction?

Are there injuries sustained at earlier stages, preventing the consolidation of the current stage and its mature presentation?

To what degree is the individual an unconscious representation of their culture and to what degree are they consciously pushing an edge?

What lines (as presented in Part III of this article) of development are lagging and what lines exceed their average stage of development?

All of these are questions that we concern ourselves with as we assess the state and stage of a patient's evolutionary arc. Each stage has its gifts, limitations, and potential allergies and addictions. Each must be healthfully consolidated and then transcended to create a stable base that supports the higher degrees of wholeness and integration synonymous with health. In each stage, the ego tends to accept a substitute gratification for wholeness that gives rise to inertia and pathology. For example, typical substitute gratifications for the first three chakras are food, sex, and power respectively.

"In each stage, the ego tends to accept a substitute gratification for wholeness that gives rise to inertia and pathology."

When an individual settles for substitute gratifications, physiological resources are usurped and diverted away from evolutionary development toward maintaining the *status quo*. In this way, the individual becomes increasingly embedded at the stage they are at. From an integral, evolutionary, and spiritual perspective, such stasis is a significant root of illness as pathology is understood as a conflict between the authentic *(zhen*:真) upright (*zheng*:正) influences and habituated forces of inertia.

Wilber covers the pathology of stages throughout his works, having laid the groundwork in the text *Transformations of Consciousness* and elaborating them in his new text, *The Religion of Tomorrow*. I refer the reader to these for more detail than I provide here.

The stages are depicted here discretely for the sake of elaboration, just as we teach the five elements discretely. In reality, they flow into each other with different capacities and lines of development (lines are covered in Part III of this series) in different states, and at different stages, in a given moment. At a given *stage* of development, a person can have a higher *state* experience. For example, a two-year-old child can enter the subtle realm while dreaming. Similarly a shaman in a tribe 50,000 years ago (fulcrum 2 in Fig. 2) could have access via trance to insights at fulcrum 6 or 7. However, those higher state experiences tend to be interpreted at the individual's and culture's actual stage of development.

Stage Pathology

Let me briefly introduce pathologies associated with each stage. Special emphasis is placed on those of the transpersonal realm due to my assessment that they are of particular concern as we aspire to practice Chinese medicine beyond the limitations of postmodernism.[15]

At Stage 1 (Neumann's pleroma and uroboros, Piaget's sensorimotor, Aurobindo's subconscient, Laozi's "Wilderness before the dawn"), the self is embedded in the material world. Stage 1 is archaic, and if injury occurs here in a way that severely compromises further development, the individual can be autistic (wholly self-absorbed) or psychotic. Less severe injury can result in eating disorders related to disturbed alimentation in the oral stage.

Stage 2 is where consciousness first arises out of the unconscious. The worldview here is magical, and injury can result in borderline pathology. In this case, subsequent ego development is frail, with the risk of decompensation under a relatively small amount of stress.

This is related to the designation of "Nervous System Weak" in the *Shen/Hammer* tradition.[16] Sexual fixations tend to implicate distortions of development at the second chakra. Stage 2 is also the basis for the manifestation of narcissism, where failure to differentiate leads to seeing others merely as an extension of one's own self.

Stage 3 represents the early mental self, and the worldview here is mythic. Injury at Stage 3 can lead to neurosis as the body's lower impulses come into conflict with membership ethics and the mind's emerging capacity for reason. This stage is a foundation for rule/role script pathology as the later ego comes into conflict with the superego, the internalized voice of authority that may persecute with harsh judgment and "heaven or hell" prerogatives. Young, and possessing an immature mind, we create our own mythic life story that can be crippling at later stages of development if it is not transcended.[17]

With the solidification of ego at Stage 4 (modernity, rationality), the individual eventually comes to suffocate in the prison of a finite and inherently limited separate self-sense. Identity neurosis arises as the individual struggles with discernment between following their conscience and adhering to society's rules.

As the ego (the separate self-sense) self-actualizes to embrace self-authorship in Stage 5 (integral awareness, Wilber's "Vision Logic," the capacity to make systems of systems), it intuits and then anticipates the ensuing transpersonal stages, experiencing them as annihilation. This can result in existential depression, isolation, anxiety, and aborted self-actualization. We may experience a "dark night" grappling with the existential implications of seeing through and feeling compelled to step beyond the created self.[18] Having succeeded in what Washburn terms the "Identity Project," we reach the peak of ego development as a separate self sense and may ask, "Is this all there is?" Or in the terms of the Talking Heads, "My god, what have I done?!"[19]

In Stage 6, we enter the transpersonal, subtle realm. Pathologies here can entail a dark night of the soul, where strong experiences of the subtle realm cause conflict with vestiges of ego that have not been adequately transcended. People can evidence split life goals, "Should I live in or leave the world?" Recoiling from development here can lead to cynicism and rejection of higher truths that have been seen.

There can also be psychic inflation as initial transcendent experiences convince the ego that *it* is enlightened. Windhorse (Tibetan: *rlung*) disorders such as muscle spasms, headaches, and difficulty breathing can represent the somatization of the struggle between ego and soul. Physiologically, more energy is released than one's degree of cultivation can accommodate. In Yogic illness, as described by Aurobindo, the great intensity of psychic/subtle energies overload lower circuits, manifesting as allergies, intestinal issues, heart problems, and, Wilber suggests, even pathologies as serious as cancer.[20]

"Subtle realm practices engaged with as medicine can be harmful and, if not done sincerely and with proper guidance, can merely deepen attachment and do harm. Happily, depth CM is an excellent therapy for opening channels and directing subtle influences so that they stop overwhelming the self-system. In this way ease and perspective may be engendered."

Suffice it to say that there are many powerful practices available in today's spiritual marketplace that if engaged in, and divorced from proper motivation, cultivation, and guidance, can wreak all sorts of havoc within the body/mind. I have treated significant teachers, veritable lineage holders, for panic attacks, insomnia, and anxiety. I have helped them to stop taking prescription medications for these conditions because, in my estimation, their bodies, minds, perhaps their souls were not developed enough to accommodate the degree or type of practice they were engaging with. Often they lacked sufficient preparation, the right context, or clarity of guidance appropriate to their chosen practice. For those with weak ego formation, there is a serious risk of decompensation and psychoses after engaging with subtle realm practices and medicines. I have seen this several times, and the risk is to be taken seriously. It bears repeating, every medicine has its appropriate time, person, dose, and context (place).

Enlightenment (for the sake of this discussion this means "development beyond ego as a separate self sense"), while an appealing construct to the mind, requires more than the mind itself can ever give, and this can create all sorts of conflict when the degree of surrender required is finally confronted. Subtle realm practices engaged with as medicine can be harmful and, if not done sincerely and with proper guidance, can merely deepen attachment and do harm. Happily, depth CM is an excellent therapy for opening channels and directing subtle influences so that they stop overwhelming the self-system. In this way ease and perspective may be engendered.

Aurobindo elaborates at length the perils of being stuck in this "intermediate zone" in an essay that reads like a condemnation of a significant part of the New Age movement.[21] Daoist scholar and physician Liu Yiming was also adamant regarding false paths.[22] I've spent a great amount of time elaborating illness at this stage because the leap from ego into the transpersonal is specifically relevant for the readership of this article.

At Stage 7, bliss may be accepted as a substitute gratification for wholeness. People can sit for lifetimes, identified as the witness, detached from the world, failing to transform and let go into nonduality. I have had experience treating people addicted to the detached perspective of the witness who were simply not cognizant of the suffering their attachment to sex, money, and power was causing themselves and their community of students. Wilber describes "pseudo-nirvana" and "pseudo-realization" as disorders here. We may also note the risk of indulgence in causal states (addiction to bliss) as a potential method of bypassing distortions in need of rectification at earlier stages of development. As Jung pointed out, "One does not become enlightened by imagining figures of light, but by making the darkness conscious."[23]

In balance, Stage 8 is represented by the tenth zen ox-herding picture where the sage returns back to the marketplace enlightened within the context of engaging with the world.[24] Wilber discusses "Failure of Differentiation" and "Failure to Integrate," or "Arhat's Disease" as disorders at Stage 8. In my own experience, every relative part of the self committed to remaining separate recoils from non-duality and, to the degree one identifies with the recoil, there can arise the poisons of cynicism and doubt both internalized within the heart/mind as well as projected on others.

Summary and Conclusion

Part II of this series has continued to lay the groundwork for an understanding of integral medicine as it is based on evolutionary values. I've elaborated the dynamics of state and stage development and introduced the notion of stage pathology and how distortions of development can lead to both addictions and allergies.

Throughout, I've emphasized that all medicine is state- and stage-specific and has its appropriate time, place, and dosage. An important function of integral medicine is to catalyze the emergence of—and help to stabilize—deeper and higher potentials representing a more wholesome evolution and integration of the self.

In Part III of this series, I will discuss lines of development and typing systems. I'll also consider the import of the evolutionary and spiritual perspectives on medicine.

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1. The four quadrants are the Upper Left (UL, "I"), Lower Left (LL, "We"), Upper Right (UR, "It"), and Lower Right (LR, "Its"). Please refer to Part I of this series for a more detailed explanation.
2. Herwig W, 1971, p. 611
3. Maslow AH, 1943, pp. 370- 396.
4. Note that Wilber's work is foundational in the field of transpersonal psychology with most work at this point either inspired by or in reaction to his writings.
5. See Jarrett LS, 1999, pp. 103-120 and 2004, pp.58-74. Audio at: https://wp.me/p9d74G-8D
6. Kegan R, 1982, p.85.
7. Jarrett LS, 2007, pp. 6-9.
8. I use term "ego" in a spiritual context as "the irrational force of resistance to wholesome, integrative change." Ego can also be understood as a stage of development necessary as a basis for healthy transcendence. These distinctions are covered in depth in my new text.
9. See Jarrett LS, 2012 and 2013.
10. For a detailed discussion of these see Wilber K, 2017, p. 101.
11. Here I use Wilber's color designation of the value memes that more accurately reflects the light spectrum. For a review of Spiral Dynamics and its import for CM, see Jarrett LS 2004, pp. 745-770.
12. In his most recent text, Wilber (2017) uses Aurobindo's designations of Para-Mind, Meta-mind, Overmind and Supermind for the third tier stages. He does not use "subtle, causal and non-dual," as these are often associated with states and not stages. For an up-to-date list of structures according to Wilber, see p. 195 of *Religion of Tomorrow*.
13. For a beautiful and breathtaking view of evolutionary spirituality, see Wilber K, 2017.
14. Beck D and Cowan C, 1995.
15. See Jarrett LS, 2015.
16. Hammer L, 1990, p. 324.
17. In *Nourishing Destiny*, I elaborate how the generation of personal mythology as a compensatory mechanism of an immature mind can lead to illness and impede development at later stages. See Jarrett LS, 1999, pp. 154-167.
18. Wilber speaks of three "Dark Nights" of the senses (gross), soul (subtle), and self (causal). Wilber K, 2011, pp. 99-100.
19. See Washburn M, 1994. Lyrics to "Once in a Lifetime" by the Talking Heads.
20. Wilber K, Engler J, Brown D, 1986, p. 121.
21. Sri Aurobindo, 1970, pp. 1039-1046.
22. Cleary T, 1986, p. 40, 95-96, 104.
23. Jung C, 1967, pp 265-266.
24. The ox-herding pictures can be seen at: http://www.columbia.edu/cu/weai/exeas/resources/oxherding.html

Interview with Robert Davis, LAc

Acupuncture for Chronic Pain in the Vermont Medicaid Population

By Jennifer A.M. Stone, LAc

Robert has delivered over 35,000 acupuncture treatments over the past 20 years as a Licensed Acupuncturist. He is currently the Co-President of the Society for Acupuncture Research. He has served as the Principle Investigator of six US National Institutes of Health acupuncture research grants. He was also the Principle Investigator of the state funded "Acupuncture for Chronic Pain in the Vermont Medicaid Population" grant. He is a member of the Steering Committee for the University of Vermont Program in Integrative Health as well as a consultant for the UVM Medical Center's Chronic Pain Program.

In response to the opioid crisis, the Vermont Legislature passed Act 173 in 2016. The legislation addresses how physicians and pharmacists manage their chronic pain patients who are taking opioids. The verbiage included education on the use of complementary and alternative therapies instead of opioid substances when treating chronic pain.

Robert Davis, LAc, led a team of researchers that conducted a pilot study on the use of acupuncture for chronic pain for Medicaid recipients. *Meridians: JAOM* Editor in Chief Jennifer Stone, LAc, interviews him here.

Jennifer Stone: ***Robert, thank you so much for granting us this interview. Your work in Vermont shows us how research can inform healthcare policymakers in the legislature. How did you first get involved with this initiative? Were you approached by the legislature or did you come up with the idea and approach them?***

Robert Davis: Thank you, Jen. I appreciate the chance to share my Vermont experience with your readers and hope it is helpful for others.

The legislature initially became aware of the potential of acupuncture in the context of their efforts to address the opioid crisis. As they began to consider legislative solutions, the lobbyist for the Vermont Acupuncture Association was able to arrange for the committees that were drafting the opioid bill to hear testimony regarding the effectiveness and advantages of acupuncture for the treatment of pain. I was involved with providing some of this testimony.

Once the bill passed and the study was funded, the Department of Vermont Health Access (DVHA), which administers the state's Medicaid program, was charged with running the study. Their team approached me to see if I would be willing to collaborate on the study. I think they approached me initially thinking that I would administer the treatments to the patients in the study. I have a history of being very involved with the medical, integrative health, and research communities. As we discussed the design of the study, I was able to educate them on the value of a pragmatic design since the questions being asked were policy questions.

For example, we were not asking whether acupuncture worked or how it worked. We were asking what would be the effect of a policy change that allows Medicaid patients with chronic pain to utilize the care of the existing Vermont licensed acupuncture workforce? Was it feasible? Would it be acceptable to these patients? Would it be effective in addressing their pain as well as their psychological, social, and occupational functions?

You can read more information about the background for the study and its design in the article: Davis R. Vermont policy makers assess the effectiveness of acupuncture treatment for chronic pain in Medicaid enrollees. *J Altern Complement Med.* 2017;23(7):499–501.

JS: ***Where did the funding come from? Was there a request for applications? Was it competitive?***

RD: The funding was provided by the state, through the Department of Vermont Health Access. Normally, an appropriation like this would qualify for a federal match, and there was an initial memo and report that this would be the case. However, since acupuncture is not a service covered by the Centers for Medicare and Medicaid Services (CMS), we did not receive a federal match. There was not an RFA [request for applications] because the study was officially run by the DVHA.

JS: ***I know that you were the principal investigator who oversaw the study. Which research institution received and managed the funds?***

RD: I was the Co-PI along with the DVHA medical director. Fortunately, supervising this project was well within my experience set, as I had run a company for ten years that received NIH Small Business Innovation Research (SBIR) grants directly, without going through a university.

We had a very short one-year timeline in which we had to complete all the work. No funds could be carried over into the next year. By the time we agreed on a study design and figured out how to handle things logistically, we only had about nine months to get Institutional Review Board approval, recruit acupuncturists and patients, deliver the treatments, process the data, and produce a report.

Licensed acupuncturists are not credentialed by DVHA since acupuncture is not a covered service. Therefore DVHA could not pay acupuncturists through the normal mechanism for delivering treatments. The workaround was to hire me as a subcontractor to get most things done.

I hired an assistant to help with recruiting, consenting, and processing the data. I subcontracted the 29 Vermont licensed acupuncturists who delivered the treatments in their offices. I also subcontracted a very experienced biostatistician whom I have worked with on previous research projects.

JS: ***How did you assemble your research team? Where did they come from? Were they researchers you've worked with in previous studies?***

RD: The research assistant I subcontracted was a graduate student at the University of Vermont who had worked for the DVHA medical director on another project. We also added another grad student during the heaviest period of recruitment. As I said previously, the biostatistician was someone whom I worked with previously.

JS: ***One hundred and fifty-six patients were enrolled in the study. They received up to 12 acupuncture treatments during a sixty-day period. How were they recruited? Did you have difficulty recruiting? What percentage of enrolled subjects completed the 12 treatments?***

RD: Fortunately, I was experienced with recruiting subjects for my other research trials. However, we were uncertain whether this population would embrace the opportunity to receive acupuncture. We were also uncertain how much help we'd get from the medical community in terms of referrals.

What we learned was that there is large demand for acupuncture in this population. Despite our very short window to recruit, we were quickly at capacity and had a waiting list. The research assistant estimates that there was enough demand to treat twice the number of patients we treated had we had the time and money to do so. We benefitted from a lot of referrals from the medical community—doctors, nurses, case managers. They were very excited to offer this treatment option to their patients.

The mean number of treatments for all subjects was 8.2. Sixty patients (38%) received the maximum of twelve treatments. One hundred and twelve patients (72%) received at least six visits. Twenty patients (13%) enrolled but never received any visits, mostly due to transportation or scheduling problems. This is a low-income population with limited resources.

JS: ***What were the results of the study?***

RD: Measurements captured prior to and at the end of the treatment period showed significant improvements in group mean pain intensity, pain interference, physical function, fatigue, anxiety, depression, sleep disturbance, and social isolation as assessed by Patient-Reported Outcomes Measurement Information System (PROMIS) measures (paired t tests, $P < .01$). Fifty-seven percent of patients using analgesic (nonopioid) medication reported reductions in use. Thirty-two percent of patients using opioid medication reported reductions in use of opioid medication following the intervention. Seventy-four percent of employed patients reported improved capacity to work. Ninety-six percent of patients said that they would recommend acupuncture to others with chronic pain, and 91% reported qualitative improvements, including physical (31%), functional/behavioral (29%), and psycho-emotional (24%) improvements.

For a full report, see Davis RT, Badger G, Valentine K, Cavert A, Coeytaux RR. Acupuncture for chronic pain in the Vermont Medicaid population: A prospective, pragmatic intervention trial. *Glob Adv Health Med.* 2018;7:2164956118769557. Published 2018 Apr 10. doi:10.1177/2164956118769557

JS: ***Did the study complete the objective in changing health care policy in Vermont?***

RD: The answer to that question is constantly evolving. One concrete change that has occurred is that both Medicaid and Blue Cross Blue Shield of Vermont (the dominant private insurer in the state) have agreed to cover acupuncture in several integrative pain treatment programs throughout the state. Medicaid has not added acupuncture to their services yet. They have stated that they need more cost data before they make this change.

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Ht – 9 少衝 *Shao Chong*/Lesser Surge

Please see bios at end of the article.

The pictures are part of a project called the "Gates of Life" portraying the nature, action, and *qi* transformation of acupuncture channels and points made by the CAM team © (Chmielnick, Ayal, Maimon). Illustration by painter Mrs. Martyna "Matti" Janik.

For more information,
see free Ht-9 video at TCM Academy: https://www.tcm.ac/course/ht-9-unfolding-the-mystery-of-universe-and-man/

By Yair Maimon, DOM, PhD, Ac and Bartosz Chmielnicki, MD

Ht-9, *Shao Chong,* is a Wood and a *jing-well* point. Both aspects are shown in this picture. Being a Wood point, Ht-9 is used for invigorating the Heart, bringing a strong movement into *shaoyin*. This is why the monk is performing meditation in movement, known as *qigong*. On one hand, it results in peace and joy, which shows an action of calming the *shen*; on the other hand, it is very strong movement.

On a psycho-emotional level this point may be understood as a point of communication with the Heart. This is shown in the picture as a small thoroughfare leading to and from the Heart that has been cut onto a tree. As a Wood point it may influence the Fire and be used for clearing Heat. That function is depicted in the form of an extinguished bonfire. As a *jing-well* point, Ht-9 strongly influences the other end of a channel—that is why it is used to clear Heat, especially from the eyes (main and *luo* channels), throat (*luo* channel), and tongue (divergent channel). The monk has open eyes and a red collar to remind us of those functions.

Characters of the Name:

少 – ***Shao*** The character shows something small (*xiao* 小) divided even smaller and means little, few, or lesser.

衝 – ***Chong*** The character is composed of the following two parts: the character *chong* 重 (repeat or weight) is put between two parts of the character 行 *xing* (walk). Together they mean repeated action taken with great effort, to rush forward, highway (where one can travel fast), main, central place (where all the highways meet or begin). It also brings forth a meaning of power—of moving with great power.

Meaning of the Name:

Lesser Surge

This name refers to the surge of warm Blood animated by *shen*, from the depth of *shaoyin* division, through the whole body, outwards, towards the skin. It is related with the Wood quality and dynamic movement characterizing this point.

Other Names:

As with most acupuncture points, they may have are additional names which can help to understand the nature of the point. One of the names of this point is 經始– *JingShi*, "Channel's beginning." This name refers to the origin of the Heart channel internally in the small intestine. It is also connected to one of Chinese medicine schools that teaches that the whole meridian system begins at this point.

Location

Shao Chong is located on the radial side of the small finger near the corner of the nail.

Action and Indication:

Jing-well point

Revive consciousness: The *jing-well* points cause strong changes and are very dynamic in nature. Ht-9, like many of *jing-well* points, revives consciousness. This function is empowered by the Wood quality of Ht-9. Moreover, the Heart is the organ housing the *shen*; therefore, Ht-9 is one of the strongest points influencing consciousness and awareness on many levels. Its powerful action was demonstrated in ancient times by the custom of biting the little fingers of corpses before burial to avoid burying someone who was in coma.

Wood point

Palpitations: Being a Wood point on Fire channel, Ht-9 strongly strengthens Heart *qi* and is indicated in case of palpitations resulting from Heart *qi* deficiency.

Moving Liver Stagnation and balancing Gall Bladder: Ht-9 is located on Fire channel and has the quality of Wood. It is also a stem point related to *yin* Wood Great Movement. Those characteristics make this point very effective in treating any stagnation in Wood phase, Liver, or Gall Bladder. This action is used in treatment of Gall Bladder-type headaches. It also helps to ensure the clarity of speech and communication with love rather than anger or judging. When Gall Bladder is stagnant, it doesn't feed the Heart, so one feels anger instead of love.

Affecting the other end of the channel

Pain at the root of the tongue, swollen tongue, tongue thrusting: The Heart divergent and *luo* channels go through the throat and tongue, moreover the Heart opens to the tongue, so Ht-9 as a *jing/ting* point has very strong effect on tongue, especially moving stagnation (Wood quality) and removing Heat (*jing/ting*)

Affecting tendomuscular meridian

Pain of the palm that radiates to the elbow, armpit and chest: Ht-9 is a *jing/ting* point, the beginning of the tendomuscular channel. For that reason, it is used in treatment of all pains and strains alongside this channel.

Shen-transformation of emotions

As a Wood point, *Shao Chong* is very tonifying point for the Heart. That is why it is used in cases of depression along with feeling of being lonely or separated from love. People in that situation are unable to experience joy and have difficulties with communication. Ht-9 is also indicated in treatment of different pains in the body due to its moving quality and ability to restore connection with *shen*.

Yair Maimon, DOM, PhD, Ac
Dr. Maimon heads the Tal Integrative Cancer Research Center, Institute of Oncology-Sheba Academic Hospital, Tel Hashomer, Israel. He serves as the president of the International Congress of Chinese Medicine in Israel (ICCM) and the head of the Refuot Integrative Medicine Center. With over 30 years of clinical, academic, and research experience in the field of integrative and Chinese medicine, Dr. Maimon combines scientific research with the inspiration from a deep understanding of Chinese medicine. He has been a keynote speaker for numerous congresses and TCM postgraduate courses. Dr. Maimon is the founder and director of a new innovative eLearning academy, the TCM Academy of Integrative Medicine, www.tcm.ac.

Bartosz Chmielnicki, MD
Bartosz Chmielnicki is a medical doctor who has been practicing and teaching acupuncture since 2004. In 2008 he established the Compleo-TCM clinic in Katowice, Poland, and soon after he opened the Academy of Acupuncture there. Dr. Chmielnicki heads the ACUART International School of Classical Acupuncture, www.acuart.pl. He teaches at many international conferences as well as in schools in Poland, Germany, Czech Republic, and Israel.

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CLINICAL PEARLS

The topic selected for this issue is:

How do You Treat Stroke in Your Clinic?

By Jill Bolte Taylor, PhD

A stroke occurs when the blood supply to part of the brain is interrupted or reduced, which deprives brain tissue of oxygen and nutrients. Within minutes, brain cells begin to die. Causes include a blocked artery (ischemic stroke) or the leaking or bursting of a blood vessel (hemorrhagic stroke).[1]

Dr. Jill Bolte Taylor, PhD is a Harvard trained and published neuroanatomist. Her research specialized in the postmortem investigation of the human brain as it relates to schizophrenia and severe mental illnesses.

In December 1996, Dr. Taylor experienced a massive stroke that resulted in total disability. After eight years of hard work rebuilding her brain using a combination of massage and acupuncture, Dr. Taylor authored the *New York Times* bestselling memoir *My Stroke of Insight: A Brain Scientist's Personal Journey*.

In February 2008, Dr. Taylor gave a presentation at the prestigious TED Conference that immediately went viral. The response to the video launched Dr. Taylor's public speaking career. She was chosen by *TIME Magazine* as one of the 100 Most Influential People in the World for 2008. She is a premiere guest on Oprah's Soul Series web-cast and has been interviewed on the Oprah Winfrey Show as well as by Dr. Oz.

Dr. Taylor now serves as the CEO of My Stroke of Insight, Inc. and as the chairman of the board of the not-for-profit Jill Bolte Taylor BRAINS, an organization dedicated to providing educational services and promoting programs related to the advancement of brain awareness, appreciation, exploration, education, injury prevention, neurological recovery, and the value of movement on mental and physical health, as well as other activities that support this purpose.

Her TED talk may be viewed at: https://www.ted.com/talks/jill_bolte_taylor_s_powerful_stroke_of_insight?language=en

I am a Harvard trained and published neuroanatomist. In 1996, I experienced a major hemorrhage in the left half of my brain. Within four hours I could not walk, talk, read, write, or recall any of my life. I was an infant in a woman's body and it would take me eight years to completely recover all cognitive and physical abilities. My experience is documented in the *New York Times* bestseller *My Stroke of Insight: A Brain Scientist's Personal Journey.*

Every ability we have is based on brain cells that perform a specific function. If any brain cells go offline, due to either trauma or cell death, we as individuals can no longer perform that function. Aphasia is the product of language-based cells going offline. Paralysis occurs when our motor cortex cells no longer function normally. Our overall health and well-being is completely dependent on the health and well-being of our cells. Our ability to recover lost function is completely dependent on the ability of our cells to regain their health.

When a congenital arterial-venous malformation (AVM) blew in my left hemisphere, many of the cells at the focal point of the trauma died simply because the blood-brain-barrier was broken in that area. In my case, the cells that died were the neurons that enabled me to understand what numbers are, and I lost all ability to calculate mathematically.

For four years, I didn't know what the number "one" meant. It was six years before I could multiply or divide again, but over time my brain regained these abilities because other cells that had survived the blow, probably those in my opposite right hemisphere, took over and learned how to perform those functions.

By the eighth year post-stroke, I had completely recovered. Because I am a cellular neuroanatomist, I saw my brain as a collection of cells that were in circuits, and as each of those circuits' underlying specific abilities had broken down, it was my job to rebuild my mind, circuit by circuit, ability by ability.

There are a group of cells in the left parietal region that define the boundaries of where we begin and end. When those cells go offline we perceive ourselves as connected to all that is around us—we see ourselves as an energy ball that is as big as the universe.

When neurons are traumatized, they tend to break off their dendritic connections and essentially roll up into little balls to protect themselves. This is similar to what we do when we have the flu if we crawl into bed—we close out the rest of the world and go to sleep. Some neurons that come into direct contact with blood will die immediately, but many others will remain alive but disconnected from the network and be functionally dormant until they are stimulated to reach out to rebuild their network.

"As many of you know, old dogma that the brain is not capable of recovery has been proven untrue. We now accept the fact that there is some neurogenesis and neuroplasticity that constantly takes place. This is why the acupuncture is so valuable..."

As many of you know, old dogma that the brain is not capable of recovery has been proven untrue. We now accept the fact that there is some neurogenesis and neuroplasticity that constantly takes place. This is why the acupuncture is so valuable—I am of the opinion that it can encourage flow in the brain, bringing new blood and energy to the traumatized cells. I myself used a combination of massage and acupuncture to help me redefine the boundaries of my body. I believe using acupuncture to help the brain recover should be a standard practice.

I'm also a huge fan of the neuro-movement program (anatbanielmethod.com) as this technique does a fantastic job to wake up the neuroplasticity inside the brain. If your patients are fortunate enough to have a practitioner near you, teaming up with them would have an increased opportunity for amazing recovery.

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How do You Treat Stroke in Your Clinic?

By William Reddy, LAc, DiplAc (NCCAOM)

Bill Reddy, LAc, DiplAc (NCCAOM) promotes AOM in integrative settings by serving on the Executive Committee of the Integrative Health Policy Consortium (IHPC) and chairing its Federal Policy Committee. Bill is an avid practitioner of various martial arts and a lecturer and author of more than 100 publications. He maintains a private practice in Annandale, Virginia.

Mirror therapy in conjunction with acupuncture can reconnect a stroke patient with their affected limbs as well as help them to regain confidence and improve their ability to perform activities of daily living. Vilayanur Ramachandran, a neuroscientist and professor at the University of California, San Diego, is considered the grandfather of mirror therapy. He developed this technique to reduce phantom limb pain in amputees as well as to improve post-stroke functionality through the stimulation of mirror neurons.

When working with patients with upper limb dysfunction, a folding mirror box is used (this can easily be built or found online). Exercises, such as touching the pads of the index finger through pinky fingers to the thumb while looking at the mirror, pronation and supination, and functional exercises, such as writing and handling small objects, can help restore motor function and coordination in the affected hand. A full-length mirror is used when working with lower limbs. Exercises include ankle plantar/dorsiflexion and rotation, hip flexion, and leg adduction/abduction.

Mirror therapy not only induces muscle activity within the inactive affected limb but also "induces balance within the ipsilesional primary motor cortex by increasing interhemispheric communication, normalizes asymmetrical electrical activities and activates specific areas such as the precuneus and the posterior cingulate cortex."[1,2]

A 2018 systematic review and meta-analysis evaluated mirror therapy's effect on gait, balance, and lower limb function. Nine studies met the inclusion criteria, and the primary outcome measures included muscle tone, motor function, balance characteristics, functional ambulation, walking velocity, and passive range of motion for ankle dorsiflexion. The authors concluded that "using mirror therapy for the treatment of certain lower limb deficits in patients with stroke may have a positive effect" but dampened the level of enthusiasm by also stating that there were some methodological weaknesses in some of the included studies.[3]

A small study evaluating hands in four hemiplegic stroke patients showed meaningful improvement in upper extremity function and occupational performance following mirror therapy.[4] In a 2018 Cochrane systematic review, Thieme et al. evaluated 57 randomized controlled trials and five randomized crossover trials with a total of 1982 participants (mean age 59 years). The authors concluded that "[t]he results indicate evidence for the effectiveness of mirror therapy for improving upper extremity motor function, motor impairment, activities of daily living, and pain, at least as an adjunct to conventional rehabilitation for people after stroke."[5]

Mirror therapy has also been used in conjunction with transcranial direct current stimulation with synergistic effects.[6]

YouTube videos for reference:

"Mirror Therapy to improve hand function after stroke." https://www.youtube.com/watch?v=up9sR6rjTwg

"Mirror Box Therapy with David Butler"
https://www.youtube.com/watch?v=hMBA15Hu35M

"MIRROR THERAPY LE"
https://www.youtube.com/watch?v=dsC5qxDltjw

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How do You Treat Stroke in Your Clinic?

By Samantha L. Francis, DAc, LAc, DiplAc (NCCAOM)

Samantha L. Francis, DAc, LAc, DiplAc (NCCAOM) specializes in chronic pain, anxiety, and autoimmune conditions. She is a faculty clinical supervisor at Maryland University of Integrative Health. She completed Dr. Hao's weekend seminar in Scalp Acupuncture and has been working with the Scalp Acupuncture system for the past year and a half. She can be reached at drsam@fivedanceswellness.com.

Stroke can be especially disturbing for a patient due to the changes in their ability and lifestyle that can ensue post-stroke, such as paralysis, changes in diet or medications, and inability to perform simple tasks around the house. Additional pressures that led to the stroke in the first place may also manifest. These include diabetes, obesity, sedentary lifestyle, or high blood pressure.[1]

Scalp acupuncture, particularly in the tradition of Dr. Jason Hao, can provide an effective treatment with fast results for the patient and can promote healing so as to increase hope that life post-stroke can become more comfortable and enjoyable.

Dr. Hao's scalp acupuncture involves various areas of the scalp that are several inches long and approximately .5 cun wide. These scalp areas correlate to the areas of the brain based on Wernicke's map of brain functions. By stimulating these areas via threading of the needle and manual or e-stim protocols, recovery of motor function is possible.

Clinical Example: Long-term post stroke partial paralysis with impairment of motor function

This patient, a white male in his mid-fifties, experienced a stroke four years ago. He had partial paralysis of his left side, including the left arm, hand, and fine motor function in the hand.

Using Dr. Hao's scalp acupuncture protocol, the practitioner treats the opposite side of the scalp from where the symptoms are and includes ear points to keep the patient calm and decrease discomfort associated with needle threading. E-stim is recommended for additional stimulation.

Treatment Protocol

All points done on right side:

- Ear shen men, Liver points;
- Praxis area (for fine motor movement in the left hand);
- Upper 1/5 Motor;
- Upper 1/5 Sensory;
- Middle 2/5 Motor;
- Middle 2/5 Sensory.

These areas correspond to the homunculus map as the trunk, neck, arm, forearm, and hand on the opposite side. Dr. Hao provides a comprehensive guide to these areas and their location in his book, *Chinese Scalp Acupuncture*.[2]

Needle Technique

Each area was needled using a DBC 20 x 30 needle via threading technique at 10- to 15-degree oblique angle into the scalp tissue. E-stim was used with portable TENS unit equipped with alligator clips instead of pads at a wavelength of 100 for ten-minute intervals on the motor areas. The patient usually reported tingling sensation in arm and hand and found it much easier to move the arm and hand after treatment. Ear points were needled using DBC 16 x 15 needles perpendicular to the point.

After ten treatments, the patient regained most of the use of his hand for work tasks and resumed lifting weights in the gym with the affected hand. Grip strength was adequate for this task.

Treatment frequency for stroke recovery is suggested at two to three treatments a week for ten treatments. However, this patient received weekly treatment for two months with excellent results. He continues an ongoing care plan at an interval of 3-4 weeks between treatments.

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How do You Treat Stroke in Your Clinic?

By Claudia Citkovitz, PhD, LAc

Claudia Citkovitz, PhD, LAc has directed the inpatient Acupuncture Service at NYU Langone Hospital - Brooklyn since 2004. Her PhD study on acupuncture during stroke rehabilitation was the first in the U.S. as was her 2006 study of acupuncture during birth. Claudia teaches and practices in New York and Massachusetts; she is an ACAOM Commissioner and Editorial Board member for several scholarly journals including *Meridians: JAOM*.

"Within eight minutes of an ischemic stroke, all of the cells immediately downstream will die. Some neighboring cells are also affected and will sicken and die over the next 7-10 days. Therefore, during that period we urgently raise clear *yang* and descend turbidity."

Whether the patient is in the hospital or visiting my office, I ask myself the same series of questions. These questions provide an efficient orientation to what is happening and how we can best help—whether or not we can use needles (e.g., when our loved ones are in the hospital). Once the appropriate diagnostic questions and treatment principles are understood, there is always a work-around with ear seeds, *tui na*, toothpick stimulation, etc.

1. Is the stroke still happening?

Within eight minutes of an ischemic stroke, all of the cells immediately downstream will die. Some neighboring cells are also affected and will sicken and die over the next 7-10 days. Therefore, during that period we urgently raise clear *yang* and descend turbidity. This will usually be *Du* channel points on the head and face to raise, with some combination of LI-4, SP-6 and PC-6 to descend. GB, UB, or Kidney and *Ren* channel points may also be chosen for MCA, ACA and PCA strokes respectively.

Hemorrhagic strokes may have abrupt or insidious onset, and bleeding may last for days. If this is the case, it's better to just do gentle constitutional and Qi Machine treatments until the patient is well stabilized.

2. Is the patient in acute distress?

Pain, nausea, and vertigo are quality-of-life emergencies. Both central post-stroke pain and nausea/vertigo seem to respond well to strong bilateral needling at "large" points—LI-4, SP-6, LV-3, ST-36, etc. Shoulder subluxation pain does well with ear seeds and contralateral ST-38 before occupational therapy.

3. Is the "Qi Machine" stuck open or closed?

Constipation is extremely common after stroke, as is urinary retention. Abdominal round rubbing, ear seeds, acupuncture and e-stim (ST-24 to ST-24, 2hz) for constipation and Ren3/5/9 for urination often work wonders. Needle VERY shallowly in distended abdomens, though—especially SP-15! Fecal incontinence is also fairly common. When it presents with urinary retention, e-stim KD-7 to KD-7 (2hz) can sometimes restore function via the tibial/sacral nerve. When urine and bowels are both incontinent, a warming strategy often works best—hot packs at front and back. This treatment is also great for constipation with cold signs and for any urinary tract infection without an excess Heat presentation.

Restoring bowel and bladder function is key to recovery. It's often unresolved even years after a stroke in chronic patients but this restoration can turn the case around.

4. How are speech and swallowing?

Regaining as much function as possible of these is more important than walking. Try GB-12, GB-20, TH-17, Ren-23 and outer *jinjin yuye* (palpate under the chin for two divots at the edge of the hypoglossal muscle, directly above the edges of the Adam's apple). These should be needled towards the base of the tongue, along with a third needle above Ren-23.

5. Before working on leg strength, how's balance?

Good leg strength with bad balance is more dangerous than when both are bad—so work on balance first! Balance points, point Zero, and big bilateral points.

6. Should we work on the leg or the arm?

Walking is a critical component of rehabilitation, and it usually makes most sense to work on that first. However, having a completely "dead" arm is also very distressing to patients. I will often do a trial of three sessions of e-stim across the wrist (from a palpable motor point on the TH channel to the Ba Xie points, five minutes each), with a second lead across the middle fifth of the motor line (connecting ear needles at the top and bottom of it). A 1- or 2hz pulse in both locations at the same time seems to remind them to work together, and often there will be some minimal return. If there is no change after three such treatments, I go back to the leg.

The legislature has provided some funds for us to look into the cost question. We hope to have some data available within the next year. Blue Cross Blue Shield of Vermont has expressed a desire to add acupuncture as a benefit to their policies, but it is not clear when and how this will occur. In summary, I'd say we are in the process of changing health care policy in Vermont, but it hasn't happened as quickly as we'd like.

JS: *I heard a presentation you gave where you say that the whole process was like being on a wild roller coaster ride. Can you elaborate for our readers?*

RD: There have been a lot of "ups and downs," advances and setbacks, progress and blockages during the whole process. Stepping back, one realizes that this is natural for most endeavors. In the moment, it can feel both exhilarating and terrifying, like a roller coaster. Fortunately, I like roller coasters, especially when riding with friends.

Below: Davis RT, Badger G, Valentine K, Cavert A, Coeytaux RR. Acupuncture for chronic pain in the Vermont Medicaid population: A prospective, pragmatic intervention trial. Glob Adv Health Med. 2018;7:2164956118769557. Published 2018 Apr 10. doi:10.1177/2164956118769557

Link to: https://www.ncbi.nlm.nih.gov/pubmed/29662722

PubMed.gov
US National Library of Medicine
National Institutes of Health

PubMed

Abstract

INTRODUCTION: In response to the opioid crisis, the 2016 Vermont legislature commissioned a study to assess acupuncture for patients with chronic pain in the Vermont Medicaid population.

OBJECTIVE: To assess the feasibility, acceptability, and effectiveness of acupuncture provided by licensed acupuncturists for Vermont Medicaid patients with chronic pain.

METHODS: A total of 156 Medicaid patients with chronic pain were offered up to 12 acupuncture treatments within a 60-day period at the offices of 28 Vermont licensed acupuncturists. PROMIS® questionnaires were administered prior to and at the end of the treatment period to assess changes in pain intensity, pain interference, physical function, fatigue, anxiety, depression, sleep disturbance, and social isolation. Questionnaires also captured patients' overall impressions of treatments as well as self-reported changes in medication use and work function.

RESULTS: One hundred eleven women (71%) and 45 men (29%) with a wide range of pain complaints received a mean of 8.2 treatments during the intervention period. Measurements captured prior to and at the end of the treatment period showed significant improvements in group mean pain intensity, pain interference, physical function, fatigue, anxiety, depression, sleep disturbance, and social isolation as assessed by Patient-Reported Outcomes Measurement Information System (PROMIS) measures (paired t tests, $P < .01$). Fifty-seven percent of patients using analgesic (nonopioid) medication reported reductions in use. Thirty-two percent of patients using opioid medication reported reductions in use of opioid medication following the intervention. Seventy-four percent of employed patients reported improved capacity to work. Ninety-six percent of patients said that they would recommend acupuncture to others with chronic pain, and 91% reported qualitative improvements, including physical (31%), functional/behavioral (29%), and psycho-emotional (24%) improvements.

CONCLUSIONS: Our findings demonstrate that acupuncture treatment for chronic pain is feasible and well received by patients in the Vermont Medicaid population. Receiving care from Licensed Acupuncturists was associated with significant improvements in physical, functional, psycho-emotional, and occupational outcomes compared with before receiving acupuncture treatments.

Evidence Based Acupuncture Symposium – Ancient Medicine, Modern Research, Evolutionary Thinking

Evidence Based Acupuncture's inaugural symposium was held September 14-15 last year in Providence, Rhode Island, hosted by the Evidence Based Acupuncture Project and sponsored by the European Traditional Chinese Medicine Association and Healthy Seminars. Attended by leaders from our national organizations, research societies, and scientific publishers, the event took place at the historic Renaissance Providence Downtown Hotel, once a Masonic Temple dating back to the 1920s. Speakers traveled from the United States' West Coast, the United Kingdom, and Israel. Attendees were from the U.S., Canada, Europe, and the Middle East.

The theme of the conference, "Ancient Medicine, Modern Research, Evolutionary Thinking," attempted to weave these concepts together globally to advance our medicine in the western medical climate. Speakers discussed the scientific landscape of mainstream medicine and how acupuncture and Chinese medicine fits into this landscape.

Understanding the context of the modern healthcare system is crucial for operating successfully in mainstream medicine today. The current healthcare climate is creating vast opportunities for the acupuncture profession to play a leading role in improving public health. Using evidence in activism, we need to upgrade communication with allied health professionals and policy makers.

Gil Barzilay, clinician, researcher, and TCM educator from Tel Aviv, presented on what the pharmaceutical industry can teach us about promoting health through acupuncture. Before studying Chinese medicine, Dr. Barzilay worked at Teva Pharmaceuticals, where he led global marketing for Teva's multiple sclerosis product Copaxone©, with sales of over $4 billion annually. In his conference presentation, Dr. Barzilay discussed the various strategies the pharmaceutical industry uses to sway thoughts and opinions surrounding health, with the primary goal of selling more products.

"Understanding the context of the modern healthcare system is crucial for operating successfully in mainstream medicine today. The current healthcare climate is creating vast opportunities for the acupuncture profession to play a leading role in improving public health. Using evidence in activism, we need to upgrade communication with allied health professionals and policy makers."

I very much enjoyed Lara McClure's delightful "Historicity of Acupuncture Practice in the Occident." Lara is the course director for the acupuncture BSc and MSc courses at the Northern College of Acupuncture in York, UK. She discussed the history of acupuncture in the West, including Churchill's *Treatise on Acupuncturation* and other early nineteenth-century texts in their original form and historical context. For example, I never knew that in 1823, the British medical journal *The Lancet* devoted an article to acupuncture in its very first volume. Lara invited us to examine the differences between the nineteenth and twenty-first century's evidence and attitudes in the context of these different cultures.

The entire program was live streamed, and the recording can be accessed for NCCAOM PDAs at: https://www.healthyseminars.com/product/evidence-based-acupuncture-symposium-2018

Report on the Society of Integrative Oncology International Conference

The 15th annual Society of Integrative Oncology International Conference was held in Scottsdale, Arizona, at the Scottsdale Resort at McCormick Ranch on October 27-29, 2018.

The conference planning committee did a spectacular job setting the stage for the event. Nestled in a southwest ranch setting, breakfast was served outside under the rising sun. The opening ceremony was conducted by a 92-year-old Native American healer and hoop-dancer who sang and danced for us.

Immediately following was a keynote presentation from the grandfather of integrative medicine in the U.S., Dr. Andrew Weil, who talked about the past, present, and future of medicine and the need to shift from focusing on disease to focusing on health and healing. The program included presentations and abstracts on topics including nutrition and natural products, acupuncture, native traditional healing, yoga and mind-body medicine, TCM, and multi-disciplinary clinics and programs from researchers and clinicians all over the world.

This year, SIO approved the creation of a special interest group (SIG) focusing on oncology acupuncture. The first meeting was held during the breakfast roundtable discussion time. The chairs of this group are myself, Dr. Weidong Lu from the Dana Farber Cancer Institute at Harvard, and Dr. Misha Cohen, clinical director of Chicken Soup Chinese Medicine. The first task this group will take on is to survey the acupuncture community on whether they feel their training is sufficient to treat cancer patients and work in an integrative oncology setting. The results of the survey will provide information for future projects.

My involvement with SIO jump-started my career in research. The first SIO conference I attended was in Atlanta in 2005. At that time there were fewer than 10 acupuncturists in attendance—90% of the attendees were MDs. This year, more than 100 acupuncturists attended from Europe, Australia, Canada, Israel and the Middle East, India, and East Asia.

Andrew Weil, regarded as the grandfather of integrative medicine in the U.S., delivers a keynote on the need to shift the focus of medicine from disease to health and healing.

When I attend these conferences, I share my research ideas during poster presentations and welcome feedback from my colleagues. I seek out and locate mentors and collaborators. I have learned to build posters and how to structure oral presentations by watching my colleagues do it. I have also learned how to structure and map out trial design and how to apply for federal funding. Many of SIO's current and past board members are on the NIH committees that review the grants that I apply for. Multi-center studies are often birthed out of SIO collaborations.

I have many acupuncturist colleagues who now work in rewarding, high-salaried jobs at comprehensive cancer research centers through their affiliation with SIO. Any medical provider—acupuncturist, MD, ND, etc.—who has an interest in research should absolutely join a research society to be in the game. Trying to write and conduct research on your own, without affiliation with a respected research society, is like playing a video game without a controller.

SIO's recently approved special interest group on oncology acupuncture met during the conference to plan their first task: a survey of the acupuncture community to determine whether acupuncturists feel their training is sufficient to treat cancer patients and work in an integrative oncology setting.

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Hyungsuk Choi, PhD, OMD, LAc is an acupuncture clinician with over 24 years of experience specializing in musculoskeletal pain disorders. Dr. Choi earned his BA degree from the School of Oriental Medicine of Kyunghee University in 1994 and his PhD in Complementary and Alternative Medicine from Cha University in 2008. Dr. Choi moved to Los Angeles, California, in 2008 to join the faculty at Samra University. He is president of the Samra Spinal Center and currently teaches at Dongguk University Los Angeles.

Adrianus Wong, MD, LAc received his Doctor of Medicine from Trisakti University, Indonesia, in 2011 and became a general practitioner in Indonesia. He completed the acupuncture program for physicians at Harvard Medical School in 2016 and obtained his Master of Science in Oriental Medicine from Dongguk University Los Angeles in 2017. He was trained in kinetic acupuncture by Dr. Choi and currently practices acupuncture in California.

Evan Mahoney, DAOM, LAc received his DAOM in 2011 jointly from Samra University and Emperor's College in Los Angeles. Dr. Mahoney was trained in kinetic acupuncture by Dr. Choi and currently serves as the president of the Kinetic Acupuncture Association, representing the East Coast branch. He authored "Acupuncture Muscle Trigger Point and Oriental Medicine Sports Therapy" in *Acupuncture Today*, July 2016. Since 2011, Dr. Mahoney has maintained an acupuncture clinic in Cape Coral, Florida.

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