Integration of Acupuncture within a Pain Relief Clinic

Based on an address to the Association of Anaesthetists, London, April 1989.

Dr Paul Marcus

Since acupuncture's re-emergence in the West some fifteen years ago it has had what the media call "a meteoric rise to fame". We know from a recent survey that many UK medical schools give relatively little teaching on acupuncture particularly to post-graduates. We also know that doctors in general, particularly the younger ones, would like to know more about acupuncture and feel it has a place in modern western practice complimentary to other conventional techniques. This may be especially true of anaesthetists who are rather experimental animals and who tend to be exposed to acupuncture in the fields of post-operative analgesia and the relief of chronic pain.

I worked part-time at St Thomas's Hospital for a couple of years recently as Honorary Clinical Assistant in the Pain Relief Department and I would like to present a personal view of the way in which acupuncture can be integrated in this setting. Bringing acupuncture, which seven years ago was regarded as even more bizarre than today, to an august establishment as St Thomas's demanded one thing: friends in high places! My patrons were Adrian Timothy the Oncologist and Doug Justin who runs the Pain Clinic, and it says much for their strength of character that they were prepared to support this concept.

A few moments ago I mentioned acupuncture's re-emergence in the West because, of course, it was actually quite widely practised in Europe during the first half of the 19th century. It was mainly used for the treatment of painful conditions, and the practitioners largely used simple insertion of needles into painful areas. Dr J M Churchill's books on "acupuncture", dedicated to Ashley Cooper, did much to popularise the technique in England especially for the treatment of musculoskeletal conditions. There was a letter on the subject in the Lancet of 1826 by a Mr Wansborough of Fulham in which it was suggested that a painful stimulus often paradoxically cured a painful condition. One of the physicians on the staff of St Thomas's Hospital at the time was John Elliotson, who later became a Professor of Medicine at University College Hospital. He was impressed by Churchill's treatises and came to use acupuncture extensively over several years. Unfortunately his reputation was subsequently undermined by his support for Mesmer's "animal magnetism" so his advocacy of acupuncture was less influential than it otherwise might have been. Because I was working full time in the pharmaceutical industry I attended the hospital one morning a week only, when the Pain Clinic was in full swing, and this timing was seen by us all as essential to achieve acupuncture's integration with other techniques. It meant that the nursing and clerical facilities could be utilised fully, patients could be seen sequentially by myself and one of the other pain specialists and informal case conferences could readily take place.

I think it is fair to say that before I went there, medical staff at the hospital had little idea which sort of case might benefit from acupuncture, and indeed I myself encountered for the first time pathology which I had not treated before in my private practice from home with GP referral. It was some months therefore before a clear pattern of general agreement emerged as to which patients should be sent for acupuncture.

The presence of an acupuncturist in the hospital created some interest and various occurrences marked my gradual acceptance. Examples would be: being asked to speak at departmental meetings; having patients referred directly by various specialists such as rheumatology, general surgery and orthopaedics, being asked to teach medical students; and, perhaps most importantly, being asked to treat members of the medical and nursing staff for such things as migraine and back pain.
I should advise anyone in similar circumstances to accept all invitations, to understate the therapeutic potential of the technique and to admit immediately any areas of uncertainty concerning prognosis and mechanism of action. Well, what sort of cases was I seeing? At the outset I treated most of the causes of chronic pain which form the bulk of the pain clinic’s workload: probably the commonest was back pain, seeing at the outset I treated most of the causes of any area. 

I also tried acupuncture for two or three cases of the loin pain haematuria syndrome, with a complete lack of success.

I saw inevitably, a number of cases of psychosomatic illness, and of course many of the long-standing pain cases had a strong psychiatric overlay. There was no element of positive discrimination in favour of neurotics in selecting cases for acupuncture, although this had occurred in other settings and probably needs to be guarded against. Acupuncture is of benefit in both free-floating and phobic anxiety, for both psychic and somatic symptoms; but in the grey area between compensation neurosis and conversion hysteria most treatments achieve little long lasting success, and acupuncture would be no exception. Just to lay one ghost, there is no evidence that a patient has to have “faith” in acupuncture for it to be successful in organic illness although acupuncture recruits the placebo effect as strongly as any pain clinic treatment, and more so than many.

As in other forms of acupuncture practice the cases were referred at a very late stage, usually as a last resort after many other kinds of treatment had been tried. This is a significant problem associated with establishing a novel medical technique and is well-known to the designers of clinical trials of new drugs, for example. On the one hand it makes a positive response less likely; on the other it increases the satisfaction of patient and doctors alike if a response happens to occur. Acupuncture has certain advantages over other forms of therapy: it is cheap, safe and simple. There is often an advantage from trying it first. A satisfactory therapeutic trial of acupuncture will only take a few weeks in most cases and its response rate in many of the conditions encountered in the pain clinic is sufficiently high to make this worthwhile before proceeding to other more expensive, hazardous and complicated procedures such as cryotherapy, nerve blocks and surgery. This proved to be one of the most difficult messages to get across in the hospital. All of the rest of the staff were trained in the other treatment techniques, used these first and thought of acupuncture only in the case of failure. In some other countries in the Far East I have seen acupuncture fully integrated into conventional medicine so that a newly presenting case is considered for acupuncture or drug treatment de novo, or may indeed receive both together. This would be a much more satisfactory arrangement. I had not worked in hospital for some years before I started my appointment and I was quite surprised at how little progress had been made in the field of medical records. We have still largely not moved away from bulky, badly organised files, often written illegibly, which seem to go missing with great regularity. I estimated that in a typical out-patient session ten percent of case notes would not be available, having been mislaid or not yet returned from other departments. It seemed fundamental to keep an age, sex, diagnosis, treatment and outcome Register of acupuncture patients to judge the effectiveness of my clinic, but it quickly became clear this was impossible because of the problems with the case records, the size of the clinical load and a lack of clerical or secretarial staff. I suspect this is characteristic of other specialties in most hospitals.

Clinical research was another slightly frustrating area. During my time at the hospital, in collaboration with the oncologists, I was able to draw up a protocol for a double-blind comparison of melodopramide and acupuncture applied to point P6 in alleviating nausea and vomiting associated with cytotoxic chemotherapy, and submit it to the Ethics Committee. This was a slow process, however, and the trial had not started by the time I left. It is interesting that Professor John Dundee’s unit at Belfast subsequently published data showing benefit from treating this point in reducing post-operative nausea, and they have subsequently gone on to examine cytotoxic emesis.

As you will know, response to acupuncture is not immediate and the treatment initially allocated has usually to be carried out several times over a period of weeks before the results are evident. Adjustments to the prescription may be required, but when an effective combination of points has been identified treatment is simply a matter of repeating the needling at intervals. I found that the number of patients requiring to be seen during a clinic increased rapidly during the first couple of months, partly due to the growing popularity of the treatment but mainly to the fact that any new cases accepted onto the books would need to be seen for follow-up treatment for five to eight weeks more and then again at one- to three-monthly intervals. Clearly a single acupuncture practitioner could not cope under these circumstances without stopping acceptance of new patients for weeks on end. When this became a problem the solution was quickly found in a small number of senior physiotherapists with an interest in acupuncture who were trained to give the treatment, and then saw all patients for routine follow-up. This sort of para-medical assistance is really obligatory for acupuncture to have a practical place in a busy pain clinic, although it is a rather
contentious issue. Some medically qualified acupuncturists feel strongly that only doctors should give this treatment, but I believe that provided a doctor takes primary responsibility for the patient and supervises the assistant closely there should be no difficulty. I would be strongly against anyone, including physiotherapists, other than a doctor treating patients without supervision especially if they came “off the streets” without prior medical referral. The assistance of the nursing staff in the pain clinic was also invaluable for preparing the patient and equipment, although this would be the same with any treatment technique.

Regarding the forms of acupuncture treatment which I utilised at the Clinic; for the vast majority of patients, simple manual needling proved satisfactory, using the minimum number of points. Several combinations were often tried, however, before the most effective was chosen for repeated treatment. Acupuncture is often rejected, in my experience, without adequate trial; which includes a sufficient number of points, a sufficient number of different combinations and a sufficient number of treatments. Electro-acupuncture was only rarely resorted to and often as a way of increasing the effect when a set of points was producing only partial benefit. Then the longer, stronger treatment afforded by electro-acupuncture could enhance the effect and further improvements could be obtained by altering the stimulus frequency. The Pain Clinic purchased a multi-channel electrical stimulator with a point detector for this purpose, and sometimes point detection was used even for manual acupuncture. A change of electrical polarity and the so-called “dense-dispersed waveform” (alternating trains of high and low frequency impulses) were routinely used to avoid adaptation of the patient to the electrical stimulus. TENS was also used on occasion, particularly when electro-acupuncture had proved successful but frequently repeated follow-up treatments were necessary. Then a small portable device was lent to the patient for home use. Patients who had previously failed on TENS were quite often referred for acupuncture and a previous negative outcome seemed not to predict for a negative response to acupuncture. Previous benefit from TENS, however, suggested that acupuncture would be beneficial. This obviously raises the question whether TENS had been used correctly previously. However, I often found it hard to judge this because of insufficiently detailed notes about the electrode placement and choice of stimulation parameters. Auriculotherapy was used occasionally when treatment of bodily points had proved ineffective, and this sometimes converted a patient from “non-responder” to “responder.” Indwelling press needles were used or the more elegant, but expensive, stud with applicator. Treatment with indwelling needles was avoided in patients with valvular heart disease, diabetes, local sepsis or in those receiving treatment with steroids.

Other forms of skin stimulation were used rarely, particular light abrasion with a pointed hammer: the so-called “plum blossom” device. This was particularly useful when a patient needed frequent treatments over a long period, because they could borrow one and use it at home. Massage of acupuncture points was also taught to the patient or spouse, and this was well received. This had several benefits: it involved the patient and family in the treatment process, it reduced the necessity for follow-up visits to the hospital and it could be used to abort attacks of certain conditions, such as migraine, in the early stages.

I found my period in the Pain Clinic an interesting one and I experienced a lot of goodwill from my colleagues. If I were to summarise my experience in the form of advice to anaesthetists or others wishing to provide acupuncture facilities as part of an NHS hospital, what would I say? Firstly, that it is a worthwhile aim. Acupuncture fits well into this setting, providing a good chance of response in many of the conditions commonly seen, often in deeply entrenched cases previously unresponsive to other forms of therapy. A patient who is seen for the first time for chronic pain should be considered for an early trial of acupuncture, which is simple, safe and cheap, either concomitantly or with non-invasive measures like drugs, or sequentially. This may be difficult if acupuncture is seen as “special” therapy practised by one individual, particularly in the large, busy clinic where the hours of attendance of the acupuncturist and the other specialist may be different. By far the best solution is for all pain relief specialists to be trained in the basics of acupuncture. These are easy to pick up and will cover probably 90 percent of eventualities. The remaining 10 percent of cases which require acupuncture but are more technically difficult to treat could be seen by the specialised acupuncture practitioner with greater experience. The follow-up treatment can be carried out by paramedics; indeed these are essential to avoid the clinic bogging down very rapidly. However, the doctor must retain overall control and should review all patients at intervals. It will be necessary to keep accurate and comprehensive records, preferably on a computer database, so the successes and failures of acupuncture in the particular clinic population can be; charted and adjustments to technique made. A policy will need to be defined concerning acceptance of patients with “non chronic pain” conditions such as soft tissue injury, arthritis, obesity and smoking. Word soon gets round local general practitioners and their patients that acupuncture is available at the hospital under the NHS, and referral and self-referral for all these will come direct from the community. It could of course be argued that this should be encouraged; but it will add materially to the caseload.

Finally, hospital practice of acupuncture in any setting offers a marvellous opportunity for clinical research. It is quite amazing how many fundamental
questions remain to be answered about a method of
treatment which has been around for thousands of
years. It needs to be scientifically proven to be
effective in a range of conditions. This proof is
gradually emerging in publications in the medical
literature, at least for the commonest illnesses.
However, the indications for different forms of
acupuncture treatment including electroacupuncture,
the optimal timing of treatment, the optimal
duration and strength of needle stimulation,
methods of predicting prognosis, an explanation for
occasional non-response in a condition which
usually benefits, the effects of concomitant medical
therapy, the possibility of utilising the body's
circadian rhythm to enhance acupuncture's effect,
of course the mechanism of action (really I could go
on indefinitely), all these remain to be elucidated.
It is the duty of persons using acupuncture in hospi-
tal to try to be scientific and at least collect
observational data, or preferably embark on a formal
clinical trial. This is so much more difficult in a pri-
vate or NHS general practice setting. An example of
what can be achieved is the study recently reported
(Christensen, et al, 1989) showing a reduction in
post-operative analgesic requirements (delivered
by a patient/triggered infusion pump) following
acupuncture given during surgery to the
unconscious patient; a neat piece of work, because
it eliminated the problem normally experienced of
providing placebo acupuncture in a double-blind
trial.

**Letter to the Editor**

**BMAS Yellow Pages Scheme**

Dear Sir,
The freedom to inform the public of the availability
of medically qualified acupuncture practitioners has
often been discussed at Committee meetings of the
Society. You, Sir, as Chairman in 1986/87 initiated
contact with the General Medical Council and I
continued this correspondence during 1988/89. The
society also submitted evidence to the Monopolies
Commission.
One of the very few concessions gained was the
approval to have dual insertions in Yellow Pages,
under 'Doctors' as well as 'Acupuncturists'. The
Society commissioned Tele-Impact to provide a
boxed advertisement restricted to full Members of
the Society.
This scheme has not materialised in the Reading
Yellow Pages area for the third year in succession
due to 'lack of support' i.e. less than two doctors
(out of an eligible nine) showing interest.
It may be of interest to ascertain if the scheme has
been successful elsewhere.
Yours faithfully

Sunil P. Liyanage, FRCP
Consultant Rheumatologist
Princess Margaret Hospital
Windsor

**I.C.M.A.R.T. ENCOURAGES FREEDOM
OF MOVEMENT FOR MEMBERS**

The British Medical Acupuncture Society proposed the
following motion at the I.C.M.A.R.T. General Assembly
in Rome on the 19th April 1990:

That individuals belonging to I.C.M.A.R.T. member societies
shall be afforded attendance rights at any scientific or clinical
meeting held by any other member society as if he were a
member of that society.
(This does not imply voting or attendance rights at Annual General,
Business or Committee meetings of any society. Nor does it imply
exemption of any fee due for attendance at a meeting)
The proposal was passed unanimously by the member
society representatives present at the meeting.
It was also agreed to set up a computerised database to hold
the details of forthcoming meetings of member societies and the
names and addresses of individual members to facilitate
circulation of information as widely and rapidly as possible
and to encourage increased attendance at acupuncture
meetings worldwide.

**TELEIMPACT advise us that a total of 47 entries
have been placed in the 1989/90 directories for the
following 15 areas:**

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Additionally, a total of 31 entries are being placed
in the 1990/91 cycle of directories for the following
10 areas:

| Blackburn | London Central | London SE |
| Bournemouth | London North | Manchester South |
| Bristol | London South | Southampton |
| Cardiff | | |

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