Community Acupuncture - Making Ming Vases From Buckets: A Reply to Lisa Rohleder

Abstract

Community Acupuncture, or the 'acupunk' version of it described by Lisa Rohleder in 'Community Acupuncture: Making Buckets from Ming Vases' in the last issue of *The Journal of Chinese Medicine*, is a vigorous, inventive and pragmatic response to the dual problem of patients being unable to afford treatment and practitioners being unable to earn a living. It offers many advantages to both parties, including the healing power of community. However, pragmatic solutions do not necessarily result in best possible practice. This article discusses the strengths and possible weaknesses of the acupunk approach.

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Introduction

Lisa Rohleder, author of 'Community Acupuncture: Making Buckets from Ming Vases' published in issue 98 of *The Journal of Chinese Medicine*,[1] has been one of the prime movers in the growing community/multibed acupuncture movement. She has bravely and vigorously addressed the 'elephant in the room' - the simple fact that a high proportion of people who train as acupuncturists fail to earn a decent living and/or drop out of practice after a few years, still heavily in debt from the cost of their education. At the same time, acupuncture treatment has traditionally been priced at a level that excludes much of the population, or else means that they cannot afford to come often enough or for long enough to benefit fully from treatment.

She principally addresses the situation in the USA, but I believe this also holds true in most Western countries. Certainly I find it so in most places that I visit to lecture, and my experience also is that few schools or colleges appear to even discuss these hard facts, since their very existence depends on a steady flow of new, optimistic students.

There may be another reason why these issues seem to be coming to a head, and that is the changing demographic of acupuncturists. Compared to two or three decades ago (in the UK at least, with the recent proliferation of university degree courses), acupuncture is increasingly being seen as a first career. Students want - and are perhaps led to expect that they are training in - a profession that will offer them a decent living, enabling them to keep a roof over their heads, feed themselves and their families, and offer them a reasonably comfortable lifestyle. Sadly this is often not the case and I suspect this has led to growing frustration.

Two issues do need to be acknowledged here in passing. The first is that nowadays, in most fields, getting a degree is no guarantee of getting work and we do need to bear this in mind when judging acupuncture education. The second is that unless acupuncturists find work with some kind of a funded scheme, they are entering the world of private medicine. And private medicine is of course a business. Those who succeed will often be those with entrepreneurial and marketing flair - skills that Lisa Rohleder, with her phenomenally successful Working Class Acupuncture clinics in Portland Oregon, clearly has.

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My own experience

When I first started practising in the late 1970s, I inherited a clinical model based on other forms of private medicine such as osteopathy, homoeopathy and psychotherapy. This meant one-to-one practice - the undivided attention of the practitioner being given to a single patient for a period of forty-five minutes upwards. Clearly, this required high fees if the practitioner was going to be earning a decent living.

I did not seriously question this model until I first went to China in the winter of 1981. I found myself in a busy hospital clinic in Nanjing, with half a dozen couches along the walls, two doctors, and a nurse whose job it was to take out the needles and

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apply moxibustion. Most of the patients were green-clad peasants from the countryside or blue-clad workers from the factories. There was no privacy; everyone listened in on the consultations, frequently interjecting encouraging comments as they waited to be seen or lay on the couches with needles in place. Nobody was in a rush. Dr. Xiao - with forty years of clinical experience under his belt - always took as long as necessary to try and fully understand the patient's problem, to make a diagnosis and a pattern differentiation. Patients then usually received full body treatment - first on the front (for twenty minutes) then on the back (for fifteen). Dr. Xiao's needling was deep, powerful and dynamic and we saw many difficult cases - including acute and emergency cases such as acute appendicitis, acute biliary ascariasis, gall stones, and recent strokes, injuries and severe sprains.

A steaming tea kettle sat on the pot-bellied stove in the middle of the room as sweet potatoes slowly baked inside, ready for our mid-day snack. It was busy, fun, energetic and - with patients returning daily or every other day for treatment from the brilliant Dr. Xiao and his less than brilliant foreign student - I saw more powerful results than I had imagined possible.

The warm, friendly, mutually supportive atmosphere of this clinic seemed to be a positive force for both patients and doctors, although I should stress that it was not the habit of Chinese patients at that time to reveal any form of emotional distress and so I could not assess how the setting mitigated against them doing so if they had wanted to.

When I returned to the UK I set about trying to copy this model as best I could, with three curtained-off couches in my treatment room and an acupuncture student as an assistant. I operated a flexible sliding fee scale and did my best to get patients to come at least twice a week. Following Dr. Xiao's example, most patients received full-body treatment on the front and back, alongside moxibustion and cupping.

A dab of history

As I thought about my response to Lisa's article, I remembered an article published in this journal in February 2008.[2] It described the tradition of itinerant doctors - those who had no clinic of their own but worked in the streets, often roaming from village to village, town to town. It is said that several famous doctors from history, for example Bian Que and Hua Tuo were, or at least began as, itinerant doctors. As I reread that article I came across these passages:

'The dictum - or marketing strategy - of the itinerant doctors could be summed up in three words: cheap, effective, convenient.'

'They used simple formulas and did not follow the complicated theory of pattern differentiation.'

'They aimed for an immediate effect, based on their practical experience, without much theorising.'

This certainly echoes the 'punk acupuncture' Lisa Rohleder advocates in her article and perhaps roots it within one of the Chinese medical traditions. She describes punk acupuncture as, 'a stripped-down, non-verbal kind of acupuncture in which practitioners spend no more than three minutes or so talking to the patient', a model in which little theory is used and even less is conveyed to the patient. What is offered is, 'fast, simple, effective treatments.'

It is probably the case that throughout history most of the Chinese population was treated by itinerant doctors. As Paul Unschuld reports,[3] ... well into the twentieth century they constituted the majority of healers for the general population. It should not be forgotten that the medicine of the scholar physicians was that of a minority; the bulk of the population had no access to the theoretical foundations and clinical applications of the medicine of systematic correspondence.'

It is important, though, to put this into context. Until the founding of the National Health Service in the UK in 1948, most Britons had no reliable access to quality medical care either. [4]

It is clear, also, that itinerant doctors were a long way from our modern ideal of best practice. Although they were often credited with successful cures (incidentally they were primarily herbalists not acupuncturists), their work was principally in the areas of pulling teeth, healing skin blemishes such as wounds, scabies, ringworm, tumours etc., treating cataracts and expelling worms. And while they may have provided some level of medical care to a population that had no alternative, there were many kinds of disorders they were unable to treat effectively.

So it wasn't until the twentieth century that some kind of ideal of best practice was established - in both Western and Chinese medicine. By that I mean that every patient, no matter what their financial status or where they lived, would receive the best possible care from doctors trained to the same level in specialist schools.[5] We modern practitioners of Chinese medicine benefit from this best practice education - a mix of basic Western medicine, the theory and practice of acupuncture and Chinese medicine derived from the scholarly tradition of the literati, and a whole range of new and old techniques - many of them empirical

and intensely practical.[6] With these tools we can aspire to become complete practitioners, adapting our practice to suit different age and patient groups, different diseases, and different countries and cultures.

My problem with Lisa Rohleder's article

If Lisa Rohleder's argument were as simple as, 'here's how we community acupuncturists practise; it works for us and our patients; these are its strengths, these are its weaknesses', my honouring of her work would be wholehearted, for she has clearly worked tirelessly on behalf of financially challenged patients and practitioners. And with acupuncture, of course, she has chosen a manual therapy that - unlike massage, tuina, osteopathy, physiotherapy etc. - can actually be administered in a few brief minutes.

But she goes much further than that. The implication and sometimes overt statement that runs through the article is that community acupuncture's way is the right, the only way, to practise. Acupuncturists who don't get it, who don't get on board, belong to the discredited 'professional culture of acupuncture,' yearning for respectability. They are 'too well-socialised' to adopt her revolutionary model which fails to deliver the importance they crave. They are like delicate orchids compared to the tough, dandelion-like acupunks. They are 'passive and self-absorbed ... dedicated long-term consumers of the acupuncture education profession,' pursuers of an 'exotic hobby' who are more keen to 'ponder the routes of the transverse and longditudinal luo,' than get their hands dirty. They are in love with their 'ming vase' of an acupuncture education, which acupunks 'take off the shelf and use like a bucket.'

So if community acupuncture according to the acupunk model is to be the blueprint for what 'acupuncture would look like if it were truly rooted in the West' - our shared acupuncture future - it seems important to take a close look at the model. Amidst its many positive features I find two that concern me.

1. No undressing

This kind of acupuncture is administered in a group setting with patients lying on recliner couches. According to Working Class Acupuncture's website,[7] 'you do not need to disrobe, you just need to roll your sleeves up to your elbows and your pants up to your knees.' This of course limits access to many core body points and many treatment techniques and means that a swathe of acupuncture points is largely consigned to oblivion.

2. Three-minute consultations and short treatment times

With a practitioner aiming to give six treatments an hour, and allotting three minutes talking time per patient, there is scant opportunity to listen and to ask, to tease out symptoms and patterns, to perform a thorough tongue and pulse diagnosis, to carry out careful palpation, range of motion and mobility testing. There will be no time for exploration of lifestyle or feelings, no incorporation of massage or tuina, cupping or herbs. Instead, Lisa Rohleder claims, 'the needles do all the necessary work' - a very brave claim.[8] I also note that in the article, acupuncture is talked of almost exclusively in terms of relieving pain. It is not clear if the word 'pain' is meant to signify suffering in general or physical pain in particular. If the latter, it would be ironic if trained acupuncturists were defining acupuncture in the same limiting terms as medical acupuncturists.

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As far as consultations are concerned, I would never advocate excessive talking, nor overly-long consultations - in fact I would say the more skilled a practitioner is, the more the consultation lasts exactly as long as necessary and no longer.

But since the acupunk model is happy to dispense with more than three minutes talking (that's four to five minutes less than the time the average British GP spends with a patient - a time which they are campaigning to have doubled),[9] what necessarily goes out of the window?[10]

First, the detailed question/answer/feedback process that is at the heart of differentiation of patterns, will have to be dispensed with. Second, according to Lisa Rohleder, practitioners will have to give up the pleasure of having patients listen to them talk about the 'concepts' of Chinese medicine, which are 'romantic', 'abstract', and lacking in personal meaning.

One of the core principles of differentiation of patterns that I was taught in China is that it points forwards towards the treatment and back towards the cause. Of course many styles of acupuncture don't use differentiation of patterns and this approach has been (incorrectly) condemned by some as the heavy-handed orthodoxy of TCM - imposed in China from the 1950s onwards.[11] Yet even if one does not choose to use pattern differentiation to determine treatment, there is a powerful argument for using it to point 'backwards towards the cause'.

Pattern differentiation is - in my opinion - unique to Chinese medicine. As well as determining treatment, it is a tool that allows the practitioner - when confronted by headaches or asthma or dysmenorrhoea or indigestion or depression - to do

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what no other medicine can do so well - to home in on what information the patient needs to know and explain it in words they can understand. For example, if someone has qi stagnation, it may be helpful to run, shout, sing, dance, acknowledge and express anger, have a beer or two, and so on, but unhelpful to rest or sleep too much or to obsess about diet. But if they suffer from qi, blood or yin deficiency, much of this is contraindicated and instead, rest and sleep, nourishing foods and avoidance of stimulants are appropriate. If a patient has Spleen deficiency it is important to prioritise diet and also to exercise and strengthen the muscles and the four limbs, while if there is epigastric pain, it is vital to eat carefully - avoiding over-eating, late eating and eating when under stress. To understand a patient's condition, mirror back to them the behaviours that they (as all of us) are often blind to,[12] offer information and sensitively explain it, discuss options for changed behaviour, all these take time as well as great skill but are to my mind a vital part of medicine.[13]

Of course it is true that rhapsodising about such things as the intricacies of Chinese pulse diagnosis can be self-indulgent and irrelevant. But the 'concepts', 'theories' and 'ideas' of Chinese medicine expressed in the relationship of suffering to human behaviour are the embodiment of Chinese medicine wisdom - a precious wisdom about the human body and the human mind, embedded in theory as a consequence of centuries of observation, experimentation and reflection.

In the mid 1980s I was lucky enough to attend two seminars with Dr. John Shen. He was primarily a herbalist, not an acupuncturist, but he came close to the multibed approach in the sense that - at the peak of his practice in Taiwan - he was seeing 200 patients a day. He explained that he was able to treat so many patients so quickly because in the early days of his practice, when he had fewer patients, he would often spend hours with a single one, asking endless questions, taking the pulse, checking the tongue, asking more questions. He developed and refined his observational skills this way, built on them with decades of experience, and - as anyone knows who was lucky enough to see him work - was finally able to home in on the heart of the patient's problem - including its cause - with just a couple of key questions.[14] In the rare hands of such a master, fairly brief consultations were sufficient to deeply understand the disorder. Few practitioners reach this level, and for a novice to build up an understanding of disease, diagnosis and pattern differentiation requires a long apprenticeship of real face-to-face time with patients.

And there was one further thing that Dr. Shen and Dr. Xiao in Nanjing shared. As Chinese medicine doctors they regarded it as part of their work to explain to their patients, simply and straightforwardly, what was wrong in terms of Chinese medicine. This was certainly not in order to show off how beautiful their Ming vase was. No, they used the concepts and theories of Chinese medicine, interwoven with their vast experience, to offer patients invaluable information about why they were ill and what they might - in their own lives - do to help themselves. For they knew that in many cases, unless life habits or mental attitudes changed, treatment would only have a short-lived effect, and over time more serious disease would arise.[15]

Concluding thoughts

There are immense limitations placed on the practice of Chinese medicine as a result of financial constraints. Many patients cannot afford the treatment they need and practitioners cannot afford to live on the low incomes generated in many practices. Community-style acupuncture can help lower the price and give work to practitioners (as well as invaluable clinical experience to novice practitioners) and it can foster a positive, warm healing atmosphere that benefits both patients and practitioners. Let us for the moment use Lisa Rohleder's term and call this community acupuncture approach 'the bucket' - a bucket that spreads healing water far and wide and, according to Lisa, replaces the effete and useless Ming vase of the 'spa setting' diletattantists and theorisers that she attacks so vigorously (even though, in the care of these Ming vase practitioners, world-wide many hundreds of thousands of patients have been helped).

Lisa Rohleder has done well to come up with a 'low-cost, high-volume business model' that benefits many patients and practitioners. It is a pragmatic solution to a difficult problem. But that does not mean that it represents best possible practice, something that every patient - whatever their income or social status - deserves. Indeed I would argue that in the form described in her article, this model risks - over time - impoverishing Chinese medicine. And if this were to become the new, dominant form of acupuncture practice in the West, I would say the cost - the loss - is too high.

Lisa Rohleder began with the Ming vase and ended up with the bucket. I would say our challenge now[16]

is to keep the down-to-earth practical value of the bucket and find a way to refine and transform it back into the precious ming vase that Chinese medicine truly is. ■

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References

1 Rohleder, L. (2012). "Community Acupuncture: Making Buckets from Ming Vases", *The Journal of Chinese Medicine*, 98/22.

2 Qiu, Y. (2008). "Itinerant Doctors in Chinese History", *The Journal of Chinese Medicine*, 86/28.

3 Unschuld, P. (2000). *Medicine in China: Historical Artifacts and Images*, p. 73. Prestel: Munich.

4 My own grandmother - a single parent earning rock-bottom wages as a cleaning lady - would often not call the doctor when one of her five children was ill as she could not afford the one penny fee.

5 Of course it has been argued that this standardised approach has resulted in the loss or diminishment of rich lineages and classical traditions. There may well be truth in this argument, but nevertheless the modern world expects that everyone should have equal access to the best-educated medical practitioners.

6 I do however agree with Andrew Nugent-Head in his article in this issue that many acupuncturists get limited clinical training, that their needling skills are undeveloped, and they have little experience of treating the kind of acute disorders that truly test their technique and practice.

7 http://workingclassacupuncture.org/

8 Acupuncture - as a complex intervention - seems to benefit from an unusually strong placebo effect. It appears that a high proportion of patients - at least fifty per cent - will get clear improvement whatever system of acupuncture is used (including sham treatment). This means that all acupuncturists, whatever style they use, are able to report positive results, and whichever kind of needling they do, they can claim that 'the needle does all the work'. However it also means that the challenge for practitioners is how best to benefit those patients who are not such easy responders.

9 http://www.dailymail.co.uk/health/article-57944/Doctors-want-patient-time-doubled.html

10 All practitioners know that some of the most relevant information in a consultation comes - not at the beginning - but far into the process.

11 As shown so clearly in Buck, C (2009), "Who Invented Bagang", *The Journal of Chinese Medicine*, 91/12, eight principle pattern differentiation dates back to the very origins of Chinese medicine.

12 Perfectly expressed in the Chinese saying, 'The last creature to discover water is the fish'.

13 While I eventually discovered that giving advice is often unhelpful - prompting unconscious rebellion - I believe that the role of medicine, of the 'superior' doctor, is to give reliable and relevant and personally tailored information in a way that is not condescending and is fully heard by the patient.

14 See, for example, the accounts of Dr. Shen's London seminars: Deadman, P (1979). "Dr. Shen Seminar, London, August 1979", *The Journal of Chinese Medicine*, 2/10, and Deadman, P. (1981). "Dr Shen Seminar London 1980", *The Journal of Chinese Medicine*, 6/1.

15 Hence the *Nei Jing Su Wen's* famous statement that the wise doctor treats/helps at the earliest possible stage.

16 And I don't deny it is a difficult one.