Teaching self-acupuncture survey report

Teaching self-acupuncture survey report – by Catrina Davy and John Hughes

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Abstract

Background: People have been teaching self-acupuncture (SA) in the UK since 1977. More recently, a small body of research has been conducted on SA. However, detailed guidelines on teaching and delivery of SA have, so far, not been developed.

Methods: Acupuncturists were invited to participate in an online survey about their experiences of teaching SA. Data from the survey was extracted, analysed using descriptive statistics, and translated in to SA teaching guidelines.

Results: One-hundred and thirty-eight acupuncturists completed the survey. Nineteen per cent of participants had taught SA. The most common symptoms for which acupuncturists taught SA were pain, nausea, anxiety, hot flushes, headaches/migraines and breathlessness. The six most commonly taught acupoints were Large Intestine 4, Stomach 36, Spleen 6, Pericardium 6, Liver 3, and Triple Energiser 5. No participants had received reports of adverse effects from their patients.

Conclusion: Acupuncturists who teach SA find it to be an acceptable and safe option for patients. The presented data has important implications for guiding the practice of SA.

Key words: self acupuncture, home acupuncture, self-care, chronic illness, survey

1. Introduction

Self-acupuncture (SA) teaching was first documented in 1683 [1] and first practiced in the UK in 1977 [2]. SA is a suitable option for people who have a chronic condition where it is either unpractical [3] or too costly [4] to attend regular acupuncture sessions, or when it is given as maintenance in between courses of practitioner-delivered acupuncture [4]. In the UK's National Health Service (NHS), there is a lack of capacity to give patients on going treatments [4], which gives further reason for the need for people to practice SA.

The small body of SA research is growing slowly with all studies so far having positive findings. A randomised controlled trial of 197 breast cancer patients with cancer-related fatigue found SA to be acceptable, feasible and safe as a maintenance treatment; and as effective as acupuncture delivered by an acupuncturist [4]. Two qualitative studies, one of which sought to gain the perspectives of eight patients and eleven practitioners [5] and the other which sought to gain the perspectives of fifteen patients who had been taught SA to manage chronic pain [6] , found SA to be acceptable, safe and manageable. A retrospective audit of 194 cancer patients with hot flushes, who were given a course of acupuncture followed by either SA using semi-permanent needles (n=144) or conventional needles (n=14), found fewer complications in the latter group [7]. An audit of SA in primary care found 10 out of the 15 patients reported successful SA treatments [8]. An audit of 38 patients with musculoskeletal pain found SA effective at reducing pain and improving quality of life [3]. Two case reports both found SA beneficial [9] [10]. A feasibility study examining the use of SA as an alternative to self-harm found it feasible, acceptable to patients and a safe treatment [11].

Some SA studies [2] [3] [9] [5] offer guidance on how to teach SA, however the guidance lack details and it is unclear where the evidence for the guidance is derived. A study which produced

guidance on the delivery of acupuncture to cancer patients includes a section on teaching SA [12]. However, again this is not detailed. Therefore, the authors conducted a survey to understand the SA teaching practices of acupuncturists in the UK with the aim of using the common findings to form guidelines for teaching SA.

2. Methods

2.1. Study design

Invitations to participate in the survey were distributed via the three largest UK professional Acupuncture Associations (the British Medical Acupuncture Society (BMAS); the British Acupuncture Council (BAcC); and the Acupuncture Association of Chartered Physiotherapists (AACP)). The invitation included a web link for acupuncturists to access the survey online. Acupuncturists were invited to participate between October 2019 and February 2020.

The survey asked participants to provide demographic information (including profession and qualifications); if they had taught SA (this was the end of the survey for those who had not taught SA); and information about their SA practices. Information about their SA practices included whether they had prior SA teaching training; how many people they taught SA per month; the number of sessions and length of time taken to teach SA; symptoms people were taught SA to manage; acupoints commonly taught; length of gap between SA teaching session(s) and review session; if consent was obtained; additional materials given to support teaching SA (for example photos or written instructions); and if any adverse events (AEs) had been reported.

2.2. Analysis of data

Data was analysed using descriptive statistics.

2.3. Translation of results into clinical guidelines

The most common, or average, responses were identified. These were discussed by the authors and translated into guidelines to support teaching SA.

3. Results

3.1. Participants characteristics

One-hundred and thirty-eight people completed the survey. The age of participants ranged from 25 to over 65 years old. Forty-eight participants (35%) were 45-55 years old. Ninety-nine participants (72%) were female. One-hundred and twenty-five participants (91%) classed their profession as acupuncturists. Other professions given were: doctor (n=12, 9%); physiotherapist (n=7, 5%); nurse (n=2, 1%); osteopath (n=2, 1%); and other (n=5, 4%) [note, participants were able to select more than one profession].

Sixty-four participants (46%) had a Licence of Acupuncture (LicAc). Fifty-seven participants (41%) had a Bachelor of Science degree (BSc) in acupuncture. Other acupuncture qualifications given were: Postgraduate diploma (n=17, 12%); Master of Science (n=13, 9%); Diploma in acupuncture (n=6, 8%); British Medical Acupuncture Society foundation course (n=5, 3%); Bachelor of Arts (n=4, 2%); Certificate of acupuncture (n=4, 2%); British Acupuncture Council - qualification not specified;

(n=3, 2%); Doctor of Philosophy (n=3, 2%); Master of Acupuncture (n=3, 2%); other (n=3, 2%) [note, participants were able to select more than one qualification].

Table 1. Participants' demographics

Age, years; median (range)	50 (25-65+)
Gender	Number (%)
Female	99 (72)
Male	38 (28)
Prefer not to say	1 (1)
Other	0
Profession of participants	
Acupuncturist	125 (91)
Doctor	12 (9)
Nurse	2 (1)
Osteopath	2 (1)
Physiotherapist	7 (5)
Other	5 (4)
Acupuncture qualifications	
Bachelor of Arts	4 (2)
Bachelor of Science degree	57 (41)
British Acupuncture Council - qualification not specified	3 (2)
British Medical Acupuncture Society foundation course	5 (3)
Certificate of acupuncture	4 (2)
Diploma in acupuncture	6 (4)
Doctor of Philosophy	3 (2)
Licence of Acupuncture	64 (46)
Master of Acupuncture	3 (2)
Master of Science	13 (9)
Postgraduate diploma	17 (12)
Other	3 (2)
Acupuncture governing bodies	
Acupuncture Association of Chartered Physiotherapists	3 (2)
Acupuncture Association of India	1 (1)
Association of Traditional Chinese Medicine	1 (1)
British Academy of Western Medical Acupuncture	1 (1)
British Acupuncture Council	117 (85)
British Medical Acupuncture Society	21 (15)
General Dental Council	1 (1)
Register of Chinese Herbal Medicine	1 (1)
The Acupuncture Society	1 (1)

One hundred and seventeen participants (85%) were members of the BAcC and 21 participants (15%) were members of BMAS. Other governing bodies participants were members of were

Acupuncture Association of Chartered Physiotherapists (AACP) (n=3, 2%); Acupuncture Association of India (AAI) (n=1, 1%); Association of Traditional Chinese Medicine (ATCM) (n=1, 1%); British Academy of Western Medical Acupuncture (BAWMA) (n=1, 1%); General Dental Council (GDC) (n=1, 1%); Register of Chinese Herbal Medicine (RCHM) (n=1, 1%) and The Acupuncture Society (n=1, 1%). One person was not a member of a regulatory body [note, participants were able to select more than one governing body]. See table 1 for a summary of the participants' demographics.

3.2. Summary of results

Twenty-six participants (19%) had taught SA to their patients. Of the 26 participants, 12 participants (46%) were members of the BAcC. Therefore, 10% of the total number of participants who completed the survey were members of the BAcC. Eleven of the 26 participants were members of the BMAS. Therefore, 52% of the total number of participants who completed the survey were members of the BMAS. One participant was a member of each of the following bodies: BAWMA, AACP and AAI. One participant was a member of both the BAcC and BMAS. One participant was not a member of a governing body.

Six participants (33%) who had taught SA had completed SA training (eight participants who did teach SA did not answer this question or subsequent questions). Participants listed twenty symptoms for which they teach SA. The top six symptoms for which people were taught SA were pain (n=10; 56%), nausea (n=7; 39%), anxiety (n=6; 33%), hot flushes (n=6; 33%), headaches/migraines (n=4; 22%) and breathlessness (n=4; 22%). Eleven participants (61%) taught SA in a private clinic; four participants (22%) in a GP practice; 3 participants (12%) at home; two participants (11%) in an NHS hospital; two participants (11%) in a hospice; and one person in a Medicare centre. Seventeen participants (94%) teach at least one person, on average, each month. Fifteen participants (83%) teach SA in one or two sessions. Seventeen participants (94%) give the person they are teaching SA an acupuncture treatment at the same consultation either all the time or sometimes. On average, participants spent 31 minutes teaching SA. The range of time given to teach SA was five to 160 minutes. Twenty-nine acupuncture points were listed as commonly taught points, although seventeen of these were listed by only one participant. The top six most commonly taught were Large Intestine 4 (n=10; 56%); Stomach 36 (n=8; 44%); and Spleen 6 (n=7; 39%); Pericardium 6 (n=5; 28%); Liver 3 (n=4; 22%); and Triple Energiser 5 (n=4; 22%). Participants taught up to six bilateral acupoints at most.

All participants (100%) reviewed the person after they had been taught SA. Twelve participants (67%) reviewed patients one or two weeks after they were taught SA. Seven participants (39%) ask people to sign a consent form before they practise SA. Eleven participants (61%) gave patients written instructions on how to perform SA. Four participants (22%) gave patients written descriptions of the location of the acupuncture points; nine participants (50%) gave patients a photograph of the acupuncture points; nine participants (50%) gave patients a diagram of the acupuncture points; three participants (17%) gave participants a video. Other methods utilised were: 'showing patients in a mirror' and 'draw where to needle with a circle with a surgical marker'.

No participants had any AEs reported to them from the people they taught SA.

3.3. Translation of results into clinical guidelines

The data was analysed and the mean responses to the survey, were identified. These findings were discussed by the authors and translated into the recommendations for teaching SA (see table 2).

Table 2. Recommendations for teaching self-acupuncture

Subject	Recommendation
Number of teaching sessions	• Teach patients over 1-2 sessions
Review of the patient	• Review patient 1-2 weeks after teaching session(s)
Content of SA teaching session	• Allocate 30 minutes to teach SA • It is practical to give people an acupuncture treatment when they are taught SA
Conditions treated	• Consider teaching people SA for the following conditions: ○ pain ○ nausea ○ anxiety ○ hot flushes ○ headaches/migraines ○ breathlessness
Patient information	• Give patients: ○ written instructions and/or ○ photo/diagram of the acupoint to aid learning
Number of points	• Teach up to 6 bilateral acupoints
Acupoints	• Consider teaching the following acupoints: ○ Large Intestine 4 ○ Stomach 36 ○ Spleen 6 ○ Pericardium 6 ○ Liver 3 ○ Triple Energiser 5
Consent form	Ask the patient to complete a consent form prior to practicing SA. The form should include information about minor and major risks
Adverse effects	Ask the patient to report any adverse effects

4. Discussion

The findings suggest that those who teach SA find it an acceptable and safe option to help people to manage a range of symptoms. The guidelines developed will support acupuncturists to teach SA safely and methodically.

Nineteen per cent of participants in the present survey taught SA. The higher than expected number may be due to people being more likely to complete the survey if they taught SA. According to the latest estimates of membership of the professional acupuncture associations [reference for their websites with membership numbers], approximately 4% of the members of the BAcC and 2% of the members of the BMAS completed the survey. Since the response rate is low the authors cannot make conclusions about the proportions of acupuncturists who teach SA in the UK.

There are concerns in some studies that SA is not safe, feasible or acceptable [2] [13] [14]. This may prevent some practitioners from teaching SA. There are some case reports of AEs from practicing SA. However, there is only one report of an AE caused by someone who had received SA training from an acupuncturist [2]. This AE was due to an unusual accident rather than incorrect needling: a girl, who was performing SA, was thrown in the air when someone jumped on the couch she was sitting on, causing the acupuncture needle to break. The girl attended an accident and emergency department for the removal of the needle. There are some cases reporting SA AEs where the person involved had not been taught SA. These include one person requiring surgical removal of a broken acupuncture needle embedded in their medulla oblongata [15]; death of one person who self-administered a needle into the pericardium [16]; one person who inserted a sewing needle into their spinal cord [17]; and one person who inserted a needle through the heart causing a pneumothorax [18]. In addition, a systematic review of case reports of AEs of acupuncture [19] identified no reports of SA AEs during the period between 2000 and 2011, when they conducted the research. In SA studies to date, [3] [4] [7] [9] [10] [11] only minor AEs have been reported, such as, bleeding, bruising, tiredness or pain. In the other SA studies, no AEs were reported [5] [8]. This suggests that, when taught well, SA is a safe option.

Interestingly only 33% of participants who taught SA had received SA training. Despite this, the study identified no differences in the reporting of AEs from those who'd received training in SA compared to those who hadn't, suggesting that it may be safe for acupuncturists to teach patients SA even without formal training in SA.

It is considered that the dose of acupuncture is related to the number of needles used [20]. Therefore, to gain the maximum benefit it is important to teach enough points to get the desired effect but not so many to be overwhelming for the patient. Participants commonly treat up to six acupoints bilaterally. This suggests six bilateral acupoints is a reasonable number for patients to needle. The most commonly taught acupoints were Large Intestine 4, Stomach 36, Spleen 6, Pericardium 6, Liver 3 and Triple Energiser 5. This suggests that participants find them to be effective, easy to teach and safe for SA. Therefore, these acupoints should be considered when teaching SA.

Sixty-one per cent of participants do not ask patients to sign a consent form before they practice SA. However, since there is a risk of AEs if SA is not taught well, the authors recommend that acupuncturists obtain consent to ensure patients are aware of the risks. Additionally, patients should be encouraged to report any AEs they experience so these can be monitored locally.

There are limitations to this study. The small sample size compromises the validity of the findings. However, this is the first time that the opinions of a group of acupuncturists have informed SA teaching guidelines. The quantitative study design was chosen to optimise the response rate. However, this study design limits the depth of data that qualitative research collects. Although the invite to participate in the study was published in the main governing bodies' magazines, the low response rate suggests that members of those governing bodies may not have seen the invite. Additionally, the invite was not published in all UK acupuncture governing bodies' magazines. Excluding the invite from some governing bodies may compromise the findings. A limitation to the survey itself was that participants were not asked if they assessed patients to ascertain competence in, or to identify any contraindications to, practicing SA. Finally, although participants were asked specifically if they had taught SA using needles, the survey did not ask participants to specify whether traditional acupuncture needles or semi-permanent needles or studs were used. Having this information could further inform SA teaching guidelines.

Most SA research is conducted on patients who have received an initial course of acupuncture from a trained acupuncture practitioner. During the course of treatment, the practitioner can assess the benefits and the competence of the patient and identify any contraindications to practice SA. During this process, patients can become familiar with the experience of receiving acupuncture. One case report of someone who had not received an initial course of acupuncture from a trained practitioner before being taught to practice SA had favourable results [10]. The authors suggest that future research examines efficacy, safety and acceptance of teaching SA to people who have not previously had acupuncture.

5. Conclusion

Acupuncturists who teach SA find it to be an acceptable and safe option for patients who are unable to have long term acupuncture delivered by a trained acupuncturist.

Declaration of interests

The authors declare there is no conflict of interests.

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